Covered California 2026 Patient-Centered Benefit Plan Designs[1]

Final Approved

April 17, 2025

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

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Individual-only Platinum Coinsurance Plan	Individual-only Platinum Copay Plan
Actuarial Value - AV 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	Coinsurance Plan: Member Cost Share	Coinsurance Plan: Deductible Applies	Copay Plan: Member Cost Share	Copay Plan: Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$15		$15	
	Other practitioner office visit	$15		$15	
	Specialist visit	$30		$30	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	$15		$15	
	X-rays and Diagnostic Imaging	$30		$30	
	Imaging (CT/PET scans, MRIs)	10%		$75	
Drugs to treat illness or condition	Tier 1	$9		$9	
	Tier 2	$16		$16	
	Tier 3	$25		$25	
	Tier 4	10% up to $250 per script		10% up to $250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	10%		$75	
	Physician/surgeon fees	10%		$20	
	Outpatient visit	10%		10%	
Need immediate attention	Emergency room facility fee (waived if admitted)	$175		$175	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	$150		$150	
	Urgent care	$15		$15	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		$225 per day up to 5 days	
	Physician/surgeon fee	10%		No charge	
Mental health, behavioral health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	$15		$15	
	Mental/behavioral health and substance use disorder other outpatient items and services	$15		$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	10%		$20	
	Outpatient Rehabilitation and Habilitation services	$15		$15	
	Skilled nursing care	10%		$125 per day up to 5 days	
	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	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	No charge		No charge	
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	20%		See 2025 Dental Copay Schedule	
Child Dental Major Services	Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	50%		See 2025 Dental Copay Schedule	
Child Orthodontics	Medically necessary orthodontics	50%		$1,000	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

	CCSB-only Platinum Coinsurance Plan	CCSB-only Platinum Copay Plan
Actuarial Value - AV 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 / $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	Coinsurance Plan: Member Cost Share	Coinsurance Plan: Deductible Applies	Copay Plan: Member Cost Share	Copay Plan: Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$15		$20	
	Other practitioner office visit	$15		$20	
	Specialist visit	$30		$30	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	$15		$20	
	X-rays and Diagnostic Imaging	$30		$30	
	Imaging (CT/PET scans, MRIs)	10%		$100	
Drugs to treat illness or condition	Tier 1	$10		$5	
	Tier 2	$25		$20	
	Tier 3	$40		$30	
	Tier 4	10% up to $250 per script		10% up to $250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	10%		$100	
	Physician/surgeon fees	10%		$25	
	Outpatient visit	10%		10%	
Need immediate attention	Emergency room facility fee (waived if admitted)	$200		$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	$150		$150	
	Urgent care	$15		$20	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		$250 per day up to 5 days	
	Physician/surgeon fee	10%		No charge	
Mental health, behavioral health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	$15		$20	
	Mental/behavioral health and substance use disorder other outpatient items and services	$15		$20	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	10%		$20	
	Outpatient Rehabilitation and Habilitation services	$15		$20	
	Skilled nursing care	10%		$150 per day up to 5 days	
	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	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	No charge		No charge	
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	20%		See 2025 Dental Copay Schedule	
Child Dental Major Services	Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	50%		See 2025 Dental Copay Schedule	
Child Orthodontics	Medically necessary orthodontics	50%		$1,000	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Individual-only Gold Coinsurance Plan	Individual-only Gold Copay Plan
Actuarial Value - AV Calculator	81.4%	81.7%
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	$9,200	$9,200
Family Out-of-pocket maximum	$18,400	$18,400
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$40		$40	
	Other practitioner office visit	$40		$40	
	Specialist visit	$70		$70	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	$40		$40	
	X-rays and Diagnostic Imaging	$75		$75	
	Imaging (CT/PET scans, MRIs)	25%		$75	
Drugs to treat illness or condition	Tier 1	$18		$18	
	Tier 2	$60		$60	
	Tier 3	$85		$85	
	Tier 4	20% up to $250 per script		20% up to $250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	30%		$130	
	Physician/surgeon fees	30%		$60	
	Outpatient visit	20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	$350		$350	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	$250		$250	
	Urgent care	$40		$40	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%		$375 per day up to 5 days	
	Physician/surgeon fee	30%		No charge	
Mental health, behavioral health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	$40		$40	
	Mental/behavioral health and substance use disorder other outpatient items and services	$40		$40	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	20%		$30	
	Outpatient Rehabilitation and Habilitation services	$40		$40	
	Skilled nursing care	30%		$150 per day up to 5 days	
	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	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	No charge		No charge	
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	20%		See 2025 Dental Copay Schedule	
Child Dental Major Services	Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	50%		See 2025 Dental Copay Schedule	
Child Orthodontics	Medically necessary orthodontics	50%		$1,000	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

