#### Covered California 2025 Patient-Centered Benefit Plan Designs<sup>1</sup>

Final Board-approved April 18, 2024

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

#### Summary of Benefits and Coverage



=	ary of Benefits and Coverage  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%		91.6%		
Actuariai value -	Plan design includes a deductible?			No		
	Integrated Individual deductible	\$0		\$0		
	Integrated Family deductible	\$0		\$0		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	60	\$0 / \$0 / \$	0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0/\$0/\$	60	\$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	Primary care visit to treat an injury, illness, or condition	\$15		\$15		
provider's office or	Other practitioner office visit	\$15		\$15		
clinic visit	Specialist visit	\$30		\$30		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$15		\$15		
Tests	X-rays and Diagnostic Imaging	\$30		\$30		
	Imaging (CT/PET scans, MRIs)	10%		\$75		
	Tier 1	\$7		\$7		
Drugs to trea	t Tier 2	\$16		\$16		
illness or	Tier 3	¢25		<b>©</b> 05		
condition	Her 5	\$25		\$25		
	Tier 4	10% up to \$250 per script		10% up to \$250 per script		
	Surgery facility fee (e.g., ASC)	10%		\$75		
Outpatient services	Physician/surgeon fees	10%		\$20		
	Outpatient visit	10%		10%		
	Emergency room facility fee (waived if admitted)	\$150		\$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		\$15		
		·				
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%		\$225 per day up to		
Hospital stay				5 days		
	Physician/surgeon fee	10%		No charge		
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$15		
behavioral health, or	Voice					
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		
11-1-	Outpatient Rehabilitation and Habilitation services	\$15		\$15		
Help recovering o	Skilled purging core			\$125 per day up to		
other special health needs		10%		5 days		
	Durable medical equipment	10%		10%		
	Hospice service	No charge		No charge		
Child eye	Eye exam	No charge		No charge		
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
Child Dental	Preventive - Cleaning					
Diagnostic	Preventive - X-ray	No charge		No charge		
and Preventive	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures	20%		See 2025 Dental		
Services	Periodontal Maintenance Services	20%		Copay Schedule		
	Crowns and Casts					
Child Day ( )	Endodontics					
Child Dental Major	Periodontics (other than maintenance)	50%		See 2025 Dental		
Services	Prosthodontics			Copay Schedule		
	Oral Surgery					
Child	Medically necessary orthodontics	50%		\$1,000		
Orthodontics	, ,	5370		ψ.,σσσ		

=	summary of Benefits and Coverage lember Cost Share amounts describe the Enrollee's out of pocket costs.		CCSB-only Platinum Coinsurance Plan		CCSB-only Platinum Copay Plan	
Actuarial Value - A	V Calculator	91.3%		90.5%		
	Plan design includes a deductible?	No		No		
	Integrated Individual deductible	\$0		\$0		
	Integrated Family deductible	\$0		\$0		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental		0	\$0 / \$0 / \$0		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$0		
	Individual Out–of–pocket maximum	\$4,500		\$4,500		
	Family Out-of-pocket maximum	\$9,000		\$9,000		
	HSA plan: Self-only coverage deductible			N/A N/A		
Common	HSA family plan: Individual deductible N/A					
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
	Primary care visit to treat an injury, illness, or condition	\$15		\$20		
Health care provider's	Other practitioner office visit	\$15		\$20		
office or	On a similar visit	<b>*</b> 00		***		
clinic visit	Specialist visit	\$30		\$30		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$15		\$20		
Tests	X-rays and Diagnostic Imaging	\$30		\$30		
	Imaging (CT/PET scans, MRIs)	10%		\$100		
	Tier 1	\$10		\$5		
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)	10%		\$100		
Outpatient	Physician/surgeon fees					
services		10%		\$25		
	Outpatient visit	10%		10%		
	Emergency room facility fee (waived if admitted)	\$200		\$150		
	Emergency room physician fee (waived if admitted)	No charge		No charge		
Need immediate attention	Medical transportation (including emergency and non-emergency)	\$150		\$150		
	Urgent care	\$15		\$20		
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  Physician/surgeon fee	10%		\$250 per day up to 5 days No charge		
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$20		
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$20		
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	10%		\$20		
W.	Outpatient Rehabilitation and Habilitation services	\$15		\$20		
Help recovering or				\$20 \$150 per day up to		
other special health needs	Skilled nursing care	10%		5 days		
nearm needs	Durable medical equipment	10%		10%		
	Hospice service	No charge		No charge		
Child eye	Eye exam	No charge		No charge		
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
<b>21</b>	Preventive - Cleaning					
Child Dental Diagnostic	Preventive - X-ray	NI= =!		NI= =1		
and Preventive	Sealants per Tooth	No charge		No charge		
FIEVEIIUVE	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental	Restorative Procedures			See 2025 Dental		
Basic Services	Periodontal Maintenance Services	20%		Copay Schedule		
OCI VICES	Crowns and Casts					
	Endodontics					
Child Dental		50%		See 2025 Dental		
Major Services	Periodontics (other than maintenance)	50%		Copay Schedule		
	Prosthodontics					
01:11:1	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000		

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Gold Coinsurance Plan		Individual-only Gold Copay Plan		
tuarial Value - A\	/ Calculator	81.5%		81.6%		
luariai value - Av	Plan design includes a deductible?	01.5% No		01.0% No		
	Integrated Individual deductible	\$0		\$0		
	Integrated Family deductible	\$0		\$0		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	)	\$0 / \$0 / \$	0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	)	\$0/\$0/\$	0	
	Individual Out-of-pocket maximum	\$8,700		\$8,700		
	Family Out-of-pocket maximum	\$17,400		\$17,400		
	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	Deduc Appli	
	Primary care visit to treat an injury, illness, or condition	\$35		\$35		
Health care provider's	Other practitioner office visit	\$35		\$35		
office or clinic visit	Specialist visit	\$65		\$65		
	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	\$15		\$15		
Drugs to treat	Tier 2	\$60		\$60		
illness or condition	Tier 3	\$85		\$85		
	Tier 4	20% up to \$250 per		20% up to \$250 per		
	Surgery facility fee (e.g., ASC)	script 30%		script \$130		
Outpatient	Physician/surgeon fees	30%		\$60		
services	Outpatient visit	20%		20%		
	Emergency room facility fee (waived if admitted)	\$330		\$330		
	Emergency room physician fee (waived if admitted)	No charge		No charge		
Need	Medical transportation (including emergency and non-emergency)	\$250		\$250		
immediate	incutating emergency and non-emergency	\$250		φ250		
attention	Urgent core	¢25		<b>#25</b>		
	Urgent care	\$35		\$35		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	30%		\$350 per day up to		
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	30%		5 days		
Mental		30%		No charge		
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$35		\$35		
behavioral health, or						
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35		\$35		
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	20%		\$30		
Help	Outpatient Rehabilitation and Habilitation services	\$35		\$35		
recovering or other special	Skilled nursing care	30%		\$150 per day up to 5 days		
health needs	Durable medical equipment	20%		20%		
	Hospice service	No charge		No charge		
Child eye	Eye exam	No charge		No charge		
care	pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam	•		, and the second		
	Preventive - Cleaning					
Child Dental Diagnostic	Preventive - X-ray					
and	Sealants per Tooth	No charge		No charge		
Preventive	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental	Restorative Procedures			See 2025 Dental		
Basic Services	Periodontal Maintenance Services	20%		Copay Schedule		
	Crowns and Casts					
	Endodontics					
Child Dental Major	Periodontics (other than maintenance)	50%		See 2025 Dental		
Services	Prosthodontics			Copay Schedule		
	Oral Surgery					
Child	Medically necessary orthodontics	50%		\$1.000		

Summary of Benefits and Coverage		CCSB-only		CCSB-only		
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Gold Coinsurance Plan		Gold Copay Plan		
Actuarial Value - A	V Calculator	79.1%		80.5%		
	Plan design includes a deductible?	Yes, Medical/Pharm	асу	Yes, Medical/Pharmacy		
	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		
	Individual Out–of–pocket maximum			\$500 / \$0 / \$0 \$7,800		
	Family Out-of-pocket maximum	\$7,800 \$15,600		\$15,600		
	HSA plan: Self-only coverage deductible			N/A		
	HSA family plan: Individual deductible	N/A		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
	Primary care visit to treat an injury, illness, or condition	\$25		\$35		
Health care	Other practitioner office visit	\$25		\$35		
provider's office or	Ottor practitioned visit	Ψ20		φυσ		
clinic visit	Specialist visit	\$50		\$55		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$25		\$35		
Tests	X-rays and Diagnostic Imaging	\$65		\$55		
	Imaging (CT/PET scans, MRIs)	20%		\$250	X	
	Tier 1	\$15		\$15		
	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		
Outmatiant	Surgery facility fee (e.g., ASC)	20%		\$300	Х	
Outpatient services	Physician/surgeon fees	20%		\$35		
	Outpatient visit	20%		20%		
	Emergency room facility fee (waived if admitted)	20%	X	\$250	Х	
	Emergency room physician fee (waived if admitted)	No charge		No charge		
Need immediate	Medical transportation (including emergency and non-emergency)	20%	X	\$250	Х	
attention	Urgent care	\$25		\$35		
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  Physician/surgeon fee	20% 20%	x x	\$600 per day up to 5 days	Х	
Mental		2070	^	No charge		
health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	\$25		\$35		
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$25		\$35		
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	20%		\$30		
Help	Outpatient Rehabilitation and Habilitation services	\$25		\$35		
recovering or other special	Skilled nursing care	20%	X	\$300 per day up to 5 days	Х	
health needs	Durable medical equipment	20%		20%		
	Hospice service	No charge		No charge		
Child eye	Eye exam	No charge		No charge		
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
OFTITE	Preventive - Cleaning					
Child Dental Diagnostic	Preventive - X-ray	No charge		No charge		
and Preventive	Sealants per Tooth	No charge		No charge		
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures	20%		See 2025 Dental Copay		
Services	Periodontal Maintenance Services	2070		Schedule		
	Crowns and Casts					
Child Dental	Endodontics					
Major	Periodontics (other than maintenance)	50%		See 2025 Dental Copay Schedule		
Services	Prosthodontics					
	Oral Surgery					
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000		

