Covered California 2026 Patient-Centered Benefit Plan Designs¹

Final Approved

July 28, 2025

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

Date: July 28, 2025

Summary of Benefits and Coverage

COVERED

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Individual-only F Coinsurance		Individual-only F Copay Pla	
Actuarial Value - A	V Calculator	91.9%		91.8%	
/ total raids / t	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0/\$0/\$	0	\$0/\$0/\$	0
	Individual Out-of-pocket maximum	\$5,000		\$5,000	
	Family Out-of-pocket maximum	\$10,000		\$10,000	
	HSA plan: Self-only coverage deductible	N/A		N/A	
0	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			·	
	nor I	\$9		\$9	
Drugs to	Tier 2	\$16		\$16	
treat illness or condition	Tier 3	\$25		\$25	
0. 00.141.1011				·	
	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	
50111005	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$175		\$175	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	\$150		\$150	
immediate attention		·		·	
	Urgent care	\$15		\$15	
		ψ.5		ψ.0	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	400/		\$225 per day up to	
Hospital stay	delivery, mental health, and substance use)	10%		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	VISILS				
substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$15		\$15	
abuse needs					
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
recovering or other special	Skilled nursing care	10%		\$125 per day up to 5 days	
health 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				
	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%		See 2025 Dental Copay Schedule	
Services					
	Crowns and Casts				
Child Dental	Endodontics	-a:-		See 2025 Dental	
Major Services	Periodontics (other than maintenance)	50%		Copay Schedule	
	Prosthodontics				
01.77	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-onl Platinum Coinsurance	-	CCSB-onl Platinum Copay Pla	i
		Comountario		oopay i ia	
tuarial Value - A		91.8%		91.1%	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0 \$0 / \$0 / \$	n	\$0 \$0 / \$0 / \$	0
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental			, , , , , ,	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out–of–pocket maximum	\$0 / \$0 / \$0 \$4,500	U	\$0 / \$0 / \$	U
	Family Out-of-pocket maximum			\$4,500 \$9,000	
	HSA plan: Self-only coverage deductible	· ·		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical	Sandaa Tura	Member Cost	Deductible	Member Cost	Deducti
Event	Service Type	Share	Applies	Share	Applie
	Primary care visit to treat an injury, illness, or condition	\$15		\$20	
Health care provider's	Other practitioner office visit	\$15		\$20	
office or	0				
clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$20	
ests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$100	
	Tier 1	\$10		\$5	
	Tive				
Orugs to reat illness	Tier 2	\$25		\$20	
reat illness or condition	Tier 3	\$40		\$30	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient	Physician/surgeon fees	10%		\$25	
services	•	10%		10%	
	Outpatient visit				
	Emergency room facility fee (waived if admitted)	\$200		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need mmediate	Medical transportation (including emergency and non-emergency)	\$150		\$150	
ttention					
	Urgent care	\$15		\$20	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		\$250 per day up to	
Hospital stay	Physician/surgeon fee	10%		5 days	
/lental		1076		No charge	
nealth, nehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$20	
health, or	Mental/behavioral health and substance use disorder other outpatient				
substance abuse needs	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 recovering or	Outpatient Rehabilitation and Habilitation services	\$15		\$20 \$150 per day up to	
other special	Skilled nursing care	10%		5 days	
nealth 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				
	Preventive - Cleaning				
Child Dental	-				
Diagnostic and	Preventive - X-ray	No charge		No charge	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		See 2025 Dental	
Services	Periodontal Maintenance Services	2070		Copay Schedule	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		See 2025 Dental	
Services	Prosthodontics			Copay Schedule	
	Oral Surgery				
Child	Grai Suryery				
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

2026 Patient-Centered Benefit Plan Designs 10.0 EHB Date: July 28, 2025

mber Cost Share	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance I		Individual-only Copay Pla	
				- Copuj i la	
uarial Value - A\	√ Calculator	81.4%		81.7%	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0	_	\$0	_
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0 / \$0 / \$	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0 \$9,200)	\$0 / \$0 / \$ \$9,200	0
	Individual Out–of–pocket maximum Family Out-of-pocket maximum	\$18,400		\$18,400	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common	A	Member Cost	Deductible	Member Cost	Deduc
Medical Event	Service Type	Share	Applies	Share	Appli
	Primary care visit to treat an injury, illness, or condition	\$40		\$40	
Health care provider's	Other practitioner office visit	\$40		\$40	
office or	·				
clinic visit	Specialist visit	\$70		\$70	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging	\$75		\$75	
	Imaging (CT/PET scans, MRIs)	25%		\$75	
	Tier 1	\$18		\$18	
Drugo to	Tier 2	\$60		\$60	
Drugs to treat illness					
or condition	Tier 3	\$85		\$85	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	30%		\$130	
Outpatient services	Physician/surgeon fees	30%		\$60	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350		\$350	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
leed	Medical transportation (including emergency and non-emergency)	\$250		\$250	
mmediate attention					
	Urgent care	\$40		\$40	
	·	***		*	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	30%		\$375 per day up to	
Hospital stay	delivery, mental health, and substance use)			5 days	
Mental	Physician/surgeon fee	30%		No charge	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$40		\$40	
behavioral health, or					
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$40		\$40	
	Prenatal care and preconception visits	No charge		No charge	
Pregnancy	·	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$40		\$40 \$150 per day up to	
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	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	N1 1		,	
and Preventive	Sealants per Tooth	No charge		No charge	
·······································	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				

Summary of Bei	nefits and Coverage	CCSB-only		CCSB-only	
-	amounts describe the Enrollee's out of pocket costs.	Gold Coinsurance Pla	,	Gold Copay Plan	
		Comsulance Fla		Сорау Ріан	
Actuarial Value - A	V Calculator	80.3%		81.7%	
	Plan design includes a deductible?	Yes, Medical/Pharm	асу	Yes, Medical/Pharr	macy
	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 Family Out-of-pocket maximum	\$7,800 \$15,600		\$7,800 \$15,600	
	HSA plan: Self-only coverage deductible			N/A	
	HSA family plan: Individual deductible			N/A	
Common			Deductible		Deductible
Medical Event	Service Type	Member Cost Share	Applies	Member Cost Share	Applies
	Primary care visit to treat an injury, illness, or condition	\$25		\$35	
Health care	Other and this are offer with	405		405	
provider's office or	Other practitioner office visit	\$25		\$35	
clinic visit	Specialist visit	\$50		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$25		\$35	
Tests	X-rays and Diagnostic Imaging	\$65		\$55	
	Imaging (CT/PET scans, MRIs)	20%		\$250	X
	Tier 1	\$15		\$15	
	Tion 2	050		040	
Drugs to treat illness	Tier 2	\$50		\$40	
or condition	Tier 3	\$80		\$70	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
	110. 1	20 / θ αρ το ψ200 ρει σαιρτ		20 % up to \$250 per 3011pt	
Outnotions	Surgery facility fee (e.g., ASC)	20%		\$300	X
Outpatient services	Physician/surgeon fees	20%		\$35	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	20%	X	\$250	X
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	20%	X	\$250	X
attention					
	Urgent care	\$25		\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	20%	X	\$600 per day up to 5 days	X
Hospital stay	Physician/surgeon fee	20%	x	No charge	
Mental		2070		THO GILLINGO	
health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$25		\$35	
health, or	Mental/behavioral health and substance use disorder other outpatient				
substance abuse needs	items and services	\$25		\$35	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
Holo	Outpatient Rehabilitation and Habilitation services	\$25		\$35	
Help recovering or	Skilled nursing care	20%	×	\$300 per day up to 5 days	X
other special health needs			^		^
	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic and	Preventive - X-ray	No charge		No charge	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	20%		See 2025 Dental Copay	
Services	Periodontal Maintenance Services	_3.0		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 of	f Benefits	and Cove	erage

Member Cost Share	e amounts describe the Enrollee's out of pocket costs.	Individual-only Silver	Plan
Actuarial Value - A	AV Calculator	71.8%	
	Plan design includes a deductible?	Yes, Medical/Pharma	асу
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,200 / \$50 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,400 / \$100 / \$	0
	Individual Out-of-pocket maximum	\$9,800	
	Family Out-of-pocket maximum	\$19,600	
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common	Service Type	Member Cost Share	Deductible

