Covered California 2026 Patient-Centered Benefit Plan Designs¹

Final Approved

April 17, 2025

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

Date: April 17, 2025

Summary of Benefits and Coverage

COVERED

Note Part	Summary of Be	nefits and Coverage	Individual only F	Distinum	Individual only F	Datinum
Provide product of the color	Member Cost Share	amounts describe the Enrollee's out of pocket costs.	_			
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	Actuarial Value - A					
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Part		· · · · · · · · · · · · · · · · · · ·				-
Common No. N						
Medical Event Princhy uses valid to treat an injury, linese, or condition 1515		HSA family plan: Individual deductible	N/A		N/A	
Private part Priv	Common	Service Type	Member Cost	Deductible	Member Cost	Deductible
Nearly Companies Section Secti	Medical Event		Share	Applies	Share	Applies
District Control or climb Specialist Vision Specialist Specialist Vision Specialist Specialist Vision Specialist Speci	Health care	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
Visit Specialists valid 5300 530 Proventive care's screening' immunication No charge No charge Lead Laboratory Tests 3515 3515 X-rays and Diagnostic Imaging immunication 3510 350 Image: Test of the company of th	provider's	Other practitioner office visit	\$15		\$15	
Laboratory Tests X-reys and Dargorsto Imaging Imaging (CITPET scare, MRIs) Tier 1 Drugs to treat Illness or Condition Tier 2 316 325 Tier 3 Tier 4 Sugary facility tee (e.g., ASC) Physicians/augen fees Outpatient services Sugary facility tee (e.g., ASC) Physicians/augen fees Outpatient vale Emergency com facility tee (waived if admittee) Emergency com facility tee (waived if admittee) Emergency com facility tee (waived if admittee) Physicians/augen fees Outpatient vale Emergency com facility tee (waived if admittee) Physicians/augen fees Outpatient vale Emergency com facility tee (waived if admittee) Medical transportation (including emergency and non-emergency) Medical		Specialist visit	\$30		\$30	
Liboratory Tesis		Preventive care/ screening/ immunization	No charge		No charge	
Tests X-rays and Diagnostic Irraging S30 S30 S30 S37 S37 S37 S37 S37 S37 S37 S37 S37 S38 S48 S37 S38 S48 S38		Laboratory Tests	_		-	
Imaging (CTPET scam, MRis) Tor 1 Tor 1 Sp 9 59 Sp 159 Tor 2 Tor 2 Tor 3 525 Sugary locitiy fee (e.g., ASC) Physician buyer locity fee (e.g., ASC) Physician buyer fee scap, ASC) Physician buyer fee (e.g., ASC) Physi	Tests	·			·	
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Tier 4 Tier 5 Tier 6 Tier 6 Tier 6 Tier 6 Tier 6 Tier 7 Tier 8 Tier 7 Tier 8 Tier 7 Tier 8 Tier 7 Tier 7 Tier 8 Tier 7 Tier 7 Tier 8 Tier 8 Tier 8 Tier 8 Tier 7 Tier 8 Tier 8 Tier 7 Tier 8		lier 1	\$9		\$9	
Tier 3 Tier 4 Ti		Tier 2	\$16		\$16	
Ter 4 10% up to \$280 per script 20% up to \$2		Tier 3	\$25		\$25	
Surgery facility fee (e.g., ASC) 10% \$75 \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$						
Outpatient services Cuspatient visit Emergency room facility fee (valved if admitted) Need immediate attention Urgent care Facility fee (e.g. hospital room) for impatient stay (including labor and deliver), mental health, and substance use) Preparatives Mental health, behavioral health and substance use disorder outpatient disors of the substance use disorder outpatient disorder outpatient disorder of the substance use disorder outpatient disorder disorder outpati		Tier 4				
Pregnancy Hospital stay Pregnancy Pregnancy Pregnancy Pregnancy Child per care Child Dental Diagnostic American Child Dental Basic Services Child Dental Basic Services		Surgery facility fee (e.g., ASC)	10%		\$75	
Ourpatient visit Emergency room facility fee (walved if admitted) S175 S175 S175 Emergency room facility fee (walved if admitted) No charge No charge		Physician/surgeon fees	10%		\$20	
Emergency room physician fee (waived if admitted) No charge No charge		Outpatient visit	10%		10%	
Need immediate attention Urgent care Facility fee (e.g. hospital corm) for inpatient stay (including labor and delivery, mental health, and substance use) Physician-surgeon fee Physician-surgeon fee Nental health, or substance abuse needs Abehavioral health, or substance abuse needs Pregnancy Prenatal care and preconception visits No charge Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Stilled nursing care Outpatient Rehabilitation and Habilitation services No charge Field bental health needs Child depetal Preventive Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Crowns and Casts Encodomics Prestriction Services Prostitudentics Oral Surgery No charge Prostitudentics Prostitudentics Prostitudentics Oral Surgery No charge Preventive Topical Fluoride Application Space Maintainers - Fixed Child Dental Major and Casts Encodomics Preventive Prostitudentics Prostitudentics No Prostitudentics Prostitudentics No Prostitudentics Prostitudentics No Pr		Emergency room facility fee (waived if admitted)	\$175		\$175	
Need immediate attention Urgent care Facility fee (e.g. hospital corm) for inpatient stay (including labor and delivery, mental health, and substance use) Physician-surgeon fee Physician-surgeon fee Nental health, or substance abuse needs Abehavioral health, or substance abuse needs Pregnancy Prenatal care and preconception visits No charge Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Stilled nursing care Outpatient Rehabilitation and Habilitation services No charge Field bental health needs Child depetal Preventive Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Crowns and Casts Encodomics Prestriction Services Prostitudentics Oral Surgery No charge Prostitudentics Prostitudentics Prostitudentics Oral Surgery No charge Preventive Topical Fluoride Application Space Maintainers - Fixed Child Dental Major and Casts Encodomics Preventive Prostitudentics Prostitudentics No Prostitudentics Prostitudentics No Prostitudentics Prostitudentics No Pr		Emergency room physician fee (waived if admitted)	No charge		No charge	
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Hospital stay		Facility fee (e.g. hospital room) for inpatient stay (including labor and			\$225 per day up to	
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Skilled nursing care other special health needs Durable medical equipment Hospice service Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Crowns and Casts Child Dental Major Services Skilled nursing care Skilled nursing care 10% 10% 10% 10% 10% 10% 10% 10% 10% 10						
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Hospice service	other special	Skilled nursing care	10%			
Child eye care Eye exam	nealth needs	Durable medical equipment	10%		10%	
Child Dental Diagnostic and Preventive Preventive Periodontal Major Services Child Dental Major Services Child Dental Major Services Child Dental Major Services Child Medically necessary orthodontics Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery No charge		Hospice service	No charge		No charge	
1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - A-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Oral Surgery Child Medically necessary orthodontics Oral Surgery No charge	Child ave save	Eye exam	No charge		No charge	
Child Dental Diagnostic and Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically peressary orthodontics Oral Surgery Preventive - Cleaning Preventive - X-ray No charge See 2025 Dental Copay Schedule See 2025 Dental Copay Schedule See 2025 Dental Copay Schedule	Cillia eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive Preventive Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically pecessary orthodontics Proventive - X-ray No charge No charge No charge No charge No charge No charge No charge No charge No charge No charge No charge See 2025 Dental Copay Schedule		Oral Exam				
Diagnostic and Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Child Dental Major Services Prosthodontics Oral Surgery Child Medically pecessary orthodontics Diagnostic No charge No charge No charge No charge No charge No charge No charge No charge No charge No charge No charge See 2025 Dental Copay Schedule 50% See 2025 Dental Copay Schedule		Preventive - Cleaning				
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Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Periodontal Maintenance Services Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically peressary orthodoptics Space 2025 Dental Copay Schedule See 2025 Dental Copay Schedule See 2025 Dental Copay Schedule	and	·	No charge		No charge	
Space Maintainers - Fixed Child Dental Basic Periodontal Maintenance Services Child Dental Major Services Child Dental Major Services Oral Surgery Child Medically necessary orthodontics See 2025 Dental Copay Schedule 50% See 2025 Dental Copay Schedule 50% See 2025 Dental Copay Schedule 50% See 2025 Dental Copay Schedule	Preventive					
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Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically necessary orthodontics See 2025 Dental Copay Schedule	Child Dental				0 0005 5	
Child Dental Major Services Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically necessary orthodontics See 2025 Dental Copay Schedule 50% \$1,000	Basic		20%			
Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically necessary orthodontics 50% See 2025 Dental Copay Schedule Some Standard Some Stand	Oct vices					
Child Dental Major Services Periodontics (other than maintenance) 50% Prosthodontics Copay Schedule Child Medically necessary orthodontics 50% \$1,000						
Services Prosthodontics Oral Surgery Child Medically pecessary orthodontics 50% \$1,000			F00/		See 2025 Dental	
Child Medically necessary orthodontics 50% \$1,000			JU%		Copay Schedule	
Child Medically necessary orthodontics 50% \$1,000						
Medically necessary orthodontics 50% \$1 000	Child					
		Medically necessary orthodontics	50%		\$1,000	