Summary	v of	Benefits	and	Coverage
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Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Silver	r Plan
Actuarial Value - A	V Calculator	71.6%	
	Plan design includes a deductible?	Yes, Medical/Pharm	асу
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,400 / \$50 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,800 / \$100 / \$	80
	Individual Out-of-pocket maximum	\$8,700	
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	\$17,400 N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
LVCIIL	Primary care visit to treat an injury, illness, or condition	\$50	
Health care	Other practitioner office visit	\$50	
provider's office or	Other practitioner office visit	φ30	
clinic visit	Specialist visit	\$90	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$18	
	Tion 2	***	Pharmacy
Drugs to treat illness or	Tier 2	\$60	deductible
condition	Tier 3	\$90	Pharmacy deductible
	Tier 4	20% up to \$250 per script	Pharmacy
	Her 4	after pharmacy deductible	deductible
	Surgery facility fee (e.g., ASC)	30%	
Outpatient services	Physician/surgeon fees	30%	
	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need	Medical transportation (including emergency and non-emergency)	\$250	
immediate attention			
	Urgent care	\$50	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	30%	Х
Hospital stay	delivery, mental health, and substance use)		^
Mental	Physician/surgeon fee	30%	
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$50	
behavioral health, or			
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$50	
	Prenatal care and preconception visits	No charge	
Pregnancy	·	No charge	
	Home health care (cost share per visit)	\$45	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$50	
other special	Skilled nursing care	30%	Х
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray		
and Preventive	Sealants per Tooth	No charge	
rieventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	20%	
	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics	5576	
	Oral Surgery		
Child			
Orthodontics	Medically necessary orthodontics	50%	

Date: April 18, 2024

and Coverage ts describe the Enrollee's out of pocket costs.  ulator  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 HSA plan: Self-only coverage deductible HSA family plan: Individual deductible  Service Type  hary care visit to treat an injury, illness, or condition  for practitioner office visit  cialist visit  ventive care/ screening/ immunization  pratory Tests  ys and Diagnostic Imaging ging (CT/PET scans, MRIs)  1  2  3  4	N/A N/A \$2,500 / \$300 / \$0 \$5,000 / \$600 / \$0 \$8,600 \$17,200 N/A	Deductible Applies	CCSB-only Silver Copay Plan  69.1%  Yes, Medical/Pharma N/A N/A \$2,500 / \$300 / \$0 \$5,000 / \$600 / \$0 \$8,750 \$17,500 N/A N/A  Member Cost Share  \$55 \$90 No charge \$55 \$90 \$300 \$19	0
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 HSA plan: Self-only coverage deductible HSA family plan: Individual deductible  Service Type  Planty care visit to treat an injury, illness, or condition  Per practitioner office visit Cialist visit Ventive care/ screening/ immunization Poratory Tests Planty Self-only coverage Planty Coverage Planty Out-of-pocket maximum Planty Out-of-pocket maximum Planty Out-of-pocket maximum Planty Out-of-pocket maximum Planty Out-of-pocket Planty Out-of-pocket maximum Planty Out-of-pocket	69.5% Yes, Medical/Pharma N/A N/A \$2,500 / \$300 / \$0 \$5,000 / \$600 / \$0 \$8,600 \$17,200 N/A N/A  Member Cost Share  \$55 \$55 \$90 No charge \$55 \$90 35% \$20 \$75	Deductible Applies	69.1% Yes, Medical/Pharma N/A N/A \$2,500 / \$300 / \$0 \$5,000 / \$600 / \$0 \$8,750 \$17,500 N/A N/A  Member Cost Share  \$55 \$55 \$90 No charge \$55 \$90 \$300	Deductible Applies
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 HSA plan: Self-only coverage deductible HSA family plan: Individual deductible  Service Type  Planty care visit to treat an injury, illness, or condition  Per practitioner office visit Cialist visit Ventive care/ screening/ immunization Poratory Tests Planty Self-only coverage Planty Coverage Planty Out-of-pocket maximum Planty Out-of-pocket maximum Planty Out-of-pocket maximum Planty Out-of-pocket maximum Planty Out-of-pocket Planty Out-of-pocket maximum Planty Out-of-pocket	Yes, Medical/Pharma N/A N/A \$2,500 / \$300 / \$0 \$5,000 / \$600 / \$0 \$8,600 \$17,200 N/A N/A  Member Cost Share  \$55 \$55 \$90 No charge \$55 \$90 35% \$20 \$75	Deductible Applies X	Yes, Medical/Pharma N/A N/A \$2,500 / \$300 / \$0 \$5,000 / \$600 / \$0 \$8,750 \$17,500 N/A N/A  Member Cost Share  \$55 \$55 \$90 No charge \$55 \$90 \$300	Deductible Applies
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 HSA plan: Self-only coverage deductible HSA family plan: Individual deductible Service Type  The practitioner office visit cialist visit ventive care/ screening/ immunization pratory Tests Type and Diagnostic Imaging Type ging (CT/PET scans, MRIs)  1 2 3	N/A N/A N/A \$2,500 / \$300 / \$0 \$5,000 / \$600 / \$0 \$8,600 \$17,200 N/A N/A  Member Cost Share  \$55 \$55 \$90 No charge \$55 \$90 35% \$20 \$75	Deductible Applies X	N/A N/A N/A \$2,500 / \$300 / \$0 \$5,000 / \$600 / \$0 \$8,750 \$17,500 N/A N/A  Member Cost Share  \$55 \$55 \$90 No charge \$55 \$90 \$300	Deductible Applies
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 HSA plan: Self-only coverage deductible HSA family plan: Individual deductible Service Type  hary care visit to treat an injury, illness, or condition er practitioner office visit cialist visit ventive care/ screening/ immunization bratory Tests ys and Diagnostic Imaging ging (CT/PET scans, MRIs)  1 2 3	N/A \$2,500 / \$300 / \$0 \$5,000 / \$600 / \$0 \$8,600 \$17,200 N/A N/A  Member Cost Share  \$55 \$55 \$90 No charge \$55 \$90 35% \$20 \$75	Deductible Applies	N/A \$2,500 / \$300 / \$0 \$5,000 / \$600 / \$0 \$8,750 \$17,500 N/A N/A  Member Cost Share  \$55 \$55 \$90 No charge \$55 \$90 \$300	Deductible Applies
Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out–of–pocket maximum Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible  Service Type  hary care visit to treat an injury, illness, or condition er practitioner office visit cialist visit ventive care/ screening/ immunization oratory Tests ys and Diagnostic Imaging ging (CT/PET scans, MRIs)  1 2 3	\$2,500 / \$300 / \$0 \$5,000 / \$600 / \$0 \$8,600 \$17,200 N/A N/A N/A  Member Cost Share  \$55 \$55 \$90 No charge \$55 \$90 35% \$20 \$75	Deductible Applies	\$2,500 / \$300 / \$0 \$5,000 / \$600 / \$0 \$8,750 \$17,500 N/A N/A  Member Cost Share  \$55 \$55 \$90 No charge \$55 \$90 \$300	Deductible Applies
Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out—of—pocket maximum Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible  Service Type  arry care visit to treat an injury, illness, or condition er practitioner office visit cialist visit ventive care/ screening/ immunization oratory Tests ys and Diagnostic Imaging ging (CT/PET scans, MRIs)  1 2 3	\$5,000 / \$600 / \$0  \$8,600  \$17,200  N/A  N/A  Member Cost Share  \$55  \$55  \$90  No charge \$55  \$90  35%  \$20  \$75	Deductible Applies	\$5,000 / \$600 / \$0  \$8,750  \$17,500  N/A  N/A  Member Cost Share  \$55  \$55  \$90  No charge  \$55  \$90  \$300	Deductible Applies
Family Out-of-pocket maximum  HSA plan: Self-only coverage deductible  HSA family plan: Individual deductible  Service Type  hary care visit to treat an injury, illness, or condition  er practitioner office visit  cialist visit  ventive care/ screening/ immunization  pratory Tests  ys and Diagnostic Imaging ging (CT/PET scans, MRIs)  1  2  3	\$17,200 N/A N/A N/A  Member Cost Share  \$55 \$55 \$90 No charge \$55 \$90 35% \$20 \$75	Applies  X  Pharmacy	\$17,500 N/A N/A  Member Cost Share  \$55 \$55 \$90 No charge \$55 \$90 \$300	Applies
HSA plan: Self-only coverage deductible HSA family plan: Individual deductible  Service Type  hary care visit to treat an injury, illness, or condition er practitioner office visit cialist visit ventive care/ screening/ immunization oratory Tests ys and Diagnostic Imaging ging (CT/PET scans, MRIs)  1 2 3	N/A N/A Member Cost Share \$55 \$55 \$90 No charge \$55 \$90 35% \$20	Applies  X  Pharmacy	N/A N/A  Member Cost Share  \$55 \$55 \$90 No charge \$55 \$90 \$300	Applies
Service Type  Paray care visit to treat an injury, illness, or condition  Per practitioner office visit  Ciallist visit  Ventive care/ screening/ immunization  Paratory Tests  ys and Diagnostic Imaging  ging (CT/PET scans, MRIs)  1  2	N/A  Member Cost Share  \$55 \$55 \$90 No charge \$55 \$90 35% \$20 \$75	Applies  X  Pharmacy	N/A  Member Cost Share  \$55  \$55  \$90  No charge  \$55  \$90  \$300	Applies
Service Type  hary care visit to treat an injury, illness, or condition  er practitioner office visit  cialist visit  ventive care/ screening/ immunization  pratory Tests  ys and Diagnostic Imaging ging (CT/PET scans, MRIs)  1  2	\$55 \$55 \$90 No charge \$55 \$90 35% \$20	Applies  X  Pharmacy	\$55 \$55 \$90 No charge \$55 \$90 \$300	Applies
nary care visit to treat an injury, illness, or condition er practitioner office visit cialist visit ventive care/ screening/ immunization pratory Tests ys and Diagnostic Imaging ging (CT/PET scans, MRIs)  1	\$55 \$55 \$90 No charge \$55 \$90 35% \$20	Applies  X  Pharmacy	\$55 \$55 \$90 No charge \$55 \$90 \$300	Applies
er practitioner office visit cialist visit //entive care/ screening/ immunization oratory Tests ys and Diagnostic Imaging ging (CT/PET scans, MRIs) 1 2	\$55 \$90 No charge \$55 \$90 35% \$20 \$75	Pharmacy	\$55 \$90 No charge \$55 \$90 \$300	x
cialist visit ventive care/ screening/ immunization pratory Tests ys and Diagnostic Imaging ging (CT/PET scans, MRIs)  1	\$90  No charge  \$55  \$90  35%  \$20  \$75	Pharmacy	\$90 No charge \$55 \$90 \$300	x
ventive care/ screening/ immunization pratory Tests ys and Diagnostic Imaging ging (CT/PET scans, MRIs)  1 2	No charge \$55 \$90 35% \$20 \$75	Pharmacy	No charge \$55 \$90 \$300	x
ventive care/ screening/ immunization pratory Tests ys and Diagnostic Imaging ging (CT/PET scans, MRIs)  1 2	No charge \$55 \$90 35% \$20 \$75	Pharmacy	No charge \$55 \$90 \$300	х
oratory Tests  ys and Diagnostic Imaging  ging (CT/PET scans, MRIs)  1	\$55 \$90 35% \$20 \$75	Pharmacy	\$55 \$90 \$300	Х
ys and Diagnostic Imaging ging (CT/PET scans, MRIs)  1 2 3	\$90 35% \$20 \$75	Pharmacy	\$90 \$300	x
ging (CT/PET scans, MRIs)  1  2	35% \$20 \$75	Pharmacy	\$300	Х
1 2 3	\$20 \$75	Pharmacy		^
2	\$75		\$19	
3				
	\$105	deductible	\$85	Pharmacy deductible
	. שועט	Pharmacy	\$110	Pharmacy
4	·	deductible		deductible
	30% up to \$250 per script after pharmacy deductible	Pharmacy deductible	30% up to \$250 per script after pharmacy deductible	Pharmacy deductible
gery facility fee (e.g., ASC)	35%	X	35%	Х
sician/surgeon fees	35%		35%	
patient visit	35%		35%	
ergency room facility fee (waived if admitted)	35%	X	35%	Х
ergency room physician fee (waived if admitted)	No charge		No charge	
lical transportation (including emergency and non-emergency)	35%	X	35%	Х
ent care	\$55		\$55	
lity fee (e.g. hospital room) for inpatient stay (including labor and	35%	X	35%	Х
sician/surgeon fee	35%	Х	35%	
tal/behavioral health and substance use disorder outpatient office s	\$55		\$55	
tal/behavioral health and substance use disorder other outpatient s and services	\$55		\$55	
natal care and preconception visits	No charge		No charge	
ne health care (cost share per visit)	35%		\$45	
patient Rehabilitation and Habilitation services	\$55		\$55	
ed nursing care	35%	X	35%	Х
		-		
exam	_		-	
	_			
Exam	o s.iai go		. to shargo	
ventive - Cleaning				
lants per Tooth	No charge		No charge	
	20%		See 2025 Dental Copay Schedule	
	F09/		See 2025 Dental Copay	
	50%		Schedule	
Surgery	50%			
ercentility en in	gency room physician fee (waived if admitted) cal transportation (including emergency and non-emergency) at care  y fee (e.g. hospital room) for inpatient stay (including labor and ry, mental health, and substance use) cian/surgeon fee al/behavioral health and substance use disorder outpatient office al/behavioral health and substance use disorder other outpatient and services  tal care and preconception visits a health care (cost share per visit) attent Rehabilitation and Habilitation services d nursing care ble medical equipment ce service xam of glasses per year (or contact lenses in lieu of glasses) Exam antive - Cleaning intive - X-ray	gency room physician fee (waived if admitted) al transportation (including emergency and non-emergency) at care  \$55  It care and preconception visits It care and preconception visits It care (cost share per visit) \$55  It care and preconception visits It care (cost share per visit) \$55  It care and preconception visits It care (cost share per visit) \$56  It care and preconception visits It care (cost share per visit) \$57  It care and preconception visits It care (cost share per visit) \$55  It care and preconception visits It care (cost share per visit) \$55  It care and preconception visits	gency room physician fee (waived if admitted) all transportation (including emergency and non-emergency) all transportation (including emergency and non-emergency)  \$55  \$56  \$57  \$58  \$58  \$58  \$58  \$58  \$58  \$58	gency room physician fee (waived if admitted) all transportation (including emergency and non-emergency)  all transportation (including emergency and non-emergency)  at care  \$55  \$55  \$55  \$55  \$55  \$55  \$55  \$