	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$50	
Health care provider's	Other practitioner office visit	\$50	
office or clinic visit	Specialist visit	\$90	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$19	
Drugs to	Tier 2	\$60	Pharma deductib
treat illness	Tier 3	\$90	Pharma
or contaction			deductib
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharma deductib
	Surgery facility fee (e.g., ASC)	30%	
Outpatient services	Physician/surgeon fees	30%	
	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need immediate attention	Medical transportation (including emergency and non-emergency)	\$250	
attention	Urgent care	\$50	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	30%	X
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	30%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$50	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$50	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$50	
recovering or other special	Skilled nursing care	30%	х
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
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		
Ohild Door t	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics Periodontics (other than maintenance)	50%	
Major Services	Periodontics (other than maintenance) Prosthodontics	5 0%	
Services			
Services	Oral Surgery		

Part	-	enefits and Coverage e amounts describe the Enrollee's out of pocket costs.	CCSB-only Silver Coinsurance Plan		CCSB-only Silver Copay Plan		
Piece 2011 Companies Com							
Property	Actuarial Value - A						
Personal state Pers		-		асу		acy	
Part		-					
Part)	
Included Challe-Special materium 56.00 18.77.00							
Part							
Common Service Type							
Secret Type Metabolic Event Privacy care visit is fined an injury, thous, or cardition Second Type Secon		HSA plan: Self-only coverage deductible	N/A		N/A		
Present Pres		HSA family plan: Individual deductible	N/A		N/A		
	Medical	Service Type	Member Cost Share		Member Cost Share		
providency of the production afformation of the production of the		Primary care visit to treat an injury, illness, or condition	\$55		\$55		
Colline visit Tends Recommendate and Everyonic Immunitation Linguity (CTPET seven Miles) Provide Acres and Everyonic Immunitation Drugs to Invasion Trees Linguity (CTPET seven Miles) Provide Acres and Everyonic Immunitation Drugs to Invasion Trees Tend Acres and Everyonic Immunitation Provide Acres and Everyonic		Other practitioner office visit	\$55		\$55		
Proverties owe deserting immunication Tests Tests	office or	Other practitioner office visit	φοσ		φοσ		
Lebousiary Tests	clinic visit	Specialist visit	\$90		\$90		
Tests X-rays and Disgrated Imaging Sign Sign X Sign		Preventive care/ screening/ immunization	No charge		No charge		
The range (CIT/PET scare, MSRs) Suggest (CIT/PET scare, MSRs) Suggest (CIT/PET scare, MSRs) The range (CIT/PET scare, MSRs) Suggest (CIT/PET scare, MSRs) Su		Laboratory Tests	\$55		\$55		
Ter 1 Drugs to treat library Ter 2 Drugs to treat library Ter 4 Drugs to candidate plant to the plant to	Tests	X-rays and Diagnostic Imaging	\$90		\$90		
Drugs to treat fillness or condition Titer 2 Titer 3 Titer 4 Surgery facility foe (e.g., ASC) Pharmacy deductible pharmacy pharmacy pharmacy p		Imaging (CT/PET scans, MRIs)	35%	X	\$300	Х	
Tree 4 20% up to 250 per corpt after phramaty declucible received in the case il linear and control to 2 and		Tier 1	\$20		\$19		
Tree 4 20% up to 250 per corpt after phramaty declucible received in the case il linear and control to 2 and		Tion 2	#7 5	Pharmacv	* 05	Pharmacv	
Ter 3 S106 Control Parameter (Control Parameter)		Her 2	\$75	deductible	\$85	deductible	
Double D		Tier 3	\$105		\$110		
Surgery facility fee (e.g., ASC)		Tier A	30% up to \$250 per script after	Pharmacy	30% up to \$250 per script after	Pharmacy	
Outpatient visit Services Outpatient visit Emergency room facility fee (waived if admitted) Emergency room facility fee (waived if admitted) Noc discontinumediate attention Urgent care 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, or substance abusiances and the state of the second residual transportation (including emergency and non-emergency) Physician-included transportation (including emergency and non-emergency) Sistematic care (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, or substances and substances abusiances and substances and substances abusiances and substances and substances abusiances abusiances and substances and substances abusiances abusiances abusiances and substances and substances and substances abusiances abusiances and substances and subst		Hel 4	pharmacy deductible	deductible	pharmacy deductible	deductible	
Services of Projection sturpton to test of the Comment of the Comm		Surgery facility fee (e.g., ASC)	35%	X	35%	Х	
Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted) Emergency room physician fee (waived if admitted) Medical transportation (including emergency and non-emergency) Urgent care Sa55 Sa56		Physician/surgeon fees	35%		35%		
Emergency room physician fee (walved if admitted) Need immediate attention Urgent care Hospital stay Hospit		Outpatient visit	35%		35%		
Medical transportation (including emergency and non-emergency) 36% X 35% X X 35% X X 35% X X X X X X X X X		Emergency room facility fee (waived if admitted)	35%	X	35%	X	
Urgent care Facility fee (s.g. hospital room) for impallient stay (including labor and delivery, mental health, and aubstance use) Mental health, behariving health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits No charge Pregnancy Prematic care and preconception visits No charge No c		Emergency room physician fee (waived if admitted)	No charge		No charge		
Urgent care \$55 \$\$55 \$\$55 \$\$5 \$\$5 \$\$5 \$\$5 \$\$5 \$\$5		Medical transportation (including emergency and non-emergency)	35%	X	35%	х	
Hospital stay Hospital stay Hospital stay Hornal cellivery, mental health, and substance use disorder outpatient office visits health, behavioral health and substance use disorder outpatient office visits health, behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits Mental/behavioral health and substance use disorder outpatient office visits No charge No charg							
Hospital stay Selivery, mental health, and substance use) 35% X 35		Urgent care	\$55		\$55		
Hospital stay Selivery, mental health, and substance use) 35% X 35							
Hospital stay Physician/surgeon fee 35% X 35%			35%	X	35%	X	
Montal health, not the health and substance use disorder outpatient office visits	Hospital stay						
hoatth, behavioral health and substance use disorder other outpatient behavioral health, or substance abuse needs Pregnancy Pregnancy Prenstal care and preconception visits No charge Stilled nursing care as special health needs believe medical equipment and substance use of special health needs Child eye care Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Basic Services Crowns and Casts Endodontics Crowns and Casts Endodontics Prosthodontics Prosthodontics Crowns and Casts Endodontics Prosthodontics Pro	Montal		35%	Χ	35%		
Neath, or substance abuse needs Section	health,		\$55		\$55		
Abuse needs items and services Pregnancy Prenatal care and preconception visits No charge No charge Home health care (cost share per visit) 35% \$45 \$45 \$45 \$45 \$45 \$45 \$45 \$45 \$45 \$45							
Pregnancy Prenatal care and preconception visits No charge No charge Home health care (cost share per visit) Outpatient Rehabilitation and Habilitation services S55 Sidled nursing care Durable medical equipment Side of the special health needs Durable medical equipment Hospice service Child eye Care Child operate Child Dental Diagnostic and Preventive Child Dental Dasjocstic Corowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Dental Major Services Oral Surgery No charge No c			\$55		\$55		
Home health care (cost share per visit) Holp recovering or other special health reeds Skilled nursing care Outpatient Rehabilitation and Habilitation services Skilled nursing care Skilled nursing care Durable medical equipment Hospice service Child eye care Child Dental Diagnostic and Preventive Child Dental Preventive Child Dental Basic Services Child Dental Basic Services Crowns and Casts Endodontics Criotal Gundant Major Services Periodontics (other than maintenance) Periodontics Oral Surgery Child Dental Majores Crown Services Crown Services Crown Services Crown Services Crown Medically necessary orthodontics Oral Surgery Child Medically necessary orthodontics Second Services Second Services Second Services Second S		Prenatal care and preconception visits	No charge		No charge		
Help recovering or other special health needs Skilled nursing care Durable medical equipment Hospice service Child eye care Child Dental Diagnostic and Preventive Preventive Child Dental Basic Services Child Dental Major Services Child Dental Major Services Child Dental Major Services Periodontal Maintenance Services Crowns and Casts Endodontics Oral Surgery Child Medically servessary orthodontics Oral Surgery Child Medically servessary orthodontics Services Skilled nursing care 35% X 35% X 35% X 35% X 35% X 35% No charge No	regulaticy	·	-		-		
recovering or other special health needs Skilled nursing care Ourable medical equipment Hospice service Child eye care Child eye care Child Dental Diagnostic and Preventive Preventive Child Dental Basic Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically precessary orthodontics Oral Surgery Child Medically precessary orthodontics Medically precessary orthodontics Services Skilled nursing care As 35% X 35% X 35% X 35% No charge No c							
ther special health needs Durable medical equipment Hospice service Child eye care Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically pecessary orthodontics Oral Surgery Child Medically pecessary orthodontics Services Serv	•		·				
Durable medical equipment Hospice service No charge Child Dental Diagnostic and Preventive Preventive Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics Oral Surgery Child Dental Major Services Draid Dental Major Services No charge	other special	Skilled nursing care	35%	X	35%	X	
Child Dental Diagnostic and Preventive Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Basic Services Crowns and Casts Endodontics Child Dental Major Services Crowns and Casts Endodontics Oral Exam No charge No	nealth needs	Durable medical equipment	35%		35%		
Child Dental Dajonostic and Preventive Child Dental Diagnostic and Preventive Child Dental Basic Services Crowns and Casts Endodontics Periodontal Maintenance Services Corowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically recessary orthodontics Sea 2025 Dental Copay Schedule See 2025 Dental Copay Schedule		Hospice service	No charge		No charge		
Child Dental Diagnostic and Preventive Child Dental Basic Services Crowns and Casts Endodontics Periodontics (other than maintenance) Child Dental Major Services Child Dental Major Services Crowns and Casts Endodontics Periodontics (other than maintenance) Coral Exam No charge See 2025 Dental Copay Schedule See 2025 Dental Copay Schedule See 2025 Dental Copay Schedule Child Dental Major Schedule Prosthodontics Oral Surgery Child Medically percessary orthodontics	Child eye	Eye exam	No charge		No charge		
Child Dental Diagnostic and Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Periodontics (other than maintenance) Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically peressary orthodontics 50% Medically peressary orthodontics 50% Sea 2025 Dental Copay Schedule Services Services Posthodontics 50% Sea 2025 Dental Copay Schedule Services Services Prosthodontics 50% Sea 2025 Dental Copay Schedule Services Services Prosthodontics 50% Sea 2025 Dental Copay Schedule Services Servic	care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
Child Dental Diagnostic and Preventive Preventive - X-ray No charge Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed 20% Child Dental Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Child Dental Major Services Periodontics (other than maintenance) Prosthodontics 50% Oral Surgery		Oral Exam					
Diagnostic and Preventive Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Child Dental Major Services Periodontics Prosthodontics Oral Surgery Child Medically recessary orthodontics Child Medically recessary orthodontics Prosthodontics Sealants per Tooth No charge No charge No charge No charge No charge No charge See 2025 Dental Copay Schedule See 2025 Dental Copay Schedule See 2025 Dental Copay Schedule		Preventive - Cleaning					
Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Periodontal Maintenance Services Child Dental Major Services Child Dental Major Services Child Dental Major Services Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically necessary orthodontics See 2025 Dental Copay Schedule See 2025 Dental Copay Schedule		Preventive - X-ray					
Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Periodontal Maintenance Services Child Dental Major Services Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically pecessary orthodontics Medically pecessary orthodontics Space Maintainers - Fixed 20% See 2025 Dental Copay Schedule See 2025 Dental Copay Schedule	and	Sealants per Tooth	No charge		No charge		
Child Dental Basic Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically peressary orthodontics See 2025 Dental Copay Schedule 50% See 2025 Dental Copay Schedule	Preventive	Topical Fluoride Application					
Child Dental Basic Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically peressary orthodontics See 2025 Dental Copay Schedule 50% See 2025 Dental Copay Schedule							
Basic Services Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Services Prosthodontics Oral Surgery Child Medically peressary orthodontics See 2025 Dental Copay Schedule See 2025 Dental Copay Schedule See 2025 Dental Copay Schedule	Child Dental	•			0 0000		
Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery Child Medically pecessary orthodontics See 2025 Dental Copay Schedule	Basic		20%				
Child Dental Major Services Periodontics (other than maintenance) Prosthodontics Oral Surgery Endodontics See 2025 Dental Copay Schedule Schedule	Services						
Child Dental Major Services Periodontics (other than maintenance) Periodontics Oral Surgery Child Medically pecessary orthodontics 50% See 2025 Dental Copay Schedule							
Major Periodontics (other than maintenance) Services Prosthodontics Oral Surgery Child Medically necessary orthodontics 50% Schedule					See 2025 Dental Copav		
Prosthodontics Oral Surgery Child Medically necessary orthodontics 50% \$1,000	-	· ·	50%				
Child Medically necessary orthodontics 50% \$1,000							
		Oral Surgery					
		Medically necessary orthodontics	50%		\$1,000		

