Covered California 2026 Patient-Centered Benefit Plan Designs¹

Proposed

January 16, 2025

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



ummary of Ben	efits and Coverage	ТМ			
-	amounts describe the Enrollee's out of pocket costs.	Individual-only I Coinsurance		Individual-only F Copay Pla	
tuarial Value - AV	/ Calculator	91.9%		91.6% 91.8	3%
	Plan design includes a deductible?			No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Individual Out–of–pocket maximum	\$4,500 \$5,0	000	\$,4500 \$5,0	000
	Family Out-of-pocket maximum	\$9,000 \$10,	000	\$9,000 \$10,	000
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible			N/A	
Common Medical	Service Type	Member Cost	Deductible Applies	Member Cost	Deductib Applies
Event	Primary care visit to treat an injury, illness, or condition	\$15	Applies	Share \$15	Applies
Health care provider's	Other practitioner office visit	\$15		\$15	
office or clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$15	
Fests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75	
		1070		φισ	
	Tier 1	\$7 \$9		\$7 \$9	
Drugs to treat	Tier 2	\$16		\$16	
liness or	Tier 3	фо <u>г</u>		¢0r	
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 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	
leed		Ŭ		Ŭ	
mmediate	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	
lospital stay	delivery, mental health, and substance use)	10%		5 days	
	Physician/surgeon fee	10%		No charge	
Mental nealth,	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$15	
behavioral nealth, or substance	Mental/behavioral health and substance use disorder other outpatient	A 15		A 15	
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	
lelp	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
ecovering or	Skilled nursing care	10%		\$125 per day up to	
other special lealth needs	-			5 days	
	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
nd Preventive	Sealants per Tooth	. 10 51161 95			
. ovenuve	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		See 2025 Dental	
Services	Periodontal Maintenance Services	_5/0		Copay Schedule	
	Crowns and Casts				
	Endodontics				
Child Dental				See 2025 Dental	
Major Services	Periodontics (other than maintenance)	50%		Copay Schedule	
	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	50%		\$1,000	

-	efits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-on Platinum Coinsurance	ı i	CCSB-on Platinum Copay Pla	í –
tuarial Value - A	/ Calculator	91.3% <u>91.8</u>	<u>8%</u>	90.5% <u>91.1</u>	<u>1%</u>
	Plan design includes a deductible?			No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Individual Out-of-pocket maximum	\$4,500		\$4,500	
	Family Out-of-pocket maximum	\$9,000		\$9,000	
	HSA plan: Self-only coverage deductible			N/A	
Common	HSA family plan: Individual deductible			N/A	
Aedical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deduc Appli
	Primary care visit to treat an injury, illness, or condition	\$15		\$20	
lealth care provider's office or	Other practitioner office visit	\$15		\$20	
ffice or linic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$20	
ests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$100	
	Tier 1	\$10		\$5	
rugs to treat Iness or	Tier 2	\$25		\$20	
ondition	Tier 3	\$40		\$30	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	10%		\$100	
	Physician/surgeon fees	10%		\$25	
ervices	Outpatient visit	10%		10%	
_	Emergency room facility fee (waived if admitted)	\$200		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
leed mmediate	Medical transportation (including emergency and non-emergency)	\$150		\$150	
ittention	Urgent care	\$15		\$20	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	100/		\$250 per day up to	
lospital stay	delivery, mental health, and substance use)	10%		5 days	
	Physician/surgeon fee	10%		No charge	
lental ealth,	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$20	
ehavioral lealth, or substance	Mental/behavioral health and substance use disorder other outpatient	\$15		\$20	
buse needs	items and services				
regnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
lelp	Outpatient Rehabilitation and Habilitation services	\$15		\$20	
ecovering or ther special	Skilled nursing care	10%		\$150 per day up to	
ealth needs	Durable medical equipment	10%		5 days 10%	
	Hospice service				
		No charge		No charge	
hild eye	Eye exam	No charge		No charge	
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
hild Dental	Preventive - X-ray				
nd	Sealants per Tooth	No charge		No charge	
reventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
hild Dental asic	Restorative Procedures	20%		See 2025 Dental	
ervices	Periodontal Maintenance Services			Copay Schedule	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		See 2025 Dental	
Services	Prosthodontics			Copay Schedule	
	Oral Surgery				
hild	Medically necessary orthodontics	50%		\$1,000	

COSL Share	e amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
ctuarial Value - A	AV Calculator	81.5% <u>81.4'</u>	<u>%</u>	81.6% <u>81.7</u>	<u>%</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	D	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	0	\$0 / \$0 / \$	0
	Individual Out-of-pocket maximum	\$8,700	<u>00</u>	\$8,700	00
	Family Out-of-pocket maximum	\$17,400 <u>\$18,4</u>	<u>400</u>	\$17,400 <u>\$18</u> ,	<u>400</u>
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A		N/A N/A	
Common Medical	Service Type	Member Cost Share	Deductible	Member Cost	Deducti
Event	Primary care visit to treat an injury, illness, or condition	\$35 <u>\$40</u>	Applies	Share \$35 <u>\$40</u>	Applie
Health care	Other practitioner office visit	\$35 <u>\$40</u>		\$35 <u>\$40</u>	
provider's office or		\$55 <u>\$40</u>		\$55 <u>\$40</u>	
clinic visit	Specialist visit	\$65 \$70		\$65 \$70	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Fests	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	
liness or					
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 services	Physician/surgeon fees	30%		\$60	
50111000	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					
immediate attention	Medical transportation (including emergency and non-emergency)	\$250		\$250	
attention	Urgent care	\$35		\$35	
	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)			up to 5 days	
	Physician/surgeon fee	30%		No charge	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$35		\$35	
health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$35		\$35	
abuse needs Pregnancy	Prenatal care and preconception visits	No charge		No charge	
ognancy	Home health care (cost share per visit)	20%		\$30	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$35		\$35 <u>\$40</u> \$150 per day up to	
other special	Skilled nursing care	30%		5 days	
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	²			
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures			See 2025 Dental	
Basic Services	Periodontal Maintenance Services	20%		Copay Schedule	
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	50%		See 2025 Dental Copay Schedule	
Services				Copay Schedule	
Services	Prosthodontics				
Services	Prosthodontics Oral Surgery				

2025 2026 Patient-Centered Benefit Plan Designs 10.0 EHB

Date: April 18, 2024 January 16, 2025

mber Cost Share a	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Gold Coinsurance Pla	n	CCSB-only Gold Copay Plan	
tuarial Value - A\	/ Calculator	79.1% 80.2%		80 5% 81 7%	
luariai value - Av	Plan design includes a deductible?	Yes, Medical/Pharm	acy	80.5% 81.7% Yes, Medical/Pharr	nacy
	Integrated Individual deductible	N/A	uoy	N/A	naoy
	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 HSA family plan: Individual deductible	N/A N/A		N/A N/A	
Common Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
Event	Primary care visit to treat an injury, illness, or condition	\$25		\$35	
Health care					
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	х
	Tier 1	\$15		\$15	
Drugs to treat illness or	Tier 2	\$50		\$40	
condition	Tier 3	\$80		\$70	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$300	Х
Outpatient services	Physician/surgeon fees	20%		\$35	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	20%	х	\$250	х
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	20%	x	\$250	х
immediate attention	Urgent care	\$25		\$35	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee	20%	x x	\$600 per day up to 5 days No charge	Х
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$25		\$35	
behavioral health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$25		\$35	
abuse needs Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Holp	Outpatient Rehabilitation and Habilitation services	\$25		\$35	
Help recovering or	Skilled nursing care	20%	x	\$300 per day up to 5 days	х
other special health needs	-		^		A
	Durable medical equipment	20%		20%	
	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	No charge		No charge	
and Preventive	Sealants per Tooth	g -		5 -	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
	Restorative Procedures	20%		See 2025 Dental Copay	
		20%		Schedule	
Basic	Periodontal Maintenance Services				
Child Dental Basic Services	Periodontal Maintenance Services Crowns and Casts				
Basic Services					
Basic Services Child Dental Major	Crowns and Casts	50%		See 2025 Dental Copay	
Basic Services Child Dental	Crowns and Casts Endodontics	50%		See 2025 Dental Copay Schedule	
Basic Services Child Dental Major	Crowns and Casts Endodontics Periodontics (other than maintenance)	50%			

