Title 10, California Code of Regulations

Adopt Section 6432, which is new regulation text to be added, to read:

SECTION 6432: 2016 STANDARD BENEFIT PLAN DESIGNS

(a) For plan year and calendar year 2016, The California Health Benefit Exchange adopts the Standard Benefit Plan Designs identified as the 2016 Standard Benefit Plan Designs dated January 15, 2015 which is incorporated by reference.

Authority: Government Code Section 100504

Reference: Government Code Sections 100503 and 100504(c); Health and Safety Code Section 1366.6(e) and Insurance Code Section 10112.3(e)

2016 Standard Benefit Plan Designs

January 15, 2015



	lember Cost Share amounts describe the Enrollee's out of pocket costs. ctuarial Value - AV Calculator		im ce Plan	Platinum Copay Plan 89.91%		
	e - AV Calculator cludes a deductible?	88.599 No	Yo .	89.919 No	/o	
	Individual deductible	\$0		\$0		
Integrated	Family deductible deductible Headical / Pharmacy / Dental	\$0 \$0 / \$0 /	/ \$ 0	\$0 \$0 / \$0 /	\$0	
Family ded	luctible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /		\$0 / \$0 /		
ndividual Out	of-pocket maximum	\$4,00		\$4,00		
-amily Out-ot- ISA plan: Self	-pocket maximum -only coverage deductible	\$8,00 N/A		\$8,000 N/A	U	
HSA family pla	n: Individual deductible	N/A		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies	
	Primary care visit to treat an injury, illness, or condition	\$20		\$20		
Health care provider's office or clinic visit	Other practitioner office visit	\$20		\$20		
	Specialist visit	\$40		\$40		
	Preventive care/ screening/ immunization	No charge		No charge		
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$20		\$20 \$40		
6313	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	\$40 10%		\$40 \$150		
	Generic drugs	\$5		\$5		
Orugs to treat	Preferred brand drugs	\$15		\$15		
liness or condition	Non-preferred brand drugs	\$25		\$25		
	Specialty drugs	10%		10%		
Outpatient	Surgery facility fee (e.g., ASC)	10%		\$250		
services	Physician/surgeon fees Outpatient visit	10%		\$40		
	Outpatient visit	10%		10%		
	Emergency room facility fee (waived if admitted)	\$150		\$150		
Need	Emergency room physician fee (waived if admitted)	10%		No charge		
veed mmediate	Emergency medical transportation	\$150		\$150		
attention	Urgent care	\$40		\$40		
lospital stay	Facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days		
	Physician/surgeon fee	10%		\$40		
	Mental/Behavioral health outpatient office visits	\$20		\$20		
	Mental/Behavioral health other outpatient items and services	\$20		\$20		
Mental	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%		\$250 per day up to 5 days		
nealth, pehavioral	Mental/Behavioral health inpatient physician/surgeon fee	10%		\$40		
nealth, or substance abuse needs	Substance Use disorder outpatient office visits	\$20		\$20		
	Substance Use disorder other outpatient items and services	\$20		\$20		
	Substance Use inpatient facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days		
	Substance use disorder inpatient physician/surgeon fee	10%		\$40		
	Prenatal care and preconception visits	No charge		No charge		
Pregnancy	Delivery and all inpatient Hospital	10%		\$250 per day		
	services Professional	10%		up to 5 days \$40	_	
	Home health care	10%		\$20		
lelp	Outpatient Rehabilitation services	\$20		\$20		
ecovering or	Outpatient Habilitation services	\$20		\$20 \$150 per day up		
other special nealth needs	Skilled nursing care	10%		to 5 days		
	Durable medical equipment Hospice service	10% No charge		10% No charge		
Child eye	Eye exam	No charge 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 Diagnostic	Preventive - Cleaning Preventive - X-ray					
and Preventive	Flederilive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	No charge		No charge		
Child Dental Basic Services	Amalgam Fill - 1 Surface	20%		\$25		
	Root Canal- Molar			\$300		
Child Dental	Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted	50%		\$150		
Major	Extraction- Complete Bony	50%		\$65 \$160		
Services						
Services Child	Porcelain with Metal Crown			\$300	_	

Summary	of	Benefits	and	Coverage

	f Benefits and Coverage					
Member Cost S	Share amounts describe the Er	rollee's out of pocket costs.	Gold Coinsurand		Gold Copay P	
Actuarial Valu	e - AV Calculator		80.34		81.05%	
	cludes a deductible?		No		No	
	Individual deductible Family deductible		\$0 \$0		\$0 \$0	
Individual	deductible, NOT integrated:	Medical / Pharmacy / Dental	\$0 / \$0 /		\$0 / \$0 /	
	luctible, NOT integrated: Me -of-pocket maximum	dical / Pharmacy / Dental	\$0 / \$0 / \$6,20		\$0 / \$0 / \$6,200	
Family Out-of-	pocket maximum		\$12,40	00	\$12,40	
	f-only coverage deductible an: Individual deductible		N/A N/A		N/A N/A	
Common						
Medical Event	Sec. 1	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
LVCIII	361	vice Type	Onare	Applies	Onarc	Applies
	Primary care visit to treat an	njury, illness, or condition	\$35		\$35	
Health care	Other practitioner office visit		\$35		\$35	
provider's office or	Canor practition of the viole		\$55		\$33	
clinic visit	nic visit					
	Specialist visit		\$55		\$55	
	Preventive care/ screening/ in	amunization	No charge		No charge	
	Laboratory Tests	munization	\$35		\$35	
Tests	X-rays and Diagnostic Imagir Imaging (CT/PET scans, MRI		\$50 20%		\$50 \$250	
	Generic drugs	3)	\$15		\$15	
Drugs to treat	Preferred brand drugs		\$50		\$50	
illness or	Non-preferred brand drugs		\$70		\$70	
condition						
	Specialty drugs Surgery facility fee (e.g., ASC	1	20%		20%	
Outpatient	Physician/surgeon fees)	20%		\$600 \$55	
services	Outpatient visit		20%		20%	
	Emergency room facility fee (waived if admitted)	\$250		\$250	
	Emergency room physician fe	ee (waived if admitted)	20%		No charge	
Need immediate	Emergency medical transport	ation	\$250		\$250	
attention						
	Urgent care		\$60		\$60	
					6000 d	
Hospital stay	Facility fee (e.g. hospital roor	n)	20%		\$600 per day up to 5 days	
	Physician/surgeon fee		20%		\$55	
	Mental/Behavioral health outp	patient office visits	\$35		\$35	
			• • • • • • • • • • • • • • • • • • • •		***	
	Mental/Behavioral health other	er outpatient items and services	\$35		\$35	
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%		\$600 per day up	
Mental health,	Mental/Behavioral health inpa				to 5 days	
behavioral	ivienta/benavioral nealth inpa	illeni priysician/surgeon ree	20%		\$55	
health, or substance	Substance Use disorder outpo	atient office visits	\$35		\$35	
abuse needs			ÇGO		ÇGO	
	Substance Use disorder other	outpatient items and services	\$35		\$35	
	Cubatanas I las innationt facil	itu faa (a a haanital room)			\$600 per day up	
	Substance Use inpatient facil	ny roe (e.g. nospital room)	20%		to 5 days	
	Substance use disorder inpat		20%		\$55	
	Prenatal care and preconcept		No charge		No charge \$600 per day	
Pregnancy	Delivery and all inpatient services	Hospital	20%		up to 5 days	
	Home health care	Professional	20%		\$55 \$30	
Help	Outpatient Rehabilitation serv		\$35		\$35	
recovering or	Outpatient Habilitation service	es	\$35		\$35 \$300 per day up	
other special health needs	Skilled nursing care Durable medical equipment		20%		to 5 days	
	Hospice service		20% No charge		20% 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	
Child Dental	Oral Exam Child Dental Preventive - Cleaning					
Diagnostic and	Preventive - X-ray		No charge		No charge	
Preventive	Sealants per Tooth Topical Fluoride Application					
OF II A E	Space Maintainers - Fixed					
Child Dental Basic	Amalgam Fill - 1 Surface		20%		\$25	
Services						
Child Dental	Root Canal- Molar Gingivectomy per Quad				\$300 \$150	
Major Services	Extraction- Single Tooth Expo Extraction- Complete Bony	sed Root or Erupted	50%		\$65	
O 01 11000	Porcelain with Metal Crown				\$160 \$300	
	r orooidiir witir Wotar Orowii					
Child Orthodontics	Medically necessary orthodor	ntics	50%		\$1,000	