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-o Silver HDHP PI	
tuarial Value - A	V Calculator	70.6%)
	Plan design includes a deductible?	Yes, integr	rated
	Integrated Individual deductible	\$3,200 integ	grated
	Integrated Family deductible	\$6,400 integ	grated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Individual Out-of-pocket maximum	\$8,300	
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	\$16,60 \$3,200	
	HSA family plan: Individual deductible	See endn	
Common Medical Event	Service Type	Member Cost Share	Deductible A
	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	259/	
	·	25%	X
	Preventive care/ screening/ immunization	No charge	V
Tosts	Laboratory Tests	25%	X
. 0313	X-rays and Diagnostic Imaging	25%	X
	Imaging (CT/PET scans, MRIs)	25% 25% up to \$250 per	X
	Tier 1	script	X
Drugs to	Tier 2	25% up to \$250 per script	X
treat illness or condition	Tier 3	25% up to \$250 per script	x
	Tier 4	25% up to \$250 per script	x
	Surgery facility fee (e.g., ASC)	25%	х
Outpatient services	Physician/surgeon fees	25%	x
services	Outpatient visit	25%	x
Need immediate attention	Emergency room facility fee (waived if admitted)	25%	x
	Emergency room physician fee (waived if admitted)	0%	x
	Medical transportation (including emergency and non-emergency)	25%	×
	Urgent care	25%	x
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	25%	X
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	25%	х
Mental health, behavioral health, or	Mental/behavioral health and substance use disorder outpatient office visits	25%	x
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	25%	x
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	25%	Х
Help	Outpatient Rehabilitation and Habilitation services	25%	х
recovering or other special	Skilled nursing care	25%	x
health needs	Durable medical equipment	25%	х
	Hospice service	0%	Х
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray		
and	Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures		
Basic Services	Periodontal Maintenance Services	20%	
_ 5 1003	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics	5575	
	SSUIOGOTINOS		
	Oral Surgery		

Date: July 28	, 2025
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-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	Silver P 100%-150%		Silver Plan 150%-200% FPL	-
uarial Value - A'		94.8%)	87.9%	
	Plan design includes a deductible? Integrated Individual deductible	No N/A		Yes, Medical/Pharm	iacy
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /	\$0	\$1,400 / \$50 / \$0)
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /		\$2,800 / \$100 / \$	
	Individual Out-of-pocket maximum	\$1,400)	\$3,350	
	Family Out-of-pocket maximum	\$2,800)	\$6,700	
	HSA plan: Self-only coverage deductible	N/A		N/A	
Common	HSA family plan: Individual deductible	N/A		N/A	
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deduct Applie
Josith core	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
lealth care rovider's	Other practitioner office visit	\$5		\$15	
office or clinic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$10		\$30	
ests	X-rays and Diagnostic Imaging	\$10		\$50	
	Imaging (CT/PET scans, MRIs)				
		\$50		\$100	
	Tier 1	\$3		\$8	
rugs to	Tier 2	\$10		\$25	Pharm deduct
r condition	Tier 3	\$15		\$45	Pharm deduct
	Tier 4	10% up to \$150 per script		15% up to \$150 per script	Pharm deduc
	Surgery facility fee (e.g., ASC)	10%		20%	
Outpatient	Physician/surgeon fees	10%		20%	
ervices	Outpatient visit	10%		20%	
	Emergency room facility fee (waived if admitted)	\$50		\$200	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
leed				_	
mmediate	Medical transportation (including emergency and non-emergency)	\$30		\$75	
atention .	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%		20%	x
lospital stay	delivery, mental health, and substance use) Physician/surgeon fee	10%		20%	
Mental nealth, nehavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$5		\$15	
ealth, or substance sbuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$5		\$15	
regnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	\$3		\$15	
loln	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
lelp ecovering or	Skilled nursing care	10%		20%	x
ther special ealth needs					^
	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
child eye	Eye exam	No charge		No charge	
are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Shild Doort	Preventive - Cleaning				
child Dental Diagnostic	Preventive - X-ray	No charge		No charge	
nd reventive	Sealants per Tooth	ino charge		ivo cilalye	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	2021		25.1	
Basic Bervices	Periodontal Maintenance Services	20%		20%	
	Crowns and Casts				
	Endodontics				
N. 11 / 5				500/	
	Periodontics (other than maintenance)	50%		50%	
Child Dental Major Services	Periodontics (other than maintenance) Prosthodontics	50%		50%	
Major		50%		50%	