	CCSB-only Gold Coinsurance Plan	CCSB-only Gold Copay Plan
Actuarial Value - AV Calculator	80.3%	81.7%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A	N/A
Integrated Family deductible	N/A	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$350 / $0 / $0	$250 / $0 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$700 / $0 / $0	$500 / $0 / $0
Individual Out–of–pocket maximum	$7,800	$7,800
Family Out-of-pocket maximum	$15,600	$15,600
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type	Gold Coinsurance: Member Cost Share	Gold Coinsurance: Deductible Applies	Gold Copay: Member Cost Share	Gold Copay: Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$25		$35	
	Other practitioner office visit	$25		$35	
	Specialist visit	$50		$55	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	$25		$35	
	X-rays and Diagnostic Imaging	$65		$55	
	Imaging (CT/PET scans, MRIs)	20%		$250	X
Drugs to treat illness or condition	Tier 1	$15		$15	
	Tier 2	$50		$40	
	Tier 3	$80		$70	
	Tier 4	20% up to $250 per script		20% up to $250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	20%		$300	X
	Physician/surgeon fees	20%		$35	
	Outpatient visit	20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	20%	X	$250	X
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	20%	X	$250	X
	Urgent care	$25		$35	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	X	$600 per day up to 5 days	X
	Physician/surgeon fee	20%	X	No charge	
Mental health, behavioral health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	$25		$35	
	Mental/behavioral health and substance use disorder other outpatient items and services	$25		$35	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	20%		$30	
	Outpatient Rehabilitation and Habilitation services	$25		$35	
	Skilled nursing care	20%	X	$300 per day up to 5 days	X
	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	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	No charge		No charge	
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	20%		See 2025 Dental Copay Schedule	
Child Dental Major Services	Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	50%		See 2025 Dental Copay Schedule	
Child Orthodontics	Medically necessary orthodontics	50%		$1,000	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Individual-only Silver Plan
Actuarial Value - AV Calculator	71.8%
Plan design includes a deductible?	Yes, Medical/Pharmacy
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 / $0
Individual Out–of–pocket maximum	$9,800
Family Out-of-pocket maximum	$19,600
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$50	
	Other practitioner office visit	$50	
	Specialist visit	$90	
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests	$50	
	X-rays and Diagnostic Imaging	$95	
	Imaging (CT/PET scans, MRIs)	$325	
Drugs to treat illness or condition	Tier 1	$19	
	Tier 2	$60	Pharmacy deductible
	Tier 3	$90	Pharmacy deductible
	Tier 4	20% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)	30%	
	Physician/surgeon fees	30%	
	Outpatient visit	30%	
Need immediate attention	Emergency room facility fee (waived if admitted)	$400	
	Emergency room physician fee (waived if admitted)	No charge	
	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 health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	$50	
	Mental/behavioral health and substance use disorder other outpatient items and services	$50	
Pregnancy	Prenatal care and preconception visits	No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	$45	
	Outpatient Rehabilitation and Habilitation services	$50	
	Skilled nursing care	30%	X
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
Child Dental Diagnostic and Preventive	Oral Exam	No charge	
	Preventive - Cleaning		
	Preventive - X-ray		
	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic Services	Restorative Procedures	20%	
	Periodontal Maintenance Services		
Child Dental Major Services	Crowns and Casts	50%	
	Endodontics		
	Periodontics (other than maintenance)		
	Prosthodontics		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	50%	

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

	CCSB-only Silver Coinsurance Plan	CCSB-only Silver Copay Plan
Actuarial Value - AV Calculator	71.2%	70.8%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A	N/A
Integrated Family deductible	N/A	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$2,500 / $300 / $0	$2,500 / $300 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$5,000 / $600 / $0	$5,000 / $600 / $0
Individual Out–of–pocket maximum	$8,600	$8,750
Family Out-of-pocket maximum	$17,200	$17,500
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type	Member Cost Share (Coinsurance Plan)	Deductible Applies	Member Cost Share (Copay Plan)	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$55		$55	
	Other practitioner office visit	$55		$55	
	Specialist visit	$90		$90	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	$55		$55	
	X-rays and Diagnostic Imaging	$90		$90	
	Imaging (CT/PET scans, MRIs)	35%	X	$300	X
Drugs to treat illness or condition	Tier 1	$20		$19	
	Tier 2	$75	Pharmacy deductible	$85	Pharmacy deductible
	Tier 3	$105	Pharmacy deductible	$110	Pharmacy deductible
	Tier 4	30% up to $250 per script after pharmacy deductible	Pharmacy deductible	30% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)	35%	X	35%	X
	Physician/surgeon fees	35%		35%	
	Outpatient visit	35%		35%	
Need immediate attention	Emergency room facility fee (waived if admitted)	35%	X	35%	X
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	35%	X	35%	X
	Urgent care	$55		$55	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	35%	X	35%	X
	Physician/surgeon fee	35%	X	35%	
Mental health, behavioral health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	$55		$55	
	Mental/behavioral health and substance use disorder other outpatient items and services	$55		$55	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	35%		$45	
	Outpatient Rehabilitation and Habilitation services	$55		$55	
	Skilled nursing care	35%	X	35%	X
	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	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	No charge		No charge	
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	20%		See 2025 Dental Copay Schedule	
Child Dental Major Services	Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	50%		See 2025 Dental Copay Schedule	
Child Orthodontics	Medically necessary orthodontics	50%		$1,000	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

	CCSB-only Silver HDHP Plan
Actuarial Value - AV Calculator	70.6%
Plan design includes a deductible?	Yes, integrated
Integrated Individual deductible	$3,200 integrated
Integrated Family deductible	$6,400 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Individual Out–of–pocket maximum	$8,300
Family Out-of-pocket maximum	$16,600
HSA plan: Self-only coverage deductible	$3,200
HSA family plan: Individual deductible	See endnote