-	f Benefits and Coverage Share amounts describe the Enrollee's out of pocket costs.	Individ	
	e - AV Calculator	70.53	
	cludes a deductible?	Yes, Medical/	
Integrated	Individual deductible	N/A	
	Family deductible deductible, NOT integrated: Medical / Pharmacy / Dental	N/A \$2,250 / \$2	250 / \$0
	ductible, NOT integrated: Medical / Pharmacy / Dental	\$4,500 / \$5 \$6,25	
Family Out-of	-of-pocket maximum -pocket maximum	\$12,5	00
	f-only coverage deductible an: 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	\$45	
Health care provider's office or clinic visit	Other practitioner office visit	\$45	
	Specialist visit	\$70	
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$35 \$65	
	Imaging (CT/PET scans, MRIs)	\$250	
	Generic drugs	\$15 \$50	Pharmac
Drugs to treat	Preferred brand drugs	\$50	deductibl
condition	Non-preferred brand drugs	\$70	Pharmac deductible
	Specialty drugs	20%	Pharmac deductibl
Outpatient	Surgery facility fee (e.g., ASC)	20%	ucuuCliDl
services	Physician/surgeon fees Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	20% \$250	X
Need	Emergency room physician fee (waived if admitted)	20%	Х
immediate attention	Emergency medical transportation	\$250	Х
attention	Urgent care	\$90	
Hospital stay	Facility fee (e.g. hospital room)	20%	Х
	Physician/surgeon fee	20%	X
	Mental/Behavioral health outpatient office visits	\$45	
	Mental/Behavioral health other outpatient items and services	\$45	
Mental	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	Х
health, behavioral	Mental/Behavioral health inpatient physician/surgeon fee	20%	Х
health, or substance abuse needs	Substance Use disorder outpatient office visits	\$45	
	Substance Use disorder other outpatient items and services	\$45	
	Substance Use inpatient facility fee (e.g. hospital room)	20%	Х
	Substance use disorder inpatient physician/surgeon fee	20%	х
	Prenatal care and preconception visits	No charge	
Pregnancy	Delivery and all inpatient Hospital services	20%	Х
	Professional Home health care	20% \$45	X
Help	Outpatient Rehabilitation services	\$45	
recovering or	Outpatient Habilitation services	\$45	
other special health needs	Skilled nursing care	20%	Х
	Durable medical equipment Hospice service	20% No charge	_
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
Child Dental	Oral Exam Preventive - Cleaning		
Diagnostic	Preventive - X-ray	No charge	
and Preventive	Sealants per Tooth Topical Fluoride Application	110 onlargo	
	Space Maintainers - Fixed		
Child Dental Basic Services	Amalgam Fill - 1 Surface	20%	
Child Dental	Root Canal- Molar		
Child Dental Major Services	Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony	50%	
	Porcelain with Metal Crown		
Child Orthodontics	Medically necessary orthodontics	50%	

	f Benefits and Coverage			IOP ver	SHO Silve	
	Share amounts describe the Er	rollee's out of pocket costs.	Coinsurance Plan		Copay Plan	
	e - AV Calculator			77%	71.45	
Integrated	cludes a deductible? Individual deductible		N	al/Pharmacy /A	Yes, Medical/ N/A	
	Family deductible deductible, NOT integrated:	Medical / Pharmacy / Dental	N/A \$1,500 / \$500 / \$0		N/A \$1,500 / \$500 / \$0	
Family dec	ductible, NOT integrated: Me t-of-pocket maximum	dical / Pharmacy / Dental	\$3,000 / \$	51,000 / \$0 500	\$3,000 / \$1,000 / \$0 \$6,500	
Family Out-of-	-pocket maximum		\$13,000		\$13,0	00
	f-only coverage deductible an: Individual deductible			/A /A	N/A N/A	
Common						
Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an	njury, illness, or condition	\$45		\$45	
Health care provider's office or clinic visit	Other practitioner office visit		\$45		\$45	
	Specialist visit	\$70		\$70		
	Preventive care/ screening/ in	nmunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagin		\$35 \$65		\$35 \$65	
	Imaging (CT/PET scans, MRI Generic drugs		20% \$15	X	\$250 \$15	
	Preferred brand drugs		\$55	Pharmacy	\$55	Pharmacy
Drugs to treat illness or				deductible Pharmacy		deductible Pharmacy
condition	Non-preferred brand drugs		\$75	deductible	\$75	deductible
	Specialty drugs		20%	Pharmacy deductible	20%	Pharmacy deductible
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees)	20%		20%	
services	Outpatient visit		20%		20% 20%	
	Emergency room facility fee (waived if admitted)	\$250	Х	\$250	Х
	Emergency room physician fe	e (waived if admitted)	20%	Х	20%	Х
Need immediate	Emergency medical transport	ation	\$250	Х	\$250	Х
attention			\$90		\$90	
Hospital stay	Facility fee (e.g. hospital roon	1)	20%	Х	20%	Х
	Physician/surgeon fee		20%	X	20%	X
	Mental/Behavioral health outp	atient office visits	\$45		\$45	
	Mental/Behavioral health other	\$45		\$45		
Mental	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	Х	20%	Х
health,	Mental/Behavioral health inpa	tient physician/surgeon fee	20%	Х	20%	Х
behavioral health, or substance abuse needs	Substance Use disorder outpo	\$45		\$45		
	Substance Use disorder other	\$45		\$45		
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%	Х	20%	х
	Substance use disorder inpat	· · ·	20%	Х	20%	Х
	Prenatal care and preconcept		No charge		No charge	
Pregnancy	Delivery and all inpatient services	Hospital	20%	X	20%	X
	Home health care	Professional	20%	X	20% \$45	X
Help	Outpatient Rehabilitation service Outpatient Habilitation service		\$45 \$45		\$45 \$45	
recovering or other special	Skilled nursing care		20%	Х	20%	х
health needs	Durable medical equipment		20%	^	20%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam 1 pair of glasses per year (or or o	contact lenses in lieu of glasses)	No charge No charge		No charge No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam		o onalyc		onaryc	
Child Dental Diagnostic	Dental Preventive - Cleaning ostic Preventive - X-ray Sealants per Tooth					
and			No charge		No charge	
Preventive	Topical Fluoride Application Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%		\$25	
	Root Canal- Molar				\$300	
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Expo	sed Root or Erupted	50%		\$150 \$65	
Services	Extraction- Complete Bony Porcelain with Metal Crown				\$160 \$300	
Child		de-				
Orthodontics	Medically necessary orthodor	TICS	50%		\$1,000	