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL	_
tuarial Value - A'		73.8%	
	Plan design includes a deductible?	Yes, Medical/Pharm N/A	nacy
	Integrated Individual deductible Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,200 / \$50 / \$0)
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,400 / \$100 / \$	60
	Individual Out-of-pocket maximum	\$8,100	
	Family Out-of-pocket maximum	\$16,200	
	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	\$50	
Health care provider's office or	Other practitioner office visit	\$50	
clinic visit	Specialist visit	\$90	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$19	
Druge to	Tier 2	\$55	Pharma
Drugs to treat illness or condition	Tier 3	\$85	deductil Pharma
or condition	Tiel 3	20% up to \$250 per script	deductil Pharma
	Tier 4	after pharmacy deductible	deductil
	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	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%	Х
	Physician/surgeon fee	30%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office	\$50	
behavioral	visits	ΨΟΟ	
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)	\$40	
Holp	Outpatient Rehabilitation and Habilitation services	\$50	
Help recovering or	Skilled nursing care	30%	x
other special health needs	-		_ ^
	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic and	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth		
	Topical Fluoride Application		
Ohiid D	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	50%	
	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	50%	

-	nefits and Coverage			Bronze	
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		HDHP Pla	n
Actuarial Value - A'	W Coloulator	63.7%		64.8%	
Actualiai Value - A	Plan design includes a deductible?	Yes, Medical/Pharr	nacy	Yes, integral	ted
	Integrated Individual deductible	N/A	пасу	\$7,200 integral	
	Integrated Framily deductible	N/A		\$14,400 integr	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,800 / \$450 / \$	60	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$11,600 / \$900 /	\$0	N/A	
	Individual Out–of–pocket maximum	\$9,800		\$7,200	
	Family Out-of-pocket maximum	\$19,600		\$14,400	
	HSA plan: Self-only coverage deductible	N/A		\$7,200	
	HSA family plan: Individual deductible	N/A		\$7,200	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$60		0%	x
Health care provider's	Other practitioner office visit	\$60		0%	x
office or clinic visit	C	405	After 1st three non-	201	
CHILIC VISIT	Specialist visit	\$95	preventive visits	0%	X
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$50		0%	X
Tests	X-rays and Diagnostic Imaging	40%	X	0%	X
	Imaging (CT/PET scans, MRIs)	40%	×	0%	X
	Tier 1	\$20		0%	×
	Tier 2	40% up to \$500 per script after	Pharmacy	0%	X
Drugs to treat illness	Her Z	pharmacy deductible	Deductible	0%	X
or condition	Tier 3	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	X
	Tier 4	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	X
	Surgery facility fee (e.g., ASC)	40%	×	0%	X
Outpatient services	Physician/surgeon fees	40%	X	0%	x
	Outpatient visit	40%	X	0%	X
	Emergency room facility fee (waived if admitted)	40%	x	0%	х
	Emergency room physician fee (waived if admitted)	No charge		0%	x
Need	Medical transportation (including emergency and non-emergency)	40%	×	0%	×
immediate attention					
	Urgent care	\$60		0%	X
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	40%	X	0%	X
	Physician/surgeon fee	40%	X	0%	X
Mental health, behavioral	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%	Х	0%	x
Help	Outpatient Rehabilitation and Habilitation services	\$60		0%	×
recovering or	Skilled nursing care	40%	X	0%	×
other special health needs					
	Durable medical equipment	40%	X	0%	X
	Hospice service	No charge		0%	X
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				
Object	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	No al		No ob	
and Preventive	Sealants per Tooth	No charge		No charge	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	20%		20%	
30.71003	Crowns and Casts				
	Endodontics				
Child Dental		50%		50%	
Major Services	Periodontics (other than maintenance)	9 0%		50%	
	Prosthodontics				
Child	Oral Surgery				
Orthodontics	Medically necessary orthodontics	50%		50%	

Summary of Benefits and Covera

Summary of Bei	nefits and Coverage		
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Catast	rophic Plan
Actuarial Value - A			
	Plan design includes a deductible? Integrated Individual deductible		integrated 50 integrated
	Integrated Family deductible		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	\$	10,150
	Family Out-of-pocket maximum	\$	20,300
	HSA family plant laditided doductible		N/A N/A
Common	HSA family plan: Individual deductible		N/A
Medical Event	Service Type	Member Cost Share	Deductible Applies
Evelit	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non-
Health care			preventive visits After 1st three non-
provider's office or	Other practitioner office visit	0%	preventive visits
clinic visit	Specialist visit	0%	X
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	X
Tests	X-rays and Diagnostic Imaging	0%	X
	Imaging (CT/PET scans, MRIs)	0%	X
	Tier 1	0%	X
Duran to	Tier 2	0%	×
Drugs to treat illness			
or condition	Tier 3	0%	X
	Tier 4	0%	×
	Surgery facility fee (e.g., ASC)	0%	×
Outpatient	Physician/surgeon fees	0%	×
services	Outpatient visit	0%	×
	Emergency room facility fee (waived if admitted)	0%	×
	Emergency room physician fee (waived if admitted)	No charge	
Need	Medical transportation (including emergency and non-emergency)	0%	×
immediate attention			
	Urgent care	0%	After 1st three non- preventive visits
			preventive visits
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	0%	x
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	0%	X
Mental	Mental/behavioral health and substance use disorder outpatient office		After 1st three non-
health, behavioral	visits	0%	preventive visits
health, or substance	Mental/behavioral health and substance use disorder other outpatient		
abuse needs	items and services	0%	X
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	Х
Help	Outpatient Rehabilitation and Habilitation services	0%	×
recovering or other special	Skilled nursing care	0%	Х
health needs	Durable medical equipment	0%	x
	Hospice service	0%	x
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	x
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray		
and Preventive	Sealants per Tooth	No charge	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	0%	X
Services	Periodontal Maintenance Services	0 70	^
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	0%	X
301 ¥1063	Prosthodontics		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	0%	Х

2026 Patient-Centered Benefit Plan Designs 10.0 EHB Date: July 28, 2025

mber Cost Share	nefits and Coverage amounts describe the Enrollee's out of pocket costs.		Plan (MAIR June 20
ember Cost Share	amounts describe the Emoline's out of pocket costs.		2025)
tuarial Value - A	V Calculator		
	Plan design includes a deductible?	Yes,	integrated
	Integrated Individual deductible	\$10,60	00 integrated
	Integrated Family deductible	\$21,20	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		10,600
	Family Out-of-pocket maximum		21,200 N/A
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible		N/A
Common		Member Cost	
Medical Event	Service Type	Share	Deductible Applie
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three no preventive visits
Health care	Other practitioner office visit	0%	After 1st three no
provider's office or		070	preventive visits
clinic visit	Specialist visit	0%	X
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	X
Tests	X-rays and Diagnostic Imaging	0%	Х
	Imaging (CT/PET scans, MRIs)	0%	Х
	Tier 1	0%	x
	Tier 2	0%	X
Drugs to treat illness			
or condition	Tier 3	0%	X
	Tier 4	0%	X
Outpatient	Surgery facility fee (e.g., ASC)	0%	X
services	Physician/surgeon fees	0%	X
	Outpatient visit	0%	X
	Emergency room facility fee (waived if admitted)	0%	Х
	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 no preventive visits
Haanital atau	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	0%	X
Hospital stay	Physician/surgeon fee	0%	Х
Mental	Mental/behavioral health and substance use disorder outpatient office		After 1st three no
health, behavioral	visits	0%	preventive visits
health, or	Mental/behavioral health and substance use disorder other outpatient		
substance abuse needs	items and services	0%	X
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	X
Holm	Outpatient Rehabilitation and Habilitation services	0%	X
Help recovering or			
other special health needs	Skilled nursing care	0%	X
	Durable medical equipment	0%	X
	Hospice service	0%	X
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X
	Oral Exam		
Child Dont-1	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth	s.iaigo	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	00/	V
	Periodontal Maintenance Services	0%	Х
Basic Services	Crowns and Casts		
Basic	Crowns and Casis		1
Basic Services	Endodontics		
Basic		0%	X
Basic Services Child Dental	Endodontics	0%	Х
Basic Services Child Dental Major	Endodontics Periodontics (other than maintenance)	0%	x