Summary of Benefits and Coverage

	amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	
tuarial Value - A\	/ Calculator	71.6% 71.7%	
luariai value - Av		Yes, Medical/Pharm	2014
	Plan design includes a deductible? Integrated Individual deductible	N/A	acy
	Integrated Individual deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,400 <u>\$5,200</u> / \$50	/ \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,800 <u>\$10,400</u> / \$10	
	Individual Out-of-pocket maximum	\$8,700 <u>\$9,800</u>	,
	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	Service Type	Member Cost Share	Deductib Applies
Event	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	
Fests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	<u>\$18 §19</u>	
		+ · - <u>+ · -</u>	Dham
Drugs to treat	Tier 2	\$60	Pharma deductik
Iness or condition	Tier 3	\$90	Pharma
Jonantion			deductik
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductit
	Surgery facility fee (e.g., ASC)	30%	
Dutpatient	Physician/surgeon fees	30%	
services			
	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need mmediate	Medical transportation (including emergency and non-emergency)	\$250	
attention			
	Urgent care	\$50	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	×
Hospital stay	delivery, mental health, and substance use)	30%	Х
	Physician/surgeon fee	30%	
Vental nealth,	Mental/behavioral health and substance use disorder outpatient office	\$50	
behavioral	visits	ψ00	
nealth, or substance	Mental/behavioral health and substance use disorder other outpatient	¢50	
abuse needs	items and services	\$50	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$50	
ecovering or		30%	x
other special nealth needs	Skilled nursing care		X
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental	Preventive - X-ray		
Diagnostic and		No charge	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Sasic Services	Periodontal Maintenance Services	2070	
	Crowns and Casts		
	Endodontics		
	Periodontics (other than maintenance)	50%	
Child Dental Major Services	Periodontics (other than maintenance)	50%	
Major	Periodontics Prosthodontics Oral Surgery	50%	

2025 2026 Patient-Centered Benefit Plan Designs 10.0 EHB

Date: April 18, 2024 January 16, 2025

-	efits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Silver Coinsurance Plar	1	CCSB-only Silver Copay Plan	
tuarial Value - A\	/ Calculator	69.5% 70.9%		69.1% 70.5%	
	Plan design includes a deductible?		асу	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	5	N/A	,
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,500 / \$300 / \$0	1	\$2,500 / \$300 / \$0)
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,000 / \$600 / \$0	1	\$5,000 / \$600 / \$0)
	Individual Out-of-pocket maximum	\$8,600		\$8,750	
	Family Out-of-pocket maximum	\$17,200		\$17,500	
	HSA plan: Self-only coverage deductible			N/A	
Common	HSA family plan: Individual deductible	N/A	Deductible	N/A	Daduati
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductil Applie
lealth agra	Primary care visit to treat an injury, illness, or condition	\$55		\$55	
lealth care provider's office or	Other practitioner office visit	\$55		\$55	
linic visit	Specialist visit	\$90		\$90	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$55		\$55	
ests	X-rays and Diagnostic Imaging	\$90		\$90	
	Imaging (CT/PET scans, MRIs)	35%	х	\$300	х
			λ		X
	Tier 1	\$20		\$19	
orugs to treat	Tier 2	\$75	Pharmacy	\$85	Pharm
Iness or	Tier 2		deductible Pharmacy		deducti Pharm
ondition	Tier 3	\$105	deductible	\$110	deducti
	Tier 4	30% up to \$250 per script after pharmacy deductible	Pharmacy deductible	30% up to \$250 per script after pharmacy deductible	Pharm deducti
	Surgery facility fee (e.g., ASC)	35%	х	35%	х
Outpatient	Physician/surgeon fees	35%		35%	
ervices	Outpatient visit	35%		35%	
	Emergency room facility fee (waived if admitted)	35%	х	35%	х
			^		^
	Emergency room physician fee (waived if admitted)	No charge		No charge	
leed mmediate ttention	Medical transportation (including emergency and non-emergency)	35%	х	35%	Х
	Urgent care	\$55		\$55	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	35%	х	35%	х
iospital stay	Physician/surgeon fee	35%	х	35%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$55		\$55	
nealth, 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	
lelp	Outpatient Rehabilitation and Habilitation services	\$55		\$55	
ecovering or	Skilled nursing care	35%	х	35%	х
other special nealth needs	Durable medical equipment	35%	-	35%	
	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	No oborg-		No shore-	
nd Preventive	Sealants per Tooth	No charge		No charge	
revenuve	Topical Fluoride Application				
	Space Maintainers - Fixed				
hild Dental	Restorative Procedures				
Basic		20%		See 2025 Dental Copay Schedule	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics			Son 2025 D+-1 C	
Major	Periodontics (other than maintenance)	50%		See 2025 Dental Copay Schedule	
Services	Prosthodontics				
	Oral Surgery				
		1			

	nefits and Coverage	CCSB-o	niy
-	amounts describe the Enrollee's out of pocket costs.	Silver HDHP P	r T
			Idii
Actuarial Value - A	✓ Calculator	71.2% <u>70</u>	.7%
	Plan design includes a deductible?	Yes, integ	rated
	Integrated Individual deductible	\$2,850	integrated
	Integrated Family deductible	\$5,700	integrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Individual Out-of-pocket maximum	\$7,500 <u>\$8</u>	
	Family Out-of-pocket maximum		
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	\$2,850 See endr	
Common			
Medical Event	Service Type	Member Cost Share	Deductible Applies
Event	Primary care visit to treat an injury, illness, or condition	25%	х
Health care		2070	~
provider's office or	Other practitioner office visit	25%	Х
clinic visit	Specialist visit	25%	х
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	25%	х
Tests	X-rays and Diagnostic Imaging	25%	x
	Imaging (CT/PET scans, MRIs)	25%	х
	Tier 1	25% up to \$250 per	x
		script	~
Drugs to treat	Tier 2	25% up to \$250 per script	х
illness or condition	Tier 3	25% up to \$250 per	x
		script	
	Tier 4	25% up to \$250 per script	х
	Surgery facility fee (e.g., ASC)	25%	х
Outpatient	Physician/surgeon fees	25%	x
services	Outpatient visit	25%	x
	Emergency room facility fee (waived if admitted)	25%	x
			x
Need	Emergency room physician fee (waived if admitted)	0%	
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
	Physician/surgeon fee	25%	х
Mental	Mental/behavioral health and substance use disorder outpatient office	259/	х
health, behavioral	visits	25%	~
health, or substance	Mental/behavioral health and substance use disorder other outpatient	250/	x
abuse needs	items and services	25%	~
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
		25%	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	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth	-	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Services	Periodontal Maintenance Services	2070	
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	50%	
Orthodontics			