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	25%	X
	Other practitioner office visit	25%	X
	Specialist visit	25%	X
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests	25%	X
	X-rays and Diagnostic Imaging	25%	X
	Imaging (CT/PET scans, MRIs)	25%	X
Drugs to treat illness or condition	Tier 1	25% up to $250 per script	X
	Tier 2	25% up to $250 per script	X
	Tier 3	25% up to $250 per script	X
	Tier 4	25% up to $250 per script	X
Outpatient services	Surgery facility fee (e.g., ASC)	25%	X
	Physician/surgeon fees	25%	X
	Outpatient visit	25%	X
Need immediate attention	Emergency room facility fee (waived if admitted)	25%	X
	Emergency room physician fee (waived if admitted)	0%	X
	Medical transportation (including emergency and non-emergency)	25%	X
	Urgent care	25%	X
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 health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	25%	X
	Mental/behavioral health and substance use disorder other outpatient items and services	25%	X
Pregnancy	Prenatal care and preconception visits	No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	25%	X
	Outpatient Rehabilitation and Habilitation services	25%	X
	Skilled nursing care	25%	X
	Durable medical equipment	25%	X
	Hospice service	0%	X
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
Child Dental Diagnostic and Preventive	Oral Exam	No charge	
	Preventive - Cleaning		
	Preventive - X-ray		
	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic Services	Restorative Procedures	20%	
	Periodontal Maintenance Services		
Child Dental Major Services	Crowns and Casts	50%	
	Endodontics		
	Periodontics (other than maintenance)		
	Prosthodontics		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	50%	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.	**Silver Plan** 100%-150% FPL	**Silver Plan** 150%-200% FPL
Actuarial Value - AV Calculator	94.8%	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 / $0	$1,400 / $50 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0	$2,800 / $100 / $0
Individual Out–of–pocket maximum	$1,400	$3,350
Family Out-of-pocket maximum	$2,800	$6,700
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	**Service Type**	**Member Cost Share**	Deductible Applies	**Member Cost Share**	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$5		$15	
	Other practitioner office visit	$5		$15	
	Specialist visit	$8		$25	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	$10		$30	
	X-rays and Diagnostic Imaging	$10		$50	
	Imaging (CT/PET scans, MRIs)	$50		$100	
Drugs to treat illness or condition	Tier 1	$3		$8	
	Tier 2	$10		$25	Pharmacy deductible
	Tier 3	$15		$45	Pharmacy deductible
	Tier 4	10% up to $150 per script		15% up to $150 per script	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)	10%		20%	
	Physician/surgeon fees	10%		20%	
	Outpatient visit	10%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	$50		$200	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	$30		$75	
	Urgent care	$5		$15	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		20%	X
	Physician/surgeon fee	10%		20%	
Mental health, behavioral health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	$5		$15	
	Mental/behavioral health and substance use disorder other outpatient items and services	$5		$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	$3		$15	
	Outpatient Rehabilitation and Habilitation services	$5		$15	
	Skilled nursing care	10%		20%	X
	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	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	No charge		No charge	
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	20%		20%	
Child Dental Major Services	Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	50%		50%	
Child Orthodontics	Medically necessary orthodontics	50%		50%	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Silver Plan 200%-250% FPL
Actuarial Value - AV Calculator	73.8%
Plan design includes a deductible?	Yes, Medical/Pharmacy
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 / $0
Individual Out–of–pocket maximum	$8,100
Family Out-of-pocket maximum	$16,200
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$50	
	Other practitioner office visit	$50	
	Specialist visit	$90	
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests	$50	
	X-rays and Diagnostic Imaging	$95	
	Imaging (CT/PET scans, MRIs)	$325	
Drugs to treat illness or condition	Tier 1	$19	
	Tier 2	$55	Pharmacy deductible
	Tier 3	$85	Pharmacy deductible
	Tier 4	20% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)	30%	
	Physician/surgeon fees	30%	
	Outpatient visit	30%	
Need immediate attention	Emergency room facility fee (waived if admitted)	$400	
	Emergency room physician fee (waived if admitted)	No charge	
	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 health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	$50	
	Mental/behavioral health and substance use disorder other outpatient items and services	$50	
Pregnancy	Prenatal care and preconception visits	No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	$40	
	Outpatient Rehabilitation and Habilitation services	$50	
	Skilled nursing care	30%	X
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	No charge	
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	20%	
Child Dental Major Services	Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	50%	
Child Orthodontics	Medically necessary orthodontics	50%	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Bronze Plan	Bronze HDHP Plan
Actuarial Value - AV Calculator	63.7%	64.8%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, integrated
Integrated Individual deductible	N/A	$7,200 integrated
Integrated Family deductible	N/A	$14,400 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$5,800 / $450 / $0	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	Bronze Plan Member Cost Share	Bronze Plan Deductible Applies	Bronze HDHP Plan Member Cost Share	Bronze HDHP Plan Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$60	After 1st three non-preventive visits	0%	X
	Other practitioner office visit	$60		0%	X
	Specialist visit	$95		0%	X
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	$50		0%	X
	X-rays and Diagnostic Imaging	40%	X	0%	X
	Imaging (CT/PET scans, MRIs)	40%	X	0%	X
Drugs to treat illness or condition	Tier 1	$20		0%	X
	Tier 2	40% up to $500 per script after pharmacy deductible	Pharmacy Deductible	0%	X
	Tier 3	40% up to $500 per script after pharmacy deductible	Pharmacy Deductible	0%	X
	Tier 4	40% up to $500 per script after pharmacy deductible	Pharmacy Deductible	0%	X
Outpatient services	Surgery facility fee (e.g., ASC)	40%	X	0%	X
	Physician/surgeon fees	40%	X	0%	X
	Outpatient visit	40%	X	0%	X
Need immediate attention	Emergency room facility fee (waived if admitted)	40%	X	0%	X
	Emergency room physician fee (waived if admitted)	No charge		0%	X
	Medical transportation (including emergency and non-emergency)	40%	X	0%	X
	Urgent care	$60		0%	X
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	40%	X	0%	X
	Physician/surgeon fee	40%	X	0%	X
Mental health, behavioral health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	$60		0%	X
	Mental/behavioral health and substance use disorder other outpatient items and services	$60		0%	X
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	40%	X	0%	X
	Outpatient Rehabilitation and Habilitation services	$60		0%	X
	Skilled nursing care	40%	X	0%	X
	Durable medical equipment	40%	X	0%	X
	Hospice service	No charge		0%	X
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam	No charge		No charge	
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Restorative Procedures	20%		20%	
	Periodontal Maintenance Services				
Child Dental Major Services	Crowns and Casts	50%		50%	
	Endodontics				
	Periodontics (other than maintenance)				
	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		50%	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Catastrophic Plan
Actuarial Value - AV Calculator	
Plan design includes a deductible?	Yes, integrated
Integrated Individual deductible	$10,150 integrated
Integrated Family deductible	$20,300 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Individual Out–of–pocket maximum	$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
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non-preventive visits
	Other practitioner office visit	0%	After 1st three non-preventive visits
	Specialist visit	0%	X
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests	0%	X
	X-rays and Diagnostic Imaging	0%	X
	Imaging (CT/PET scans, MRIs)	0%	X
Drugs to treat illness or condition	Tier 1	0%	X
	Tier 2	0%	X
	Tier 3	0%	X
	Tier 4	0%	X
Outpatient services	Surgery facility fee (e.g., ASC)	0%	X
	Physician/surgeon fees	0%	X
	Outpatient visit	0%	X
Need immediate attention	Emergency room facility fee (waived if admitted)	0%	X
	Emergency room physician fee (waived if admitted)	No charge	
	Medical transportation (including emergency and non-emergency)	0%	X
	Urgent care	0%	After 1st three non-preventive visits
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	0%	X
	Physician/surgeon fee	0%	X
Mental health, behavioral health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three non-preventive visits
	Mental/behavioral health and substance use disorder other outpatient items and services	0%	X
Pregnancy	Prenatal care and preconception visits	No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	0%	X
	Outpatient Rehabilitation and Habilitation services	0%	X
	Skilled nursing care	0%	X
	Durable medical equipment	0%	X
	Hospice service	0%	X
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	No charge	
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	0%	X
Child Dental Major Services	Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	0%	X
Child Orthodontics	Medically necessary orthodontics	0%	X