Date: April 18			
<del>-</del>	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-o Silver HDHP P	•
Actuarial Value - A	√ Calculator	71.2%	
totuariai Value - A	Plan design includes a deductible?		
	Integrated Individual deductible	\$2,850 integ	
	Integrated Family deductible	\$5,700 integ	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Individual Out-of-pocket maximum	\$7,500	)
	Family Out-of-pocket maximum	\$15,00	0
	HSA plan: Self-only coverage deductible		
Common	HSA family plan: Individual deductible	See endr	lote
Medical Event	Service Type	Member Cost Share	Deductible Applie
	Primary care visit to treat an injury, illness, or condition	25%	х
Health care provider's	Other practitioner office visit	25%	x
office or clinic visit	Specialist visit	25%	x
Cillic Visit			^
	Preventive care/ screening/ immunization	No charge	V
Toots	Laboratory Tests	25%	X
Tests	X-rays and Diagnostic Imaging	25%	X
	Imaging (CT/PET scans, MRIs)	25%	Х
	Tier 1	25% up to \$250 per script	X
Drugs to treat	Tier 2	25% up to \$250 per	x
illness or condition	Tier 3	script 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%	Х
	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%	Х
Need immediate 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
Mental	Physician/surgeon fee	25%	Х
health, behavioral health, 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%	X
Help	Outpatient Rehabilitation and Habilitation services	25%	X
recovering or other special	Skilled nursing care	25%	x
health needs	Durable medical equipment	25%	X
	Hospice service	0%	Х
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental	Preventive - X-ray		
Diagnostic and	Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic	Periodontal Maintenance Services	20%	
Services	Periodonial Maintenance Services  Crowns and Casts		
	Endodontics		
Child Dental Major		50%	
Services	Periodontics (other than maintenance)  Prosthodontics	50 /6	
	Prostnodontics Oral Surgery		
Child			
Orthodontics	Medically necessary orthodontics	50%	

Date: April 18, 2024

•	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver P		Silver Plan	
	·	100%-150%	% FPL	150%-200% FPL	•
ctuarial Value - A\	/ Calculator	94.7%		88.0%	
	Plan design includes a deductible?			Yes, Medical/Pharmacy	
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A \$0 / \$0 /	·\$Ω	N/A \$1,400 / \$350 / \$6	n
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /		\$2,800 / \$700 / \$6	
	Individual Out-of-pocket maximum	\$1,30		\$3,050	,
	Family Out-of-pocket maximum	\$2,600		\$6,100	
	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	
16363					
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$8	
Drugs to treat	Tier 2	\$10		\$25	Pharmac deductible
illness or	Ti 2	<b>*</b> 45		0.45	Pharmac
condition	Tier 3	\$15		\$45	deductible
	Tier 4	10% up to \$150 per script		15% up to \$150 per script	Pharmacy deductible
	Surgery facility fee (e.g., ASC)	10%		20%	
Outpatient	Physician/surgeon fees	10%		20%	
services	Outpatient visit	10%		20%	
	Emergency room facility fee (waived if admitted)	\$50		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$30		\$75	
immediate	medical transportation (including emergency and non-emergency)	φ30		\$75	
attention	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and				
Hospital stay	delivery, mental health, and substance use)	10%	Х	20%	Х
	Physician/surgeon fee	10%		20%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$5		\$15	
behavioral	visits	Ų.		<b>V</b> .0	
health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
abuse needs Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
	Outpatient Rehabilitation and Habilitation services			\$15	
Help recovering or		\$5		·	
other special	Skilled nursing care	10%	X	20%	Х
health needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray				
and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic	Periodontal Maintenance Services	20%		20%	
Services					
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	50%		50%	
	Prosthodontics				
	Oral Surgery				
Child					