Summary of Benefits and Coverage

Silver Plan Silver Plan Member Cost Share amounts describe the Enrollee's out of pocket costs. 100%-150% FPL 150%-200% FPL Actuarial Value - AV Calculator 94.7% <u>94.8%</u> 88.0% <u>87.8%</u> Plan design includes a deductible? Yes, Medical/Pharmacy Yes, Medical/Pharmacy Integrated Individual deductible N/A N/A Integrated Family deductible N/A N/A \$1,400 / \$350 <u>\$50</u> / \$0 Individual deductible, NOT integrated: Medical / Pharmacy / Dental \$0 / \$0 / \$0 Family deductible, NOT integrated: Medical / Pharmacy / Dental \$0 / \$0 / \$0 \$2,800 / \$700 \$100 / \$0 Individual Out-of-pocket maximum \$,1300 \$1,400 \$3,050 \$3,350 Family Out-of-pocket maximum \$2,600 <u>\$2,800</u> \$6,100 <u>\$6,700</u> N/A HSA plan: Self-only coverage deductible N/A N/A HSA family plan: Individual deductible N/A Common Medical Member Cost Share Deductible Applies Deductible Applies Service Type Member Cost Share Event Primary care visit to treat an injury, illness, or condition \$5 \$15 Health care provider's office or Other practitioner office visit \$5 \$15 clinic visit Specialist visit \$8 \$25 Preventive care/ screening/ immunization No charge No charge \$8 \$10 Laboratory Tests \$20 \$30 Tests X-rays and Diagnostic Imaging \$8 \$10 <u>\$40</u> \$50 Imaging (CT/PET scans, MRIs) \$100 \$50 Tier 1 \$3 \$8 Pharmacy Tier 2 \$10 \$25 Drugs to treat deductible illness or Pharmacv condition Tier 3 \$15 \$45 . deductible 10% up to \$150 p Pharmacy Tier 4 15% up to \$150 per script deductible script Surgery facility fee (e.g., ASC) 10% 20% Outpatient services Physician/surgeon fees 10% 20% Outpatient visit 10% 20% Emergency room facility fee (waived if admitted) <u>\$150</u> \$200 \$50 Emergency room physician fee (waived if admitted) No charge No charge Medical transportation (including emergency and non-emergency) Need \$30 \$75 immediate ttention Urgent care \$5 \$15 Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) 10% 20% Х Х Hospital stay Physician/surgeon fee 10% 20% Mental Mental/behavioral health and substance use disorder outpatient office \$5 \$15 health. visits behavioral health, or Mental/behavioral health and substance use disorder other outpatient substance \$5 \$15 items and services abuse needs Prenatal care and preconception visits No charge Pregnancy No charge Home health care (cost share per visit) \$3 \$15 Outpatient Rehabilitation and Habilitation services \$5 \$15 Help recovering or Skilled nursing care 20% 10% х х other special health needs Durable medical equipment 10% 15% Hospice service No charge No charge Eye exam No charge No charge Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Oral Exam Preventive - Cleaning Child Dental Preventive - X-ray Diagnostic No charge No charge and Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed Child Dental Restorative Procedures 20% 20% Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Child Dental Major Services Periodontics (other than maintenance) 50% 50% Prosthodontics Oral Surgery Child Medically necessary orthodontics 50% 50%

mber Cost Share a	amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPI	_
tuarial Value - A\	/ Calculator	73.9%	
	Plan design includes a deductible?	Yes, Medical/Pharm	nacy
	Integrated Individual deductible	N/A	-
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,400	<mark>50</mark> / \$0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,800	<u>\$100</u> / \$0
	Individual Out–of–pocket maximum	\$7,350	
	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	
Health care provider's	Other practitioner office visit	\$35	
office or		# 05 # 00	
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	\$20	
	Tier 2	*	Pharma
Drugs to treat illness or	Tier 2	\$55	deductik
condition	Tier 3	\$85	Pharma deductik
	Tier 4	20% up to \$250 per script	Pharma
	Tier 4	after pharmacy deductible	deductil
Outpatient	Surgery facility fee (e.g., ASC)	30%	
services	Physician/surgeon fees	30%	
	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$350 \$400	
Veed	Emergency room physician fee (waived if admitted)	No charge	
	Medical transportation (including emergency and non-emergency)	\$250	
immediate attention			
attention	Urgent care	\$35	
		ψοσ	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	200/	x
Hospital stay	delivery, mental health, and substance use)	30%	^
	Physician/surgeon fee	30%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$35	
behavioral	visits		
health, or substance 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	Skilled nursing care	30%	x
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		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	NIL	
and Preventive	Sealants per Tooth	No charge	
reventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	20%	
00111003	Crowns and Casts		
	Endodontics		
Child Dental		E00/	
Major Services	Periodontics (other than maintenance)	50%	
	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	50%	

2025 2026 Patient-Centered Benefit Plan Designs 10.0 EHB

Date: April 18, 2024 January 16, 2025 Summary of Benefits and Coverage

mber Cost Share a	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Plar	a
tuarial Value - AV	/ Calculator	63.6% <u>63.5%</u>		64.9% 64.89	<u>%</u>
	Plan design includes a deductible?	Yes, Medical/Pharn	nacy	Yes, integrat	
	Integrated Individual deductible	N/A	,	\$6,650 integra	
	Integrated Family deductible	N/A		\$13,300 integrated	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,800 / \$450 / \$	50	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$11,600 / \$900 /	\$0	N/A	
	Individual Out–of–pocket maximum	\$8,850 \$9,800		\$6,650 \$7,20	00
	Family Out-of-pocket maximum	\$1,7700 \$19,60	0	\$13,300 \$14,4	400
	HSA plan: Self-only coverage deductible	N/A		\$6,650	
	HSA family plan: Individual deductible	N/A		\$6,650	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deduct Applie
	Primary care visit to treat an injury, illness, or condition	\$60		0%	х
lealth care provider's	Other practitioner office visit	\$60		0%	x
office or clinic visit	Specialist visit	\$95	After 1st three non-	0%	v
chinic visit			preventive visits		x
_	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40 \$50		0%	X
lests .	X-rays and Diagnostic Imaging	40%	x	0%	х
	Imaging (CT/PET scans, MRIs)	40%	x	0%	х
	Tier 1	\$19 \$20		0%	х
			Dhormos		
Drugs to treat	Tier 2	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	х
illness or condition	Tier 3	40% up to \$500 per script after	Pharmacy	0%	x
		pharmacy deductible	Deductible		~
	Tier 4	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	х
	Surgery facility fee (e.g., ASC)	40%	x	0%	x
Outpatient					
services	Physician/surgeon fees	40%	X	0%	х
	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%	X
	Medical transportation (including emergency and non-emergency)	40%	x	0%	x
immediate attention					
	Urgent care	\$60		0%	x
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	40%	x	0%	x
Hospital stay	delivery, mental health, and substance use)	40%	^	0%	^
	Physician/surgeon fee	40%	х	0%	Х
Mental	Mental/behavioral health and substance use disorder outpatient office	\$60		0%	x
health, behavioral	visits	φου		078	~
health, or substance	Mental/behavioral health and substance use disorder other outpatient	A AA			
abuse needs	items and services	\$60		0%	Х
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	x	0%	X
Help	Outpatient Rehabilitation and Habilitation services	\$60		0%	х
recovering or other special	Skilled nursing care	40%	x	0%	x
health needs	Durable medical equipment	40%	x	0%	x
			^		x
	Hospice service	No charge		0%	X
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray				
and	Sealants per Tooth	No charge		No charge	
Preventive	' Topical Fluoride Application				
Child Dentel	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		20%	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dr. 1	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		50%	
Services	Prosthodontics				
	Oral Surgery				1

2025 <u>2026</u> Patient-Centered Benefit Plan Designs 10.0 EHB Date: April 18, 2024 <u>January 16, 2025</u>