	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-onl Platinum Coinsurance		CCSB-onl Platinum Copay Pla	ĺ
	V Coloulator	0.1			
Actuarial Value - A	V Calculator Plan design includes a deductible?	91.8% No		91.1% No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0/\$0/\$	0
	Individual Out-of-pocket maximum	\$4,500		\$4,500	
	Family Out-of-pocket maximum	\$9,000		\$9,000	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$15		\$20	
Health care provider's office or clinic	Other practitioner office visit	\$15		\$20	
visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$20	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$100	
	Tier 1	\$10		\$5	
Drugs to treat	Tier 2	\$25		\$20	
illness or condition	Tier 3	\$40		\$30	
	Tier 4	10% up to \$250 per script		10% up to \$250 per	
	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient services	Physician/surgeon fees	10%		\$25	
301 11003	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$200		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$150		\$150	
immediate attention					
	Urgent care	\$15		\$20	
	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 health,	Mental/behavioral health and substance use disorder outpatient office	\$15		\$20	
behavioral health, or	visits	ψ.0		Ψ20	
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	
J	Home health care (cost share per visit)	10%		\$20	
	Outpatient Rehabilitation and Habilitation services	\$15		\$20	
Help recovering or		·		\$150 per day up to	
other special health needs	Skilled nursing care	10%		5 days	
nearth needs	Durable medical equipment	10%		10%	
	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 Dantal	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth	No charge		140 charge	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	0007		See 2025 Dental	
Basic Services	Periodontal Maintenance Services	20%		Copay Schedule	
	Crowns and Casts				
	Endodontics				
				See 2025 Dental	
Child Dental Major	Periodontics (other than maintenance)	50%			
	Periodontics (other than maintenance) Prosthodontics	50%		Copay Schedule	
Major		50%			

Printed commendation Final Printed Commendation Medical Commenda	ember Cost Snare	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
Independent	ctuarial Value - A	V Calculator	81.4%		81.7%	
Part		Plan design includes a deductible?	No		No	
Interleducial enduciation (NOT integrated: Medical of Phomosory Pointed \$0.7 10.7 10 \$0.7 10		Integrated Individual deductible	\$0		\$0	
Family deductable NOT segrepted Natical Planemany Plane Family deductable Not segrepted National Planemany Planemany 18,000		Integrated Family deductible	\$0		\$0	
Includes Culti-Process and summary 18 200 ST8-200 ST8-		Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0 / \$0 / \$	0
Part		Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0 / \$0 / \$	0
THIS A part Self-city oversign deductions (NA NA) HIS A family prior individual deductions (NA NA) Formation (NA NA) Province rare self-city from the self-city oversign deduction (NA NA) Province are serioring immunoritien. Despetitions of self-city (NA NA) Province are serioring immunoritien. Province are serioring immunoritie		Individual Out–of–pocket maximum	\$9,200		\$9,200	
Machine Mach						
Medical Event Primary care visit to treat an injury, lineas, or condition Selection care Selecti						
Marchite and College practicioner office vield \$40 \$40 \$70		Service Type				Deduc Appli
Other protectioner efficies visit (fisher or cellinal fisher or cellin		Primary care visit to treat an injury, illness, or condition	\$40		\$40	
Activation of the control of the con		Other practitioner office visit	\$40		\$40	
Preventive care's screening' immunization Laboratory Traits Laborato	office or clinic					
Labonatory Tests Xerys and Digramstic Invaging S75 S75 S75 S75 S75 S75 S75 S75 S75 S75 S75 S75 S75 S75 S75 S75 S75 S75 S75 S75 S75 S75 S75 S75 S75 S75 S75 S75 S75 S75 S75 S75	VISIT	·	\$70		\$70	
Trey and Diagnostic Imaging Imaging (CT-PET scarce, MRIs) Ter 1 Ter 2 Secondary 1 Ter 2 Ter 3 Ter 4 Surgery facility fee (e.g., ASC) Physiciannissurgeon fees Outpatient view Surgery facility fee (e.g., ASC) Physiciannissurgeon fees Outpatient view Surgery facility fee (e.g., ASC) Physiciannissurgeon fees Outpatient view Surgery facility fee (e.g., ASC) Physiciannissurgeon fees Outpatient view Surgery facility fee (e.g., ASC) Surgery facility fee (e.g., ASC) Physiciannissurgeon fees Outpatient view Surgery facility fee (e.g., ASC) Surgery facility fee (e.g., A		Preventive care/ screening/ immunization	No charge		No charge	
Imaging (CT/PET scans, MRis) Ter 1 Ter 1 S18 \$18 \$18 \$18 \$18 \$18 \$18 \$1		Laboratory Tests	\$40		\$40	
Tier 1 Tier 2 Tier 2 Tier 3 Tier 3 Tier 4 Tier 2 Tier 4 Tier 3 Tier 4 Tier 3 Tier 4 Tier 4 Tier 3 Tier 4 Tier 4 Tier 3 Tier 4 Tier 4 Tier 5 Tier 4 Tier 6 Tier 7 Tier 7 Tier 7 Tier 7 Tier 8 Tier 9 Ti	ests	X-rays and Diagnostic Imaging	\$75		\$75	
Tier 2 S880 S880 S880 S880 S880 S880 S880 S8		Imaging (CT/PET scans, MRIs)	25%		\$75	
Tier 2 S880 S880 S880 S880 S880 S880 S880 S8		Tier 1	\$18		\$18	
Ter 3 Ter 4 Ter 3 Surgery facility foe (e.g., ASC) Physician/surgeon fees Outpatient visit Condition Ter 3 Surgery facility foe (e.g., ASC) Physician/surgeon fees Outpatient visit Emergency room facility fee (walved if admitted) Surgery facility fee (e.g., based in commentation for tending fee feet feet feet feet feet feet feet						
Tier 3 \$85 \$85 \$85 \$85 \$85 \$85 \$85 \$85 \$85 \$85		Tier 2	\$60		\$60	
Trier 4 20% up to \$250 per script 20% up to		Tier 3	\$85		\$85	
Surgery facility fee (e.g. ASC) Physician/surgeon fees Outpatient envices Outpatient visit Emergency room lacility fee (valved if admitted) Emergency room physician fee (walved if admitted) Emergency room physician fee (walved if admitted) No charge No charge No charge No charge No charge Additional facility fee (e.g. hospital room) for impotent stay (including labor and delivery, mental health, and substance use disorder outpatient office walved if admitted) No charge Physician/surgeon fee Admittal health, Mental/healvioral health and substance use disorder outpatient office walves Intention No charge Pregnancy Prenatal care and preconception visits No charge Pregnancy Prenatal care and preconception visits No charge Durable medical equipment Hospice service Durable medical equipment Hospice service Coral Exam Preventive - Citering Preventive -						
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Dutpatient Physician/surgeon fees Outpatient vielt Emergency room facility fee (walved if admitted) Emergency room facility fee (walved if admitted) Medical transportation (including emergency and non-emergency) Urgent care Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mortal health, and substance use) Physician/surgeon fee Physi		Surgery facility fee (e.g., ASC)	30%		\$130	
Cupatient visit Outpatient visit Emergency room facility fee (valved if admitted) Emergency room facility fee (valved if admitted) Emergency room physician fee (valved if admitted) Medical transportation (including emergency and non-emergency) Medical transportation (including emergency and non-emergency) Vigent care Facility fee (e.g., hospital room) for impatient stay (including labor and delivery, mental health, and substance use) Physician/surgoon fee Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient items and services with tems and services and services Pregnancy Prenatal care and preconception visits No charge Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services SAII Stop and day up to Stip or day up to Stip	_					
Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted) Emergency room physician fee (waived if admitted) No charge Medical transportation (including emergency and non-emergency) Urgent care Urgent care Facility fee (e.g. hospital room) for inpatient stay (including labor and deliver), mental health, and substance use) Presylations urgent fee Montal/behavioral health and substance use disorder outpatient office visits water and preconception visits Montal/behavioral health and substance use disorder outpatient office visits water and preconception visits Montal/behavioral health and substance use disorder outpatient in the same and services Pregnancy Prenatal care and preconception visits No charge Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care Outpatient Rehabilitation and Habilitation services Skilled nursing care Durable medical equipment Hospice Service No charge No charge Preventive - X-ray Sealand Dental Jagnostic Preventive - X-ray	services				·	
Emergency room physician fee (waived if admitted) Medical transportation (including emergency and non-emergency) Urgent care Urgent care \$40 \$40 \$40 \$40 \$40 \$40 \$40 \$4						
Medical transportation (including emergency and non-emergency) Lingent care Medical transportation (including emergency and non-emergency) Lingent care S40 S40 S40 S40 S40 S40 S40 S4						
Intendiate transition Urgent care Facility fee (e.g., hospital room) for impatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee Mental health, and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient imme and services Pregnancy Prenatal care and preconception visits No charge Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services \$40 \$40 \$40 \$40 \$40 \$40 \$40 \$4		Emergency room physician fee (waived if admitted)	No charge		No charge	
trention Urgent care Sacility fee (e.g., bospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee 30% No charge		Medical transportation (including emergency and non-emergency)	\$250		\$250	
Facility fee (e.g. hospital stay Playsidan/suggeon fee						
delivery, mental health, and substance use) Physician/surgeon fee Mental health, or behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits No charge Child Dental denta		Urgent care	\$40		\$40	
delivery, mental health, and substance use disorder outpatient office visits Mental health, or behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits No charge Preventive - Cleaning Preventive - Cleaning Preventive - X-ray Sealants per Tooth Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Crowns and Casts Endodontics Periodontal Maintenance Services Crowns and Casts Endodontics Prosthodontics Oral Surgery		Facility fee (e.g. hospital room) for inpatient stay (including labor and			\$375 per day up to	
Physician/surgeon fee 30% No charge Mental health, behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services Pregnancy Prenatal care and preconception visits No charge Prenatal care and preconception visits No charge Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services Skilled nursing care Skilled nursing care Ourable medical equipment Hospice service No charge Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Thild out and the preventive - Cleaning Preventive - Cleaning Preventive - Cleaning Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Searvices Crowns and Casts Endodontics Periodontal Maintenance Services Crowns and Casts Endodontics Periodontal Maintenance Services Oral Surgery Prosthodontics Oral Surgery	Hospital stay		30%			
visits visits visits visits visits Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services Pregnancy Prenatal care and preconception visits No charge Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services \$40 \$40 \$40 \$40 Uutpatient Rehabilitation and Habilitation services \$40 \$40 \$40 \$40 \$40 \$40 \$40 \$4		Physician/surgeon fee	30%		No charge	
visits visits Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services Mental/behavioral health and substance use disorder other outpatient items and services Pregnancy Prenatal care and preconception visits No charge No charge Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services \$40 \$40 \$40 \$40 \$40 \$40 \$40 \$4	Mental health.	Mental/behavioral health and substance use disorder outpatient office	#40		¢40	
Mental/behavioral health and substance use disorder other outpatient items and services Pregnancy Prenatal care and preconception visits No charge Home health care (cost share per visit) Precovering or other special read of the part	pehavioral	·	\$4U		\$40	
abuse needs litems and services litems and preconception visits litems and services litems and preconception visits litems and services litems and preconception visits litems and	·	Mental/behavioral health and substance use disorder other outpatient				
Home health care (cost share per visit) Cutpatient Rehabilitation and Habilitation services Skilled nursing care No charge Cral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Sasic Services Crowns and Casts Endodontics Periodontial Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	abuse needs	·	\$40		\$40	
Outpatient Rehabilitation and Habilitation services Skilled nursing care Skilled nursing care Skilled nursing care Durable medical equipment Hospice service No charge Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontial Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Outpatient Rehabilitation and Habilitation services \$40 \$40 \$40 \$40 \$40 \$40 \$40 \$40 \$40 \$4	Pregnancy	Prenatal care and preconception visits	No charge		No charge	
Skilled nursing care covering or other special realth needs Durable medical equipment Hospice service Child eye care Child Dental Diagnostic and Preventive Child Dental Sasic Service Restorative Procedures Periodontics Crowns and Casts Endodontics Prosthodontics Oral Surgery Skilled nursing care 30% \$150 per day up to 5 days 20% No charge Services Services \$20% \$20% \$30% \$3150 per day up to 5 days 20% No charge No charge No charge No charge No charge No charge Services Services Services \$20% \$30% \$30% \$3150 per day up to 5 days 20% No charge No charge No charge No charge No charge Services Services Services \$30% \$3150 per day up to 5 days 20% No charge No charge No charge No charge Services Services Services \$30% \$30% \$30% \$30% \$30% \$30% \$30% \$30		Home health care (cost share per visit)	20%		\$30	
Skilled nursing care pother special realth needs Durable medical equipment Durable medical equip	Heln	Outpatient Rehabilitation and Habilitation services	\$40		\$40	
Durable medical equipment Durable medical equipment Hospice service No charge No cha	ecovering or		·		\$150 per day up to	
Hospice service Hospice service No charge Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	-					
Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Crowns and Casts Endodontics Periodontal Maior Services Prosthodontics Oral Surgery Eye exam No charge						
Child Dental Diagnostic and Preventive - Cleaning Preventive - Cleaning Preventive - Cleaning Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Periodontal Maintenance Services Child Dental Basic Periodontal Maintenance Services Crowns and Casts Endodontics Prosthodontics Oral Surgery No charge		Hospice service	No charge		No charge	
1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery No charge No charge No charge No charge	Child eve care	Eye exam	No charge		No charge	
Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery No charge No charge No charge No charge No charge No charge No charge No charge See 2025 Dental Copay Schedule See 2025 Dental Copay Schedule See 2025 Dental Copay Schedule	Uju dare	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Periodontal Maintenance Services Child Dental Copay Schedule Child Dental Basic Periodontics Periodontics Periodontics Oral Surgery Prosthodontics Oral Surgery		Oral Exam				
Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Child Dental Agor Services Child Dental Agor Periodontics Periodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery No charge See 2025 Dental Copay Schedule		Preventive - Cleaning				
Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery No charge See 2025 Dental Copay Schedule	Child Dental Diagnostic	Preventive - X-ray				
Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Topical Fluoride Application See 2025 Dental Copay Schedule See 2025 Dental Copay Schedule See 2025 Dental Copay Schedule	ınd		No charge		No charge	
Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Space Maintainers - Fixed 20% See 2025 Dental Copay Schedule 50% See 2025 Dental Copay Schedule	Preventive					
Restorative Procedures Periodontal Maintenance Services Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Dental Surgery See 2025 Dental Copay Schedule 50% See 2025 Dental Copay Schedule						
Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery See 2025 Dental Copay Schedule See 2025 Dental Copay Schedule See 2025 Dental Copay Schedule	Child Dantal					
Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery			20%			
Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Endodontics See 2025 Dental Copay Schedule	Services	Periodontal Maintenance Services			Copay Scriedule	
Periodontics (other than maintenance) Prosthodontics Oral Surgery See 2025 Dental Copay Schedule		Crowns and Casts				
Periodontics (other than maintenance) Prosthodontics Oral Surgery See 2025 Dental Copay Schedule	Child Dental	Endodontics				
Prosthodontics Oral Surgery	Major	Periodontics (other than maintenance)	50%			
Phild	Services	Prosthodontics			Jopay Jonedule	
Phild		Oral Surgery				
Medically necessary orthodontics 50% \$1,000	hild					