Summary	of	<b>Benefits</b>	and	Coverage
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-	nefits and Coverage	Silver Plan	
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	200%-250% FPL	
Actuarial Value - A	√ Calculator	73.9%	
/ totalina value / t	Plan design includes a deductible?	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	,
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,400 / \$350 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,800 / \$700 / \$	60
	Individual Out-of-pocket maximum	\$7,350	
	Family Out-of-pocket maximum	\$14,700	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A	
Common			Deductible
Medical Event	Service Type	Member Cost Share	Applies
Health save	Primary care visit to treat an injury, illness, or condition	\$35	
Health care provider's	Other practitioner office visit	\$35	
office or clinic visit	Specialist visit	\$85	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$20	
		Ψ∠∪	D
Drugs to treat	Tier 2	\$55	Pharmacy deductible
illness or condition	Tier 3	\$85	Pharmacy
		20% up to \$250 per script	deductible Pharmacy
	Tier 4	after pharmacy deductible	deductible
	Surgery facility fee (e.g., ASC)	30%	
Outpatient services	Physician/surgeon fees	30%	
	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$350	
	Emergency room physician fee (waived if admitted)	No charge	
Need	Medical transportation (including emergency and non-emergency)	\$250	
immediate attention			
	Urgent care	\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	30%	Х
Hospital stay	delivery, mental health, and substance use)		,
Mental	Physician/surgeon fee	30%	
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$35	
behavioral health, or			
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35	
Pregnancy	Prenatal care and preconception visits	No charge	
Januario y	Home health care (cost share per visit)	\$40	
	Outpatient Rehabilitation and Habilitation services		
Help recovering or		\$35	
other special health needs	Skilled nursing care	30%	Х
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth	Č	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Services	Periodontal Maintenance Services	2370	
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	50%	
Orthodontics			

Date: April 18, 2024

Summary of Benefits and Coverage

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		Bronze HDHP Plai	n
ctuarial Value - A	V Calculator	63.6%		64.9%	
otaariai valao 71	Plan design includes a deductible?	Yes, Medical/Pharn	nacy	Yes, integral	red
	Integrated Individual deductible	N/A	пасу	\$6,650 integral	
	Integrated Family deductible	N/A		\$13,300 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	\$8,850		\$6,650	
	Family Out-of-pocket maximum	\$17,700		\$13,300	
	HSA plan: Self-only coverage deductible	N/A		\$6,650	
	HSA family plan: Individual deductible	N/A		\$6,650	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$60		0%	Х
Health care provider's	Other practitioner office visit	\$60		0%	X
office or	Constitution of the	<b>40</b> 5	After 1st three non-	004	· ·
clinic visit	Specialist visit	\$95	preventive visits	0%	X
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		0%	Х
Tests	X-rays and Diagnostic Imaging	40%	X	0%	X
	Imaging (CT/PET scans, MRIs)	40%	X	0%	x
	Tier 1	\$19		0%	x
			Dhar		
Drugs to treat	Tier 2	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	X
illness or condition	Tier 3	40% up to \$500 per script after	Pharmacy	0%	x
		pharmacy deductible	Deductible		``
	Tier 4	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	Х
	Surgery facility fee (e.g., ASC)	40%	X	0%	X
Outpatient	Physician/surgeon fees	40%	×	0%	X
services	, ,				
	Outpatient visit	40%	X	0%	X
	Emergency room facility fee (waived if admitted)	40%	X	0%	X
	Emergency room physician fee (waived if admitted)	No charge		0%	X
Need immediate	Medical transportation (including emergency and non-emergency)	40%	X	0%	Х
attention	Urgent care	\$60		0%	x
	Facility fee (e.g. hospital room) for inpatient stay (including labor and				
Hospital stay	delivery, mental health, and substance use)	40%	X	0%	X
	Physician/surgeon fee	40%	x	0%	х
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$60		0%	Х
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$60		0%	x
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	x	0%	Х
Help	Outpatient Rehabilitation and Habilitation services	\$60		0%	×
Help recovering or	·				
other special health needs	Skilled nursing care	40%	X	0%	X
	Durable medical equipment	40%	X	0%	X
	Hospice service	No charge		0%	х
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and	·	No charge		No charge	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
a	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		20%	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dantal	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		50%	
Services	Prosthodontics				
	Oral Surgery				
Child					
Orthodontics	Medically necessary orthodontics	50%		50%	

Summary	, of	Renefits	and	Coverage
Summany	<i>,</i> 01	Denenio	anu	Coverage

Summary of Ber	nefits and Coverage		
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Catast	rophic Plan
Actuarial Value - A\	√ Calculator		
	Plan design includes a deductible?	Yes,	integrated
	Integrated Individual deductible	\$9,20	0 integrated
	Integrated Family deductible	\$18,40	00 integrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out–of–pocket maximum		N/A \$9,200
	Family Out-of-pocket maximum		18,400
	HSA plan: Self-only coverage deductible		N/A
	HSA family plan: Individual deductible		N/A
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non- preventive visits
Health care provider's	Other practitioner office visit	0%	After 1st three non-
office or clinic visit	Specialist visit	0%	preventive visits X
Cillic Visit	Preventive care/ screening/ immunization	No charge	^
	Laboratory Tests	0%	Х
Tests	X-rays and Diagnostic Imaging	0%	×
	Imaging (CT/PET scans, MRIs)	0%	x
	Tier 1	0%	X
Drugs to treat illness or	Tier 2	0%	X
condition	Tier 3	0%	Х
	Tier 4	0%	Х
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	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
Mental	Physician/surgeon fee	0%	Х
health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three non- preventive visits
health, or substance	Mental/behavioral health and substance use disorder other outpatient	0%	x
abuse needs	items and services		^
Pregnancy	Prenatal care and preconception visits	No charge	V
	Home health care (cost share per visit)	0%	X
Help recovering or	Outpatient Rehabilitation and Habilitation services	0%	X
other special health needs	Skilled nursing care	0%	X
	Durable medical equipment	0%	X
	Hospice service	0%	Х
Child eye care	Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge 0%	X
	Oral Exam	U70	^
	Preventive - Cleaning		
Child Dental	Preventive - X-ray		
Diagnostic and	Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	251	
Basic Services	Periodontal Maintenance Services	0%	Х
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	0%	Х
Services	Prosthodontics		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	0%	X