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Catast	rophic Plan
	·		
ctuarial Value - A	V Calculator		
	Plan design includes a deductible?		integrated
	Integrated Individual deductible		9,800 integrated
	Integrated Family deductible	\$18,400 <u>\$1</u>	<u>19,600</u> integrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Individual Out-of-pocket maximum		\$9,200
	Family Out-of-pocket maximum		18,400
	HSA plan: Self-only coverage deductible		N/A
	HSA family plan: Individual deductible		N/A
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non- preventive visits
Health care provider's office or	Other practitioner office visit	0%	After 1st three non preventive visits
clinic visit	Specialist visit	0%	х
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	х
Tests	X-rays and Diagnostic Imaging	0%	х
	Imaging (CT/PET scans, MRIs)	0%	х
	Tier 1	0%	x
		0%	A
Drugs to treat	Tier 2	0%	х
illness or condition	Tier 3	0%	х
	Tier 4	0%	х
	Surgery facility fee (e.g., ASC)	0%	x
Outpatient	Physician/surgeon fees	0%	x
services	Outpatient visit	0%	х
	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)		X
immediate attention	medical transportation (including energency and non-energency)	0%	X
	Urgent care	0%	After 1st three non- preventive visits
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	0%	х
Hospital stay	delivery, mental health, and substance use)		
•• • •	Physician/surgeon fee	0%	Х
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three non preventive visits
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	0%	х
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	х
Help	Outpatient Rehabilitation and Habilitation services	0%	х
recovering or other special	Skilled nursing care	0%	х
health needs	Durable medical equipment	0%	x
	Hospice service	0%	x
	Eye exam	No charge	~
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	х
	oral Exam	0 %	^
Child Dental	Preventive - Cleaning		
Diagnostic and	Preventive - X-ray	No charge	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	0%	х
Services	Periodontal Maintenance Services	- / 0	~
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	0%	х
Services	Prosthodontics		
	Oral Surgery		

mber Cost Share a	amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Sil 100%-1509		CA Enh CSR Silver 8 150%-200% FPL	
tuarial Value - AV	/ Calculator	95.1%	5	88.9%	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /	\$0	\$0 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /	\$0	\$0 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$1,150	0	\$3,000	
	Family Out-of-pocket maximum	\$2,300	0	\$6,000	
	HSA plan: Self-only coverage deductible	N/A		N/A	
Common	HSA family plan: Individual deductible	N/A		N/A	
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
le althe anna	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
ealth care rovider's	Other practitioner office visit	\$5		\$15	
office or clinic visit	Specialist visit	\$8		\$25	
inne visit					
_	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8		\$20	
Tests	X-rays and Diagnostic Imaging	\$8		\$40	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$5	
	Tier 2	* **		AC-	
orugs to treat Iness or	Tier 2	\$10		\$25	
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	
leed mmediate	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%	
lospital stay	delivery, mental health, and substance use) Physician/surgeon fee	10%		20%	
Mental nealth, pehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
ealth, or substance sbuse 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	
lelp	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
ecovering or	Skilled nursing care	10%		20%	
ther special ealth needs	-				
	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
hild eye	Eye exam	No charge		No charge	
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
hild Dental	Preventive - X-ray				
nd	Sealants per Tooth	No charge		No charge	
reventive	Topical Fluoride Application				
hild Dental	Space Maintainers - Fixed				
Basic	Restorative Procedures	20%		20%	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
/lajor	Periodontics (other than maintenance)	50%		50%	
Services	Prosthodontics				
	Oral Surgery				

/ Calculator	79.2%	
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	
	N/A N/A	
Service Type	Member Cost Share	Deductibl Applies
Primary care visit to treat an injury, illness, or condition	\$35	Applies
Other practitioner office visit	\$35	
	φ33	
Specialist visit	\$85	
Preventive care/ screening/ immunization	No charge	
Laboratory Tests	\$50	
X-rays and Diagnostic Imaging	\$95	
Imaging (CT/PET scans, MRIs)	\$325	
Tier 1	\$15	
Tier 2	\$55	
	ψυυ	
Tier 3	\$85	
Tier 4	20% up to \$250 per script	
Surgery facility fee (e.g., ASC)	30%	
Physician/surgeon fees	30%	
Outpatient visit	30%	
Emergency room facility fee (waived if admitted)	\$350	
	Ū.	
	φ230	
Urgent core	¢ог	
orgeni care	\$3D	
Facility fee (e.g. hospital room) for inpatient stay (including labor and	30%	
Physician/surgeon ree	30%	
Mental/behavioral health and substance use disorder outpatient office visits	\$35	
Mental/behavioral health and substance use disorder other outpatient items and services	\$35	
Prenatal care and preconception visits	No charge	
	\$40	
-		
Durable medical equipment	20%	
Hospice service	No charge	
Eye exam	No charge	
1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
Oral Exam		
Preventive - Cleaning		
Preventive - X-ray	No observo	
Sealants per Tooth	no charge	
Topical Fluoride Application		
Space Maintainers - Fixed		
Restorative Procedures		
Periodontal Maintenance Services	20%	
Crowns and Casts		
Endodontics		
	50%	
	0070	
Prosthodontics		
Prosthodontics Oral Surgery		
	Plan design includes a deductible Integrated Individual deductible Individual deductible, NOT integrated: Kedical / Pharmacy / Dental Family deductible, NOT integrated: Kedical / Pharmacy / Dental Family deductible, NOT integrated: Kedical / Pharmacy / Dental Family deductible, NOT integrated: Kedical / Pharmacy / Dental Family deductible, NOT integrated: Kedical / Pharmacy / Dental Family deductible, NOT integrated: Kedical / Pharmacy / Dental Family deductible, NOT integrated: Kedical / Pharmacy / Dental Family deductible, NOT integrated: Kedical / Pharmacy / Dental Family care visit to treat an injury, illness, or condition Other practitioner office visit Preventive care/ screening/ mmunization Faray and Diagnostic imaging inging (CT/PET scans, MRIs) Ter 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees Outgetant visit Faregroup com facility fee (waived if admitted) Medical transportation (including emergency and non-emergency) Physician/surgeon fee Notarisurgeon fee Physician/surgeon fee Notarisurgeon fee Notarisurgeon fee Notarisurgeon fee Notarisurgeon fee <	Pin design nucluies a deductionNot Insignated EnduitationIndividual deductible, NOT integrated: Madical / Pharmacy / DealASX / SV / SV / SVIndividual deductible, NOT integrated: Madical / Pharmacy / DealASX / SV / SV / SVIndividual deductible, NOT integrated: Madical / Pharmacy / DealMaxIndividual deductible, NOT integrated: Markal / Pharmacy / DealMaxIndividual deductible / NOT Instrumed deductibleMaxIndividual deductible / NOT Instrumed deductibleMaxIndividual deductible / NOT Instrumed deductibleMaxIndividual deductible / NOT Instrumed deductibleMaxPrimary care vialt to treat an injury. Intersor occoditionSistematPreventive and screening / ImmunizationNo charge ImmunizationSistematLaboratory TestsSistematSistematPreventive and screening / ImmunizationSistematSistematInter 1SistematSistematInter 2SistematSistematInter 3SistematSistematInter 4SistematSistematInter 4SistematSistematInter 4SistematSistematInter 5SistematSistematInter 5SistematSistematInter 5SistematSistematInter 5SistematSistematInter 5SistematSistematInter 5SistematSistematInter 5SistematSistematInter 5SistematSistematInter 6Sistem



immarv of Ben	efits and Coverage		1			
-	amounts describe the Enrollee's out of pocket costs.	Individual-only Platinum Coinsurance Plan		Individual-only Platinum Copay Plan		
tuarial Value - A\	/ Calculator	91.9%		91.6% 91.8	3%	
					<u>770</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	
					000	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			N/A N/A		
Common Medical		Member Cost	Deductible	Member Cost	Deducti	
Event	Service Type	Share	Applies	Share	Applie	
lealth care	Primary care visit to treat an injury, illness, or condition	\$15		\$15		
orovider'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		
ests	X-rays and Diagnostic Imaging					
0313		\$30		\$30		
	Imaging (CT/PET scans, MRIs)	10%		\$75		
	Tier 1	\$7 \$9		\$7 \$9		
Orugs to treat	Tier 2	\$16		\$16		
Iness or	Tier 3	¢つE		¢or		
ondition		\$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						
ervices	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		
leed mmediate Ittention	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		
lospital stay	delivery, mental health, and substance use)	10%		5 days		
	Physician/surgeon fee	10%		No charge		
lental	Mental/behavioral health and substance use disorder outpatient office					
ealth, behavioral	visits	\$15		\$15		
nealth, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$15		
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	10%		\$20		
lelp	Outpatient Rehabilitation and Habilitation services	\$15		\$15		
ecovering or other special	Skilled nursing care	10%		\$125 per day up to 5 days		
ealth needs	Durable medical equipment	10%		10%		
	Hospice service	No charge		No charge		
Child eye	Eye exam	No charge		No charge		
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
	Preventive - Cleaning					
hild Dental	•					
Diagnostic	Preventive - X-ray	Not Covered		Not Covered		
nd 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					
	oral ourgory					
Child						