Date: April 17 Summary of Be	nefits and Coverage	CCSB-only		CCSB-only	
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Gold Coinsurance Pla	n	Gold Copay Plan	
Actuarial Value - A	NV Calculator	80.3%		81.7%	
	Plan design includes a deductible?	Yes, Medical/Pharm	асу	Yes, Medical/Pharr	nacy
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$350 / \$0 / \$0 \$700 / \$0 / \$0		\$250 / \$0 / \$0 \$500 / \$0 / \$0	
	Individual Out-of-pocket maximum			\$7,800	
	Family Out-of-pocket maximum			\$15,600	
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$25		\$35	
Health care provider's	Other practitioner office visit	\$25		\$35	
office or clinic		·		·	
visit	Specialist visit	\$50		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$25		\$35	
Tests	X-rays and Diagnostic Imaging	\$65		\$55	
	Imaging (CT/PET scans, MRIs)	20%		\$250	Χ
	Tier 1	\$15		\$15	
Drugge to treat	Tier 2	\$50		\$40	
Drugs to treat illness or					
condition	Tier 3	\$80		\$70	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$300	X
Outpatient services	Physician/surgeon fees	20%		\$35	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	20%	X	\$250	X
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	20%	X	\$250	X
immediate attention					
	Urgent care	\$25		\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	20%	X	\$600 per day up to 5 days	X
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	20%	X	No charge	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$25		\$35	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	005		405	
abuse needs	items and services	\$25		\$35	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$25		\$35	
recovering or other special	Skilled nursing care	20%	X	\$300 per day up to 5 days	X
health needs	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eve core	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 Diagnostic	Preventive - X-ray				
and Preventive	Sealants per Tooth	No charge		No charge	
i revenuve	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures			See 2025 Dental Copay	
Basic Services	Periodontal Maintenance Services	20%		Schedule Schedule	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		See 2025 Dental Copay	
Services	Prosthodontics			Schedule	
	Oral Surgery				
Child	Medically necessary orthodontics	50%		\$1,000	
Orthodontics		JU /0		ψ1,000	

Date: April 17, 2025

Oral Surgery

Medically necessary orthodontics

50%

Child

Orthodontics

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	r Plan
otugriol Volume	V Calculator	74.00/	
ctuarial Value - A	V Calculator Plan design includes a deductible?	71.8% Yes, Medical/Pharm	1307
	Integrated Individual deductible	Yes, Medical/Pharm	асу
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,200 / \$50 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,400 / \$100 / \$	\$ O
	Individual Out–of–pocket maximum	\$9,800	
	Family Out-of-pocket maximum	\$19,600	
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	\$50	
Health care	Other prostitioner office visit	\$ 50	
provider's office or clinic	Other practitioner office visit	\$50	
/isit	Specialist visit	\$90	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$19	
Orugs to treat	Tier 2	\$60	Pharma deductib
liness or	Tion 2	***	Pharma
condition	Tier 3	\$90	deductib
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductib
	Surgery facility fac (a.c. ASC)		นอนนับแม้
Outpatient	Surgery facility fee (e.g., ASC)	30%	
services	Physician/surgeon fees	30%	
	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need mmediate attention	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$50	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	30%	X
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$50	
nealth, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$50	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
John	Outpatient Rehabilitation and Habilitation services	\$50	
delp ecovering or			
other special nealth needs	Skilled nursing care	30%	X
Julia Heeus	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	Eye exam	No charge	
ojo odi e	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray		
and	Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dantal	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		
	5 O CH 5 H H 5 D CH 7		