	uary 15, 2015				
Summary of	f Benefits and Coverage)	SHOP		
Member Cost S	Share amounts describe the E	nrollee's out of pocket costs.	Silver HSA Plan		
Actuarial Valu	ie - AV Calculator		70.50%		
	ncludes a deductible?		Yes, integr	rated	
Integrated	Individual deductible		\$2,000 inte	grated	
Integrated	Family deductible deductible, NOT integrated:	Medical / Pharmacy / Dental	\$4,000 integrated N/A		
Family ded	ductible, NOT integrated: Mo		N/A		
Individual Out Family Out-of	t-of-pocket maximum -pocket maximum		\$6,250 \$12,50		
HSA plan: Sel	f-only coverage deductible		\$2,000)	
HSA family pl	an: Individual deductible		See endr	note	
Common Medical					
Event	Se	rvice Type	Member Cost Share	Deductible Applies	
	Primary care visit to treat an	injury, illness, or condition	20%	х	
Health care provider's office or clinic visit	Other practitioner office visit		20%	х	
	Specialist visit		20%	х	
	Preventive care/ screening/ i	mmunization	No charge	X	
Tests	Laboratory Tests X-rays and Diagnostic Imagi	ng	20% 20%	X	
	Imaging (CT/PET scans, MR		20%	X	
	Generic drugs		20%	X	
Drugs to treat	Preferred brand drugs		20%	Х	
illness or condition	Non-preferred brand drugs		20%	x	
	Specialty drugs		20%	Х	
	Surgery facility fee (e.g., AS	2)	20%	X	
Outpatient services	Physician/surgeon fees	,	20%	X	
3CI VICC3	Outpatient visit		20%	X	
	Emergency room facility fee	(waived if admitted)	20%	Х	
	Emergency room physician	ee (waived if admitted)	20%	х	
Need immediate	Emergency medical transportation		20%	Х	
attention	Urgent care		20%	х	
	Facility fee (e.g. hospital roo	m)	20%	Х	
Hospital stay		,			
	Physician/surgeon fee		20%	X	
	Mental/Behavioral health out	patient office visits	20%	Х	
	Mental/Behavioral health oth	er outpatient items and services	20%	Х	
Mental	Mental/Behavioral health inp	atient facility fee (e.g.hospital room)	20%	Х	
health,	Mental/Behavioral health inp	atient physician/surgeon fee	20%	х	
behavioral health, or substance abuse needs	Substance Use disorder out	patient office visits	20%	х	
	Substance Use disorder other	er outpatient items and services	20%	х	
	Substance Use inpatient fac	lity fee (e.g. hospital room)	20%	Х	
	Substance use disorder inpa		20%	х	
	Prenatal care and preconcep			^	
Pregnancy			No charge 20%	Х	
. regnancy	Delivery and all inpatient services	Hospital	20%	X	
	Home health care	Professional	20%	X	
Help	Outpatient Rehabilitation ser		20%	Х	
recovering or	Outpatient Habilitation service	100	20%	X	
other special health needs	Skilled nursing care Durable medical equipment		20%	X	
	Hospice service		20%	X	
	Fire even		No charge		
Child eye					
Child eye care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge		
care	1 pair of glasses per year (or Oral Exam	contact lenses in lieu of glasses)	No charge		
Child Dental Diagnostic	1 pair of glasses per year (or Oral Exam Preventive - Cleaning Preventive - X-ray	contact lenses in lieu of glasses)			
care Child Dental	1 pair of glasses per year (or Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application	contact lenses in lieu of glasses)	No charge		
Child Dental Diagnostic and Preventive Child Dental Basic	1 pair of glasses per year (or Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	contact lenses in lieu of glasses)			
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Toalants per Tooth Space Maintainers - Fixed Amalgam Fill - 1 Surface	contact lenses in lieu of glasses)	No charge		
Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental	1 pair of glasses per year (or Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad		No charge		
Care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major	1 pair of glasses per year (or Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topace Huoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exp		No charge		
Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental	1 pair of glasses per year (or Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad		No charge		
Care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major	1 pair of glasses per year (or Oral Exam Preventive - Cleaning Preventive - Kray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal-Molar Gingivectomy per Quad Extraction- Single Tooth Exp Extraction- Complete Bony	osed Root or Erupted	No charge		

Primary care visit to treat an injury, illness, or condition \$5	
Plant design includes a steucutible? Ves, Medicaul/Pharmacy Ves, Medicaul/Pharmacy Ves, Medicaul/Pharmacy Ves, Medicaul/Pharmacy Ves, Medicaul/Pharmacy NA	L
Integrated Individual deductible NA NA NA NA NA NA NA N	
Integrated Family deductible NA NA NA Family deductible NA NA Family deductible NA NA NA NA NA NA NA N	nacy
Employ deductable, NOT Integrated: Medical / Pharmacy / Dental 150.7 \$0.7 \$0.0 \$1.00 \$10.00 \$2.25.	
SA 1,000 SA	
Mary March Marc	
Primary care visit to treat an injury, iliness, or condition \$5	
Medical Event Service Type Sharro	
Chebro provider's office or clinic visit	ductible pplies
Second S	
Preventive care/ screening/ immunization	
Laboratory Tests	
X-rays and Diagnostic Imaging S8 \$25 \$100 \$200	
Genetic drugs	
Preferred brand drugs	
Non-preferred brand drugs S15 S35 Proceedings	armacy
Non-prefered brand drugs	ductible
Supering Final Property Supering Final Property Supering Final Property	ductible
Outpatient services Physician/surgeon fees 10% 15% Outpatient visit 10% 15% 15% Emergency room facility fee (waived if admitted) \$30 X \$75 Emergency room physician fee (waived if admitted) 10% X 15% Emergency room physician fee (waived if admitted) \$30 X \$75 Urgent care \$6 \$30 X \$75 Hospital stay Facility fee (e.g. hospital room) 10% X 15% Physician/surgeon fee 10% X 15% 15% Mental/Behavioral health outpatient office visits \$5 \$15 \$15 Mental/Behavioral health inpatient facility fee (e.g.hospital room) 10% X 15% Mental/Behavioral health inpatient physician/surgeon fee 10% X 15% Substance Use disorder outpatient office visits \$5 \$15 Substance Use disorder other outpatient items and services \$5 \$15 Substance Use inpatient facility fee (e.g. hospital room) 10% X 15% Su	armacy ductible
Services Outpatient visit 10% 15% 15% 10% 15% 10% 15% 10% 15% 15% 15% 15% 15% 15% 15% 15% 15% 15	
Emergency room facility fee (waived if admitted)	
Emergency room physician fee (waived if admitted)	х
Need Immediate attention Sanor	Х
Hospital stay	X
Physician/surgeon fee 10% X 15% Mental/Behavioral health outpatient office visits \$5 \$15 Mental/Behavioral health other outpatient items and services \$5 \$15 Mental/Behavioral health inpatient facility fee (e.g. hospital room) 10% X 15% Mental/Behavioral health inpatient physician/surgeon fee 10% X 15% Mental/Behavioral health inpatient physician/surgeon fee 10% X 15% Substance Use disorder outpatient office visits \$5 \$15 Substance Use disorder outpatient items and services \$5 \$15 Substance Use inpatient physician/surgeon fee 10% X 15% Substance Use inpatient physician/surgeon fee 10% X 15% Prenatal care and preconception visits No charge No charge Pregnancy Delivery and all inpatient Hospital 10% X 15% Professional 10% X 15% Help recovering or outpatient Rehabilitation services \$5 \$15 Outpatient Habilitations ervices \$5 \$15 Outpatient Habilitation services \$5 \$15 Stilled nursing care	
Mental/Behavioral health outpatient office visits \$5	X X
Mental health, behavioral health inpatient facility fee (e.g.hospital room) 10% X 15% behavioral health, or substance abuse needs Substance Use disorder outpatient office visits \$5 \$15 Substance Use disorder outpatient items and services \$5 \$15 Substance Use inpatient facility fee (e.g. hospital room) 10% X 15% \$15 Substance Use inpatient facility fee (e.g. hospital room) 10% X 15% \$15 Substance Use inpatient physician/surgeon fee 10% X 15% \$15 Prenatal care and preconception visits No charge No charge Prenated care and preconception visits 10% X 15% \$15% \$15 Delivery and all inpatient Hospital 10% X 15% \$15% \$15 \$15 Uutpatient Rehabilitation services \$5 \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$15	<u>^</u>
Mental health, behavioral health inpatient physician/surgeon fee 10% X 15%	
health, behavioral health inpatient physician/surgeon fee 10% X 15% health, or substance abuse needs Substance Use disorder outpatient office visits \$5 \$15 \$15 \$ Substance Use disorder outpatient items and services \$5 \$15 \$ Substance Use inpatient facility fee (e.g. hospital room) 10% X 15% \$ Substance use disorder inpatient physician/surgeon fee 10% X 15% \$ Prenatal care and preconception visits No charge No charge Pregnancy Delivery and all inpatient Hospital 10% X 15% \$ Professional 10% X 15% \$ Home health care \$3 \$15 \$ Outpatient Rehabilitation services \$5 \$15 \$ Unpatient Habilitation services \$5 \$15 \$ Stilled nursing care \$10% X 15% \$ Substance Use disorder outpatient items and services \$5 \$15 \$ Substance Use disorder outpatient items and services \$5 \$15 \$ Substance Use disorder outpatient items and services \$5 \$15 \$ Substance Use disorder outpatient items and services \$5 \$15 \$ Substance Use disorder outpatient items and services \$5 \$15 \$ Substance Use disorder outpatient items and services \$5 \$15 \$ Substance Use disorder outpatient items and services \$5 \$15 \$ Substance Use disorder outpatient items and services \$5 \$15 \$ Substance Use disorder outpatient items and services \$5 \$15 \$ Substance Use disorder outpatient items and services \$5 \$15 \$ Substance Use disorder outpatient items and services \$5 \$15 \$ Substance Use disorder outpatient items and services \$5 \$ Substance Use disorder outpatient items and services \$5 \$ Substance Use disorder outpatient items and services \$5 \$ Substance Use disorder outpatient items and services \$5 \$ Substance Use disorder outpatient items and services \$5 \$ Substance Use disorder outpatient items and services \$5 \$ Substance Use disorder outpatient items and services \$5 \$ Substance Use disorder outpatient items and services \$5 \$ Substance Use disorder outpatient items and services \$5 \$ Substance Use disorder outpatient items and services \$5 \$ Substance Use disorder outpatient items and services \$5 \$ Substance Use disorder outpatient items and s	х
substance abuse needs Substance Use disorder outpatient office visits Substance Use disorder outpatient items and services Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Prenatal care and preconception visits No charge Pregnancy Delivery and all inpatient Hospital Services Professional Home health care Outpatient Rehabilitation services Uutpatient Habilitation services Substance Use disorder outpatient items and services \$5 \$15 Outpatient Habilitation services \$5 \$15 Outpatient Habilitation services \$5 \$15 Stiled nursing care	х
Substance Use inpatient facility fee (e.g. hospital room) 10% X 15%	
Substance use disorder inpatient physician/surgeon fee 10% X 15%	
Pregnancy Pregnancy Pregnancy Delivery and all inpatient services Professional 10% X 15%	х
Delivery and all inpatient services	х
Services Professional 10% X 15%	v
Home health care \$3 \$15	X
Help recovering or other special Skilled nursing care State	Х
recovering or cother special Skilled nursing care 10% X 15%	
health needs	х
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 Dental Preventive - Cleaning	
Diagnostic and Preventive - X-ray No charge No charge	
Preventive Topical Fluoride Application Space Maintainers - Fixed	
Child Dental Basic Amalgam Fill - 1 Surface 20% 20%	
Services Root Canal- Molar	
Child Dental Gingivectomy per Quad Major Extraction- Single Tooth Exposed Root or Erupted 50%	
major Extraction Single Tourit Exposed Root of Elupted 50% Services Extraction Complete Bony Porcelain with Metal Crown	
Child Orthodontics Medically necessary orthodontics 50% 50%	