Primary care visit to treat an injury, times, or condition    Season   Seas	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		
Pina ordinary   Pina ordinar		40.1.1.	05.40		00.004		
Interview of the control of the cont	uarial Value - A\			)			
Interior		-					
Family code.ettle, NOT integrated. Material / Premanage / Dark   \$1,00   \$1,							
Included and or of posted measures Persol Doctor Services Persol Doctor Services Person Services Person Services Types Person Services Person			\$0 / \$0 /	\$0	\$0 / \$0 / \$0		
Private   Priv		Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /	\$0	\$0 / \$0 / \$0		
THE ACT OF		Individual Out-of-pocket maximum	\$1,150	)	\$3,000		
Primary care void to best an injury, lineas, or condition   Sarvice Type		Family Out-of-pocket maximum	\$2,30	)	\$6,000		
Service Type  Privacy care visit to test as later, considering the service of the							
Primary serv wait to treat an intry. Ilmans, or condition seath teams fiftee or interview Province or a stocking from the wait Specialist visit Province or a stocking immunitization No charge Immunitization Tier 1 No Stocking immunitization No charge Immunitization Tier 2 Stocking immunitization Tier 2 Stocking immunitization Tier 3 Stocking immunitization Tier 3 Stocking immunitization Tier 4 Stocking immunitization Tier 3 Stocking immunitization Tier 4 Stocking immunitization Tier 3 Stocking immunitization Tier 4 Stocking immunitization Tier 4 Stocking immunitization Tier 3 Stocking immunitization Tier 3 Stocking immunitization Tier 4 Stocking immunitization Tier 4 Stocking immunitization Tier 3 Stocking immunitization Tier 3 Stocking immunitization Tier 4 Stocking immunitization Tier 4 Stocking immunitization Tier 4 Stocking immunitization Tier 5 Stocking immunitization Tier 4 Stocking immunitization Tier 4 Stocking immunitization Tier 5 Stocking immunitization Tier 4 Stocking immunitization Tier 5 Stocking immunitization Tier 4 Stocking immunitization Tier 5 Stocking immunitization Tier 5 Stocking immunitization Tier 6 Stocking immunitization Tier 6 Tier 7 Stocking immunitization Tier 7 Tier 2 Stocking immunitization Tier 8 Stocking immunitization Tier 8 Tier 7 Tier 2 Stocking immunitization Tier 8 Tier 7 Tier 2 Stocking immunitization Tier 8 Tier 4 Stocking immunitization Tier 8 Tier 7 Tier 2 Tier 7 Tier 2 Tier 7 Tier 2 Tier 7 T	Common	nsa family pian. Individual deductible			N/A		
Security of the comments of th		Service Type			Member Cost Share	Deduc Appli	
Committee value of the control of th		Primary care visit to treat an injury, illness, or condition	\$5		\$15		
A specialist visit  Preventive care a covering immurzation  Laboratory Tests  X-rey and Disprise to Ireal  Laboratory Tests  X-rey and Disprise to Ireal  Inner 2  Ter 2  Surgery facility for (e.g., ASC)  Physicianifus green fees  Outpetition  Ter 4  Surgery facility fee (e.g., ASC)  Physicianifus green fees  Outpetition  Ter 2  Surgery facility fee (e.g., ASC)  Physicianifus green fees  Outpetition  Ter 2  Surgery facility fee (e.g., ASC)  Physicianifus green fees  Outpetition  Ter 1  Emergery commissible (washed if admitted)  Emergery commission (reducting emergery and non-emergery of commissible (washed if admitted)  Emergery commission (reducting emergery and non-emergery of commission of commission of commission of commission of commission of		Other practitioner office visit	\$5		\$15		
Prevertive care/ surevirup/immunication	office or						
Laboratory Tests	clinic visit	·					
Acceptable   Comparing Comparing   Sale		-	_		-		
Irruging (CTIPET scare, MRts)  Ter 1  Ter 1  Ter 2  Sample to train  Ter 2  Ter 3  Ter 4  Surpey facility fee (e.g., ASC)  Physicinebrangeon fees  Outpatient retrition  Ligent care  Emergency room physician fee (waived if admitted)  Modeal transportation (including emergency and non-emergency)  Ligent care  Facility fee (e.g., hospital room) for inpatient stay (including below and divisory, mental health and substance use disorder outpatient of the visits  Merital Ferhancoral health and substance use disorder outpatient							
Tier 1  Tier 2  Tier 2  Tier 3  Tier 3  Tier 4  Tier 4  Tier 3  Tier 4  Tier 4  Tier 4  Tier 4  Tier 4  Tier 4  Tier 5  Tier 4  Tier 5  Tier 4  Tier 5  Tier 4  Tier 6  Tier 6  Tier 6  Tier 7  Tier 7  Tier 8  Surgery facility for (e.g., ASC)  Physician-futurgoon foes  Difficult of the control of the contro	ests						
Tree 2 \$10 tests or condition   Test 2 \$10 \$25 \$15 \$45 \$15 \$45 \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$1		Imaging (CT/PET scans, MRIs)	\$50		\$100		
Times of the condition		Tier 1	\$3		\$5		
Interest or Tier 3  Tier 4  Tier 5  Tier 5  Tier 5  Tier 6  Tier 6  Tier 6  Tier 6  Tier 7  Tier 6  Tier 7  Tier 8  Tier 9  Ti	Orugs to treat	Tier 2	\$10		\$25		
Tier 4 10% up to \$150 per script scri	liness or	Tier 3	\$15		\$45		
Surgery facility fee (e.g., ASC)  Physicianisus/geno floss  Outpatient envices  Physicianisus/geno floss  Outpatient violt  Emergency room facility fee (walved if admitted)  Emergency room physician fee (walved if admitted)  Medical transportation (including emergency and non-emergency)  Urgent care  Urgent care  Urgent care  Facility fee (e.g., hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  Physicianisus/genofe envices  Pregnancy  Prenatal care and pre-conception visits  No charge  Silled nursing care  Durable medical equipment  Hospita service  Preventive  Preventive - Cleaning  Preventive - Crows and Cleate  Endodontics  Command Cleate  Endodontics  Cleaning Cleate - Cleaning  Preventiv	onation				Ų.		
Dutpatient   Physicianisurgeno fees   10%   20		Tier 4			15% up to \$150 per script		
Control of the process of the proces		Surgery facility fee (e.g., ASC)	10%		20%		
Emergency room facility fee (walved if admitted) Emergency room physician fee (walved if admitted) No charge Medical transportation (including emergency and non-emergency)  Urgent care  Urgent care  Facility fee (e.g. hospital room) for impatient stay (including labor and diversey, mental health, and substance use) Physician/surgeon fee  Individency in the physician fee in the physici	_	Physician/surgeon fees	10%		20%		
Emergency room physician fee (walved if admitted)   No charge   No charge		Outpatient visit	10%		20%		
Medical transportation (including emergency and non-emergency)  Urgent care  SS  S15  Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon 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 office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits No charge Pregnancy Pregnancy Pregnancy Pregnancy Pregnancy Pregnancy Pregnancy Pregnancy Prednancy Pregnancy Prednancy Preventive - Cleaning Preventive - Cle		Emergency room facility fee (waived if admitted)	\$50		\$150		
Intendiate attention  Urgent care  Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee  Indental delivery, 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 other outpatient files and services  Mental/behavioral health and substance use disorder other outpatient office visits  Mental/behavioral health and substance use disorder other outpatient files  Mental/behavioral health and substance use disorder other outpatient office visits  Mental/behavioral health and substance use disorder other outpatient office visits  Mental/behavioral health and substance use disorder other outpatient office visits  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  Static visits  Stat		Emergency room physician fee (waived if admitted)	No charge		No charge		
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 behavioral health and substance use disorder outpatient office visits  whental 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  No charge  Promatal care and preconception visits  No charge  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Topical Fluoride Application  Space Maintainers - Fixed  Child Dental  Basic  Bervices  Crowns and Casts  Crowns and Casts  Crowns and Casts  Endodontics  Periodontics (other than maintenance)  Prosthodontics  Periodontics (other than maintenance)  Prosthodontics	Need	Medical transportation (including emergency and non-emergency)	\$30		\$75		
Urgent care  Urgent care  Urgent care  Urgent care  Urgent care  Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use) Physician/surgeon fee  10%  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder other outpatient ferms and services  Mental/behavioral health and substance use disorder other outpatient ferms and services  Mental/behavioral health and substance use disorder other outpatient ferms and services  Mental/behavioral health and substance use disorder other outpatient ferms and services  No charge  Prenatal care and preconception visits  No charge  Oral Exam  Preventive - Cleaning  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Topical Fluoride Application  Space Maintainers - Fixed  Child Dental  Sasic  Periodontal Maintenance Services  Crows and Casts  Endodontics  Periodontics  Periodontics (other than maintenance)  Prosthodontics  Periodontics  Periodontics  Periodontics  Periodontics							
Facility fee (e.g., hospital stay delivery, mental health, and substance use)  Hospital stay delivery, mental health, and substance use)  Physician/surgeon fee  10%  20%  Mental/behavioral health and substance use disorder outpatient office visits  abelativer of the substance use disorder outpatient office visits  Prenatal care and preconception visits  No charge  Prenatal care and preconception visits  No charge  Prenatal care and preconception visits  No charge  Home health care (cost share per visit)  Sal  Stilled nursing care  Durable medical equipment  Hospice service  No charge  Preventive - Cleaning  Preventive - X-ray  Sealants per Tooth  Topical Fluoride Application  Space Maintainers - Fixed  Preventive Procedures  Periodoritia Maintenance Services  Crowns and Casts  Endodontics  Periodoritics  Periodoritics  Periodoritics  Periodoritics  Periodoritics		Urgent care	\$5		\$15		
delivery, mental health, and substance use) Physician/surgeon fee Physician Physicia							
Preventive   Pre			10%		20%		
Mental beath, beath, beath, beath, beath, or beath wisits  Mental/behavioral health and substance use disorder outpatient office visits  Mental/behavioral health and substance use disorder other outpatient items and services  Mental/behavioral health and substance use disorder other outpatient items and services  Mental/behavioral health and substance use disorder other outpatient items and services  Mental/behavioral health and substance use disorder other outpatient items and services  Mental/behavioral health and substance use disorder other outpatient items and services  Mental/behavioral health and substance use disorder other outpatient items and services  Mental/behavioral health and substance use disorder other outpatient items and services  No charge	Hospital stay		10%		20%		
health, visits visits where the company of the comp	Mental		.570		2370		
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) Signature of the precovering or other per visit or the precovering or other special health needs  Pregnancy Prenatal care and preconception visits No charge  No charge Skilled nursing care Durable medical equipment Hospice service No charge No charge Preventive Preventive - Cleaning Preventive - Cleaning Preventive - A-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Crowns and Casts Endodontics Periodontics Prosthodontics Prosthodontics Prosthodontics Prosthodontics	nealth,		\$5		\$15		
biblistics needs litems and services litems an	nealth, or	Mental/hehavioral health and substance use disorder other outnations					
Home health care (cost share per visit)  Outpatient Rehabilitation and Habilitation services  Skilled nursing care  Skilled nursing care  Durable medical equipment  Hospice service  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 - A-ray  Sealants per Tooth  Topical Fluoride Application  Space Maintainers - Fixed  Restorative Procedures  Periodontial Maintenance Services  Crowns and Casts  Endodontics  Periodontics  Home health care (cost share per visit)  \$3  \$15  \$15  \$20%  20%  No charge  Searlies  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  Prosthodontics	substance abuse needs		\$5		\$15		
Actificity of the period of th	Pregnancy	Prenatal care and preconception visits	No charge		No charge		
Skilled nursing care purable medical equipment purable medical equipme		Home health care (cost share per visit)	\$3		\$15		
Skilled nursing care Durable medical equipment Hospice service Durable medical equipment Hospice service No charge N	lelp	Outpatient Rehabilitation and Habilitation services	\$5		\$15		
Durable medical equipment  Hospice service  No charge	ecovering or	Skilled nursing care	10%		20%		
Hospice service  Eye exam  I pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Restorative Procedures Periodontal Maintenance Services  Child Dental Services  Child Dental Major Services  Prosthodontics  No charge	nealth needs	-					
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  Child Dental Basic Bervices  Crowns and Casts Endodontics Periodontics (other than maintenance) Proventives  Eye exam No charge							
1 pair of glasses per year (or contact lenses in lieu of glasses)  No charge  Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Services Periodontal Maintenance Services  Crowns and Casts Endodontics Periodontics (other than maintenance) Proventives  1 pair of glasses per year (or contact lenses in lieu of glasses) No charge			-		-		
Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Services Crowns and Casts Endodontics Periodontals (other than maintenance) Prosthodontics Prosthodontics  Oral Exam Preventive - Cleaning No charge 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  Child Dental Major Services Periodontics			140 Glaige		140 Glarge		
Child Dental Diagnostic and Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Periodontal Maintenance Services  Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Prosthod							
Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Services Periodontal Maintenance Services  Child Dental Child Dental Basic Services Periodontics  Child Dental Basic Fixed  Crowns and Casts Fixed  Crowns and Casts Fixed  20%  20%  20%  50%  50%  Fosthodontics  Frosthodontics							
Topical Fluoride Application Space Maintainers - Fixed  Child Dental Basic Periodontal Maintenance Services  Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Prosthodontics	Diagnostic and		No charge		No charge		
Space Maintainers - Fixed  Restorative Procedures Periodontal Maintenance Services  Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Prosthodontics							
Child Dental Restorative Procedures Periodontal Maintenance Services  Crowns and Casts Endodontics Periodontics (other than maintenance) Periodontics Prosthodontics Prosthodontics							
Periodontal Maintenance Services  Crowns and Casts  Endodontics  Periodontics (other than maintenance)  Prosthodontics  Prosthodontics	Child Dont						
Crowns and Casts  Endodontics  Periodontics (other than maintenance)  Prosthodontics  Crowns and Casts  50%  50%	Basic		20%		20%		
Child Dental Major Periodontics (other than maintenance) Services Prosthodontics  Endodontics  50%  50%	Services						
Child Dental Major Periodontics (other than maintenance) 50% 50%  Prosthodontics							
Services Prosthodontics	Child Dental						
Prosthodontics	Major Services		50%		50%		
Oral Surgery							
		Oral Surgery					