Summary of Be	nefits and Coverage	CCSB-only		CCSB-only		
	amounts describe the Enrollee's out of pocket costs.	Silver Coinsurance Plar		Silver Copay Plan		
		Comsurance Plan		Copay Plan		
Actuarial Value - A	AV Calculator	71.2%		70.8%		
	Plan design includes a deductible?	Yes, Medical/Pharma	acy	Yes, Medical/Pharm	nacy	
	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 / \$		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,000 / \$600 / \$0		\$5,000 / \$600 / \$	0	
	Individual Out-of-pocket maximum			\$8,750		
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible			\$17,500 N/A		
	HSA family plan: Individual deductible			N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
	Primary care visit to treat an injury, illness, or condition	\$55		\$55		
Health care provider's	Other practitioner office visit	\$55		\$55		
office or clinic						
visit	Specialist visit	\$90		\$90		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$55		\$55		
Tests	X-rays and Diagnostic Imaging	\$90		\$90		
	Imaging (CT/PET scans, MRIs)	35%	Χ	\$300	X	
	Tier 1	\$20		\$19		
D	Tier 2	\$75	Pharmacy	\$85	Pharmacy	
Drugs to treat illness or		Ψίσ	deductible	ΨΟΟ	deductible Pharmacy	
condition	Tier 3	\$105	Pharmacy deductible	\$110	deductible	
	Tier 4	30% up to \$250 per script after	Pharmacy	30% up to \$250 per script	Pharmacy	
		pharmacy deductible	deductible	after pharmacy deductible	deductible	
Outpatient	Surgery facility fee (e.g., ASC)	35%	Х	35%	X	
services	Physician/surgeon fees	35%		35%		
	Outpatient visit	35%		35%		
	Emergency room facility fee (waived if admitted)	35%	Х	35%	X	
	Emergency room physician fee (waived if admitted)	No charge		No charge		
Need immediate	Medical transportation (including emergency and non-emergency)	35%	Х	35%	X	
attention						
	Urgent care	\$55		\$55		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	35%	X	35%	X	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	35%	Х	35%		
		0070	~	0070		
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$55		\$55		
health, or substance	Montal/habaviaral haplth and aubatanae use disorder other autostiont					
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		
	Outpatient Rehabilitation and Habilitation services	\$55		\$55		
Help recovering or						
other special health needs	Skilled nursing care	35%	Х	35%	Х	
Houral Hecus	Durable medical equipment	35%		35%		
	Hospice service	No charge		No charge		
Child eye care	Eye exam	No charge		No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
	Preventive - Cleaning					
Child Dental Diagnostic	Preventive - X-ray	No shares		No observe		
and Preventive	Sealants per Tooth	No charge		No charge		
. revenuve	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental	Restorative Procedures			See 2025 Dental Copay		
Basic Services	Periodontal Maintenance Services	20%		See 2025 Dental Copay Schedule		
	Crowns and Casts					
	Endodontics					
Child Dental Major	Periodontics (other than maintenance)	50%		See 2025 Dental Copay		
Services	Prosthodontics Prosthodontics	JU /0		Schedule		
Child	Oral Surgery					
Orthodontics	Medically necessary orthodontics	50%		\$1,000		

-	e amounts describe the Enrollee's out of pocket costs.	CCSB-or Silver HDHP PI	
ctuarial Value - A	V Calculator	70.6%	
radia valdo 7	Plan design includes a deductible?	Yes, integr	
	Integrated Individual deductible	\$3,200 integ	
	Integrated Family deductible	\$6,400 integ	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Individual Out-of-pocket maximum	\$8,300	1
	Family Out-of-pocket maximum	\$16,600	0
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	\$3,200 See endn	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	25%	X
lealth care	Other practitioner office visit	25%	Х
orovider's office or clinic	Other practitioner office visit	25%	^
risit	Specialist visit	25%	Х
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	25%	X
ests	X-rays and Diagnostic Imaging	25%	Х
	Imaging (CT/PET scans, MRIs)	25%	X
		25% up to \$250 per	Х
	Tier 1	script	Х
Orugs to treat	Tier 2	25% up to \$250 per script	Х
illness or condition	Tier 3	25% up to \$250 per script	Х
	Tier 4	25% up to \$250 per	X
	Company facility for (a.g., ACC)	script	V
Outpatient	Surgery facility fee (e.g., ASC)	25%	X
services	Physician/surgeon fees	25%	Х
	Outpatient visit	25%	Х
	Emergency room facility fee (waived if admitted)	25%	Х
	Emergency room physician fee (waived if admitted)	0%	Χ
leed mmediate attention	Medical transportation (including emergency and non-emergency)	25%	X
	Urgent care	25%	Х
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	25%	X
	Physician/surgeon fee	25%	X
Mental health, behavioral nealth, or	Mental/behavioral health and substance use disorder outpatient office visits	25%	Х
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	25%	X
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	25%	Х
łelp	Outpatient Rehabilitation and Habilitation services	25%	Х
ecovering or	Skilled nursing care	25%	X
other special nealth needs			
	Durable medical equipment	25%	X
	Hospice service	0%	Х
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic and Preventive	Preventive - X-ray		
	Sealants per Tooth	No charge	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic		20%	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	50%	
ei vices	Prosthodontics		
	Oral Surgery		
Child			

Date: April 17, 2025

•	e amounts describe the Enrollee's out of pocket costs.	Silver P 100%-1509		Silver Plan 150%-200% FPI	_
Actuarial Value - A	AV Calculator	94.8%	6	87.9%	
	Plan design includes a deductible?	No		Yes, Medical/Pharm	nacy
	Integrated Individual deductible	N/A		N/A	·
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$1,400 / \$50 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /	/ \$0	\$2,800 / \$100 / \$	0
	Individual Out-of-pocket maximum	\$1,40	0	\$3,350	
	Family Out-of-pocket maximum		0	\$6,700	
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible			N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Haaldh aana	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
Health care provider's	Other practitioner office visit	\$5		\$15	
office or clinic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$10		\$30	
Tests	X-rays and Diagnostic Imaging	\$10		\$50	
	Imaging (CT/PET scans, MRIs)	\$10		\$100	
				·	
	Tier 1	\$3		\$8	Db
Drugs to treat	Tier 2	\$10		\$25	Pharmacy deductible
condition	Tier 3	\$15		\$45	Pharmacy deductible
	Tier 4	10% up to \$150 per script		15% up to \$150 per script	Pharmacy deductible
	Surgery facility fee (e.g., ASC)	10%		20%	
Outpatient services	Physician/surgeon fees	10%		20%	
	Outpatient visit	10%		20%	
	Emergency room facility fee (waived if admitted)	\$50		\$200	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	\$30		\$75	
attention					
	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%		20%	X
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	10%		20%	
		1070		2070	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
health, or substance	Mantal/habaniantha atthematic				
abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Help	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
recovering or other special	Skilled nursing care	10%		20%	X
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			Ů	
	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				
Basic Services	Periodontal Maintenance Services	20%		20%	
OCI VICES	Crowns and Casts				
	Endodontics				
Child Dental		E00/		F00/	
Major Services	Periodontics (other than maintenance)	50%		50%	
	Prosthodontics Oral Surgery				
Child	Oral Surgery Medically pages any orthodoptics	F00/		500/	
Orthodontics	Medically necessary orthodontics	50%		50%	

_		- 4		_
Summarv	O t	Benefits	and	Coverage

Common	Service Type	Member Cost Share Deductible
	HSA family plan: Individual deductible	N/A
	HSA plan: Self-only coverage deductible	N/A
	Family Out-of-pocket maximum	\$16,200
	Individual Out–of–pocket maximum	\$8,100
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,400 / \$100 / \$0
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,200 / \$50 / \$0
	Integrated Family deductible	N/A
	Integrated Individual deductible	N/A
	Plan design includes a deductible?	Yes, Medical/Pharmacy
Actuarial Value - A	AV Calculator	73.8%
Member Cost Share	e amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL

	HSA family plan: Individual deductible	ctible N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$50	
Health care provider's	Other practitioner office visit	\$50	
office or clinic		·	
visit	Specialist visit	\$90	
_	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$50 \$95	
16515	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$19	
Drugs to treat	Tier 2	\$55	Pharmad deductible
illness or condition	Tier 3	\$85	Pharmad
		20% up to \$250 per script	deductibl Pharmad
	Tier 4	after pharmacy deductible	deductibl
	Surgery facility fee (e.g., ASC)	30%	
Outpatient services	Physician/surgeon fees	30%	
	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	\$250	
attention			
	Urgent care	\$50	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%	Х
Hospital stay	Physician/surgeon fee	30%	
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$50	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$50	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
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	<u> </u>	
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray		
and	Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	20%	
	Crowns and Casts		
Oblida	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
OCI VICES	1		
CONTOCS	Oral Surgery		