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

	CA Enh CSR Silver 94 Plan 100%-150% FPL	CA Enh CSR Silver 87 Plan 150%-200% FPL
Actuarial Value - AV Calculator	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 / $0
Individual Out–of–pocket maximum	$1,150	$3,000
Family Out-of-pocket maximum	$2,300	$6,000
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type	CA Enh CSR Silver 94 Plan: Member Cost Share	CA Enh CSR Silver 94 Plan: Deductible Applies	CA Enh CSR Silver 87 Plan: Member Cost Share	CA Enh CSR Silver 87 Plan: Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$5		$15	
	Other practitioner office visit	$5		$15	
	Specialist visit	$8		$25	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	$8		$20	
	X-rays and Diagnostic Imaging	$8		$40	
	Imaging (CT/PET scans, MRIs)	$50		$100	
Drugs to treat illness or condition	Tier 1	$3		$5	
	Tier 2	$10		$25	
	Tier 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 immediate attention	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)	$30		$75	
	Urgent care	$5		$15	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		20%	
	Physician/surgeon fee	10%		20%	
Mental health, behavioral health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	$5		$15	
	Mental/behavioral health and substance use disorder other outpatient items and services	$5		$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	$3		$15	
	Outpatient Rehabilitation and Habilitation services	$5		$15	
	Skilled nursing care	10%		20%	
	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	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	No charge		No charge	
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	20%		20%	
Child Dental Major Services	Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	50%		50%	
Child Orthodontics	Medically necessary orthodontics	50%		50%	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