	Share amounts describe the Er	nrollee's out of pocket costs.	Silver F 200%-250 72.91	% FPL
	cludes a deductible? Individual deductible		Yes, Medical/I	
Integrated	Family deductible		N/A	
Individual	deductible, NOT integrated:	Medical / Pharmacy / Dental	\$1,900 / \$2	
	luctible, NOT integrated: Me -of-pocket maximum	dical / Pharmacy / Dental	\$3,800 / \$5 \$5,45	
Family Out-of-	-pocket maximum		\$10,90	
	f-only coverage deductible an: Individual deductible		N/A N/A	
Common	-		107	
Medical Event	Sei	vice Type	Member Cost Share	Deductibl Applies
	Primary care visit to treat an	injury, illness, or condition	\$40	
Health care provider's office or clinic visit	Other practitioner office visit		\$40	
	Specialist visit		\$55	
	Preventive care/ screening/ ir	nmunization	No charge	
Tests	Laboratory Tests	20	\$35	
10313	X-rays and Diagnostic Imagin Imaging (CT/PET scans, MR		\$50 \$250	
	Generic drugs		\$15	Di .
Drugs to treat	Preferred brand drugs		\$45	Pharmac deductible
illness or	Non-preferred brand drugs		\$70	Pharmac
condition				deductibl Pharmac
	Specialty drugs		20%	deductibl
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	C)	20%	
services	Outpatient visit		20%	
	Emergency room facility fee ((waived if admitted)	\$250	Х
Need	Emergency room physician for		20%	Х
immediate	Emergency medical transport	\$250	Х	
attention	Urgent care		\$80	
		,		
Hospital stay	Facility fee (e.g. hospital roor	п)	20%	Х
	Physician/surgeon fee		20%	X
	Mental/Behavioral health out	\$40		
	Mental/Behavioral health other	\$40		
Mental	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	20%	Х
health, behavioral	Mental/Behavioral health inpa	atient physician/surgeon fee	20%	Х
health, or substance abuse needs	Substance Use disorder outp			
abase necas		atient office visits	\$40	
abuse needs	Substance Use disorder othe	r outpatient items and services	\$40	
abuse needs	Substance Use inpatient facil	r outpatient items and services ity fee (e.g. hospital room)	\$40 20%	x
abuse needs	Substance Use inpatient facil Substance use disorder inpat	r outpatient items and services ity fee (e.g. hospital room) ient physician/surgeon fee	\$40	X X
abuse needs	Substance Use inpatient facil	r outpatient items and services ity fee (e.g. hospital room) ient physician/surgeon fee	\$40 20%	
Pregnancy	Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcep Delivery and all inpatient	r outpatient items and services ity fee (e.g. hospital room) ient physician/surgeon fee	\$40 20% 20%	
	Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcep Delivery and all inpatient services	r outpatient items and services ity fee (e.g. hospital room) ient physician/surgeon fee ition visits	\$40 20% 20% No charge 20% 20%	Х
Pregnancy	Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcep Delivery and all inpatient services Home health care	r outpatient items and services ity fee (e.g. hospital room) ient physician/surgeon fee tion visits Hospital Professional	\$40 20% 20% No charge 20% 20% \$40	X
Pregnancy	Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcep Delivery and all inpatient services	r outpatient items and services ity fee (e.g. hospital room) ient physician/surgeon fee tion visits Hospital Professional	\$40 20% 20% No charge 20% 20%	X
Pregnancy Help recovering or other special	Substance Use inpatient facili Substance use disorder inpat Prenatal care and preconcep Delivery and all inpatient services Hundelith care Outpatient Rehabilitation sen	r outpatient items and services ity fee (e.g. hospital room) ient physician/surgeon fee tion visits Hospital Professional	\$40 20% 20% No charge 20% 20% \$40 \$40	X
Pregnancy Help recovering or	Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcep Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service	r outpatient items and services ity fee (e.g. hospital room) ient physician/surgeon fee tion visits Hospital Professional	\$40 20% 20% No charge 20% \$40 \$40 \$40 20% No charge	X X X
Pregnancy Help recovering or other special health needs Child eye	Substance Use inpatient facili Substance use disorder inpat Prenatal care and preconcep Delivery and all inpatient services Home health care Outpatient Rehabilitation servic Skilled nursing care Durable medical equipment Hospice service Eye exam	r outpatient items and services ity fee (e.g. hospital room) ient physician/surgeon fee tion visits Hospital Professional vices	\$40 20% 20% No charge 20% \$40 \$40 \$40 20% 20% No charge No charge	X X X
Pregnancy Help recovering or other special health needs	Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcep Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service	r outpatient items and services ity fee (e.g. hospital room) ient physician/surgeon fee tion visits Hospital Professional vices	\$40 20% 20% No charge 20% \$40 \$40 \$40 20% No charge	X X X
Pregnancy Help recovering or other special health needs Child eye care Child Dental	Substance Use inpatient facili Substance use disorder inpat Prenatal care and preconcep Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or Oral Exam Preventive - Cleaning	r outpatient items and services ity fee (e.g. hospital room) ient physician/surgeon fee tion visits Hospital Professional vices	\$40 20% 20% No charge 20% \$40 \$40 \$40 20% 20% No charge No charge	X X X
Pregnancy Help recovering or other special health needs Child eye care	Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcep Delivery and all inpatient services Home health care Outpatient Rehabilitation servic Skilled nursing care Durable medical equipment Hospitoe service Eye exam 1 pair of glasses per year (or Oral Exam Preventive - Cleaning Preventive - X-ray	r outpatient items and services ity fee (e.g. hospital room) ient physician/surgeon fee tion visits Hospital Professional vices	\$40 20% 20% No charge 20% \$40 \$40 \$40 20% 20% No charge No charge	X X X
Pregnancy Help recovering or other special health needs Child eye care Child Dental Diagnostic	Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcep Delivery and all inpatient services Home health care Outpatient Rehabilitation servic Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application	r outpatient items and services ity fee (e.g. hospital room) ient physician/surgeon fee tion visits Hospital Professional vices es	\$40 20% 20% No charge 20% \$40 \$40 \$40 \$40 No charge No charge No charge	X X X
Pregnancy Help recovering or other special health needs Child bental Diagnostic and Preventive	Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcep Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or Oral Exam Preventive - X-ray Sealants per Tooth	r outpatient items and services ity fee (e.g. hospital room) ient physician/surgeon fee tion visits Hospital Professional vices es	\$40 20% 20% No charge 20% \$40 \$40 \$40 \$40 No charge No charge No charge	X X X
Pregnancy Help recovering or other special health needs Child eye care Child Dental Diagnostic and	Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcep Delivery and all inpatient services Home health care Outpatient Rehabilitation servi Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface	r outpatient items and services ity fee (e.g. hospital room) ient physician/surgeon fee tion visits Hospital Professional vices es	\$40 20% 20% No charge 20% \$40 \$40 \$40 \$40 No charge No charge No charge	X X X
Pregnancy Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services	Substance Use inpatient facili Substance use disorder inpati Prenatal care and preconcep Delivery and all inpatient services Home health care Outpatient Rehabilitation sen Outpatient Habilitation servic Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - Service Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal-Molar	r outpatient items and services ity fee (e.g. hospital room) ient physician/surgeon fee tion visits Hospital Professional vices es	\$40 20% 20% No charge 20% \$40 \$40 \$40 20% No charge No charge No charge	X X X
Pregnancy Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic	Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcep Delivery and all inpatient services Home health care Outpatient Rehabilitation servi Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface	r outpatient items and services ity fee (e.g. hospital room) ient physician/surgeon fee tion visits Hospital Professional vices es	\$40 20% 20% No charge 20% \$40 \$40 \$40 20% No charge No charge No charge	X X X