Date: April 17, 2025

Summary of Benefits and Coverage

·	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Pla	n
Actuarial Value	V Calculator	63.7%		64.8%	
Actuarial Value - A			nacy		od
	Plan design includes a deductible? Integrated Individual deductible	Yes, Medical/Pharn N/A	nacy	Yes, integrat \$7,200 integra	
	Integrated Family deductible	N/A		\$14,400 integr	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,800 / \$450 / \$	60	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$11,600 / \$900 /	\$0	N/A	
	Individual Out–of–pocket maximum	\$9,800		\$7,200	
	Family Out-of-pocket maximum	\$19,600		\$14,400	
	HSA plan: Self-only coverage deductible	N/A		\$7,200	
	HSA family plan: Individual deductible	N/A		\$7,200	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Heelth core	Primary care visit to treat an injury, illness, or condition	\$60		0%	X
Health care provider's	Other practitioner office visit	\$60		0%	X
office or clinic visit	Specialist visit	\$95	After 1st three non-	0%	X
	Preventive care/ screening/ immunization	No charge	preventive visits	No charge	
	Laboratory Tests	\$50		0%	X
Tests	X-rays and Diagnostic Imaging	40%	X	0%	X
. 55.0	Imaging (CT/PET scans, MRIs)	40%	X	0%	X
			^		
	Tier 1	\$20		0%	Х
Drugs to treat	Tier 2	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	Х
illness or	Tier 3	40% up to \$500 per script after	Pharmacy	00/	V
condition	Her 3	pharmacy deductible	Deductible	0%	Х
	Tier 4	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	X
	Surgery facility fee (e.g., ASC)	40%	X	0%	Х
Outpatient					
services	Physician/surgeon fees	40%	X	0%	X
	Outpatient visit	40%	X	0%	X
	Emergency room facility fee (waived if admitted)	40%	X	0%	X
	Emergency room physician fee (waived if admitted)	No charge		0%	Х
Need immediate	Medical transportation (including emergency and non-emergency)	40%	X	0%	Х
attention					
	Urgent care	\$60		0%	Х
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	40%	X	0%	Х
Hospital stay	Physician/surgeon fee	40%	X	0%	X
Montal hoolth	Mental/behavioral health and substance use disorder outpatient office				
Mental health, behavioral	visits	\$60		0%	X
health, or substance	Mental/behavioral health and substance use disorder other outpatient				
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%	X
recovering or other special	Skilled nursing care	40%	X	0%	X
health needs	Durable medical equipment	40%	X	0%	Х
	Hospice service	No charge		0%	X
	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 and	·	No charge		No charge	
Preventive	Sealants per Tooth Tapical Fluorida Application				
	Topical Fluoride Application				
OLULD	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		20%	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	50%		50%	
Services	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		50%	
Orthodontics	salouny neododary orthodoridos	JU /0		50 /0	

Summary of Be	nefits and Coverage		
Member Cost Share	e amounts describe the Enrollee's out of pocket costs.	Catast	rophic Plan
Actuarial Value - A	AV Calculator		
	Plan design includes a deductible?	Yes,	integrated
	Integrated Individual deductible	\$10,15	0 integrated
	Integrated Family deductible	\$20,30	00 integrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A N/A
	Individual Out-of-pocket maximum	\$	10,150
	Family Out-of-pocket maximum		20,300
	HSA plan: Self-only coverage deductible		N/A
	HSA family plan: Individual deductible		N/A
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non- preventive visits
Health care provider's	Other practitioner office visit	0%	After 1st three non- preventive visits
office or clinic visit	Specialist visit	0%	X
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	X
Tests	X-rays and Diagnostic Imaging	0%	X
	Imaging (CT/PET scans, MRIs)	0%	X
	Tier 1	0%	X
	Tier 2		
Drugs to treat illness or	Tier 2	0%	X
condition	Tier 3	0%	X
	Tier 4	0%	X
	Surgery facility fee (e.g., ASC)	0%	X
Outpatient services	Physician/surgeon fees	0%	X
	Outpatient visit	0%	X
	Emergency room facility fee (waived if admitted)	0%	X
	Emergency room physician fee (waived if admitted)	No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	0%	X
attention	Urgent care	0%	After 1st three non-
	organic data	070	preventive visits
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	0%	X
, and plane of the	Physician/surgeon fee	0%	X
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%	X
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	X
Help	Outpatient Rehabilitation and Habilitation services	0%	X
recovering or other special	Skilled nursing care	0%	X
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%	X
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth	No charge	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	0%	X
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	0%	X
	Prosthodontics Onel Supreme		
Child	Oral Surgery		
Orthodontics	Medically necessary orthodontics	0%	Х

_	nefits and Coverage	04 = 1 00=	6 4 5	A. F. 1 . C. T. C. T.	7.01
ember Cost Share	amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Sil 100%-150%		CA Enh CSR Silver 87 150%-200% FPL	
ctuarial Value - A	V Calculator	95.4%		89.6%	
	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	
	Individual Out-of-pocket maximum	\$1,150		\$3,000	
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	\$2,300 N/A)	\$6,000 N/A	
	HSA family plan: Individual deductible	N/A N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	\$5	7,41,410	\$15	
Health care	Other practitioner office visit	\$ 5		\$15	
provider's office or clinic		·		·	
visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8		\$20	
Tests	X-rays and Diagnostic Imaging	\$8		\$40	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$5	
illness or	Tier 2	\$10		\$25	
	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	Physician/surgeon fees	10%		20%	
services	Outpatient visit	10%		20%	
	Emergency room facility fee (waived if admitted)	\$50		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$30		\$75	
immediate attention	Medical transportation (including emergency and non-emergency)	ψ30		φίσ	
	Urgent care	\$5		\$15	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		20%	
	Physician/surgeon fee	10%		20%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$5		\$15	
abuse needs	items and services			·	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
other special	Skilled nursing care	10%		20%	
health needs	Durable medical equipment	10%		15%	
	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 Dectal	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth	140 onarge		140 ondigo	
	Topical Fluoride Application				

20%

50%

50%

20%

50%

50%

Space Maintainers - Fixed

Periodontal Maintenance Services

Periodontics (other than maintenance)

Medically necessary orthodontics

Restorative Procedures

Crowns and Casts

Endodontics

Prosthodontics

Oral Surgery

Child Dental

Child Dental

Orthodontics

Major Services

Child

Basic

Services

_				_
Summary	of	Benefits	and	Coverage

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	HSA family plan: Individual deductible	N/A	
	HSA plan: Self-only coverage deductible	N/A	
	Family Out-of-pocket maximum	\$12,200	
	Individual Out-of-pocket maximum	\$6,100	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	
	Integrated Family deductible	N/A	
	Integrated Individual deductible	N/A	
	Plan design includes a deductible?	No	
octuarial Value - A	V Calculator	80.4%	
lember Cost Share	amounts describe the Emoliee's out of pocket costs.	Above 200% FPL	-
lember Cost Share	amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Silver 73	

	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$35	
Health care provider's	Other practitioner office visit	\$35	
office or clinic		·	
visit	Specialist visit	\$85	
	Preventive care/ screening/ immunization	No charge \$50	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$95	
10313	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$15	
Drugs to treat	Tier 2	\$55	
Ilness or condition	Tier 3	\$85	
	Tier 4	20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	30%	
Outpatient services	Physician/surgeon fees	30%	
	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$350	
	Emergency room physician fee (waived if admitted)	No charge	
Need mmediate attention	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$35	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%	
	Physician/surgeon fee	30%	
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$35	
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 other special	Skilled nursing care	30%	
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		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray		
and Preventive	Sealants per Tooth	No charge	
revenuve	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	20%	
	Crowns and Casts		
Child Dantal	Endodontics		
Child Dental	Periodontics (other than maintenance)	50%	
Major			
	Prosthodontics		
Major	Prosthodontics Oral Surgery		

9.5 EHB

Date: April 17, 2025

Summary of Benefits and Coverage



-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Individual-only F		Individual-only F	Platinum
Wember Cost Share	amounts describe the Emoliee's out of pocket costs.	Coinsurance	Plan	Copay Pla	ın
Actuarial Value - A	V Calculator	91.9%		91.8%	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Individual Out-of-pocket maximum	\$5,000		\$5,000	
	Family Out-of-pocket maximum	\$10,000		\$10,000	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
provider's	Other practitioner office visit	\$15		\$15	
office or clinic visit	Specialist visit	\$30		\$30	
				,	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$15		\$15	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75	
	Tier 1	\$9		\$9	
	Tier 2	\$16		\$16	
Drugs to treat illness or	HOLE	φισ		φισ	
condition	Tier 3	\$25		\$25	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$75	
Outpatient	Physician/surgeon fees	10%		\$20	
services					
	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$175		\$175	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate attention	Medical transportation (including emergency and non-emergency)	\$150		\$150	
	Urgent care	\$15		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%		\$225 per day up to	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	10%		5 days No charge	
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$15	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
recovering or	Skilled nursing care	10%		\$125 per day up to	
other special health needs	Durable medical equipment	10%		5 days 10%	
	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 Day	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth	INUL COVETED		INUL COVETED	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
Services					
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	
Or thoughties					