Date:	July	28,	2025
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Member Cost Share	amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Sil 100%-1509		CA Enh CSR Silver 8' 150%-200% FPL	
	W2.11	95.40	,	99.994	
ctuarial Value - A	V Calculator Plan design includes a deductible?	95.49 No	o	89.6% 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	\$1,15	0	\$3,000	
	Family Out-of-pocket maximum	\$2,30	0	\$6,000	
	HSA plan: Self-only coverage deductible			N/A	
- (HSA family plan: Individual deductible	N/A	I	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	Consistint visit	00		405	
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	
Drugs to	Tier 2	\$10		\$25	
treat illness					
or condition	Tier 3	\$15		\$45	
	Tier 4	10% up to \$150 per script		15% up to \$150 per script	
0	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	
immediate attention					
	Urgent care	\$5		\$15	
11	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 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	
Halm	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
Help recovering or					
other special health needs	Skilled nursing care	10%		20%	
	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				
01.11.17	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	No oborg-		No observe	
and Preventive	Sealants per Tooth	No charge		No charge	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Services	20%		20%	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		50%	
Services	Prosthodontics	5570		3370	
Child	Oral Surgery				
Orthodontics	Medically necessary orthodontics	50%		50%	

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Silver 73 Above 200% FPL	
	V2.1.1.1		
tuarial Value - A		80.4%	
	Plan design includes a deductible?	No	
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$6,100	
	Family Out-of-pocket maximum	\$12,200 N/A	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A	
Common			Deductil
Medical Event	Service Type	Member Cost Share	Applies
	Primary care visit to treat an injury, illness, or condition	\$35	
Health care provider's	Other practitioner office visit	\$35	
office or clinic visit	Specialist visit	\$85	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$15	
Drugs to	Tier 2	\$55	
treat illness or condition	Tier 3	\$85	
	Tier 4	20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	30%	
Outpatient	Physician/surgeon fees	30%	
services			
	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$350	
	Emergency room physician fee (waived if admitted)	No charge	
Need 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	30%	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	30%	
Mental	, -	3070	
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$35	
behavioral health, or	Mental/behavioral health and substance use disorder other outpatient		
substance abuse needs	items and services	\$35	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Help	Outpatient Rehabilitation and Habilitation services	\$35	
recovering or other special	Skilled nursing care	30%	
health needs	Durable medical equipment	20%	
	Hospice service		
		No charge	
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth	Ü	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	20%	
Services	Periodontal Maintenance Services	2070	
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	50%	
Services	Prosthodontics		
	Oral Surgery		

Date: July 28, 2025

Summary of Benefits and Coverage



Summary of Be	nefits and Coverage	Individual-only F		Individual-only F	Datinum
Member Cost Share	amounts describe the Enrollee's out of pocket costs.	Coinsurance		Copay Pla	
Actuarial Value - A		91.9%		91.8%	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0	•	\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$		\$0 / \$0 / \$	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$0 / \$	0
	Individual Out-of-pocket maximum	\$5,000		\$5,000	
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	\$10,000 N/A		\$10,000 N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common		Marrie a Octob		Marrie a Octob	
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Lvoiit	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
Health care					
provider's office or	Other practitioner office visit	\$15		\$15	
clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$15	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$75	
	Tier 1			·	
	nor I	\$9		\$9	
Drugs to	Tier 2	\$16		\$16	
treat illness or condition	Tier 3	\$25		\$25	
				·	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$75	
Outpatient	Physician/surgeon fees	10%		\$20	
services	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$175		\$175	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need					
immediate	Medical transportation (including emergency and non-emergency)	\$150		\$150	
attention					
	Urgent care	\$15		\$15	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		\$225 per day up to 5 days	
ricopital stay	Physician/surgeon fee	10%		No charge	
Mental	Mental/behavioral health and substance use disorder outpatient office				
health, behavioral	visits	\$15		\$15	
health, or substance	Mental/behavioral health and substance use disorder other outpatient				
abuse needs	items and services	\$15		\$15	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$15	
recovering or	Skilled nursing care	10%		\$125 per day up to	
other special health needs				5 days	
	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
cure	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dantal	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth	Not Govered		Not Govered	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	N . 2		N · O	
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics			1.50 5570100	
Child	Oral Surgery				
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

=	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-onl Platinum Coinsurance	-	CCSB-onl Platinum Copay Pla	Ī
ctuarial Value - A	V Calculator	91.8%		91.1%	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0		\$0	
	Integrated Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$	0	\$0 / \$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					
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		\$20	
provider's office or	Other practitioner office visit	\$15		\$20	
clinic visit	Specialist visit	\$30		\$30	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$15		\$20	
Tests	X-rays and Diagnostic Imaging	\$30		\$30	
	Imaging (CT/PET scans, MRIs)	10%		\$100	
	Tier 1	\$10		\$5	
Drugs to	Tier 2	\$25		\$20	
treat illness or condition	Tier 3	\$40		\$30	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	10%		\$100	
Outpatient	Physician/surgeon fees	10%		\$25	
services	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$200		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	,			
immediate attention	medical transportation (including emergency and not remergency)	\$150		\$150	
attention	Urgent care	\$15		\$20	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	10%		\$250 per day up to	
Hospital stay	delivery, mental health, and substance use) Physician/surgeon fee	10%		5 days No charge	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$15		\$20	
behavioral health, or	Mental/behavioral health and substance use disorder other outpatient				
substance abuse needs	items and services	\$15		\$20	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	10%		\$20	
Help	Outpatient Rehabilitation and Habilitation services	\$15		\$20	
recovering or other special	Skilled nursing care	10%		\$150 per day up to 5 days	
health 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				
	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 Services	Periodontal Maintenance Services	Not Covered		Not Covered	
20111003	Crowns and Casts				
	Endodontics				
Child Dental Major		Not Covered		Not Covered	
Major Services	Periodontics (other than maintenance)	NOT COVERED		NOT COVERED	
	Prosthodontics Oral Surgary				
Child	Oral Surgery				
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

2026 Patient-Centered Benefit Plan Designs 9.5 EHB Date: July 28, 2025

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Individual-only Coinsurance		Individual-only Copay Pla	
tuarial Value - A		81.4%		81.7%	
	Plan design includes a deductible?	No		No	
	Integrated Individual deductible	\$0 \$0		\$0 ©0	
	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 \$0 / \$0 / \$0)	\$0 \$0 / \$0 / \$:n
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0		\$0 / \$0 / \$	
	Individual Out-of-pocket maximum	\$9,200	,	\$9,200	
	Family Out-of-pocket maximum	\$18,400		\$18,400	
	HSA plan: Self-only coverage deductible	N/A		N/A	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deduc Appl
	Primary care visit to treat an injury, illness, or condition	\$40		\$40	
Health care provider's	Other practitioner office visit	\$40		\$40	
office or clinic visit	Specialist visit	\$70		\$70	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$40		\$40	
Tests	X-rays and Diagnostic Imaging	\$75		\$75	
	Imaging (CT/PET scans, MRIs)	25%		\$75	
	Tier 1	\$18		\$18	
Drugs to treat illness	Tier 2	\$60		\$60	
or condition	Tier 3	\$85		\$85	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	30%		\$130	
	Physician/surgeon fees	30%		\$60	
	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$350		\$350	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	\$250		\$250	
attention	Urgent care	\$40		\$40	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%		\$375 per day up to	
Hospital stay	Physician/surgeon fee	30%		5 days No charge	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$40		\$40	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$40		\$40	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	20%		\$30	
llala	Outpatient Rehabilitation and Habilitation services	\$40		\$40	
Help recovering or				\$150 per day up to	
other special health needs	Skilled nursing care	30%		5 days	
	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child					