Summary	of	Renefits	and	Coverage

Actuarial Value - I Plan design inclu Integrated Ind Integrated Fan Individual ded Family deduct Individual Out-of- Family Out-of-poc HSA plan: Self-on	ivides a deductible? Iividual deductible iividual deductible ductible, NOT integrated: Medical / Pharmacy / Dental tible, NOT integrated: Medical / Pharmacy / Dental -pocket maximum cket maximum iivi coverage deductible Individual deductible Service Type	81.1 Yes, inte \$6,500 in \$13,000 ir N/ N/ S6,5.50 in 10,100 ir N/	9% egrated tegrated integrated A A 600	## Bron: ### 61.06 Yes, integ \$4,500 inte \$9,000 inte N/A N/A	grated egrated egrated	
Plan design inclu- Integrated Indi Integrated Fan Individual ded Family deduct Individual Out-of- Family Out-of-poc HSA plan: Self-on HSA family plan: Common Medical	ivides a deductible? Iividual deductible iividual deductible ductible, NOT integrated: Medical / Pharmacy / Dental tible, NOT integrated: Medical / Pharmacy / Dental -pocket maximum cket maximum iivi coverage deductible Individual deductible Service Type	Yes, inte \$6,500 in \$13,000 ir N/ N/ \$6,5 \$13,	egrated tegrated ntegrated A A	Yes, integ \$4,500 inte \$9,000 inte N/A	grated egrated egrated	
Integrated Ind Integrated Fan Individual ded Family deduct Individual Out-of- Family Out-of-poc HSA plan: Self-on HSA family plan: I	lividual deductible milly deductible ductible, NOT integrated: Medical / Pharmacy / Dental tible, NOT integrated: Medical / Pharmacy / Dental -pocket maximum cket maximum nly coverage deductible Individual deductible Service Type	\$6,500 in \$13,000 ir N/. N/. \$6,5 \$13,	tegrated ntegrated A A 600	\$4,500 inte \$9,000 inte N/A	egrated egrated	
Integrated Fan Individual ded Family deduct Individual Out-of- Family Out-of-poc HSA plan: Self-on HSA family plan: I	mily deductible ductible, NOT integrated: Medical / Pharmacy / Dental tible, NOT integrated: Medical / Pharmacy / Dentalpocket maximum cket maximum ly coverage deductible Individual deductible Service Type	\$13,000 ir N/. N/. \$6,5 \$13,1	ntegrated A A 600	\$9,000 into N/A	egrated	
Individual ded Family deduct Individual Out-of- Family Out-of-poc HSA plan: Self-on HSA family plan: Common Medical	Juctible, NOT integrated: Medical / Pharmacy / Dental tible, NOT integrated: Medical / Pharmacy / Dentalpocket maximum cket maximum ly coverage deductible Individual deductible Service Type	N/. N/. \$6,5 \$13,	A A 600	N/A		
Individual Out-of- Family Out-of-poo HSA plan: Self-on HSA family plan: I	pocket maximum cket maximum lly coverage deductible Individual deductible Service Type	\$6,5 \$13, N/	600	IN/A		
Family Out-of-poo HSA plan: Self-on HSA family plan: I Common Medical	cket maximum nly coverage deductible Individual deductible Service Type	\$13, N/		\$6,500		
HSA family plan: I Common Medical	Individual deductible Service Type			\$13,0	00	
Common Medical	Service Type			\$4,50 \$4,50		
Medical						
Event		Member Cost	Deductible	Member Cost	Deductible	
Lvent	iman, and violate to treat on injury. Illegan or condition	Share	Applies After 1st	Share	Applies	
Pri	imary care visit to treat an injury, illness, or condition	\$70	three non- preventive visits	40%	х	
Health care provider's Oth	her practitioner office visit	\$70	After 1st three non- preventive visits	40%	х	
clinic visit	ecialist visit	\$90	After 1st three non- preventive	40%	х	
Pre	eventive care/ screening/ immunization	No charge	visits	No charge		
Lat	boratory Tests	\$40		40%	X	
	rays and Diagnostic Imaging aging (CT/PET scans, MRIs)	0%	X	40% 40%	X	
	eneric drugs	0%	X	40%	X	
Drugs to treat	eferred brand drugs	0%	х	40%	Х	
illness or condition	on-preferred brand drugs	0%	Х	40%	Х	
	pecialty drugs	0%	Х	40%	Х	
Outpatient	urgery facility fee (e.g., ASC) sysician/surgeon fees	0%	X	40% 40%	X	
services	utpatient visit	0%	X	40%	X	
Em	nergency room facility fee (waived if admitted)	0%	Х	40%	Х	
Em	nergency room physician fee (waived if admitted)	0%	х	40%	х	
Need	nergency medical transportation	0%	X	40%	X	
attention	gent care	\$120	After 1st three non- preventive visits	40%	х	
Hospital stay	cility fee (e.g. hospital room)	0%	×	40%	Х	
	sysician/surgeon fee	0%	X	40%	Х	
Me	ental/Behavioral health outpatient office visits	\$70	After 1st three non- preventive visits	40%	х	
Me	ental/Behavioral health other outpatient items and services	\$70	After 1st three non- preventive visits	40%	х	
Mental	ental/Behavioral health inpatient facility fee (e.g.hospital room)	0%	х	40%	Х	
health, behavioral	ental/Behavioral health inpatient physician/surgeon fee	0%	Х	40%	Х	
health, or	abstance Use disorder outpatient office visits	\$70	After 1st three non- preventive visits	40%	х	
Sul	obstance Use disorder other outpatient items and services	\$70	After 1st three non- preventive visits	40%	х	
Sul	abstance Use inpatient facility fee (e.g. hospital room)	0%	x	40%	Х	
	abstance use disorder inpatient physician/surgeon fee	0%	х	40%	Х	
	enatal care and preconception visits	No charge		No charge		
	Hospital rvices	0%	Х	40%	X	
	Professional ome health care	0%	X	40%	X	
Uolp Ou	utpatient Rehabilitation services	\$70	^	40%	Х	
recovering or	utpatient Habilitation services	\$70		40%	Х	
health needs	illed nursing care	0%	Х	40%	Х	
Du	urable medical equipment ospice service	0% No charge	Х	40% 0%	X	
	e exam	No charge No charge		No charge		
	pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	al Exam					
Child Dental Pre	eventive - Cleaning eventive - X-ray	No sha		No sha		
and Sea Preventive Top	ealants per Tooth spical Fluoride Application space Maintainers - Fixed	No charge		No charge		
Child Dental Basic Am Services	nalgam Fill - 1 Surface	20%		20%		
	oot Canal- Molar ngivectomy per Quad					
Major Ext Services Ext	ngivectomy per Quad traction- Single Tooth Exposed Root or Erupted traction- Complete Bony proclain with Metal Crown	50%		50%		
Child	edically necessary orthodontics	50%		50%		