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-on Platinum Coinsurance	ı İ	CCSB-on Platinum Copay Pla	ı İ
		Comsulance	FIGII	Copay Fia	
tuarial Value - A\	/ Calculator	91.3% <u>91.8</u>	<u>3%</u>	90.5% <u>91.1</u>	<u>%</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 / \$	
	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	
	HSA plan: Self-only coverage deductible			N/A N/A	
Common	HSA family plan: Individual deductible	Member Cost	Deductible	Member Cost	Deduct
Medical Event	Service Type	Share	Applies	Share	Appli
la althua an	Primary care visit to treat an injury, illness, or condition	\$15		\$20	
Health care provider's office or clinic visit	Other practitioner office visit	\$15		\$20	
	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$20	
Fests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$100	
	Tier 1	\$10		\$5	
Drugs to treat Ilness or	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	
Dutpatient	Physician/surgeon fees	10%			
ervices				\$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 mmediate attention	Medical transportation (including emergency and non-emergency)	\$150		\$150	
	Urgent care	\$15		\$20	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%		\$250 per day up to	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	10%		5 days No charge	
Mental nealth, pehavioral	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	
lain	Outpatient Rehabilitation and Habilitation services	\$15		\$20	
Help recovering or				\$20 \$150 per day up to	
other special nealth needs	Skilled nursing care	10%		5 days	
iounti needs	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	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					
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				

	a mounts describe the Enrollee's out of pocket costs.	Coinsurance	Plan	Copay Pla	In
tuarial Value - A	AV Calculator	81.5% <u>81.4'</u>	<u>%</u>	81.6% <u>81.7</u>	<u>'%</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	\$8,700	<u>00</u>	\$8,700	<u>:00</u>
	Family Out-of-pocket maximum	\$17,400 <u>\$18,4</u>	<u>400</u>	\$17,400 <u>\$18</u> ,	400
	HSA plan: Self-only coverage deductible			N/A	
Common	HSA family plan: Individual deductible	N/A		N/A	
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deducti Applie
Health care	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
provider's	Other practitioner office visit	\$35		\$35	
clinic visit	Specialist visit	\$65 \$70		\$65 \$70	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
ſests					
0010	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	
Iness or condition	Tier 3	\$85		\$85	
onunion		20% up to \$250 per		20% up to \$250 per	
	Tier 4	script		script	
Vutnotiont	Surgery facility fee (e.g., ASC)	30%		\$130	
Dutpatient services	Physician/surgeon fees	30%		\$60	
	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	
mmediate	······································	\$200		\$200	
attention	Urgent care	\$35		\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	30%		\$350 \$375 per day	
lospital stay	delivery, mental health, and substance use)			up to 5 days	
	Physician/surgeon fee	30%		No charge	
/lental lealth,	Mental/behavioral health and substance use disorder outpatient office visits	\$35		\$35	
ehavioral	VISIIS				
ealth, or substance subse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35		\$35	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
lolp	Outpatient Rehabilitation and Habilitation services	\$35		\$35	
lelp ecovering or				\$150 per day up to	
other special	Skilled nursing care	30%		5 days	
ealth needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	-			
	Preventive - Cleaning				
hild Dental	-				
)iagnostic Ind	Preventive - X-ray	Not Covered		Not Covered	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	NIC		NHO	
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dental		Not Ocurry 1		Not Course 1	
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	

2025 2026 Patient-Centered Benefit Plan Designs 9.5 EHB

Date: April 18, 2024 January 16, 2025

-	efits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Gold		CCSB-only Gold	
bor Oost Griare a		Coinsurance Pla	n	Copay Plan	
tuarial Value - AV	/ Calculator	79.1% <u>80.2%</u>		80.5% <u>81.7%</u>	
	Plan design includes a deductible?	Yes, Medical/Pharm	acy	Yes, Medical/Pharmacy	
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A \$350 / \$0 / \$0		N/A \$250 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$700 / \$0 / \$0		\$500 / \$0 / \$0	
	Individual Out–of–pocket maximum	\$7,800		\$7,800	
	Family Out-of-pocket maximum	\$15,600		\$15,600	
	HSA plan: Self-only coverage deductible	N/A		N/A	
Common	HSA family plan: Individual deductible	N/A	Deductible	N/A	Deductib
Medical Event	Service Type	Member Cost Share	Applies	Member Cost Share	Applies
lealth care	Primary care visit to treat an injury, illness, or condition	\$25		\$35	
provider's	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	х
	Tier 1	\$15		\$15	
	Tier 2				
Drugs to treat liness or		\$50		\$40 \$70	
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	Х
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 mmediate	Medical transportation (including emergency and non-emergency)	20%	x	\$250	х
attention	Urgent care	\$25		\$35	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee	20%	x x	\$600 per day up to 5 days No charge	х
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$25		\$35	
behavioral health, or substance	visits Mental/behavioral health and substance use disorder other outpatient	\$25		\$35	
abuse needs	items and services				
Pregnancy	Prenatal care and preconception visits Home health care (cost share per visit)	No charge 20%		No charge \$30	
	Outpatient Rehabilitation and Habilitation services	\$25		\$35	
Help recovering or					
other special nealth needs	Skilled nursing care	20%	X	\$300 per day up to 5 days	Х
icanii neeus	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				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
nd Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	Not Covered		Not Opvored	
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
Child Dentel	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
	- ·				

mber Cost Share a	amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	r Plan
tuarial Value - A\		71.6% <u>71.7%</u>	
	Plan design includes a deductible?	Yes, Medical/Pharm	lacy
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	1.00
	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	007\$0
	Individual Out–of–pocket maximum	\$ 8,700 <u>\$9,800</u>	
	Family Out-of-pocket maximum	\$17,400 <u>\$19.600</u>	<u>)</u>
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A	
Common			Deductib
Medical Event	Service Type	Member Cost Share	Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$50	
provider's	Other practitioner office visit	\$50	
office or clinic visit	Specialist visit	\$90	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Toete			
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$18	
	Tier 2	\$60	Pharma
Drugs to treat Ilness or		\$0U	deductib
condition	Tier 3	\$90	Pharma deductib
	T	20% up to \$250 per script	Pharma
	Tier 4	after pharmacy deductible	deductib
	Surgery facility fee (e.g., ASC)	30%	
Outpatient	Physician/surgeon fees	30%	
services	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	\$250	
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)	30%	
Mental	Physician/surgeon fee	30%	
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$50	
behavioral health, or	Visito		
substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$50	
abuse needs		No oborgo	
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%	х
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
	- Eye exam	No charge	
Child eye care		-	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth	1101 0010100	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	' Restorative Procedures		
Basic		Not Covered	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		
			1