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Silver 73 Above 200% FPI	
		. 15010 20070111	
uarial Value - A\	/ Calculator	79.2%	
	Plan design includes a deductible?	No	
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$6,100	
	Family Out-of-pocket maximum	\$12,200	
	HSA plan: Self-only coverage deductible	N/A	
Camman	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductil Applie
	Primary care visit to treat an injury, illness, or condition	\$35	
Health care provider's office or	Other practitioner office visit	\$35	
clinic visit	Specialist visit	\$85	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$15	
Drugs to treat	Tier 2	\$55	
condition	Tier 3	\$85	
	Tier 4	20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	30%	
Outpatient services	Physician/surgeon fees	30%	
oci vices	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$350	
		·	
Need	Emergency room physician fee (waived if admitted)	No charge	
mmediate attention	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	30%	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	30%	
Mental nealth,	Mental/behavioral health and substance use disorder outpatient office	\$35	
behavioral	visits	Ψ00	
nealth, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$35	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$35	
other special	Skilled nursing care	30%	
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth	-	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	200/	
Basic Services	Periodontal Maintenance Services	20%	
	Crowns and Casts		
	Endodontics		
Child Dontal			
Child Dental Major	Periodontics (other than maintenance)	50%	
	Periodontics (other than maintenance)  Prosthodontics	50%	
Major	,	50%	

#### Summary of Benefits and Coverage



Summary of B	enefits and Coverage	Th.			
Member Cost Sha	re amounts describe the Enrollee's out of pocket costs.	Individual-only F		Individual-only F	
		Coinsurance	ridii	Copay Pla	ul
Actuarial Value	AV Coloulator	04.00/		04.69/	
Actuarial Value -		91.9%		91.6%	
	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 / \$	
			U		U
	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		Marshau Caat	5	Member Cost	5
Medical	Service Type	Member Cost Share	Deductible Applies	Share	Deductible Applies
Event					
	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
Health care	Other practitioner office visit	<b>645</b>		<b>645</b>	
provider's office or	Other practitioner office visit	\$15		\$15	
clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$15	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%			
	maging (OTA ET Sound, WING)	1070		\$75	
	Tier 1	\$7		\$7	
Drugs to trea	t Tier 2	\$16		\$16	
illness or	Tier 3	605		605	
condition	Her 3	\$25		\$25	
	Tier 4	10% up to \$250 per		10% up to \$250 per	
	Tiel 4	script		script	
	Surgery facility fee (e.g., ASC)	10%		\$75	
Outpatient					
services	Physician/surgeon fees	10%		\$20	
	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	\$150		\$150	
attention					
	Urgent eare	<b>645</b>		£45	
	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)	1070		5 days	
	Physician/surgeon fee	10%		No charge	
Mental	Mental/behavioral health and substance use disorder outpatient office				
health,	visits	\$15		\$15	
behavioral health, or					
substance	Mental/behavioral health and substance use disorder other outpatient	\$15		\$15	
abuse needs	items and services			, -	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
		_		_	
	Home health care (cost share per visit)	10%		\$20	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
recovering of		10%		\$125 per day up to	
other special health needs				5 days	
	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
01 " 1	Eye exam	No charge		No charge	
Child eye care	·	_		_	
cai c	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental	, and the second				
Diagnostic and Preventive	Preventive - X-ray	Not Covered		Not Covered	
	Sealants per Tooth				
i revenuve	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	Not C		Not C	
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
00.41063					
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services					
	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	
Orthodontics	,				

Summary of Benefits and Coverage  Member Cost Share amounts describe the Enrollee's out of pocket costs.		CCSB-only Platinum Coinsurance Plan		CCSB-only Platinum Copay Plan	
Actuarial Value - A	√ Calculator	91.3%		90.5%	
	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	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible			N/A N/A	
Common	TISA family plant. Individual deductible				
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$15		\$20	
Health care provider's	Other practitioner office visit	\$15		\$20	
office or clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$20	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$100	
	Tier 1	\$10		\$5	
Drugs to treat illness or	Tier 2	\$25		\$20	
condition	Tier 3	\$40		\$30	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
0.4	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient services	Physician/surgeon fees	10%		\$25	
	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$200		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate attention	Medical transportation (including emergency and non-emergency)	\$150		\$150	
	Urgent care	\$15		\$20	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  Physician/surgeon fee	10%		\$250 per day up to 5 days No charge	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$20	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$20	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$20	
recovering or	Skilled nursing care	10%		\$150 per day up to	
other special health needs	Durable medical equipment	10%		5 days 10%	
	Hospice service	No charge		No charge	
01.11	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	140 Griarge		140 Grange	
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and		Not Covered		Not Covered	
Preventive	Sealants per Tooth  Topical Elization Application				
	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				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
Ohite	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

=	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only	
		Coinsurance	Pian	Copay Pla	ın
tuarial Value - A\	√ Calculator	81.5%		81.6%	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	)	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	)	\$0 / \$0 / \$	0
	Individual Out-of-pocket maximum	\$8,700		\$8,700	
	Family Out-of-pocket maximum	\$17,400		\$17,400	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
Health care	Other practitioner office visit	\$35		\$35	
provider's office or	Other practitioner office visit	φοσ		φυσ	
clinic visit	Specialist visit	\$65		\$65	
	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	\$15		\$15	
	nor i	CΙΦ		φ15	
Drugs to treat	Tier 2	\$60		\$60	
illness or condition	Tier 3	\$85		\$85	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
Outpatient	Surgery facility fee (e.g., ASC)	30%		\$130	
services	Physician/surgeon fees	30%		\$60	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$330		\$330	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$250		\$250	
immediate attention		<b>,</b>		,	
attention	Lirgant core	<b>#25</b>		<b>#2</b> 5	
	Urgent care	\$35		\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	200/		\$350 per day up to	
Hospital stay	delivery, mental health, and substance use)	30%		5 days	
	Physician/surgeon fee	30%		No charge	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$35		\$35	
behavioral	visits	ΨΟΟ		ΨΟΟ	
health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$35		\$35	
abuse needs	items and services	ψ33		ψυυ	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Help	Outpatient Rehabilitation and Habilitation services	\$35		\$35	
recovering or	Skilled nursing care	30%		\$150 per day up to	
other special health needs				5 days	
	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic and Preventive	Preventive - X-ray				
	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				
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Major Services					
Services	Prosthodontics				
Services	Prosthodontics Oral Surgery				

Date: April 18, 2024

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-only Gold Coinsurance Pla	n	CCSB-only Gold Copay Plan		
tuarial Value - A\	√ Calculator	79.1%		80.5%		
	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	\$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		
<u>.</u>	HSA family plan: Individual deductible	N/A		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductil Applies	
	Primary care visit to treat an injury, illness, or condition	\$25		\$35		
Health care	Other practitioner office visit	¢05		<b>#3</b> E		
provider's office or	Other practitioner office visit	\$25		\$35		
clinic visit	Specialist visit	\$50		\$55		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$25		\$35		
Tests	X-rays and Diagnostic Imaging	\$65		\$55		
	Imaging (CT/PET scans, MRIs)	20%		\$250	х	
				·	Χ	
	Tier 1	\$15		\$15		
Drugo to to	Tier 2	\$50		\$40		
Orugs to treat Ilness or						
condition	Tier 3	\$80		\$70		
	Tier 4	20% up to \$250 per script		20% up to \$250 per script		
	Surgery facility fee (e.g., ASC)	20%		\$300	Х	
Outpatient services	Physician/surgeon fees	20%		\$35		
	Outpatient visit	20%		20%		
	Emergency room facility fee (waived if admitted)	20%	X	\$250	Х	
	Emergency room physician fee (waived if admitted)			·		
Need		No charge		No charge		
immediate attention	Medical transportation (including emergency and non-emergency)	20%	Х	\$250	Х	
	Urgent care	\$25		\$35		
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)  Physician/surgeon fee	20% 20%	x x	\$600 per day up to 5 days	Х	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$25		\$35		
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$25		\$35		
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	20%		\$30		
				·		
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$25		\$35		
other special	Skilled nursing care	20%	X	\$300 per day up to 5 days	Х	
health needs	Durable medical equipment	20%		20%		
	Hospice service	No charge		No charge		
Child eye	Eye exam	No charge		No charge		
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam	·-·· g -		·-·· g -		
Child Dental	Preventive - Cleaning					
Diagnostic	Preventive - X-ray	Not Covered		Not Covered		
and Preventive	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental	Restorative Procedures					
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered		
Del VICES						
	Crowns and Casts					
	Endodontics					
Child Dental	Endodoffics					
Major	Periodontics (other than maintenance)	Not Covered		Not Covered		
Child Dental Major Services		Not Covered		Not Covered		
Major	Periodontics (other than maintenance)	Not Covered		Not Covered		