Summary of	Benefits and	Coverage

Returnial Value - AV Calculator Plan delargian includes a deductibite? Integrated individual deductibite? Integrated individual deductibite? Integrated individual deductibite? Integrated individual deductibite. Will integrated individual deductibite. Will image and the property of	Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.			Catastrophic Plan		
Pinn designate includes a desincentible? S6.550 integrated integrated Family deductible S6.550 integrated S6.550 integrated N/A				- Januari Opi		
Integrated Individual deductible Integrated Tampit deductible Individual Uniteductible, NOT Integrated: Medical / Pharmacy / Dental Individual Uniteductible, NOT Integrated: Medical / Pharmacy / Dental Individual Uniteductible, NOT Integrated: Medical / Pharmacy / Dental Individual Uniteductible, NOT Integrated: Medical / Pharmacy / Dental Individual Uniteductible Individual Uniteductible INA Integrated Pharmacy of Dental Integrated Tampit (Integrated Integrated Integr				Yes, inte	grated	
Individual deductible, NOT integrated: Medical Pharmacy Dental N/A	Integrated	Individual deductible		\$6,850 int	egrated	
Family deductible, NOT integrated: Medical Pharmacy / Dental Sci 500	Integrated Individual	Family deductible deductible, NOT integrated:	Medical / Pharmacy / Dental			
Samily Out-of-pocket maximum S13,700	Family ded	luctible, NOT integrated: Me				
Member Cost Desirement Member Cost Desirement Member Cost Desirement Name Nam	Family Out-of-	pocket maximum		\$13,7	00	
Primary care visit to treat an injury, illness, or condition Original preventive providers Original provider						
Member Cost Share		-		1,61		
Health care providers office of clinic visit Health care providers office of clinic visit Specialist visit Norbardary Tests X-rays and Diagnostic Imaging Ork X-xays and Diagnostic	Medical			Member Cost	Deductible	
Primary care visit to treat an injury, illness, or condition 0%	Event	Ser	vice Type	Share		
treatmine and provider's office or sit of sit office or sit of sit office or sit of sit office or sit office or sit office or sit of sit office or sit office or sit of sit office or sit of sit office or si		Primary care visit to treat an i	njury, illness, or condition	0%	three non- preventive visits	
Specialist visit Preventive care/ screening/ immunization Preventive care/ screening/ immunization No charge Laboratory Tests	provider's office or	Other practitioner office visit		0%	three non- preventive	
Laboratory Tests				0%	х	
Tests X-rays and Diagnostic Imaging 0 % X X			nmunization			
Generic drugs Non-preferred brand drugs Non-preferred brand drugs Non-preferred brand drugs Specialty drugs Specialty drugs Surgery facility fee (e.g. ASC) Physician/surgeon fees O''s X Physician/surgeon fees O''s X Emergency room facility fee (waived if admitted) Emergency room facility fee (waived if admitted) Urgent care Emergency room physician fee (waived if admitted) Urgent care Pregnery Facility fee (e.g. hospital room) Physician/surgeon fee O''s X After 1st three non-preventive visits Mental/Behavioral health other outpatient items and services Physician/surgeon fee Mental/Behavioral health inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient facility fee (e.g. hospital room) Substance Use disorder outpatient office visits Westance Use disorder outpatient facility fee (e.g. hospital room) Substance Use disorder outpatient facility fee (e.g. hospital room) Substance Use disorder outpatient facility fee (e.g. hospital room) Substance Use disorder outpatient facility fee (e.g. hospital room) Substance Use disorder outpatient facility fee (e.g. hospital room) Substance Use disorder outpatient facility fee (e.g. hospital room) Substance Use disorder outpatient fems and services O''s AX After 1st three non-preventive visits Substance Use disorder outpatient fems and services O''s AX After 1st of three non-preventive visits Substance Use disorder outpatient fems and services O''s AX After 1st of three non-preventive visits Substance Use disorder outpatient fems and services O''s AX After 1st of three non-preventive visits Substance Use disorder outpatient fems and services O''s AX After 1st of three non-preventive visits Substance Use disorder outpatient fems and services O''s AX After 1st of three non-preventive visits Substance Use disorder outpatient fems and services O''s AX After 1st of three non-preventive visits After 1st of three non-preventive visits Aft	Tests	X-rays and Diagnostic Imagin		0%	Х	
Drugs to treat			s)			
Non-preferred brand drugs						
Surgery facility fee (e.g., ASC)	illness or					
Surgery facility fee (e.g., ASC)		Specialty drugs		0%	Х	
Pregnarcy Pregnancy Pregnancy Pregnancy Pregnancy Substance Use disorder outpatient facility fee (e.g. hospital room) Pregnancy Substance Use disorder outpatient facility fee (e.g. hospital room) Pregnancy Preventive rooms Professional Professional Professional Professional Professional Professional Professional Preventive rooms Professional Professional Professional Professional Professional Professional Professional Professional Preventive rooms Preve	0	Surgery facility fee (e.g., ASC)	0%	Х	
Emergency room facility fee (walved if admitted)						
Emergency room physician fee (waived if admitted) Emergency medical transportation Urgent care Pregility fee (e.g. hospital room) Mental/Behavioral health outpatient office visits Mental/Behavioral health outpatient office visits Mental/Behavioral health inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient physician/surgeon fee Mental/Behavioral health inpatient physician/surgeon fee Mental/Behavioral health inpatient physician/surgeon fee Substance Use disorder outpatient office visits Substance Use disorder outpatient filens and services Substance Use inpatient facility fee (e.g. hospital room) Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Pregnancy Pregnancy Pregnancy Prepnatic care and preconception visits Delivery and all inpatient encount of the professional Help recovering or other special health care Outpatient Habilitation services Ovide Skilled nursing care Durable medical equipment Hospics service Ovide Exam Preventive - Cleaning P			usived if edmitted			
Emergency medical transportation Common						
Hospital stay Facility fee (e.g. hospital room)	Need					
Urgent care		Emergency medical transport	0%			
Physician/surgeon fee	attention	Urgent care		0%	three non- preventive	
Mental/Behavioral health outpatient office visits	Hoenital etay	Facility fee (e.g. hospital roon	n)	0%	х	
Mental/Behavioral health outpatient office visits Mental/Behavioral health other outpatient items and services Mental/Behavioral health inpatient facility fee (e.g.,hospital room) Mental/Behavioral health inpatient facility fee (e.g.,hospital room) Mental/Behavioral health inpatient physician/surgeon fee Mental/Behavioral health inpatient physician/surgeon fee Substance Use disorder outpatient office visits Substance Use disorder outpatient items and services Substance Use disorder outpatient items and services Substance Use disorder outpatient physician/surgeon fee Prenatal care and preconception visits Substance use disorder inpatient physician/surgeon fee Prenatal care and preconception visits No charge Pregnancy Pregnancy Pregnancy Home health care Outpatient Rehabilitation services Ow% X Child eye care Child pental Diagnostic and Preventive - Cleaning Preventive - Cleani	ricopital ctay	Physician/surgeon fee		0%	Х	
Mental/Behavioral health other outpatient items and services Mental/Behavioral health inpatient facility fee (e.g.hospital room) Mental/Behavioral health inpatient physician/surgeon fee Mental/Behavioral health inpatient physician/surgeon fee Substance Substance Use disorder outpatient office visits Substance Use disorder other outpatient items and services Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance Use inpatient physician/surgeon fee Pregnancy Pregnancy Pregnancy Delivery and all inpatient physician/surgeon fee No charge Pregnancy Delivery and all inpatient physician/surgeon fee No charge Pregnancy Delivery and all inpatient physician/surgeon fee No charge Delivery and all inpatient physician/surgeon fee No charge Pregnancy Delivery and all inpatient physician/surgeon fee No charge Thom health care Owk X Cuptatient Rehabilitation services Owk X Cuptatient Rehabilitation services Owk X Substance Use disorder outpatient physician/surgeon fee Owk X Child eve care Child pental Diagnostic and Preventive Cleaning Prev		Mental/Behavioral health outpatient office visits		0%	three non- preventive visits	
Mental/Behavioral health Mental/Behavioral h		Mental/Behavioral health other	0%	three non- preventive		
Mental/Behavioral health inpatient physician/surgeon fee 0% X	Mental	Mental/Behavioral health inpa	0%	Х		
substance Use disorder outpatient office visits substance Use disorder outpatient items and services Substance Use disorder other outpatient items and services Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Pregnancy Pregnancy Delivery and all inpatient Hospital No charge Pregnancy Delivery and all inpatient Hospital O% X Professional O% X Durable health care O% X Outpatient Rehabilitation services O% X Outpatient Re	health,	Mental/Behavioral health inpa	0%	Х		
Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Pregnancy Pregnancy Delivery and all inpatient services Home health care Outpatient Rehabilitation services No charge Home health care Outpatient Rehabilitation services Outpatient Rehabilitation services Skilled nursing care Owk X X Author of Same o	health, or substance	Substance Use disorder outpa	0%	three non- preventive visits		
Substance use disorder inpatient physician/surgeon fee 0% X Pregnancy Pregnancy Delivery and all inpatient Hospital 0% X Home health care 0/4 Cutpatient Rehabilitation services 0% X Outpatient Habilitation services 0% X Outpatient Rehabilitation services 0% X Outpa		Substance Use disorder other	0%	three non- preventive		
Pregnancy Pregnancy Delivery and all inpatient services Professional Delivery and all inpatient services Delivery and all inpatient services Professional Delivery and all inpatient services Delivery and and services Delivery and all inpatient services Delivery and Delivery and services Delivery and all inpatient services Delivery and Delivery and Services Delivery and all inpatient services Delivery and Delivery and Services Delivery and all inpatient services Delivery and Delivery and Delivery and Services Delivery and Delivery		Substance Use inpatient facili	ty fee (e.g. hospital room)	0%	х	
Pregnancy Pregnancy Delivery and all inpatient services Professional Delivery and all inpatient services Delivery and all inpatient services Professional Delivery and all inpatient services Delivery and and services Delivery and all inpatient services Delivery and Delivery and services Delivery and all inpatient services Delivery and Delivery and Services Delivery and all inpatient services Delivery and Delivery and Services Delivery and all inpatient services Delivery and Delivery and Delivery and Services Delivery and Delivery		Substance use disorder inner	ent physician/surgeon fee	0%	×	
Pregnancy						
Services	Pregnancy				х	
Home health care		services	·			
Dutpatient Habilitation services			ione			
Skilled nursing care						
Durable medical equipment 0% X Hospice service 0% X Child eye Eye exam No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) 0% X Child Dental Diagnostic and Preventive - Cleaning Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Amalgam Fill - 1 Surface 0% X Child Dental Gingivectomy per Quad Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted 0% X Services Extraction- Complete Bony Services Extraction- Complete Bony X X Child Medically in the Medi	other special	Skilled nursing care		0%	Х	
Eye exam	health needs					
Child Dental Diagnostic and Preventive Cleaning Preventive - Cleaning Preventive - Cleaning Diagnostic and Preventive - Cleaning Preventive - Child Dental Basic Amalgam Fill - 1 Surface Child Dental Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted O% X Services Extraction- Complete Bony Porcelain with Metal Crown X Child Medically necessary orthodontics	Ohillet avec				X	
Preventive - Cleaning Preventive - Veray No charge		1 pair of glasses per year (or o	contact lenses in lieu of glasses)		Х	
Diagnostic and Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Sealants Per Tooth Topical Fluoride Application Space Maintainers - Fixed Services Amalgam Fill - 1 Surface O% X Child Dental Basic Root Canal- Molar Services Root Canal- Molar X Child Dental Gingivectomy per Quad X Major Extraction- Single Tooth Exposed Root or Erupted O% X Extraction- Single Tooth Exposed Root or Erupted O% X Porcelain with Metal Crown X Child Medically necessary orthodrotics O% X						
and Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Amalgam Fill - 1 Surface 0% X Services Root Canal- Molar X Child Dental Gingivectomy per Quad X Major Extraction- Single Tooth Exposed Root or Erupted 0% X Services Extraction- Complete Bony X Porcelain with Metal Crown X Child Medically necessary orthodontics 0% X						
Child Dental Basic Amalgam Fill - 1 Surface 0% X Services Services X Child Dental Major Extraction- Single Tooth Exposed Root or Erupted X X Services Extraction- Complete Bony X X Porcelain with Metal Crown X X Child Medically necessary orthodostics 0% X	and	Sealants per Tooth Topical Fluoride Application		No charge		
Root Canal- Molar	Basic			0%	х	
Major Extraction- Single Tooth Exposed Root or Erupted 0% X Services Extraction- Complete Bony X Porcelain with Metal Crown X Child Merlically necessary orthodontics 0% X						
Services Extraction- Complete Bony X Porcelain with Metal Crown X Child Merlically necessary orthodontics 0% X			sed Root or Frunted	0%		
		Extraction- Complete Bony			Х	
		Medically necessary orthodor	itics	0%	Х	