Date: July 28, Summary of Bei	nefits and Coverage	CCSB-only		CCSB-only		
-	amounts describe the Enrollee's out of pocket costs.	Gold Coinsurance Pla	n	Gold Copay Plan		
		Comodiumo Fia		oopay r iaii		
Actuarial Value - A	V Calculator	80.3%		81.7%		
	Plan design includes a deductible?		acy	Yes, Medical/Pharr	macy	
	Integrated Individual deductible Integrated Family deductible	N/A N/A		N/A N/A		
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$350 / \$0 / \$0		\$250 / \$0 / \$0		
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$700 / \$0 / \$0		\$500 / \$0 / \$0		
	Individual Out-of-pocket maximum	\$7,800		\$7,800		
	Family Out-of-pocket maximum	\$15,600		\$15,600		
	HSA plan: Self-only coverage deductible	N/A		N/A		
	HSA family plan: Individual deductible	N/A		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
	Primary care visit to treat an injury, illness, or condition	\$25		\$35		
Health care provider's	Other practitioner office visit	\$25		\$35		
office or						
clinic visit	Specialist visit	\$50		\$55		
	Preventive care/ screening/ immunization	No charge		No charge		
Toota	Laboratory Tests	\$25		\$35		
Tests	X-rays and Diagnostic Imaging	\$65		\$55		
	Imaging (CT/PET scans, MRIs)	20%		\$250	Х	
	Tier 1	\$15		\$15		
Drugs to	Tier 2	\$50		\$40		
treat illness or condition	Tier 3	\$80		\$70		
or condition	1161 3	φου		\$70		
	Tier 4	20% up to \$250 per script		20% up to \$250 per script		
Outpatient	Surgery facility fee (e.g., ASC)	20%		\$300	Х	
services	Physician/surgeon fees	20%		\$35		
	Outpatient visit	20%		20%		
	Emergency room facility fee (waived if admitted)	20%	X	\$250	Х	
	Emergency room physician fee (waived if admitted)	No charge		No charge		
Need 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)	20%	х	\$600 per day up to 5 days	Х	
	Physician/surgeon fee	20%	Х	No charge		
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	Outpatient Rehabilitation and Habilitation services	\$25		\$35		
recovering or other special	Skilled nursing care	20%	×	\$300 per day up to 5 days	X	
health needs	Durable medical equipment	20%		20%		
	Hospice service	No charge		No charge		
Child ava	Eye exam	No charge		No charge		
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
	Preventive - Cleaning					
Child Dental Diagnostic	Preventive - X-ray					
and	Sealants per Tooth	Not Covered		Not Covered		
Preventive	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental	Restorative Procedures					
Basic Services	Periodontal Maintenance Services	Not Covered		Not Covered		
	Crowns and Casts					
	Endodontics					
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered		
Services	Prosthodontics					
	Oral Surgery					
Child	Medically necessary orthodontics	Not Covered		Not Covered		
Orthodontics	scany necessary orthodorness	Not Govered		NOT COVERED		

Summary	of Benef	fits and C	coverage

Summary of Be	enefits and Coverage		
Member Cost Share	e amounts describe the Enrollee's out of pocket costs.	Individual-only Silver	Plan
Actuarial Value - A	AV Calculator	71.8%	
	Plan design includes a deductible?	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,200 / \$50 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,400 / \$100 / \$	0
	Individual Out-of-pocket maximum	\$9,800	
	Family Out-of-pocket maximum	\$19,600	
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	5	450	

	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$50	
Health care provider's	Other practitioner office visit	\$50	
office or	Specialist visit	\$90	
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	\$50	
Tests	X-rays and Diagnostic Imaging	\$95	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$19	
Drugs to	Tier 2	\$60	Pharmadeductib
treat illness	Tier 3	* 00	Pharma
or condition	riei 3	\$90	deductib
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmad deductib
	Surgery facility fee (e.g., ASC)	30%	
Outpatient services	Physician/surgeon fees	30%	
	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$400	
	Emergency room physician fee (waived if admitted)	No charge	
Need immediate attention	Medical transportation (including emergency and non-emergency)	\$250	
	Urgent care	\$50	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%	Х
Hospital stay	Physician/surgeon fee	30%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$50	
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	\$50	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$50	
recovering or other special	Skilled nursing care	30%	х
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
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	Not Covered	
and Preventive	Sealants per Tooth	Not Govered	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	Not Covered	
	Prosthodontics		
Child	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	Not Covered	

Summary of Ber	nefits and Coverage	CCSB-only		CCSB-only	
- -	amounts describe the Enrollee's out of pocket costs.	Silver		Silver	
	•	Coinsurance Plan		Copay Plan	
Actuarial Value - A	V Calculator	71.2%		70.8%	
	Plan design includes a deductible?	Yes, Medical/Pharma	асу	Yes, Medical/Pharm	acy
	Integrated Individual deductible	N/A		N/A	
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,500 / \$300 / \$0		\$2,500 / \$300 / \$6)
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,000 / \$600 / \$0		\$5,000 / \$600 / \$6)
	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	
	HSA family plan: Individual deductible	N/A		N/A	
Common Medical	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Event			7 450.00		7 (50)
Health care	Primary care visit to treat an injury, illness, or condition	\$55		\$55	
Health care provider's	Other practitioner office visit	\$55		\$55	
office or clinic visit	Specialist visit	\$90		\$90	
	Preventive care/ screening/ immunization				
	-	No charge		No charge	
Tests	Laboratory Tests	\$55		\$55	
16919	X-rays and Diagnostic Imaging	\$90	v	\$90	.,
	Imaging (CT/PET scans, MRIs)	35%	Х	\$300	Х
	Tier 1	\$20		\$19	
Drugg to	Tier 2	\$75	Pharmacy	\$85	Pharmacy
Drugs to treat illness			deductible Pharmacy		deductible Pharmacy
or 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%	X	35%	X
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Medical transportation (including emergency and non-emergency)	35%	Х	35%	X
immediate attention					
	Urgent care	\$55		\$55	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	35%	Х	35%	X
Hospital stay	delivery, mental health, and substance use)				
	Physician/surgeon fee	35%	Х	35%	
Mental health,	Mental/behavioral health and substance use disorder outpatient office visits	\$55		\$55	
behavioral health, or	Note:				
substance	Mental/behavioral health and substance use disorder other outpatient items and services	\$55		\$55	
abuse needs		N. I			
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Home health care (cost share per visit)	35%		\$45	
Help	Outpatient Rehabilitation and Habilitation services	\$55		\$55	
recovering or other special	Skilled nursing care	35%	Х	35%	X
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	Preventive - X-ray				
Diagnostic and	Sealants per Tooth	Not Covered		Not Covered	
Preventive					
	Topical Fluoride Application				
Child Day 1	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
Jei vices	Prosthodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