2025 2026 Patient-Centered Benefit Plan Designs 9.5 EHB

Date: April 18, 2024 January 16, 2025

•	efits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Silver Coinsurance Plan	1	CCSB-only Silver Copay Plan	
tuarial Value - A	V Calculator	69.5% <u>70.9%</u>		69.1% 70.5%	
	Plan design includes a deductible?	Yes, Medical/Pharma	acv	Yes, Medical/Pharmacy	
	Integrated Individual deductible	N/A)	N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,500 / \$300 / \$0		\$2,500 / \$300 / \$0	D
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,000 / \$600 / \$0		\$5,000 / \$600 / \$0	0
	Individual Out–of–pocket maximum	\$8,600		\$8,750	
	Family Out-of-pocket maximum	\$17,200		\$17,500	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductil Applies
	Primary care visit to treat an injury, illness, or condition	\$55		\$55	
Health care		A			
provider's office or	Other practitioner office visit	\$55		\$55	
clinic visit	Specialist visit	\$90		\$90	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$55		\$55	
Fests	X-rays and Diagnostic Imaging	\$90		\$90	
	Imaging (CT/PET scans, MRIs)	35%	Х	\$300	Х
	Tier 1	\$20		\$19	
	Tier 2	<u>ሱ ግ ር</u>	Pharmacy	¢05	Pharm
Drugs to treat Ilness or		\$75	deductible	\$85	deducti
condition	Tier 3	\$105	Pharmacy deductible	\$110	Pharm deducti
	Tier 4	30% up to \$250 per script after	Pharmacy	30% up to \$250 per script after	Pharm
		pharmacy deductible	deductible	pharmacy deductible	deducti
	Surgery facility fee (e.g., ASC)	35%	Х	35%	х
Outpatient services	Physician/surgeon fees	35%		35%	
	Outpatient visit	35%		35%	
	Emergency room facility fee (waived if admitted)	35%	х	35%	х
			~		~
Need	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate attention	Medical transportation (including emergency and non-emergency)	35%	Х	35%	Х
	Urgent care	\$55		\$55	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	35%	х	35%	х
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	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$55		\$55	
other special	Skilled nursing care	35%	Х	35%	Х
health needs	Durable medical equipment	35%		35%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	7 1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	i to shargo		i to oridi go	
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 Services	Periodontal Maintenance Services	Not Covered		Not Covered	
03111003	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				

	nefits and Coverage	CCSB-o	niv
-	amounts describe the Enrollee's out of pocket costs.	Silver	
		HDHP P	lan
Actuarial Value - A	V Calculator	71.2% <u>70</u>	<u>.7%</u>
	Plan design includes a deductible?	Yes, integr	ated
	Integrated Individual deductible	\$2,850 <u>\$3,200</u> i	ntegrated
	Integrated Family deductible	\$5,700	ntegrated
	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	Service Type	Member Cost Share	Deductible Applies
Event	Primary care visit to treat an injury, illness, or condition	25%	х
Health care		2370	~
provider's office or	Other practitioner office visit	25%	Х
clinic visit	Specialist visit	25%	х
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	25%	х
Tests	X-rays and Diagnostic Imaging	25%	х
	Imaging (CT/PET scans, MRIs)	25%	х
	Tier 1	25% up to \$250 per	x
		script	٨
Drugs to treat	Tier 2	25% up to \$250 per script	х
illness or condition	Tier 3	25% up to \$250 per	х
		script	
	Tier 4	25% up to \$250 per script	Х
	Surgery facility fee (e.g., ASC)	25%	Х
Outpatient	Physician/surgeon fees	25%	х
services	Outpatient visit	25%	х
	· Emergency room facility fee (waived if admitted)	25%	х
	Emergency room physician fee (waived if admitted)	0%	x
Need	Medical transportation (including emergency and non-emergency)	25%	x
immediate		2376	^
attention		05%	Y
	Urgent care	25%	Х
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		
Hospital stay	delivery, mental health, and substance use)	25%	Х
	Physician/surgeon fee	25%	Х
Mental health,	Mental/behavioral health and substance use disorder outpatient office	25%	х
behavioral	visits		
health, or substance	Mental/behavioral health and substance use disorder other outpatient	25%	х
abuse needs	items and services		
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	25%	Х
Help	Outpatient Rehabilitation and Habilitation services	25%	х
recovering or other special	Skilled nursing care	25%	х
health needs	Durable medical equipment	25%	х
	Hospice service	0%	х
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam	5	
	Preventive - Cleaning		
Child Dental	Preventive - X-ray		
Diagnostic and	Sealants per Tooth	Not Covered	
Preventive	Topical Fluoride Application		
Child Dental	Space Maintainers - Fixed		
Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental			
Major Services	Periodontics (other than maintenance)	Not Covered	
	Prosthodontics		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	Not Covered	

2025 2026 Patient-Centered Benefit Plan Designs 9.5 EHB

Date: April 18, 2024 January 16, 2025 Summary of Benefits and Coverage Silver Plan Silver Plan Member Cost Share amounts describe the Enrollee's out of pocket costs 100%-150% FPL 150%-200% FPL Actuarial Value - AV Calculator 94.7% <u>94.8%</u> 88.0% <u>87.8%</u> Plan design includes a deductible? Yes, Medical/Pharmacy Yes, Medical/Pharmacy 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 / \$0 \$2,800 / \$700 \$100 / \$0 Individual Out-of-pocket maximum \$,1300 \$1,400 \$3,050 \$3,350 Family Out-of-pocket maximum \$2,600 <u>\$2,800</u> \$6,100 <u>\$6,700</u> N/A HSA plan: Self-only coverage deductible N/A N/A HSA family plan: Individual deductible N/A Common Medical Member Cost Share Deductible Applies Service Type Member Cost Share Event Primary care visit to treat an injury, illness, or condition \$5 \$15 Health care provider's office or Other practitioner office visit \$5 \$15 clinic visit Specialist visit \$8 \$25 Preventive care/ screening/ immunization No charge No charge \$8 \$10 Laboratory Tests Tests X-rays and Diagnostic Imaging \$8 \$10 <u>\$40</u> \$50 Imaging (CT/PET scans, MRIs) \$100 \$50 Tier 1 \$3 \$8 Tier 2 \$10 \$25 Drugs to treat illness or condition Tier 3 \$15 \$45 10% up to \$150 p Tier 4 15% up to \$150 per script script Surgery facility fee (e.g., ASC) 10% 20% Outpatient services Physician/surgeon fees 10% 20% Outpatient visit 10% 20% Emergency room facility fee (waived if admitted) \$150 \$200 \$50 Emergency room physician fee (waived if admitted) No charge No charge Need Medical transportation (including emergency and non-emergency) \$30 \$75 immediate ttention Urgent care \$5 \$15 Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) 10% 20% Х Hospital stay Physician/surgeon fee 10% 20% Mental Mental/behavioral health and substance use disorder outpatient office \$5 \$15 health. visits behavioral health, or Mental/behavioral health and substance use disorder other outpatient substance \$5 \$15 items and services abuse needs Prenatal care and preconception visits No charge Pregnancy No charge Home health care (cost share per visit) \$3 \$15 Outpatient Rehabilitation and Habilitation services \$5 \$15 Help recovering or Skilled nursing care 20% 10% х other special health needs Durable medical equipment 10% 15% Hospice service No charge No charge Eye exam No charge No charge Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Oral Exam Preventive - Cleaning Child Dental Preventive - X-ray Diagnostic Not Covered Not Covered and Sealants per Tooth Preventive