_	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-onl Platinum Coinsurance		CCSB-onl Platinum Copay Pla	ĺ
Actuarial Value - A	V Calculator	91.8%		91.1%	
	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	
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible			\$9,000 N/A	
	HSA family plan: Individual deductible			N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible
Wedical Everit	Primary care visit to treat an injury, illness, or condition	\$15	Арріїез	\$20	Applies
Health care				·	
provider's office or clinic	Other practitioner office visit	\$15		\$20	
visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$20	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$100	
	Tier 1	\$10		\$5	
Drugs to treat	Tier 2	\$25		\$20	
illness or condition	Tier 3	\$40		\$30	
	Tier 4	10% up to \$250 per		10% up to \$250 per	
	Surgery facility fee (e.g., ASC)	script		script \$100	
Outpatient	Physician/surgeon fees	10%		\$25	
services	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)			\$150	
		\$200			
Need mmediate	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	\$150		\$150	
attention	Urgent care	\$15		\$20	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee	10%		\$250 per day up to 5 days No charge	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$20	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$20	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$20	
recovering or other special	Skilled nursing care	10%		\$150 per day up to	
health needs	Durable medical equipment	10%		5 days 10%	
	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	3-			
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and	Sealants per Tooth	Not Covered		Not Covered	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic		Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics	 			
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
Child	Oral Surgery				
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

ember Cost Share	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
atuarial Value A	V Coloulator	04 40/		04.70/	
ctuarial Value - A	Plan design includes a deductible?	81.4% No		81.7% No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0 / \$0 / \$	60
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0)	\$0 / \$0 / \$	60
	Individual Out–of–pocket maximum	\$9,200		\$9,200	
	Family Out-of-pocket maximum	\$18,400		\$18,400	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	1
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deduc Appli
	Primary care visit to treat an injury, illness, or condition	\$40		\$40	
Health care provider's	Other practitioner office visit	\$40		\$40	
office or clinic		·		·	
/isit	Specialist visit	\$70		\$70	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging	\$75		\$75	
	Imaging (CT/PET scans, MRIs)	25%		\$75	
	Tier 1	\$18		\$18	
Drugg to to	Tier 2	\$60		\$60	
Orugs to treat Ilness 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	
1003	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350		\$350	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$250		\$250	
mmediate	Medical transportation (including emergency and non-emergency)	Ψ230		φ230	
eed	Liraont care	\$40		\$40	
	Urgent care	\$40		\$40	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	30%		\$375 per day up to	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	30%		5 days No charge	
	•	30 %		ivo charge	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$40		\$40	
health, or substance					
abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$40		\$40	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$40		\$40	
ecovering or	Skilled nursing care	30%		\$150 per day up to	
other special nealth needs	Durable medical equipment	20%		5 days 20%	
	Hospice service	No charge		No charge	
	F	No charge		No charge	
Child eye care	Eye exam				
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam			No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)			No charge	
Child Dental Diagnostic	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	No charge			
Child Dental Diagnostic	pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning			No charge Not Covered	
Child Dental Diagnostic	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray	No charge			
Child Dental Diagnostic	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	No charge			
Child Dental Diagnostic and Preventive Child Dental	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application	No charge Not Covered		Not Covered	
Child Dental Diagnostic and Preventive Child Dental Basic	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	No charge			
Child Dental Diagnostic and Preventive Child Dental Basic	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures	No charge Not Covered		Not Covered	
Child Dental Diagnostic and Preventive Child Dental Basic Services	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services	No charge Not Covered		Not Covered	
Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts	No charge Not Covered		Not Covered	
Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major Services	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics	Not Covered Not Covered		Not Covered	
Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance)	Not Covered Not Covered		Not Covered	

9.5 EHB

Date: April 17 Summary of Be	nefits and Coverage	CCSB-only		CCSB-only	
Member Cost Share	e amounts describe the Enrollee's out of pocket costs.	Gold Coinsurance Pla	n	Gold Copay Plan	
Actuarial Value - A	AV Calculator	80.3%		81.7%	
	Plan design includes a deductible?	Yes, Medical/Pharm	асу	Yes, Medical/Pharr	nacy
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$350 / \$0 / \$0 \$700 / \$0 / \$0		\$250 / \$0 / \$0 \$500 / \$0 / \$0	
	Individual Out-of-pocket maximum			\$7,800	
	Family Out-of-pocket maximum	\$15,600		\$15,600	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$25		\$35	
Health care provider's	Other practitioner office visit	\$25		\$35	
office or clinic	Specialist visit	\$50		\$55	
VISIL		·			
	Preventive care/ screening/ immunization Laboratory Tests	No charge \$25		No charge \$35	
Tests	X-rays and Diagnostic Imaging	\$65		\$55 \$55	
	Imaging (CT/PET scans, MRIs)	20%		\$250	X
					X
	Tier 1	\$15		\$15	
Drugs to treat	Tier 2	\$50		\$40	
illness or condition	Tier 3	\$80		\$70	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	20%		\$300	Х
Outpatient	Physician/surgeon fees	20%		\$35	
services	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	20%	X	\$250	X
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	20%	X	\$250	X
immediate attention	3 3 3,			,	
	Urgent care	\$25		\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	X	\$600 per day up to 5 days	X
Hospital stay	Physician/surgeon fee	20%	X	No charge	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$25		\$35	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$25		\$35	
abuse needs	Reported care and processoration visits				
Pregnancy	Prenatal care and preconception visits Home health care (cost share per visit)	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$25		\$35	
other special health needs	Skilled nursing care	20%	X	\$300 per day up to 5 days	Х
	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 and	Preventive - X-ray	Not Covered		Not Covered	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
Child Dental	Space Maintainers - Fixed				
Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics Devicedontics (other than maintenance)	Nat O		Net O	
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics Oral Surgary				
Child	Oral Surgery				
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

Summary of Benefits and Coverage	
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lember Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Silver	Plan
Actuarial Value - A	V Calculator	71.8%	
	Plan design includes a deductible?	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	,
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,200 / \$50 / \$0)
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,400 / \$100 / \$	SO
	Individual Out–of–pocket maximum	\$9,800	
	Family Out-of-pocket maximum	\$19,600	
	HSA plan: Self-only coverage deductible	N/A	
Common	HSA family plan: Individual deductible	N/A	Dodustible
Medical Event	Service Type	Member Cost Share	Deductible 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	
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$19	
Drugs to treat	Tier 2	\$60	Pharmacy deductible
illness or	Tior 2	\$00	Pharmacy
condition	Tier 3	\$90	deductible
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
	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	000/	
Hospital stay	delivery, mental health, and substance use)	30%	X
	Physician/surgeon fee	30%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$50	
health, or			
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$50	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$50	
recovering or other 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	140 Orlange	
Child Dental	Preventive - Cleaning		
Diagnostic and	Preventive - X-ray	Not Covered	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
•	Prosthodontics Oral Surgery		

9.5 EHB

Date: April 17	7, 2025				
-	enefits and Coverage	CCSB-only Silver		CCSB-only Silver	
Member Cost Share	e amounts describe the Enrollee's out of pocket costs.	Coinsurance Plan	1	Copay Plan	
Actuarial Value - A	\\/ Calculator	71.2%		70.8%	
Actualial value - A	Plan design includes a deductible?		acv	Yes, Medical/Pharmacy	
	Integrated Individual deductible	N/A		N/A	iacy
	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		\$5,000 / \$600 / \$	0
	Individual Out-of-pocket maximum			\$8,750	
	Family Out-of-pocket maximum			\$17,500 N/A	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			N/A N/A	
Common			Dodwatible		Deductible
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Applies
	Primary care visit to treat an injury, illness, or condition	\$55		\$55	
Health care provider's	Other practitioner office visit	\$55		\$55	
office or clinic visit	Specialist visit	\$90		\$90	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$55		\$55	
Tests	X-rays and Diagnostic Imaging	\$90		\$90	
	Imaging (CT/PET scans, MRIs)	35%	X	\$300	X
			,		,
	Tier 1	\$20		\$19	
Drugs to treat	Tier 2	\$75	Pharmacy deductible	\$85	Pharmacy deductible
illness or condition	Tier 3	\$105	Pharmacy	\$110	Pharmacy
		30% up to \$250 per script after	deductible Pharmacy	30% up to \$250 per script	deductible Pharmacy
	Tier 4	pharmacy deductible	deductible	after pharmacy deductible	deductible
	Surgery facility fee (e.g., ASC)	35%	X	35%	X
Outpatient services	Physician/surgeon fees	35%		35%	
	Outpatient visit	35%		35%	
	Emergency room facility fee (waived if admitted)	35%	X	35%	X
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	35%	X	35%	X
attention					
	Urgent care	\$55		\$55	
He switch store	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	35%	X	35%	Х
Hospital stay	Physician/surgeon fee	35%	X	35%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	0.55		0.5	
behavioral	visits	\$55		\$55	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$55		\$55	
abuse needs	items and services	ΨΟΟ		Ψοσ	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	35%		\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$55		\$55	
recovering or other special	Skilled nursing care	35%	X	35%	X
health needs	Durable medical equipment	35%		35%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
omic 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 Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth	Not Covered		Not Covered	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