	CA Enh CSR Silver 73 Plan Above 200% FPL
Actuarial Value - AV Calculator	80.4%
Plan design includes a deductible?	No
Integrated Individual deductible	N/A
Integrated Family deductible	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0
Individual Out–of–pocket maximum	$6,100
Family Out-of-pocket maximum	$12,200
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$35	
	Other practitioner office visit	$35	
	Specialist visit	$85	
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests	$50	
	X-rays and Diagnostic Imaging	$95	
	Imaging (CT/PET scans, MRIs)	$325	
Drugs to treat illness or condition	Tier 1	$15	
	Tier 2	$55	
	Tier 3	$85	
	Tier 4	20% up to $250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	30%	
	Physician/surgeon fees	30%	
	Outpatient visit	30%	
Need immediate attention	Emergency room facility fee (waived if admitted)	$350	
	Emergency room physician fee (waived if admitted)	No charge	
	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 substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	$35	
	Mental/behavioral health and substance use disorder other outpatient items and services	$35	
Pregnancy	Prenatal care and preconception visits	No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	$40	
	Outpatient Rehabilitation and Habilitation services	$35	
	Skilled nursing care	30%	
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	No charge	
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	20%	
Child Dental Major Services	Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	50%	
Child Orthodontics	Medically necessary orthodontics	50%	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Individual-only Platinum Coinsurance Plan	Individual-only Platinum Copay Plan
Actuarial Value - AV 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 provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$15		$15	
	Other practitioner office visit	$15		$15	
	Specialist visit	$30		$30	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	$15		$15	
	X-rays and Diagnostic Imaging	$30		$30	
	Imaging (CT/PET scans, MRIs)	10%		$75	
Drugs to treat illness or condition	Tier 1	$9		$9	
	Tier 2	$16		$16	
	Tier 3	$25		$25	
	Tier 4	10% up to $250 per script		10% up to $250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	10%		$75	
	Physician/surgeon fees	10%		$20	
	Outpatient visit	10%		10%	
Need immediate attention	Emergency room facility fee (waived if admitted)	$175		$175	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	$150		$150	
	Urgent care	$15		$15	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		$225 per day up to 5 days	
	Physician/surgeon fee	10%		No charge	
Mental health, behavioral health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	$15		$15	
	Mental/behavioral health and substance use disorder other outpatient items and services	$15		$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	10%		$20	
	Outpatient Rehabilitation and Habilitation services	$15		$15	
	Skilled nursing care	10%		$125 per day up to 5 days	
	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	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not Covered		Not Covered	
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	Not Covered		Not Covered	
Child Dental Major Services	Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	Not Covered		Not Covered	
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

	CCSB-only Platinum Coinsurance Plan	CCSB-only Platinum Copay Plan
Actuarial Value - AV 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 / $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
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$15		$20	
	Other practitioner office visit	$15		$20	
	Specialist visit	$30		$30	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	$15		$20	
	X-rays and Diagnostic Imaging	$30		$30	
	Imaging (CT/PET scans, MRIs)	10%		$100	
Drugs to treat illness or condition	Tier 1	$10		$5	
	Tier 2	$25		$20	
	Tier 3	$40		$30	
	Tier 4	10% up to $250 per script		10% up to $250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	10%		$100	
	Physician/surgeon fees	10%		$25	
	Outpatient visit	10%		10%	
Need immediate attention	Emergency room facility fee (waived if admitted)	$200		$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	$150		$150	
	Urgent care	$15		$20	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		$250 per day up to 5 days	
	Physician/surgeon fee	10%		No charge	
Mental health, behavioral health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	$15		$20	
	Mental/behavioral health and substance use disorder other outpatient items and services	$15		$20	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	10%		$20	
	Outpatient Rehabilitation and Habilitation services	$15		$20	
	Skilled nursing care	10%		$150 per day up to 5 days	
	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	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not Covered		Not Covered	
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	Not Covered		Not Covered	
Child Dental Major Services	Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	Not Covered		Not Covered	
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Individual-only Gold Coinsurance Plan	Individual-only Gold Copay Plan
Actuarial Value - AV Calculator	81.4%	81.7%
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	$9,200	$9,200
Family Out-of-pocket maximum	$18,400	$18,400
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$40		$40	
	Other practitioner office visit	$40		$40	
	Specialist visit	$70		$70	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	$40		$40	
	X-rays and Diagnostic Imaging	$75		$75	
	Imaging (CT/PET scans, MRIs)	25%		$75	
Drugs to treat illness or condition	Tier 1	$18		$18	
	Tier 2	$60		$60	
	Tier 3	$85		$85	
	Tier 4	20% up to $250 per script		20% up to $250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	30%		$130	
	Physician/surgeon fees	30%		$60	
	Outpatient visit	20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	$350		$350	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	$250		$250	
	Urgent care	$40		$40	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%		$375 per day up to 5 days	
	Physician/surgeon fee	30%		No charge	
Mental health, behavioral health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	$40		$40	
	Mental/behavioral health and substance use disorder other outpatient items and services	$40		$40	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	20%		$30	
	Outpatient Rehabilitation and Habilitation services	$40		$40	
	Skilled nursing care	30%		$150 per day up to 5 days	
	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	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not Covered		Not Covered	
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	Not Covered		Not Covered	
Child Dental Major Services	Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	Not Covered		Not Covered	
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