	lember Cost Share amounts describe the Enrollee's out of pocket costs.		Platinu Coinsurance 88.59	e Plan	Platinum Copay Plan 89.91%	
	e - AV Calculator			7o	No	0
Integrated	Individual deductible		No \$0		\$0	
	Family deductible	Medical / Pharmacy / Dental	\$0 \$0 / \$0 /	' \$ 0	\$0 \$0 / \$0 /	\$0
Family ded	luctible, NOT integrated: Me		\$0 / \$0 /	\$0	\$0 / \$0 /	\$0
	of-pocket maximum pocket maximum		\$4,00 \$8,00		\$4,000 \$8,000	
HSA plan: Self	-only coverage deductible		N/A	U	N/A	,
HSA family pla	n: Individual deductible		N/A		N/A	
Common					Maria bar Oasa	
Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductibl Applies
	Primary care visit to treat an	injury, illness, or condition	\$20		\$20	
Health care provider's	Other practitioner office visit		\$20		\$20	
office or	·					
clinic visit						
	Specialist visit		\$40		\$40	
	Preventive care/ screening/ ir	nmunization	No shores		No shores	
	Laboratory Tests	imunization	No charge \$20		No charge \$20	
Tests	X-rays and Diagnostic Imaging (CT/PET scans, MR	ng	\$40		\$40	
	Generic drugs	(8)	10% \$5		\$150 \$5	
Druge to troot	Preferred brand drugs		\$15		\$15	
Drugs to treat illness or	-					
condition	Non-preferred brand drugs		\$25		\$25	
	Specialty drugs		10%		10%	
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees		10% 10%		\$250 \$40	
services	Outpatient visit		10%		10%	
	Emergency room facility fee	(waived if admitted)	\$150		\$150	
	Emergency room physician f		10%			
Need	Emergency medical transpor		\$150		No charge \$150	
immediate attention	Emergency medicar transpor	lation	\$150		φ130	
	Urgent care		\$40		\$40	
Hospital stay	Facility fee (e.g. hospital room	n)	10%		\$250 per day up to 5 days	
	Physician/surgeon fee		10%		\$40	
	Mental/Behavioral health outpatient office visits		\$20		\$20	
	Mental/Behavioral health other outpatient items and services		\$20		\$20	
	Mantal (Dahar dasal bashbilan	ation for the factor of a bounded area.	4004		\$250 per day up	
Mental health,		atient facility fee (e.g.hospital room)	10%		to 5 days	
behavioral	Mental/Behavioral health inpa	atient physician/surgeon fee	10%		\$40	
health, or substance abuse needs	Substance Use disorder outpatient office visits		\$20		\$20	
	Substance Use disorder other outpatient items and services		\$20		\$20	
	Substance Use inpatient facil	ity fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Substance use disorder inpat	ient physician/surgeon fee	10%		\$40	
	Prenatal care and preconcep	tion visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	10%		\$250 per day up to 5 days	
	services	Professional	10%		up to 5 days	
	Home health care	da	10%		\$20	
Help	Outpatient Rehabilitation service Outpatient Habilitation service		\$20 \$20		\$20 \$20	
recovering or other special	Skilled nursing care		10%		\$150 per day up	
health needs	Durable medical equipment		10%		to 5 days 10%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam 1 pair of glasses per year (or	contact lenses in lieu of plasses)	No charge No charge		No charge No charge	
	Oral Exam	or remote at ilou or glasses)	i vo ciialye		i vo uiai ge	
Child Dental	Preventive - Cleaning					
Diagnostic and	Preventive - X-ray Sealants per Tooth		Not Covered		Not Covered	
Preventive	Topical Fluoride Application					
Child Dental	Space Maintainers - Fixed					
Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Child Dental	Root Canal- Molar Gingivectomy per Quad				Not Covered Not Covered	
Major	Extraction- Single Tooth Exp	osed Root or Erupted	Not Covered		Not Covered	
Services	Extraction- Complete Bony Porcelain with Metal Crown				Not Covered Not Covered	
Child						
Orthodontics	Medically necessary orthodor	nucs	Not Covered		Not Covered	