9.5 EHB
Date: April 17, 2025

_	nefits and Coverage e amounts describe the Enrollee's out of pocket costs.	CCSB-or Silver HDHP PI	
ctuarial Value - A	AV Calculator	70.6%	
	Plan design includes a deductible?	Yes, integra	ated
	Integrated Individual deductible	\$3,200 integ	
	Integrated Family deductible	\$6,400 integ	rated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Individual Out-of-pocket maximum	\$8,300	
	Family Out-of-pocket maximum	\$16,600	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	\$3,200 See endn	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	25%	X
lealth care provider's	Other practitioner office visit	25%	Х
office or clinic	Carlot practition office viola	2070	^
risit	Specialist visit	25%	Х
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	25%	Χ
Tests Tests	X-rays and Diagnostic Imaging	25%	Χ
	Imaging (CT/PET scans, MRIs)	25%	Х
	Tier 1	25% up to \$250 per	Х
	Time	script 25% up to \$250 per	_
Orugs to treat Uness or condition	Tier 2 Tier 3	script 25% up to \$250 per	X
Junion	Tier 4	script 25% up to \$250 per	X
		script	
Outpatient	Surgery facility fee (e.g., ASC)	25%	Х
services	Physician/surgeon fees	25%	Х
	Outpatient visit	25%	Х
	Emergency room facility fee (waived if admitted)	25%	X
	Emergency room physician fee (waived if admitted)	0%	X
Need mmediate attention	Medical transportation (including emergency and non-emergency)	25%	Х
	Urgent care	25%	Х
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	25%	Х
	Physician/surgeon fee	25%	Х
Mental health, behavioral nealth, or	Mental/behavioral health and substance use disorder outpatient office visits	25%	Х
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	25%	Х
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	25%	Χ
lelp	Outpatient Rehabilitation and Habilitation services	25%	Χ
ecovering or other special	Skilled nursing care	25%	Х
nealth needs	Durable medical equipment	25%	Х
	Hospice service	0%	X
	Eye exam	No charge	^
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam	140 Glaige	
Child Dental	Preventive - Cleaning		
Diagnostic and	Preventive - X-ray	Not Covered	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dantal	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		

	amounts describe the Enrollee's out of pocket costs.	Silver P 100%-150%		Silver Plan 150%-200% FPl	
		10070 1007		30070 20070	
Actuarial Value - A	V Calculator	94.8%	, 0	87.9%	
	Plan design includes a deductible?	No		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 /		\$1,400 / \$50 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /		\$2,800 / \$100 / \$	0
	Individual Out-of-pocket maximum		0	\$3,350	
	Family Out-of-pocket maximum		0	\$6,700	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			N/A N/A	
Common	Service Type	Member Cost	Deductible	Member Cost Share	Deductible
Medical Event	Primary care visit to treat an injury, illness, or condition	Share \$5	Applies	\$15	Applies
Health care				·	
provider's office or clinic	Other practitioner office visit	\$5		\$15	
visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$10		\$30	
Tests	·	\$10		\$50	
16313	X-rays and Diagnostic Imaging				
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$8	
Drugs to treat	Tier 2	\$10		\$25	Pharmacy deductible
illness or condition	Tier 3	\$15		\$45	Pharmacy deductible
	Tier 4	10% up to \$150 per		15% up to \$150 per script	Pharmacy deductible
	Surgery facility fee (e.g., ASC)	script		20%	deductible
Outpatient					
services	Physician/surgeon fees	10%		20%	
	Outpatient visit	10%		20%	
	Emergency room facility fee (waived if admitted)	\$50		\$200	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$30		\$75	
immediate attention					
	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		20%	X
Hospital stay	Physician/surgeon fee	10%		20%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$5		\$15	
behavioral health, or	visits	·		·	
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
Help recovering or	·	·			
other special	Skilled nursing care	10%		20%	X
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			ű	
	Preventive - Cleaning				
Child Dental	·				
Diagnostic and	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	No. O		N 0	
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dental	Periodontics (other than maintenance)	Not Covered		Not Covered	
Major Services	Periodontics (other than maintenance) Prosthodontics	INOT COVELED		NOL COVEIEU	
	Programmes	ı			
Child	Oral Surgery				

Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs. Actuarial Value - AV Calculator Plan design includes a deductible? Integrated Individual deductible Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum Family Out-of-pocket maximum Sa,100 HSA plan: Self-only coverage deductible N/A HSA family plan: Individual deductible N/A	Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Member Cost Share amounts describe the Enrollee's out of pocket costs. Actuarial Value - AV Calculator Plan design includes a deductible? Integrated Individual deductible Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum Family Out-of-pocket maximum \$8,100		HSA family plan: Individual deductible	N/A	
Member Cost Share amounts describe the Enrollee's out of pocket costs. Actuarial Value - AV Calculator Plan design includes a deductible? Integrated Individual deductible Integrated Family deductible Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out—of—pocket maximum Silver Plan 200%-250% FPL Yes, Medical/Pharmacy N/A N/A N/A \$5,200 / \$50 / \$0 \$10,400 / \$100 / \$0		HSA plan: Self-only coverage deductible	N/A	
Member Cost Share amounts describe the Enrollee's out of pocket costs. Actuarial Value - AV Calculator Plan design includes a deductible? Integrated Individual deductible Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental \$10,400 / \$100 / \$0		Family Out-of-pocket maximum	\$16,200	
Member Cost Share amounts describe the Enrollee's out of pocket costs. Silver Plan 200%-250% FPL Actuarial Value - AV Calculator Plan design includes a deductible? Integrated Individual deductible Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Silver Plan 200%-250% FPL 73.8% Yes, Medical/Pharmacy N/A N/A Silver Plan 200%-250% FPL 73.8%		Individual Out-of-pocket maximum	\$8,100	
Member Cost Share amounts describe the Enrollee's out of pocket costs. Actuarial Value - AV Calculator Plan design includes a deductible? Integrated Individual deductible N/A Integrated Family deductible N/A		Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,400 / \$100 / \$	60
Member Cost Share amounts describe the Enrollee's out of pocket costs. Actuarial Value - AV Calculator Plan design includes a deductible? Integrated Individual deductible N/A		Individual deductible, NOT integrated: Medical / Pharmacy / Dental)
Member Cost Share amounts describe the Enrollee's out of pocket costs. Actuarial Value - AV Calculator Plan design includes a deductible? Silver Plan 200%-250% FPL 73.8% Yes, Medical/Pharmacy	Integrated Family deductible		N/A	
Member Cost Share amounts describe the Enrollee's out of pocket costs. Silver Plan 200%-250% FPL Actuarial Value - AV Calculator 73.8%		Integrated Individual deductible	N/A	
Member Cost Share amounts describe the Enrollee's out of pocket costs. Silver Plan 200%-250% FPL		Plan design includes a deductible?	Yes, Medical/Pharm	acy
Member Cost Share amounts describe the Enrollee's out of pocket costs Silver Plan	Actuarial Value - A	AV Calculator	73.8%	
Member Cost Share amounts describe the Enrollee's out of pocket costs Silver Plan			200%-250% FPI	-
Summary of Benefits and Coverage	Member Cost Share	amounts describe the Enrollee's out of pocket costs.		
	Summary of Be	nefits and Coverage		

	HSA family plan: Individual deductible	N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
	Primary care visit to treat an injury, illness, or condition	\$50		
Health care provider's	Other practitioner office visit	\$50		
office or clinic visit	Specialist visit	\$90		
	Preventive care/ screening/ immunization	No charge		
	Laboratory Tests	\$50		
Tests	X-rays and Diagnostic Imaging	\$95		
	Imaging (CT/PET scans, MRIs)	\$325		
	Tier 1	\$19		
Drugs to treat	Tier 2	\$55	Pharmac deductible	
illness or	Tier 3	\$85	Pharmac	
condition	Tier 3	•	deductibl	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmac deductibl	
	Surgery facility fee (e.g., ASC)	30%		
Outpatient services	Physician/surgeon fees	30%		
	Outpatient visit	30%		
	Emergency room facility fee (waived if admitted)	\$400		
	Emergency room physician fee (waived if admitted)	No charge		
Need immediate attention	Medical transportation (including emergency and non-emergency)	\$250		
	Urgent care	\$50		
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%	X	
	Physician/surgeon fee	30%		
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$50		
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$50		
Pregnancy	Prenatal care and preconception visits	No charge		
	Home health care (cost share per visit)	\$40		
Help	Outpatient Rehabilitation and Habilitation services	\$50		
recovering or other special	Skilled nursing care	30%	X	
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			
	Preventive - Cleaning			
Child Dental Diagnostic	Preventive - X-ray			
and Preventive	Sealants per Tooth	Not Covered		
rievelitive	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental	Restorative Procedures			
Basic Services	Periodontal Maintenance Services	Not Covered		
	Crowns and Casts			
Child Dental	Endodontics			
Major	Periodontics (other than maintenance)	Not Covered		
Services	Prosthodontics			
	Oral Surgery			