Deductible Applies

Pharmacy

deductible

Pharmacv

. deductible

Pharmacy

deductible

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Topical Fluoride Application Space Maintainers - Fixed Child Dental Restorative Procedures Not Covered Not Covered Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Child Dental Major Services Periodontics (other than maintenance) Not Covered Not Covered Prosthodontics Oral Surgery Child Medically necessary orthodontics Not Covered Not Covered

and whene we have been set in the set of the set o	mber Cost Share a	amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPI	-
Image of the set of t	tuarial Value - A\	/ Calculator	73.9%	
Image and backed back		Plan design includes a deductible?		acv
InductionInductionInductionInductionSeriesInduction <td></td> <td>•</td> <td></td> <td></td>		•		
Individual departation NCT indugate: Markad / Pharmary / Deal 1993 (Markad Pharmary / Deal 1993 (Markad Pharmary / Deal 1993 (Markad Pharmary / Deal 		-		
Individual Dub-d-pocket maximum 24-230 B 200 24-230 B 200 24-200 2			\$5,400	<u>50</u> / \$0
Individual Dur-diposter maximum 97-330 Ballot 158 April 294 (2000) consider duration 168 family plan: individual decisticitie 164 April 294 (2000) 169 (2000) Common Medical Properties of Section of Term Medical Base 1000 Section 3000 (2000) Section 3000 (2000) Member Medical Base 1000 (2000) Member Member Base 1000 (2000) Member Member Base 1000 (2000) Member Member Base 1000 (2000) Member Member Base 1000 (2000) Member Base 1000 (2000) Member				
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libring condition condition ter 4Ter 3SSSParame deduction deducti	Drugs to treat	Tier 2	\$55	
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Interesting and states and s		Emergency room physician fee (waived if admitted)	No charge	
attention Urgent care \$355 House and the set of th		Medical transportation (including emergency and non-emergency)	\$250	
Constraint Constra				
delivery, mental health, and substance use) 0.0% X Mental heatth, ophysician/surgeon fee 30% 30% Mental heatth, ophysician/surgeon fee 30% 30% Mental heatth, ophysician/surgeon fee 30% 30% Mental heatth, ophysician/surgeon fee 30% 500 Mental/behavioral health and substance use disorder outpatient office visits 585 500 500 Mental/behavioral health and substance use disorder other outpatient substance. 586 550 500 Mental terms and services 545 550 550 Pregnancy Freegnancy 600 toharge 7 Heap recovering of other special freeovering of there special freeovering of freeovering of there special freeove		Urgent care	\$35	
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Help recovering of brief special health need Outpatient Rehabilitation and Habilitation services \$365 550 30% X Skilled nursing care 30% X Durable medical equipment 20% No charge Hospice service No charge No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge Image: Contact lenses in lieu of glasses) Child eye recentive Oral Exam No charge Image: Contact lenses in lieu of glasses) Preventive - Cleaning Preventive - Cleaning Image: Contact lenses in lieu of glasses) Preventive - Staad Salants per Tooth Image: Contact lenses in lieu of glasses) Topical Fluoride Application Space Maintainers - Fixed Image: Contact lenses Child Dental Basic Services Restorative Procedures Not Covered Periodontal Maintenance Services Image: Contact lense Image: Contact lense Child Dental Basic Services Crowns and Casts Image: Contact lense Image: Contact lense Periodontics (other than maintenance) Prosthodontics Not Covered Image: Contact lense Vidio Surgery Oral Surgery Image: Contact lense Image: Contact lense Image: Contact lense			-	
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care1 pair of glasses per year (or contact lenses in lieu of glasses)No chargeOral ExamOral ExamPreventive - CleaningPreventive - CleaningPreventive - X-rayPreventive - X-raySealants per ToothProtective - X-rayTopical Fluoride ApplicationPreventive - Size Maintainers - FixedBasicRestorative ProceduresPeriodontal Maintenance ServicesNot CoveredChild Dental MajorCrowns and CastsPeriodonticsPeriodonticsPeriodonticsPeriodontics (other than maintenance)ProsthodonticsNot CoveredOral SurgeryOral Surgery	Child eye	Eye exam	No charge	
Child Dental Diagnostic and Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - FixedNot CoveredHere PreventiveChild Dental Basic ServicesRestorative Procedures Periodontal Maintenance ServicesNot CoveredImage: ServiceChild Dental Major ServicesCrowns and Casts Endodontics (other than maintenance)Not CoveredImage: ServiceChild Dental Major ServicesCrowns and Casts (Frosthodontics (other than maintenance)Not CoveredImage: Service	-	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
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Child Dental Diagnostic and Preventive - X-ray Preventive - X-ray Not Covered Sealants per Tooth Topical Fluoride Application Preventive Space Maintainers - Fixed Not Covered Preventive Child Dental Basic Services Restorative Procedures Not Covered Preventive Child Dental Basic Services Restorative Procedures Not Covered Preventive Crowns and Casts Endodontics Not Covered Preventive Periodontics (other than maintenance) Not Covered Not Covered Proventive Vajor Services Oral Surgery Oral Surgery Not Covered Preventive		Preventive - Cleaning		
Indigitation and Preventive Sealants per Tooth Not Covered Sealants per Tooth Topical Fluoride Application Proventive Space Maintainers - Fixed Not Covered Child Dental Basic Restorative Procedures Not Covered Services Periodontal Maintenance Services Not Covered Crowns and Casts Endodontics Not Covered Periodontics (other than maintenance) Not Covered Not Covered Prosthodontics Oral Surgery Oral Surgery Not Covered		-		
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Basic Services Not Covered Periodontal Maintenance Services Not Covered Child Dental Major Services Endodontics Periodontics (other than maintenance) Not Covered Prosthodontics Oral Surgery Not Covered		Space Maintainers - Fixed		
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Child Dental Major Periodontics (other than maintenance) Not Covered Services Prosthodontics Oral Surgery		Endodontics		
Services Prosthodontics Oral Surgery			Not Covered	
Oral Surgery			1101 0010100	
		Oral Surgery		

2025 2026 Patient-Centered Benefit Plan Designs 9.5 EHB

Date: April 18, 2024 January 16, 2025 Summary of Benefits and Coverage

tuarial Value - AV	/ Calculator	63.6% <u>63.5%</u>			
				64.9% <u>64.8</u>	<u>%</u>
	Plan design includes a deductible?	Yes, Medical/Pharr	nacv	Yes, integrat	
	Integrated Individual deductible	N/A	,	\$6,650 integra	
	Integrated Family deductible	N/A		\$13,300 integr	rated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,800 / \$450 / \$	δ0	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$11,600 / \$900 /	\$0	N/A	
	Individual Out–of–pocket maximum	\$8,850 \$9,800		\$6,650 \$7,20	00
	Family Out-of-pocket maximum	\$1,7700 \$19,60	0	\$13,300 \$14,4	400
	HSA plan: Self-only coverage deductible	N/A N/A		\$6,650	
Common	HSA family plan: Individual deductible			\$6,650	Deducti
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Applie
Health care	Primary care visit to treat an injury, illness, or condition	\$60		0%	x
provider's office or	Other practitioner office visit	\$60		0%	x
clinic visit	Specialist visit	\$95	After 1st three non- preventive visits	0%	x
	Preventive care/ screening/ immunization	No charge	Proventive VISILS	No charge	
	Laboratory Tests	\$40 \$50		0%	х
Tests	X-rays and Diagnostic Imaging	40%	x	0%	x
	Imaging (CT/PET scans, MRIs)	40%	x	0%	x
	Tier 1	\$19 \$20		0%	x
				0%	X
Drugs to treat	Tier 2	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	x
illness or condition	Tier 3	40% up to \$500 per script after	Pharmacy	0%	x
		pharmacy deductible	Deductible		
	Tier 4	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	x
	Surgery facility fee (e.g., ASC)	40%	x	0%	x
Outpatient	Physician/surgeon fees	40%	x	0%	x
services	Outpatient visit	40%	x	0%	x
_	Emergency room facility fee (waived if admitted)	40%	x	0%	x
	Emergency room physician fee (waived if admitted)	No charge		0%	x
Need		-	v	0%	
immediate attention	Medical transportation (including emergency and non-emergency)	40%	X		X
	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%	x
Hospital stay	Physician/surgeon fee	40%	x	0%	x
Mental	Mental/behavioral health and substance use disorder outpatient office				
health, behavioral	visits	\$60		0%	X
health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$60		0%	x
abuse needs Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	x	0%	x
Halm	Outpatient Rehabilitation and Habilitation services	\$60		0%	x
Help recovering or					
other special health needs	Skilled nursing care	40%	Х	0%	X
	Durable medical equipment	40%	Х	0%	X
	Hospice service	No charge		0%	Х
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 Druth	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth			NUL COVERED	
reventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dental		Not Covered		Not Coursed	
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
	Oral Surgery			1	