-	nefits and Coverage amounts describe the Enrollee's out of pocket costs.	CCSB-o Silver HDHP PI	
tuarial Value - A	V Calculator	70.6%)
	Plan design includes a deductible?	Yes, integr	rated
	Integrated Individual deductible	\$3,200 integ	grated
	Integrated Family deductible	\$6,400 integ	grated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	Individual Out-of-pocket maximum	\$8,300	
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible	\$16,60 \$3,200	
	HSA family plan: Individual deductible	See endn	
Common Medical Event	Service Type	Member Cost Share	Deductible A
	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
omino viole	·		^
	Preventive care/ screening/ immunization	No charge 25%	X
Tests	Laboratory Tests X-rays and Diagnostic Imaging	25%	X
. 30.0	Imaging (CT/PET scans, MRIs)	25%	X
		25% up to \$250 per	
	Tier 1	script	X
Drugs to	Tier 2	25% up to \$250 per script	Х
treat illness or condition	Tier 3	25% up to \$250 per script	x
	Tier 4	25% up to \$250 per script	×
	Surgery facility fee (e.g., ASC)	25%	X
Outpatient services	Physician/surgeon fees	25%	x
	Outpatient visit	25%	x
	Emergency room facility fee (waived if admitted)	25%	х
	Emergency room physician fee (waived if admitted)	0%	×
Need immediate attention	Medical transportation (including emergency and non-emergency)	25%	x
	Urgent care	25%	x
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	25%	Х
	Physician/surgeon fee	25%	X
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	25%	x
health, or substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	25%	x
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	25%	Х
Help	Outpatient Rehabilitation and Habilitation services	25%	х
recovering or other special	Skilled nursing care	25%	x
health needs	Durable medical equipment	25%	х
	Hospice service	0%	X
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 Services	Periodontal Maintenance Services	Not Covered	
_ 5 1003	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver P 100%-150%		Silver Plan 150%-200% FPL	
	W0.1.11				
tuarial Value - A	V Calculator Plan design includes a deductible?	94.8% No	0	87.9% Yes, Medical/Pharm	201
	Integrated Individual deductible	N/A		N/A	acy
	Integrated Family deductible	N/A		N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /	\$0	\$1,400 / \$50 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /	\$0	\$2,800 / \$100 / \$	0
	Individual Out-of-pocket maximum	\$1,400)	\$3,350	
	Family Out-of-pocket maximum	\$2,800)	\$6,700	
	HSA plan: Self-only coverage deductible 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	Deductibl Applies
Event	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
Health care				·	
provider's office or	Other practitioner office visit	\$5		\$15	
clinic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$10		\$30	
Tests	X-rays and Diagnostic Imaging	\$10		\$50	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$8	
Orugs to	Tier 2	\$10		\$25	Pharma deductib
reat illness or condition	Tier 3	\$15		\$45	Pharma
	Tier 4	10% up to \$150 per		15% up to \$150 per script	deductib
	Surgery facility fee (e.g., ASC)	script		20%	deductib
Outpatient	Physician/surgeon fees	10%		20%	
services					
	Outpatient visit	10%		20%	
	Emergency room facility fee (waived if admitted)	\$50		\$200	
lood	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate	Medical transportation (including emergency and non-emergency)	\$30		\$75	
attention	Urgent care	\$5		\$ 15	
Hospital stay	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		20%	Х
	Physician/surgeon fee	10%		20%	
Mental nealth	Mental/behavioral health and substance use disorder outpatient office	\$5		\$15	
health, behavioral	visits	ψυ		υιυ	
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	
. ogunoy	Home health care (cost share per visit)	\$3		\$15	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
other special	Skilled nursing care	10%		20%	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				
Child David	Preventive - Cleaning				
Child Dental Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
and Preventive	Sealants per Tooth	NOT COVERED		Not Covered	
2.2	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental	Restorative Procedures	Not O.		N-4 O	
Basic Bervices	Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
	Endodontics				
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics				
	Oral Surgery				
Child					
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPI	-
ctuarial Value - A	V Calculator	73.8%	
duariai value - A	Plan design includes a deductible?	Yes, Medical/Pharm	2004
	Integrated Individual deductible	N/A	iacy
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,200 / \$50 / \$0)
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$10,400 / \$100 / \$	
	Individual Out-of-pocket maximum	\$8,100	
	Family Out-of-pocket maximum	\$16,200	
	HSA plan: Self-only coverage deductible	N/A	
	HSA family plan: Individual deductible	N/A	
Common Medical	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	
	Imaging (CT/PET scans, MRIs)	\$325	
	Tier 1	\$19	
Drugs to	Tier 2	\$55	Pharmad
treat illness			deductibl Pharmad
or condition	Tier 3	\$85	deductibl
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmad 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	
Need	Emergency room physician fee (waived if admitted)	No charge	
immediate	Medical transportation (including emergency and non-emergency)	\$250	
attention			
	Urgent care	\$50	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	30%	X
Hospital stay	delivery, mental health, and substance use)		
Mantal	Physician/surgeon fee	30%	
Mental health, behavioral	Mental/behavioral health and substance use disorder outpatient office visits	\$50	
health, or substance	Mental/behavioral health and substance use disorder other outpatient		
abuse needs	items and services	\$50	
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	\$40	
Help	Outpatient Rehabilitation and Habilitation services	\$50	
recovering or other special	Skilled nursing care	30%	X
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
	•	-	
Child eye care	Eye exam 1 pair of glasses per year (or contact lenses in liqu of glasses)	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	Not Covered	
Basic Services	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		

	and the same of th			Bronze	
ember Cost Share	amounts describe the Enrollee's out of pocket costs.	Bronze Plan		HDHP Pla	n
ctuarial Value - A\	√ Calculator	63.7%		64.8%	
	Plan design includes a deductible?	Yes, Medical/Pharn	nacv	Yes, integral	ted
	Integrated Individual deductible	N/A	·,	\$7,200 integra	
	Integrated Family deductible	N/A		\$14,400 integr	ated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,800 / \$450 / \$	60	N/A	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$11,600 / \$900 /	\$0	N/A	
	Individual Out-of-pocket maximum	\$9,800		\$7,200	
	Family Out-of-pocket maximum	\$19,600		\$14,400	
	HSA plan: Self-only coverage deductible	N/A N/A		\$7,200 \$7,200	
Common	HSA family plan: Individual deductible	IN/A		\$7,200	
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care	Primary care visit to treat an injury, illness, or condition	\$60		0%	X
provider's office or	Other practitioner office visit	\$60		0%	Х
clinic visit	Specialist visit	\$95	After 1st three non- preventive visits	0%	x
	Preventive care/ screening/ immunization	No charge	•	No charge	
	Laboratory Tests	\$50		0%	Х
Tests	X-rays and Diagnostic Imaging	40%	x	0%	x
	Imaging (CT/PET scans, MRIs)	40%	×	0%	х
	Tier 1	\$20		0%	х
			Dharman		
Drugs to	Tier 2	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	Х
treat illness or condition	Tier 3	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	x
	Tier 4	40% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	0%	×
	Surgery facility fee (e.g., ASC)	40%	X	0%	Х
Outpatient services	Physician/surgeon fees	40%	x	0%	x
services	Outpatient visit	40%	×	0%	x
	Emergency room facility fee (waived if admitted)	40%	x	0%	x
	Emergency room physician fee (waived if admitted)	No charge		0%	×
Need	Medical transportation (including emergency and non-emergency)	40%	×	0%	X
mmediate attention	gggg	4070	^	0,0	
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) Physician/surgeon fee	40% 40%	X X	0%	X
Mental		40%	^	076	^
health,	Mental/behavioral health and substance use disorder outpatient office visits	\$60		0%	Х
behavioral 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%	х
Help	Outpatient Rehabilitation and Habilitation services	\$60		0%	х
recovering or other special	Skilled nursing care	40%	X	0%	x
health needs	Durable medical equipment	40%	X	0%	X
	Hospice service	No charge		0%	x
	Eye exam	No charge		No charge	^
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	_		-	
	Oral Exam	No charge		No charge	
Child Dental	Preventive - Cleaning				
Diagnostic and	Preventive - X-ray	Not Covered		Not Covered	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services				
	Crowns and Casts				
Child Dental	Endodontics				
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
GEI VICES	Prosthodontics				
	Oral Surgery				

Summary	of Bene	efits and	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	V Calculator		
	Plan design includes a deductible?	Yes,	integrated
	Integrated Individual deductible		integrated
	Integrated Family deductible	\$20,30	00 integrated
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	¢	N/A 10 150
	Individual Out–of–pocket maximum Family Out-of-pocket maximum		10,150 20,300
	HSA plan: Self-only coverage deductible	•	N/A
	HSA family plan: Individual deductible		N/A
Common		Member Cost	
Medical Event	Service Type	Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non-
Health care	011 111 151 111		preventive visits After 1st three non-
provider's office or	Other practitioner office visit	0%	preventive visits
clinic visit	Specialist visit	0%	Х
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	X
Tests	X-rays and Diagnostic Imaging	0%	X
	Imaging (CT/PET scans, MRIs)	0%	х
	Tier 1	0%	Х
Drugs to treat illness	Tier 2	0%	Х
or condition	Tier 3	0%	х
	Tier 4	0%	X
	Surgery facility fee (e.g., ASC)	0%	Х
Outpatient services	Physician/surgeon fees	0%	х
Scivices	Outpatient visit	0%	X
	Emergency room facility fee (waived if admitted)	0%	Х
	Emergency room physician fee (waived if admitted)	No charge	
Need	Medical transportation (including emergency and non-emergency)	0%	X
immediate attention	g,g,	070	Α
attention	Urgent care	0%	After 1st three non-
	orgenic care	U76	preventive visits
	Facility fee (e.g. hospital room) for inpatient stay (including labor and		
Hospital stay	delivery, mental health, and substance use)	0%	X
	Physician/surgeon fee	0%	Х
Mental health,	Mental/behavioral health and substance use disorder outpatient office	0%	After 1st three non-
behavioral	visits	070	preventive visits
health, or substance	Mental/behavioral health and substance use disorder other outpatient	0%	×
abuse needs	items and services	070	Α
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	Х
Help	Outpatient Rehabilitation and Habilitation services	0%	x
recovering or other special	Skilled nursing care	0%	x
health needs	Durable medical equipment	0%	x
	Hospice service	0%	X
Ohild	Eye exam	No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X
	Oral Exam	070	Α
	Preventive - Cleaning		
Child Dental	Preventive - X-ray		
Diagnostic and	•	Not Covered	
Preventive	Sealants per Tooth		
	Topical Fluoride Application		
01.11.5	Space Maintainers - Fixed		
Child Dental Basic	Restorative Procedures	Not Covered	
Services	Periodontal Maintenance Services		
	Crowns and Casts		
Child Dental	Endodontics		
Major Services	Periodontics (other than maintenance)	Not Covered	
Jei vices	Prosthodontics		
	Oral Surgery		
Child Orthodontics	Medically necessary orthodontics	Not Covered	
O anodonucs			