Summary of	of Benefits	and Coverage
Summary C	n Dellellis	and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.		Bronze Plan	Bronze HDHP Plan		
A atura vial Malura A	N Coloulator	62.70/		64.99/	
Actuarial Value - A		63.7%	nacy	64.8%	rod
	Plan design includes a deductible? Integrated Individual deductible	Yes, Medical/Pharmacy		Yes, integrated \$7,200 integrated	
	Integrated Family deductible	N/A N/A		\$14,400 integrated	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,800 / \$450 / \$	50	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$11,600 / \$900 /		N/A	
	Individual Out–of–pocket maximum	\$9,800		\$7,200	
	Family Out-of-pocket maximum	\$19,600		\$14,400	
	HSA plan: Self-only coverage deductible	N/A		\$7,200	
	HSA family plan: Individual deductible	N/A		\$7,200	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$60		0%	X
Health care provider's	Other practitioner office visit	\$60		0%	X
office or clinic visit	Specialist visit	\$95	After 1st three non-	0%	X
Viole		·	preventive visits		Α
	Preventive care/ screening/ immunization	No charge		No charge	V
Toolo	Laboratory Tests	\$50	V	0%	X
Tests	X-rays and Diagnostic Imaging	40%	X	0%	X
	Imaging (CT/PET scans, MRIs)	40%	X	0%	X
	Tier 1	\$20		0%	X
Drugs to treat	Tier 2	40% up to \$500 per script after	Pharmacy	0%	X
illness or		pharmacy deductible 40% up to \$500 per script after	Deductible Pharmacy		
condition	Tier 3	pharmacy deductible	Deductible	0%	X
	Tier 4	40% up to \$500 per script after	Pharmacy	0%	X
		pharmacy deductible	Deductible		.,
Outpatient	Surgery facility fee (e.g., ASC)	40%	X	0%	Х
services	Physician/surgeon fees	40%	X	0%	Х
	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 immediate	Medical transportation (including emergency and non-emergency)	40%	X	0%	X
attention	Urgent care	\$60		0%	х
Heavital stay	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
Montal hoolth	Mental/behavioral health and substance use disorder outpatient office				
Mental health, behavioral	visits	\$60		0%	X
health, or substance	Mental/behavioral health and substance use disorder other outpatient				
abuse needs	items and services	\$60		0%	X
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%	X
recovering or other special	Skilled nursing care	40%	X	0%	X
health needs	Durable medical equipment	40%	X	0%	X
	Hospice service	No charge		0%	X
	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 and	Sealants per Tooth	Not Covered		Not Covered	
Preventive					
	Topical Fluoride Application				
Child Dontal	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
OCI VICES	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	
Orthodontics					

Date: April 17, 2025

Summary of Benefits and Coverage

-	nefits and Coverage e amounts describe the Enrollee's out of pocket costs.	Catast	rophic Plan
Actuarial Value - A	AV Calculator		
	Plan design includes a deductible?		integrated
	Integrated Individual deductible Integrated Family deductible		50 integrated 00 integrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	φ20,30	N/A
	Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Individual Out–of–pocket maximum	\$	10,150
	Family Out-of-pocket maximum	\$	20,300
	HSA plan: Self-only coverage deductible		N/A
	HSA family plan: Individual deductible		N/A
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non- preventive visits
Health care provider's office or clinic	Other practitioner office visit	0%	After 1st three non- preventive visits
visit	Specialist visit	0%	X
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	X
Tests	X-rays and Diagnostic Imaging	0%	Х
	Imaging (CT/PET scans, MRIs)	0%	Х
	Tier 1	0%	Х
	Tion 2		V
Drugs to treat illness or	Tier 2	0%	X
condition	Tier 3	0%	X
	Tier 4	0%	X
Outpatient	Surgery facility fee (e.g., ASC)	0%	X
services	Physician/surgeon fees	0%	X
	Outpatient visit	0%	X
	Emergency room facility fee (waived if admitted)	0%	X
	Emergency room physician fee (waived if admitted)	No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	0%	X
attention			After 1st three non-
	Urgent care	0%	preventive visits
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	0%	X
Hospital stay	delivery, mental health, and substance use)		
	Physician/surgeon fee	0%	X
Mental 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%	X
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	Х
Help	Outpatient Rehabilitation and Habilitation services	0%	X
recovering or other special	Skilled nursing care	0%	X
health needs	Durable medical equipment	0%	X
	Hospice service	0%	Х
Child ove care	Eye exam	No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	Х
	Oral Exam		
OLUAN	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth	THOI COVEIED	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services	5570100	
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	Not Covered	
	Prosthodontics		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	Not Covered	

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Silv 100%-150%		CA Enh CSR Silver 8 150%-200% FPL	
tuarial Value - A	AV Calculator	95.4%	Ď	89.6%	
	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	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /		\$0 / \$0 / \$0	
	Individual Out-of-pocket maximum			\$3,000	
	Family Out-of-pocket maximum)	\$6,000	
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
Health care provider's	Other practitioner office visit	\$5		\$15	
office or clinic					
visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8		\$20	
Tests	X-rays and Diagnostic Imaging	\$8		\$40	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$5	
Orugs to treat	Tier 2	\$10		\$25	
liness or	Tier 3	\$1 5		¢45	
condition	Her 3	\$15		\$45	
	Tier 4	10% up to \$150 per script		15% up to \$150 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	10%		20%	
	Physician/surgeon fees	10%		20%	
	Outpatient visit	10%		20%	
Need	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)				
mmediate	Medical transportation (including enlergency and non-enlergency)	\$30		\$75	
attention					
	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%		20%	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	10%		20%	
	Physician/surgeon ree	10%		20%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
pehavioral nealth, or	Violid				
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
,	Home health care (cost share per visit)	\$3		\$15	
				·	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
other special	Skilled nursing care	10%		20%	
nealth needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
	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	. io onargo		. 10 Undigo	
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	N. C		111.5	
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dental		Not Course		Not Course	
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
	Oral Surgery				
Child		Not Covered		Not Covered	

Child

Orthodontics

Medically necessary orthodontics

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Silver 73 Above 200% FPI	
ctuarial Value - A	V Calculator	80.4%	
otaariai value 7	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 Event	Service Type	Member Cost Share	Deductil Applie
viedicai Everit	Primary care visit to treat an injury, illness, or condition	\$35	Дрріїе:
Health care	Other practitioner office visit	\$35	
office or clinic		·	
/isit	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	
Dun-1	Tier 2	\$55	
Orugs to treat Ilness or			
condition	Tier 3	\$85	
	Tier 4	20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	30%	
Outpatient .	Physician/surgeon fees	30%	
services	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$350	
	Emergency room physician fee (waived if admitted)	No charge	
Need mmediate	Medical transportation (including emergency and non-emergency)	\$250	
attention	Urgent care	\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	30% 30%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$35	
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	
Holm	Outpatient Rehabilitation and Habilitation services	\$35	
Help recovering or	Skilled nursing care	30%	
other special nealth needs			
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	1 pair of glasses per year (or contact lenses in liqu of glasses)	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic and	Preventive - X-ray	Not Covered	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
N	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	
20.11003	Prosthodontics		
	Oral Surgery		
Child			

Not Covered

Endnotes to Covered California 2026 Patient-Centered Benefit Plan Designs

These endnotes and the Patient-Centered Benefit Plan Designs apply only to covered services.

Notes:

- Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. Innetwork services include services provided by an out-of-network provider but are approved as in-network by the issuer.
- 2) For covered out of network services in a PPO plan, these Patient-Centered Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
- 3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
- 4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
- 5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of (1) the specified deductible amount for individual coverage or (2) the minimum deductible amount for family coverage specified by the IRS in its revenue procedure for the 2026 calendar year for inflation adjusted amounts for Health Savings Accounts (HSAs), issued pursuant to section 223 of the Internal Revenue Code. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
- 6) Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the \$45 copayment, the lesser amount is the applicable cost-sharing amount.
- 7) Where indicated, the deductible is waived for the first three non-preventive visits combined, which may include office visits, urgent care visits, and/or outpatient Mental Health/Substance Use Disorder visits.
- 8) Member cost-share for oral anti-cancer drugs shall not exceed \$250 for a script of up to 30 days per state law (Health and Safety Code § 1367.656; Insurance Code § 10123.206).
- 9) In the Platinum and Gold Copay Plans, inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of a continuous stay.

- 10) For drugs to treat an illness or condition, the copay or co-insurance applies to an up to 30-day prescription supply. Nothing in this note precludes an issuer from offering mail order prescriptions at a reduced cost-share.
- 11) As applicable, for the child dental portion of the benefit design, an issuer may choose the child dental standard benefit copay or coinsurance design, regardless of whether the issuer selects the copay or the coinsurance design for the non-dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits, and glasses (or contact lenses in lieu of glasses) under Child Eye Care.
- 12) A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 2026 Dental Copay Schedule.
- 13) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
- 14) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Patient-Centered Benefit Plan Designs.
- 15) Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
- 16) Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
- 17) Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate. Services provided by specialists for the treatment of mental health or substance use disorder conditions shall be categorized as Mental/Behavioral health or Substance Use disorder outpatient services.
- 18) The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, Podiatrists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than the specialist visit

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

Tier	Definition
1	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;
	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.