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Actuarial Value - AV Calculator	80.3%	81.7%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A	N/A
Integrated Family deductible	N/A	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$350 / $0 / $0	$250 / $0 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$700 / $0 / $0	$500 / $0 / $0
Individual Out–of–pocket maximum	$7,800	$7,800
Family Out-of-pocket maximum	$15,600	$15,600
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	**Service Type**	**Member Cost Share**	Deductible Applies	**Member Cost Share**	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$25		$35	
	Other practitioner office visit	$25		$35	
	Specialist visit	$50		$55	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	$25		$35	
	X-rays and Diagnostic Imaging	$65		$55	
	Imaging (CT/PET scans, MRIs)	20%		$250	X
Drugs to treat illness or condition	Tier 1	$15		$15	
	Tier 2	$50		$40	
	Tier 3	$80		$70	
	Tier 4	20% up to $250 per script		20% up to $250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	20%		$300	X
	Physician/surgeon fees	20%		$35	
	Outpatient visit	20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	20%	X	$250	X
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	20%	X	$250	X
	Urgent care	$25		$35	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	X	$600 per day up to 5 days	X
	Physician/surgeon fee	20%	X	No charge	
Mental health, behavioral health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	$25		$35	
	Mental/behavioral health and substance use disorder other outpatient items and services	$25		$35	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	20%		$30	
	Outpatient Rehabilitation and Habilitation services	$25		$35	
	Skilled nursing care	20%	X	$300 per day up to 5 days	X
	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	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not Covered		Not Covered	
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	Not Covered		Not Covered	
Child Dental Major Services	Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	Not Covered		Not Covered	
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

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	Individual-only Silver Plan
Actuarial Value - AV Calculator	71.8%
Plan design includes a deductible?	Yes, Medical/Pharmacy
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 / $0
Individual Out–of–pocket maximum	$9,800
Family Out-of-pocket maximum	$19,600
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$50	
	Other practitioner office visit	$50	
	Specialist visit	$90	
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests	$50	
	X-rays and Diagnostic Imaging	$95	
	Imaging (CT/PET scans, MRIs)	$325	
Drugs to treat illness or condition	Tier 1	$19	
	Tier 2	$60	Pharmacy deductible
	Tier 3	$90	Pharmacy deductible
	Tier 4	20% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)	30%	
	Physician/surgeon fees	30%	
	Outpatient visit	30%	
Need immediate attention	Emergency room facility fee (waived if admitted)	$400	
	Emergency room physician fee (waived if admitted)	No charge	
	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 health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	$50	
	Mental/behavioral health and substance use disorder other outpatient items and services	$50	
Pregnancy	Prenatal care and preconception visits	No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	$45	
	Outpatient Rehabilitation and Habilitation services	$50	
	Skilled nursing care	30%	X
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
Child Dental Diagnostic and Preventive	Oral Exam	Not Covered	
	Preventive - Cleaning		
	Preventive - X-ray		
	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic Services	Restorative Procedures	Not Covered	
	Periodontal Maintenance Services		
Child Dental Major Services	Crowns and Casts	Not Covered	
	Endodontics		
	Periodontics (other than maintenance)		
	Prosthodontics		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	Not Covered	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

	CCSB-only Silver Coinsurance Plan	CCSB-only Silver Copay Plan
Actuarial Value - AV Calculator	71.2%	70.8%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A	N/A
Integrated Family deductible	N/A	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$2,500 / $300 / $0	$2,500 / $300 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$5,000 / $600 / $0	$5,000 / $600 / $0
Individual Out–of–pocket maximum	$8,600	$8,750
Family Out-of-pocket maximum	$17,200	$17,500
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type	Member Cost Share (Coinsurance Plan)	Deductible Applies	Member Cost Share (Copay Plan)	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$55		$55	
	Other practitioner office visit	$55		$55	
	Specialist visit	$90		$90	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	$55		$55	
	X-rays and Diagnostic Imaging	$90		$90	
	Imaging (CT/PET scans, MRIs)	35%	X	$300	X
Drugs to treat illness or condition	Tier 1	$20		$19	
	Tier 2	$75	Pharmacy deductible	$85	Pharmacy deductible
	Tier 3	$105	Pharmacy deductible	$110	Pharmacy deductible
	Tier 4	30% up to $250 per script after pharmacy deductible	Pharmacy deductible	30% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)	35%	X	35%	X
	Physician/surgeon fees	35%		35%	
	Outpatient visit	35%		35%	
Need immediate attention	Emergency room facility fee (waived if admitted)	35%	X	35%	X
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	35%	X	35%	X
	Urgent care	$55		$55	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	35%	X	35%	X
	Physician/surgeon fee	35%	X	35%	
Mental health, behavioral health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	$55		$55	
	Mental/behavioral health and substance use disorder other outpatient items and services	$55		$55	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	35%		$45	
	Outpatient Rehabilitation and Habilitation services	$55		$55	
	Skilled nursing care	35%	X	35%	X
	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	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not Covered		Not Covered	
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	Not Covered		Not Covered	
Child Dental Major Services	Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	Not Covered		Not Covered	
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

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Actuarial Value - AV Calculator	70.6%
Plan design includes a deductible?	Yes, integrated
Integrated Individual deductible	$3,200 integrated
Integrated Family deductible	$6,400 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Individual Out–of–pocket maximum	$8,300
Family Out-of-pocket maximum	$16,600
HSA plan: Self-only coverage deductible	$3,200
HSA family plan: Individual deductible	See endnote