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	Catastrophic	Plan (MAIR June 2025)
	V Onlawlater		
uarial Value - A	Plan design includes a deductible?	Yes.	integrated
	Integrated Individual deductible		00 integrated
	Integrated Family deductible	\$21,20	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		\$10,600
	Family Out-of-pocket maximum HSA plan: Self-only coverage deductible		S21,200 N/A
	HSA family plan: Individual deductible		N/A
Common Medical Event	Service Type	Member Cost Share	Deductible App
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three in preventive vis
Health care provider's	Other practitioner office visit	0%	After 1st three i
ffice or linic visit	Specialist visit	0%	X
	Preventive care/ screening/ immunization	No charge	^
	Laboratory Tests	0%	X
Tests .	X-rays and Diagnostic Imaging	0%	X
	Imaging (CT/PET scans, MRIs)	0%	X
		-	
	Tier 1	0%	X
Orugs to	Tier 2	0%	X
reat illness or condition	Tier 3	0%	x
	Tier 4	0%	X
	Surgery facility fee (e.g., ASC)	0%	X
Outpatient services	Physician/surgeon fees	0%	Х
	Outpatient visit	0%	X
	Emergency room facility fee (waived if admitted)	0%	X
	Emergency room physician fee (waived if admitted)	No charge	
Need mmediate	Medical transportation (including emergency and non-emergency)	0%	Х
attention			
	Urgent care	0%	After 1st three preventive vis
	Facility fee (e.g. hospital room) for inpatient stay (including labor and	0%	x
Hospital stay	delivery, mental health, and substance use)		
Mandal	Physician/surgeon fee	0%	Х
Mental nealth,	Mental/behavioral health and substance use disorder outpatient office visits	0%	After 1st three preventive vis
pehavioral nealth, or			•
substance abuse needs	Mental/behavioral health and substance use disorder other outpatient items and services	0%	X
Pregnancy	Prenatal care and preconception visits	No charge	
	Home health care (cost share per visit)	0%	x
Help	Outpatient Rehabilitation and Habilitation services	0%	X
ecovering or other special	Skilled nursing care	0%	x
nealth needs	Durable medical equipment	0%	x
	Hospice service	0%	x
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	x
	Oral Exam		
	Preventive - Cleaning		
Child Dental Diagnostic	Preventive - X-ray	N=10	
and Preventive	Sealants per Tooth	Not Covered	
. C . Share	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	Not C	
Basic Bervices	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
Child Dent-1	Endodontics		
Child Dental Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		
Child	Medically necessary orthodontics	Not Covered	

mber Cost Share	amounts describe the Enrollee's out of pocket costs.	CA Enh CSR Sil 100%-1509		CA Enh CSR Silver 87 150%-200% FPL	
uarial Value - A	V Calculator	95.4%		89.6%	
uanai value - A	Plan design includes a deductible?		,	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)	\$6,000	
	HSA family plant Individual deductible			N/A N/A	
Common	HSA family plan: Individual deductible			IVA	
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductil Applie
	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	
ests	X-rays and Diagnostic Imaging	\$8		\$40	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1				
		\$3		\$5	
rugs to reat illness	Tier 2	\$10		\$25	
r condition	Tier 3	\$15		\$45	
	Tier 4	10% up to \$150 per script		15% up to \$150 per script	
	Surgery facility fee (e.g., ASC)	10%		20%	
Outpatient 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 ttention					
	Urgent care	\$5		\$15	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	10%		20%	
Hospital stay	Physician/surgeon fee	10%		20%	
Mental nealth,	Mental/behavioral health and substance use disorder outpatient office	\$5		\$15	
pehavioral	visits	ψ0		V 10	
nealth, 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	
Heln	Outpatient Rehabilitation and Habilitation services	\$5		\$15	
Help recovering or	Skilled nursing care	10%		20%	
other special nealth needs	-				
	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic and	Preventive - X-ray	Not Covered		Not Covered	
Preventive	Sealants per Tooth				
	Topical Fluoride Application				
Shild Deat	Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services Crowns and Casts				
	Crowns and Casts				
Child Dental	Endodontics	N. CO.			
Major Services	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics				
Child	Oral Surgery				
Child Orthodontics	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	
tuarial Value - A	V Calculator	80.4%	
	Plan design includes a deductible?	No	
	Integrated Individual deductible	N/A	
	Integrated Family deductible	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	
	Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0	
	Individual Out-of-pocket maximum	\$6,100	
	Family Out-of-pocket maximum	\$12,200 N/A	
	HSA plan: Self-only coverage deductible HSA family plan: Individual deductible	N/A	
Common	,		D. J. #
Medical Event	Service Type	Member Cost Share	Deductil Applie
	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	\$15	
Orugs to	Tier 2	\$55	
reat illness or condition	Tier 3	\$85	
	Tier 4	20% up to \$250 per script	
	Surgery facility fee (e.g., ASC)	30%	
Outpatient	Physician/surgeon fees	30%	
services	Outpatient visit	30%	
	Emergency room facility fee (waived if admitted)	\$350	
	Emergency room physician fee (waived if admitted)	No charge	
Need mmediate	Medical transportation (including emergency and non-emergency)	\$250	
attention	Urgent care	* 05	
	organicare	\$35	
	Facility fee (e.g. hospital room) for inpatient stay (including labor and delivery, mental health, and substance use)	30%	
Hospital stay	Physician/surgeon fee	30%	
Mental	Mental/behavioral health and substance use disorder outpatient office		
health, behavioral	visits	\$35	
nealth, or substance	Mental/behavioral health and substance use disorder other outpatient	\$35	
abuse needs	items and services		
Pregnancy	Prenatal care and preconception visits Home health care (cost share per visit)	No charge \$40	
Help recovering or	Outpatient Rehabilitation and Habilitation services	\$35	
other special	Skilled nursing care	30%	
nealth 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	Not Covered	
reventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental	Restorative Procedures	,	
Basic Services	Periodontal Maintenance Services	Not Covered	
	Crowns and Casts		
Child Dental	Endodontics		
Major	Periodontics (other than maintenance)	Not Covered	
Services	Prosthodontics		
	Oral Surgery		

Endnotes to Covered California 2026 Patient-Centered Benefit Plan Designs

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

Notes:

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

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

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

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

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

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

- 25) A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary.
- 26) The health issuer may not impose a member cost share for Diabetes Self-Management which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member's physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.
- 27) The cost sharing for hospice services applies regardless of the place of service.
- 28) For all FDA-approved tobacco cessation medications, no limits on the number of days for the course of treatment (either alone or in combination) may be imposed during the plan year.
- 29) For inpatient stays, if the facility does not bill the facility fee and physician/surgeon fee separately, an issuer may apply the cost-sharing requirements for the facility fee to the entire charge.
- 30) For any benefit plan design in which a designation of Individual-Only or CCSB-Only is not present, the benefit plan design shall be applicable to the individual and small group markets. If a health plan seeks to offer such benefit plan design(s) in both markets, they shall be treated as separate benefit plan designs for purposes of regulatory compliance.
- 31) The out-of-pocket maximum in the Bronze HDHP shall not exceed the maximum out-of-pocket limit specified by the IRS in its revenue procedure for the 2026 calendar year for inflation adjusted amounts for HDHPs linked to Health Savings Accounts (HSAs), issued pursuant to section 26 U.S.C Section 223.
- 32) These Endnotes do not limit an issuer's obligations to comply with applicable Federal, State, or local laws, rules, or regulations. In the event an issuer is subject to a newly enacted or amended law, rule, or regulation that conflicts with the requirements of these Endnotes, an issuer shall comply with the law, rule, or regulation and any applicable guidance from its regulatory authority. Where these Endnotes exceed requirements imposed by law, an issuer shall comply with the requirements in these Endnotes.