	amounts describe the Enrollee's out of pocket costs.	outus	trophic Plan
tuarial Value - A	✓ Calculator		
	Plan design includes a deductible?	Yes,	integrated
	Integrated Individual deductible	\$9,200	9,800 integrated
	Integrated Family deductible	\$18,400	19,600 integrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Individual Out-of-pocket maximum	:	\$9,200
	Family Out-of-pocket maximum	\$	518,400
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible		N/A N/A
Common Medical	Service Type	Member Cost	Deductible Applie
Event	Primary care visit to treat an injury, illness, or condition	Share 0%	After 1st three no
Health care provider's	Other practitioner office visit	0%	preventive visits After 1st three no
office or			preventive visits
clinic visit	Specialist visit	0%	Х
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	х
Tests	X-rays and Diagnostic Imaging	0%	х
	Imaging (CT/PET scans, MRIs)	0%	х
	Tier 1	0%	x
Drugs to treat	Tier 2	0%	x
illness or	Tier 3	0%	×
condition		0%	X
	Tier 4	0%	X
	Surgery facility fee (e.g., ASC)	0%	Х
Outpatient services	Physician/surgeon fees	0%	Х
	Outpatient visit	0%	х
	Emergency room facility fee (waived if admitted)	0%	х
	Emergency room physician fee (waived if admitted)	No charge	
leed	Medical transportation (including emergency and non-emergency)	0%	x
immediate attention	Urgent care	0%	After 1st three no
	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		After 1st three no
health, behavioral health, or	visits	0%	preventive visit
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	0%	х
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	х
Help	Outpatient Rehabilitation and Habilitation services	0%	x
recovering or other special	Skilled nursing care	0%	x
health needs	Durable medical equipment	0%	x
	Hospice service	0%	x
			^
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	Х
	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	Restorative Procedures	Not Ocure	
Basic Services	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		
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Crowns and Casts

Prosthodontics Oral Surgery

Periodontics (other than maintenance)

Medically necessary orthodontics

Child Dental Major Services

Child

Date: April 18, 2024 January 16, 2025 Summary of Benefits and Coverage CA Enh CSR Silver 94 Plan CA Enh CSR Silver 87 Plan Member Cost Share amounts describe the Enrollee's out of pocket costs. 100%-150% FPL 150%-200% FPL Actuarial Value - AV Calculator 95.1% 88.9% Plan design includes a deductible? No No N/A N/A Integrated Individual deductible Integrated Family deductible N/A N/A Individual deductible, NOT integrated: Medical / Pharmacy / Dental \$0 / \$0 / \$0 \$0 / \$0 / \$0 Family deductible, NOT integrated: Medical / Pharmacy / Dental \$0 / \$0 / \$0 \$0 / \$0 / \$0 Individual Out-of-pocket maximum \$1,150 \$3,000 Family Out-of-pocket maximum \$2.300 \$6.000 HSA plan: Self-only coverage deductible N/A N/A HSA family plan: Individual deductible N/A N/A Common Medical Member Cost Share Deductible Applies Deductible Applies Service Type Member Cost Share Event Primary care visit to treat an injury, illness, or condition \$5 \$15 Health care provider's office or Other practitioner office visit \$5 \$15 clinic visit Specialist visit \$8 \$25 Preventive care/ screening/ immunization No charge No charge Laboratory Tests \$8 \$20 Tests X-rays and Diagnostic Imaging \$8 \$40 Imaging (CT/PET scans, MRIs) \$50 \$100 Tier 1 \$3 \$5 Tier 2 \$10 \$25 Drugs to treat illness or condition Tier 3 \$15 \$45 10% up to \$150 p Tier 4 15% up to \$150 per script script Surgery facility fee (e.g., ASC) 10% 20% Outpatient services Physician/surgeon fees 10% 20% Outpatient visit 10% 20% Emergency room facility fee (waived if admitted) \$50 \$150 Emergency room physician fee (waived if admitted) No charge No charge Medical transportation (including emergency and non-emergency) Need \$30 \$75 immediate ttention Urgent care \$5 \$15 Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) 10% 20% Hospital stay Physician/surgeon fee 10% 20% Mental Mental/behavioral health and substance use disorder outpatient office \$5 \$15 health. visits behavioral health, or Mental/behavioral health and substance use disorder other outpatient substance \$5 \$15 items and services abuse needs Prenatal care and preconception visits No charge No charge Pregnancy Home health care (cost share per visit) \$3 \$15 Outpatient Rehabilitation and Habilitation services \$5 \$15 Help recovering or Skilled nursing care 10% 20% other special health needs Durable medical equipment 10% 15% Hospice service No charge No charge Eye exam No charge No charge Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Oral Exam Preventive - Cleaning Child Dental Preventive - X-ray Diagnostic Not Covered Not Covered and Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed Child Dental Restorative Procedures Not Covered Not Covered Basic Periodontal Maintenance Services Services

Not Covered

Not Covered

Not Covered

Not Covered

mber Cost Share a	amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Silver 7 Above 200% FPL	
tuarial Value - A\	/ Calculator	79.2%	
	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 HSA family plan: Individual deductible	N/A N/A	
Common Medical	Service Type	Member Cost Share	Deductible
Event	Primary care visit to treat an injury, illness, or condition	\$35	Applies
Health care	Other practitioner office visit	\$35	
provider's office or clinic visit		φ33	
	Specialist visit	\$85	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$15	
Drugs to treat	Tier 2	\$55	
illness or	T 0	A AF	
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%	
361 11065	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			
attention	Urgent care	\$35	
		ФОО	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	30%	
Hospital stay	delivery, mental health, and substance use)	30%	
	Physician/surgeon fee	30%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$35	
behavioral health, 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	Skilled nursing care	30%	
other special health needs	Durable medical equipment	20%	
	Hospice service	No charge	
	Eve exam		
Child eye care		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	No charge	
Child Dental	Preventive - Cleaning		
Diagnostic and	Preventive - X-ray	Not Covered	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
Child Dentel	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	rostriodontics		

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.
- 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:

T :	Definition
Tier	Definition
1	1) Most generic drugs and low cost preferred brands.
	1) Non-preferred generic drugs;
	2) Preferred brand name drugs; and
2	3) Any other drugs recommended by the plan's
	pharmaceutical and therapeutics (P&T) committee based on
	drug safety, efficacy and cost.
	1) Non-preferred brand name drugs or;
	2) Drugs that are recommended by P&T committee based
3	on drug safety, efficacy and cost or;
	3) Generally have a preferred and often less costly
	therapeutic alternative at a lower tier.
	1) Drugs that the Food and Drug Administration (FDA) or
	drug manufacturer requires to be distributed through
	specialty pharmacies;
4	2) Drugs that require the enrollee to have special training or
4	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.