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	25%	X
	Other practitioner office visit	25%	X
	Specialist visit	25%	X
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests	25%	X
	X-rays and Diagnostic Imaging	25%	X
	Imaging (CT/PET scans, MRIs)	25%	X
Drugs to treat illness or condition	Tier 1	25% up to $250 per script	X
	Tier 2	25% up to $250 per script	X
	Tier 3	25% up to $250 per script	X
	Tier 4	25% up to $250 per script	X
Outpatient services	Surgery facility fee (e.g., ASC)	25%	X
	Physician/surgeon fees	25%	X
	Outpatient visit	25%	X
Need immediate attention	Emergency room facility fee (waived if admitted)	25%	X
	Emergency room physician fee (waived if admitted)	0%	X
	Medical transportation (including emergency and non-emergency)	25%	X
	Urgent care	25%	X
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 health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	25%	X
	Mental/behavioral health and substance use disorder other outpatient items and services	25%	X
Pregnancy	Prenatal care and preconception visits	No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	25%	X
	Outpatient Rehabilitation and Habilitation services	25%	X
	Skilled nursing care	25%	X
	Durable medical equipment	25%	X
	Hospice service	0%	X
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not Covered	
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	Not Covered	
Child Dental Major Services	Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	Not Covered	
Child Orthodontics	Medically necessary orthodontics	Not Covered	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Silver Plan 100%-150% FPL	**Silver Plan** 150%-200% FPL
Actuarial Value - AV Calculator	94.8%	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 / $0	$1,400 / $50 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0	$2,800 / $100 / $0
Individual Out–of–pocket maximum	$1,400	$3,350
Family Out-of-pocket maximum	$2,800	$6,700
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	**Service Type**	**Member Cost Share**	Deductible Applies	**Member Cost Share**	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$5		$15	
	Other practitioner office visit	$5		$15	
	Specialist visit	$8		$25	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	$10		$30	
	X-rays and Diagnostic Imaging	$10		$50	
	Imaging (CT/PET scans, MRIs)	$50		$100	
Drugs to treat illness or condition	Tier 1	$3		$8	
	Tier 2	$10		$25	Pharmacy deductible
	Tier 3	$15		$45	Pharmacy deductible
	Tier 4	10% up to $150 per script		15% up to $150 per script	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)	10%		20%	
	Physician/surgeon fees	10%		20%	
	Outpatient visit	10%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	$50		$200	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Medical transportation (including emergency and non-emergency)	$30		$75	
	Urgent care	$5		$15	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		20%	X
	Physician/surgeon fee	10%		20%	
Mental health, behavioral health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	$5		$15	
	Mental/behavioral health and substance use disorder other outpatient items and services	$5		$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	$3		$15	
	Outpatient Rehabilitation and Habilitation services	$5		$15	
	Skilled nursing care	10%		20%	X
	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	
Child Dental Diagnostic and Preventive	Oral Exam	Not Covered		Not Covered	
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Restorative Procedures	Not Covered		Not Covered	
	Periodontal Maintenance Services				
Child Dental Major Services	Crowns and Casts	Not Covered		Not Covered	
	Endodontics				
	Periodontics (other than maintenance)				
	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Silver Plan 200%-250% FPL
Actuarial Value - AV Calculator	73.8%
Plan design includes a deductible?	Yes, Medical/Pharmacy
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 / $0
Individual Out–of–pocket maximum	$8,100
Family Out-of-pocket maximum	$16,200
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$50	
	Other practitioner office visit	$50	
	Specialist visit	$90	
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests	$50	
	X-rays and Diagnostic Imaging	$95	
	Imaging (CT/PET scans, MRIs)	$325	
Drugs to treat illness or condition	Tier 1	$19	
	Tier 2	$55	Pharmacy deductible
	Tier 3	$85	Pharmacy deductible
	Tier 4	20% up to $250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)	30%	
	Physician/surgeon fees	30%	
	Outpatient visit	30%	
Need immediate attention	Emergency room facility fee (waived if admitted)	$400	
	Emergency room physician fee (waived if admitted)	No charge	
	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 health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	$50	
	Mental/behavioral health and substance use disorder other outpatient items and services	$50	
Pregnancy	Prenatal care and preconception visits	No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	$40	
	Outpatient Rehabilitation and Habilitation services	$50	
	Skilled nursing care	30%	X
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not Covered	
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	Not Covered	
Child Dental Major Services	Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	Not Covered	
Child Orthodontics	Medically necessary orthodontics	Not Covered	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Bronze Plan	Bronze HDHP Plan
Actuarial Value - AV Calculator	63.7%	64.8%
Plan design includes a deductible?	Yes, Medical/Pharmacy	Yes, integrated
Integrated Individual deductible	N/A	$7,200 integrated
Integrated Family deductible	N/A	$14,400 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$5,800 / $450 / $0	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	Bronze Plan: Member Cost Share	Bronze Plan: Deductible Applies	Bronze HDHP Plan: Member Cost Share	Bronze HDHP Plan: Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$60	After 1st three non-preventive visits	0%	X
	Other practitioner office visit	$60		0%	X
	Specialist visit	$95		0%	X
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	$50		0%	X
	X-rays and Diagnostic Imaging	40%	X	0%	X
	Imaging (CT/PET scans, MRIs)	40%	X	0%	X
Drugs to treat illness or condition	Tier 1	$20		0%	X
	Tier 2	40% up to $500 per script after pharmacy deductible	Pharmacy Deductible	0%	X
	Tier 3	40% up to $500 per script after pharmacy deductible	Pharmacy Deductible	0%	X
	Tier 4	40% up to $500 per script after pharmacy deductible	Pharmacy Deductible	0%	X
Outpatient services	Surgery facility fee (e.g., ASC)	40%	X	0%	X
	Physician/surgeon fees	40%	X	0%	X
	Outpatient visit	40%	X	0%	X
Need immediate attention	Emergency room facility fee (waived if admitted)	40%	X	0%	X
	Emergency room physician fee (waived if admitted)	No charge		0%	X
	Medical transportation (including emergency and non-emergency)	40%	X	0%	X
	Urgent care	$60		0%	X
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	40%	X	0%	X
	Physician/surgeon fee	40%	X	0%	X
Mental health, behavioral health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	$60		0%	X
	Mental/behavioral health and substance use disorder other outpatient items and services	$60		0%	X
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	40%	X	0%	X
	Outpatient Rehabilitation and Habilitation services	$60		0%	X
	Skilled nursing care	40%	X	0%	X
	Durable medical equipment	40%	X	0%	X
	Hospice service	No charge		0%	X
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not Covered		Not Covered	
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	Not Covered		Not Covered	
Child Dental Major Services	Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	Not Covered		Not Covered	
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