Date: April 18, 2024

Summary	of	Benefits	and	Coverage

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Individual-only Silve	r Plan
	·	•	
Actuarial Value - A\	/ Calculator	71.6%	
	Plan design includes a deductible?	Yes, Medical/Pharm	асу
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,400 / \$50 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,800 / \$100 / \$	60
	Individual Out-of-pocket maximum	\$8,700	
	Family Out-of-pocket maximum	\$17,400 N/A	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A	
Common Medical	Service Type	Member Cost Share	Deductible Applies
Event	Primary care visit to treat an injury, illness, or condition	\$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	
10010	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$18	
Drugs to treat	Tier 2	\$60	Pharmacy deductible
illness or	Tier 3	<b>¢00</b>	Pharmacy
condition	Hel 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	Medical transportation (including emergency and non-emergency)	\$250	
immediate	model and portation (modeling emorgency and non-emorgency)	Ψ230	
attention	Urgent care	<b>\$</b> 50	
	orgen care	\$50	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		
Hospital stay	delivery, mental health, and substance use)	30%	X
	Physician/surgeon fee	30%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$50	
behavioral	VISILS		
health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$50	
abuse needs			
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$50	
recovering or other special	Skilled nursing care	30%	X
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental	Preventive - X-ray		
Diagnostic and	Sealants per Tooth	Not Covered	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic	Periodontal Maintenance Services	Not Covered	
Services			
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	Not Covered	
	Prosthodontics		
21.11	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	Not Covered	

Summary of Benefits and Coverage		CCSB-only		CCSB-only		
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver Coinsurance Plan	١	Silver Copay Plan		
Actuarial Male	V Calculator	00.50/		00.497		
Actuarial Value - A		69.5%		69.1%		
	Plan design includes a deductible? Integrated Individual deductible	Yes, Medical/Pharma N/A	ю	Yes, Medical/Pharm N/A	acy	
	Integrated Hidvidual 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	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Event	Primary care visit to treat an injury, illness, or condition	\$55		\$55		
Health care		·		·		
provider's office or	Other practitioner office visit	\$55		\$55		
clinic visit	Specialist visit	\$90		\$90		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$55		\$55		
Tests	X-rays and Diagnostic Imaging	\$90		\$90		
	Imaging (CT/PET scans, MRIs)	35%	Х	\$300	x	
			^	·	^	
	Tier 1	\$20		\$19		
Drugs to treat	Tier 2	\$75	Pharmacy	\$85	Pharmacy	
illness or			deductible Pharmacy	·	deductible Pharmacy	
condition	Tier 3	\$105	deductible	\$110	deductible	
	Tier 4	30% up to \$250 per script after	Pharmacy	30% up to \$250 per script after	Pharmacy	
		pharmacy deductible	deductible	pharmacy deductible	deductible	
Outpatient	Surgery facility fee (e.g., ASC)	35%	Х	35%	Х	
services	Physician/surgeon fees	35%		35%		
	Outpatient visit	35%		35%		
	Emergency room facility fee (waived if admitted)	35%	Χ	35%	X	
	Emergency room physician fee (waived if admitted)	No charge		No charge		
Need	Medical transportation (including emergency and non-emergency)	35%	X	35%	х	
immediate attention						
	Urgent care	\$55		\$55		
		·		·		
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	050/	V	059/		
Hospital stay	delivery, mental health, and substance use)	35%	Х	35%	X	
	Physician/surgeon fee	35%	Χ	35%		
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$55		\$55		
behavioral	visits	ΨΟΟ		ΨΟΟ		
health, or substance	Mental/behavioral health and substance use disorder other outpatient	\$55		\$55		
abuse needs	items and services	ΨΟΟ		ΨΟΟ		
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Home health care (cost share per visit)	35%		\$45		
Help	Outpatient Rehabilitation and Habilitation services	\$55		\$55		
recovering or	Skilled nursing care	35%	Х	35%	x	
other special health needs			^		^	
	Durable medical equipment	35%		35%		
	Hospice service	No charge		No charge		
Child eye	Eye exam	No charge		No charge		
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
	Preventive - Cleaning					
Child Dental Diagnostic	Preventive - X-ray					
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		
Sei vices	Prosthodontics					
	Oral Surgery					
Child	Medically necessary orthodontics	Not Covered		Not Covered		
Orthodontics	•					

Date: April 18	, 2024		
-	nefits and Coverage	CCSB-o Silver	•
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	HDHP P	
	V0.1.1.	74.00/	
Actuarial Value - A	v Calculator  Plan design includes a deductible?	71.2% Yes, integi	
	Integrated Individual deductible	\$2,850 integ	
	Integrated Framily deductible	\$5,700 integ	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Individual Out-of-pocket maximum	\$7,500	)
	Family Out-of-pocket maximum	\$15,00	0
	HSA plan: Self-only coverage deductible		
Common	HSA family plan: Individual deductible	See endi	lote
Medical	Service Type	Member Cost Share	Deductible Applies
Event	Primary care visit to treat an injury, illness, or condition	25%	X
Health care			^
provider's office or	Other practitioner office visit	25%	X
clinic visit	Specialist visit	25%	X
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	25%	X
Tests	X-rays and Diagnostic Imaging	25%	X
	Imaging (CT/PET scans, MRIs)	25%	Х
	Tier 1	25% up to \$250 per script	X
	Tier 2	25% up to \$250 per	x
Drugs to treat illness or	not 2	script 25% up to \$250 per	^
condition	Tier 3	script	X
	Tier 4	25% up to \$250 per	x
	0 ( 17) ( ( ) ( )	script	.,
Outpatient	Surgery facility fee (e.g., ASC)	25%	X
services	Physician/surgeon fees	25%	X
	Outpatient visit	25%	X
	Emergency room facility fee (waived if admitted)	25%	X
Need	Emergency room physician fee (waived if admitted)	0%	X
immediate	Medical transportation (including emergency and non-emergency)	25%	X
attention		250/	
	Urgent care	25%	X
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		
Hospital stay	delivery, mental health, and substance use)	25%	X
	Physician/surgeon fee	25%	X
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	25%	X
behavioral health, or	VISIG		
substance	Mental/behavioral health and substance use disorder other outpatient items and services	25%	X
abuse needs	Prenatal care and preconcention visits	No oborgo	
Pregnancy	Prenatal care and preconception visits  Home health care (cost share per visit)	No charge	×
	Home health care (cost share per visit)		
Help recovering or	Outpatient Rehabilitation and Habilitation services	25%	X
other special health needs	Skilled nursing care	25%	X
nouth needs	Durable medical equipment	25%	X
	Hospice service	0%	X
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic and	Preventive - X-ray	Not Covered	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
Child Dental	Space Maintainers - Fixed		
Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics	Not C	
Major Services	Periodontics (other than maintenance)	Not Covered	
	Prosthodontics Oral Surgery		
Child			
Orthodontics	Medically necessary orthodontics	Not Covered	

Date: April 18, 2024

Summary	of	<b>Benefits</b>	and	Coverage
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flember Cost Share amounts describe the Enrollee's out of pocket costs.		Silver Plan 100%-150% FPL		Silver Plan 150%-200% FPL	
ctuarial Value - AV	/ Calculator	94.7%	b	88.0%	
	Plan design includes a deductible?	Yes, Medical/F	Pharmacy	Yes, Medical/Pharm	асу
	Integrated Individual deductible	N/A		N/A	
Integrated Family deductible		N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /	\$0	\$1,400 / \$350 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /	\$0	\$2,800 / \$700 / \$	0
	Individual Out–of–pocket maximum	\$1,300	)	\$3,050	
	Family Out-of-pocket maximum	\$2,600	)	\$6,100	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A		N/A N/A	
Common	TIOA Tannily pian. Individual deductible	Member Cost	Dadwalla	IVA	Do do otible
Medical Event	Service Type	Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
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	
. 0313					
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$8	
Druge to troat	Tier 2	\$10		\$25	Pharmacy
Drugs to treat illness or					deductible Pharmacy
condition	Tier 3	\$15		\$45	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%	deductible
Outpatient					
services	Physician/surgeon fees	10%		20%	
	Outpatient visit	10%		20%	
	Emergency room facility fee (waived if admitted)	\$50		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
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	10%	X	20%	x
Hospital stay	delivery, mental health, and substance use)				
Mental	Physician/surgeon fee	10%		20%	
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
behavioral health, or					
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
	Outpatient Rehabilitation and Habilitation services			·	
Help recovering or		\$5		\$15	
other special	Skilled nursing care	10%	X	20%	X
health needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental	Preventive - X-ray				
Diagnostic and		Not Covered		Not Covered	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
Ohild D	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	<b>Silver Plan</b> 200%-250% FPI	_
		230 % 200 % 1 1 1	_
ctuarial Value - A\		73.9%	
	Plan design includes a deductible?	Yes, Medical/Pharm	nacy
	Integrated Individual deductible Integrated Family deductible	N/A N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,400 / \$350 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,800 / \$700 / \$	
	Individual Out-of-pocket maximum	\$7,350	
	Family Out-of-pocket maximum	\$14,700	
	HSA plan: Self-only coverage deductible	N/A	
Common	HSA family plan: Individual deductible	N/A	
Medical Event	Service Type	Member Cost Share	Deductib Applies
Licelth core	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	
Cillic Visit	·		
	Preventive care/ screening/ immunization	No charge	
<b>T</b> .	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$20	
Dwise to t	Tier 2	\$55	Pharma
Drugs to treat illness or	No. 2	φυσ	deductik
condition	Tier 3	\$85	Pharma deductil
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductil
	Surgery facility fee (e.g., ASC)	30%	
Outpatient services	Physician/surgeon fees	30%	
services	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$350	
	Emergency room physician fee (waived if admitted)	No charge	
Need		Ğ	
immediate	Medical transportation (including emergency and non-emergency)	\$250	
attention	Urgent care	\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%	X
Hospital stay	Physician/surgeon fee	30%	
Mental	Mental/behavioral health and substance use disorder outpatient office	\$35	
health, behavioral	visits	φοσ	
health, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$35	
abuse needs		No oborgo	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$35	
other special	Skilled nursing care	30%	X
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray		
and	Sealants per Tooth	Not Covered	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic	Periodontal Maintenance Services	Not Covered	
Services			
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	Not Covered	
20171003	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	Not Covered	

Date: April 18, 2024

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.		Bronze Plan	Bronze HDHP Plan		
Actuarial Value - A	V Calculator	63.6%		63.6%	
Actuariai value - A					
Plan design includes a deductible?		Yes, Medical/Pharr N/A	nacy	Yes, integrated	
	Integrated Individual deductible			\$6,650 integrated	
Integrated Family deductible		N/A	20	\$13,300 integrated	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,800 / \$450 / \$		N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$11,600 / \$900 /	\$0	N/A	
	Individual Out-of-pocket maximum	\$8,850		\$6,650	
	Family Out-of-pocket maximum	\$17,700		\$13,300	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A		\$6,650 \$6,650	
Common Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible
Event	Primary care visit to treat an injury, illness, or condition	\$60	Boddonbie / pplies	0%	Applies X
Health care		Ψ00		0,0	^
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	
	-	-		0%	X
<b>-</b>	Laboratory Tests	\$40	.,		
Tests	X-rays and Diagnostic Imaging	40%	X	0%	X
	Imaging (CT/PET scans, MRIs)	40%	Х	0%	Х
	Tier 1	\$19		0%	x
	Time	40% up to \$500 per script after	Pharmacy		
Drugs to treat illness or	Tier 2	pharmacy deductible	Deductible	0%	X
condition	Tier 3	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	Х
		40% up to \$500 per script after	Pharmacy		
	Tier 4	pharmacy deductible	Deductible	0%	X
	Surgery facility fee (e.g., ASC)	40%	X	0%	X
Outpatient	Physician/surgeon fees	40%	×	0%	X
services	, ,			0%	
	Outpatient visit	40%	X		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%	x
	Facility fee (e.g. hospital room) for inpatient stay (including labor and				
Hospital stay	delivery, mental health, and substance use)	40%	X	0%	X
	Physician/surgeon fee	40%	X	0%	Х
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$60		0%	x
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$60		0%	x
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	40%	×	0%	X
	Outpatient Rehabilitation and Habilitation services	\$60		0%	×
Help recovering or	Outpatient Renabilitation and Habilitation services	\$00		0%	^
other special	Skilled nursing care	40%	X	0%	X
health needs	Durable medical equipment	40%	X	0%	X
	Hospice service	No charge		0%	х
Child eye	Eye exam	No charge		No charge	
care	pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	. To onal go		, to change	
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
Jer vices					
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
001 VI003	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	
Orthodontics					

Summary	, of	Renefite	and	Coverage
Summany	, 01	Denenio	anu	Coverage

Summary of Ber	nefits and Coverage		
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Catast	trophic Plan
Actuarial Value - A	V Calculator		
Actuariai value - A	Plan design includes a deductible?	Yes.	integrated
	Integrated Individual deductible		0 integrated
	Integrated Family deductible	\$18,40	00 integrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Individual Out-of-pocket maximum		\$9,200
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	<b>\$</b>	18,400 N/A
	HSA family plan: Individual deductible		N/A
Common	Ounies Ture	Member Cost	De des Albiro Accorde
Medical Event	Service Type	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%	×
Tests	X-rays and Diagnostic Imaging	0%	×
	Imaging (CT/PET scans, MRIs)	0%	×
	Tier 1	0%	X
		0.70	^
Drugs to treat illness or	Tier 2	0%	X
condition	Tier 3	0%	×
	Tier 4	0%	X
	1101 -	0 76	^
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%	×
Mond	Emergency room physician fee (waived if admitted)	No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	0%	X
attention	Unantana	00/	After 1st three non-
	Urgent care	0%	preventive visits
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	00/	
Hospital stay	delivery, mental health, and substance use)	0%	X
Mandal	Physician/surgeon fee	0%	X
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three non- preventive visits
behavioral health, or			•
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	0%	×
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	×
Help	Outpatient Rehabilitation and Habilitation services	0%	×
recovering or other special	Skilled nursing care	0%	×
health needs	Durable medical equipment	0%	×
	Hospice service	0%	×
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	×
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray		
and Preventive	Sealants per Tooth	Not Covered	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services	Oovoicu	
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	Not Covered	
	Prosthodontics		
Ok "III	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	Not Covered	

Member Cost Share amounts describe the Enrollee's out of pocket costs.		CA Enh CSR Silver 94 Plan 100%-150% FPL		CA Enh CSR Silver 87 Plan 150%-200% FPL	
ctuarial Value - A\	/ Calculator	95.1%		88.9%	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /	\$0	\$0 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /	\$0	\$0 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$1,150	)	\$3,000	
	Family Out-of-pocket maximum	\$2,300	)	\$6,000	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A		N/A N/A	
Common Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deduc Appli
Event	Primary care visit to treat an injury, illness, or condition	\$5	, фрисо	\$15	, tpp
Health care provider's	Other practitioner office visit	\$5		\$15	
office or	Other practitioner office visit	ΨΟ		Ψισ	
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 condition	Tier 3	\$15		\$45	
condition		10% up to \$150 per			
	Tier 4	script		15% up to \$150 per script	
O	Surgery facility fee (e.g., ASC)	10%		20%	
Outpatient services	Physician/surgeon fees	10%		20%	
	Outpatient visit	10%		20%	
	Emergency room facility fee (waived if admitted)	\$50		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$30		\$75	
mmediate attention		ΨΟΟ		Ψ	
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%	
Hospital stay	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 items and services	\$5		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
Lala	Outpatient Rehabilitation and Habilitation services	\$5 \$5		\$15	
Help recovering or					
other special health needs	Skilled nursing care	10%		20%	
leann needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray				
and	Sealants per Tooth	Not Covered		Not Covered	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic		Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
CCI VICES	Prosthodontics				
	Oral Surgery				
Child	Medically necessary orthodontics	Not Covered		Not Covered	

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Silver 73 Above 200% FPL	
il.\/_l	/ O-laulater	79.2%	
uarial Value - A\		79.2% No	
	Plan design includes a deductible? Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	
	Individual Out–of–pocket maximum	\$6,100	
	Family Out-of-pocket maximum	\$12,200	
	HSA plan: Self-only coverage deductible	N/A	
Common	HSA family plan: Individual deductible	N/A	
Medical Event	Service Type	Member Cost Share	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	\$35	
Health care provider's	Other practitioner office visit	\$35	
office or clinic visit	Specialist visit	\$85	
Jiiiio Viole	Preventive care/ screening/ immunization		
	· ·	No charge	
Tests	Laboratory Tests  X-rays and Diagnostic Imaging	\$50 \$95	
. 0313			
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$15	
Orugs to treat	Tier 2	\$55	
liness or	Tier 3	\$85	
ondition			
	Tier 4	20% up to \$250 per script	
Dutactions	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	
attention	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 nealth,	Mental/behavioral health and substance use disorder outpatient office	\$35	
oehavioral	visits	***	
nealth, or substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$35	
abuse needs			
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Help	Outpatient Rehabilitation and Habilitation services	\$35	
ecovering or other special	Skilled nursing care	30%	
nealth needs	Durable medical equipment	20%	
	Hospice service	No charge	
		No charge	
Child eve	Eye exam	140 orlange	
Child eye care	Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
		-	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	-	
Child Dental	1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam	-	
Child Dental Diagnostic	1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam  Preventive - Cleaning  Preventive - X-ray	-	
care 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	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	
Child Dental Diagnostic and Preventive	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	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	
Child Dental Diagnostic and Preventive	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	
Child Dental Diagnostic and Preventive	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	
Child Dental Diagnostic and Preventive Child Dental Basic Gervices 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  Endodontics	No charge  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  Crowns and Casts  Endodontics  Periodontics (other than maintenance)	No charge  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  Endodontics	No charge  Not Covered	

#### **Endnotes to Covered California 2025 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 2025 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.
- 12) A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 2025 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:

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

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

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

- 25) A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary.
- 26) The health issuer may not impose a member cost share for Diabetes Self-Management which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member's physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.
- 27) The cost sharing for hospice services applies regardless of the place of service.
- 28) For all FDA-approved tobacco cessation medications, no limits on the number of days for the course of treatment (either alone or in combination) may be imposed during the plan year.
- 29) For inpatient stays, if the facility does not bill the facility fee and physician/surgeon fee separately, an issuer may apply the cost-sharing requirements for the facility fee to the entire charge.
- 30) For any benefit plan design in which a designation of Individual-Only or CCSB-Only is not present, the benefit plan design shall be applicable to the individual and small group markets. If a health plan seeks to offer such benefit plan design(s) in both markets, they shall be treated as separate benefit plan designs for purposes of regulatory compliance.
- 31) The out-of-pocket maximum in the Bronze HDHP shall not exceed the maximum out-of-pocket limit specified by the IRS in its revenue procedure for the 2025 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.