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

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

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

	CA Enh CSR Silver 94 Plan 100%-150% FPL	CA Enh CSR Silver 87 Plan 150%-200% FPL
Actuarial Value - AV Calculator	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 / $0
Individual Out–of–pocket maximum	$1,150	$3,000
Family Out-of-pocket maximum	$2,300	$6,000
HSA plan: Self-only coverage deductible	N/A	N/A
HSA family plan: Individual deductible	N/A	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$5		$15	
	Other practitioner office visit	$5		$15	
	Specialist visit	$8		$25	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	$8		$20	
	X-rays and Diagnostic Imaging	$8		$40	
	Imaging (CT/PET scans, MRIs)	$50		$100	
Drugs to treat illness or condition	Tier 1	$3		$5	
	Tier 2	$10		$25	
	Tier 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 immediate attention	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)	$30		$75	
	Urgent care	$5		$15	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		20%	
	Physician/surgeon fee	10%		20%	
Mental health, behavioral health, or substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	$5		$15	
	Mental/behavioral health and substance use disorder other outpatient items and services	$5		$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	$3		$15	
	Outpatient Rehabilitation and Habilitation services	$5		$15	
	Skilled nursing care	10%		20%	
	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	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not Covered		Not Covered	
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	Not Covered		Not Covered	
Child Dental Major Services	Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	Not Covered		Not Covered	
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

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

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

	CA Enh CSR Silver 73 Plan Above 200% FPL
Actuarial Value - AV Calculator	80.4%
Plan design includes a deductible?	No
Integrated Individual deductible	N/A
Integrated Family deductible	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	$0 / $0 / $0
Individual Out–of–pocket maximum	$6,100
Family Out-of-pocket maximum	$12,200
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	**Service Type**	**Member Cost Share**	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	$35	
	Other practitioner office visit	$35	
	Specialist visit	$85	
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests	$50	
	X-rays and Diagnostic Imaging	$95	
	Imaging (CT/PET scans, MRIs)	$325	
Drugs to treat illness or condition	Tier 1	$15	
	Tier 2	$55	
	Tier 3	$85	
	Tier 4	20% up to $250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	30%	
	Physician/surgeon fees	30%	
	Outpatient visit	30%	
Need immediate attention	Emergency room facility fee (waived if admitted)	$350	
	Emergency room physician fee (waived if admitted)	No charge	
	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 substance abuse needs	Mental/behavioral health and substance use disorder outpatient office visits	$35	
	Mental/behavioral health and substance use disorder other outpatient items and services	$35	
Pregnancy	Prenatal care and preconception visits	No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	$40	
	Outpatient Rehabilitation and Habilitation services	$35	
	Skilled nursing care	30%	
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not Covered	
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	Not Covered	
Child Dental Major Services	Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery	Not Covered	
Child Orthodontics	Medically necessary orthodontics	Not Covered	

Endnotes to Covered California 2026 Patient-Centered Benefit Plan Designs

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

Notes:

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

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

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

25) A plan’s formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan’s formulary.
26) The health issuer may not impose a member cost share for Diabetes Self-Management which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member’s physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.
27) The cost sharing for hospice services applies regardless of the place of service.
28) For all FDA-approved tobacco cessation medications, no limits on the number of days for the course of treatment (either alone or in combination) may be imposed during the plan year.
29) For inpatient stays, if the facility does not bill the facility fee and physician/surgeon fee separately, an issuer may apply the cost-sharing requirements for the facility fee to the entire charge.
30) For any benefit plan design in which a designation of Individual-Only or CCSB-Only is not present, the benefit plan design shall be applicable to the individual and small group markets. If a health plan seeks to offer such benefit plan design(s) in both markets, they shall be treated as separate benefit plan designs for purposes of regulatory compliance.
31) The out-of-pocket maximum in the Bronze HDHP shall not exceed the maximum out-of-pocket limit specified by the IRS in its revenue procedure for the 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.