Summary of	f Benefits and Coverage					
Member Cost S	Share amounts describe the Er	rollee's out of pocket costs.	Gold Coinsurance Plan		Gold Copay P	lan
Actuarial Valu	e - AV Calculator		80.34		81.059	
Plan design in	cludes a deductible?		No		No	
	Individual deductible Family deductible		\$0 \$0		\$0 \$0	
Individual	deductible, NOT integrated:		\$0 / \$0 /		\$0 / \$0 /	
	luctible, NOT integrated: Me -of-pocket maximum	dical / Pharmacy / Dental	\$0 / \$0 / \$6,20		\$0 / \$0 / \$6,200	
Family Out-of-	pocket maximum		\$12,40		\$12,40	
	f-only coverage deductible an: Individual deductible		N/A N/A		N/A N/A	
Common						
Medical			Member Cost	Deductible	Member Cost	Deductible
Event	Ser	vice Type	Share	Applies	Share	Applies
	Primary care visit to treat an i	injury, illness, or condition	\$35		\$35	
Health care	Other practitioner office visit		\$35		\$35	
provider's office or	Other practitioner office visit		φ33		φ33	
clinic visit						
	Specialist visit		\$55		\$55	
	Preventive care/ screening/ in	amunization	No shores		No oborgo	
	Laboratory Tests	IIIIuiizatioii	No charge \$35		No charge \$35	
Tests	X-rays and Diagnostic Imagin		\$50		\$50 \$250	
	Imaging (CT/PET scans, MRI Generic drugs	-,	20% \$15		\$250 \$15	
Drugs to treat	Preferred brand drugs		\$50		\$50	
illness or	Non-preferred brand drugs		\$70		\$70	
condition						
	Specialty drugs		20%		20%	
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	·)	20%		\$600 \$55	
services	Outpatient visit		20%		20%	
	Emergency room facility fee (waived if admitted)	\$250		\$250	
	Emergency room physician fe	ee (waived if admitted)	20%		No charge	
Need immediate	Emergency medical transport	ation	\$250		\$250	
attention						
	Urgent care		\$60		\$60	
Hospital stay	Facility fee (e.g. hospital roon	n)	20%		\$600 per day up to 5 days	
	Physician/surgeon fee		20%		\$55	
	Mental/Behavioral health outp	nation office visits	\$35		\$35	
	ivienta/ benavioral neattriout	atient office visits	\$35		\$35	
	Mental/Behavioral health other	er outpatient items and services	\$35		\$35	
					\$600 per day up	
Mental	Mental/Behavioral health inpa	itient facility fee (e.g.hospital room)	20%		to 5 days	
health, behavioral	Mental/Behavioral health inpa	itient physician/surgeon fee	20%		\$55	
health, or						
substance abuse needs	Substance Use disorder outpa	atient office visits	\$35		\$35	
	Substance Use disorder other	outpatient items and services	\$35		\$35	

	Substance Use inpatient facili	ity fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Substance use disorder inpat	ient physician/surgeon fee	20%		\$55	
	Prenatal care and preconcept		No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%		\$600 per day up to 5 days	
	services	Professional	20%		\$55	
	Home health care Outpatient Rehabilitation serv	rices	20% \$35		\$30 \$35	
Help recovering or	Outpatient Habilitation service		\$35		\$35	
other special	Skilled nursing care		20%		\$300 per day up to 5 days	
health needs	Durable medical equipment		20%		20%	
Child eye	Hospice service Eye exam		No charge No charge		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 Diagnostic	Preventive - Cleaning Preventive - X-ray		Not Covered		Not Covered	
and	Sealants per Tooth		Not Covered		Not Covered	
Preventive	Topical Fluoride Application Space Maintainers - Fixed					
Child Dental						
Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
	Root Canal- Molar				Not Covered	
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Expo	osed Root or Erupted	Not Covered		Not Covered Not Covered	
Services	Extraction- Complete Bony	.,			Not Covered	
Child	Porcelain with Metal Crown				Not Covered	
Child Orthodontics	Medically necessary orthodor	itics	Not Covered		Not Covered	

Member Cost S	f Benefits and Coverage Share amounts describe the Er		Silver	Plan
Actuarial Valu	ie - AV Calculator		70.53	3%
Plan design ir	ncludes a deductible?		Yes, Medical/	Pharmacy
	Individual deductible		N/A	١.
	Family deductible deductible, NOT integrated:	Medical / Pharmacy / Dental	N/A \$2,250 / \$2	
	ductible, NOT integrated: Me	dical / Pharmacy / Dental	\$4,500 / \$5	
	t-of-pocket maximum -pocket maximum		\$6,25 \$12,5	
HSA plan: Sel	f-only coverage deductible		N/A N/A	١
	an: Individual deductible		IN/P	,
Common Medical			Member Cost	Deductible
Event		vice Type	Share	Applies
	Primary care visit to treat an	injury, illness, or condition	\$45	
Health care provider's office or clinic visit	Other practitioner office visit		\$45	
	Specialist visit		\$70	
	Preventive care/ screening/ in	nmunization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagir	ng	\$35 \$65	
	Imaging (CT/PET scans, MRI		\$250	
	Generic drugs		\$15	Pharmac
Drugs to treat	Preferred brand drugs		\$50	deductibl
illness or condition	Non-preferred brand drugs		\$70	Pharmac deductibl
	Specialty drugs		20%	Pharmac
	Surgery facility fee (e.g., ASC	S)	20%	deductibl
Outpatient services	Physician/surgeon fees		20%	
SCI VICES	Outpatient visit		20%	
	Emergency room facility fee ((waived if admitted)	\$250	Х
	Emergency room physician fe	ee (waived if admitted)	20%	х
Need immediate	Emergency medical transport	tation	\$250	Х
attention	Urgent care		\$90	
Hospital stay	Facility fee (e.g. hospital room	n)	20%	Х
	Physician/surgeon fee Mental/Behavioral health outp	20% \$45	X	
	Mental/Behavioral health other	er outpatient items and services	\$45	
Mental	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	20%	х
health,	Mental/Behavioral health inpa	atient physician/surgeon fee	20%	х
behavioral health, or substance abuse needs	Substance Use disorder outp	atient office visits	\$45	
	Substance Use disorder other	r outpatient items and services	\$45	
	Substance Use inpatient facil	ity fee (e.g. hospital room)	20%	х
	Substance use disorder inpat		20%	Х
December	Prenatal care and preconcept		No charge	
Pregnancy	Delivery and all inpatient services	Hospital	20%	X
	Home health care	Professional	20% \$45	X
Help	Outpatient Rehabilitation services		\$45	
recovering or	Outpatient Habilitation service	5	\$45	.,
other special health needs	Skilled nursing care		20%	Х
	Durable medical equipment Hospice service		20% No charge	
Child eye	Eye exam		No charge	
care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge	
Child Dental	Oral Exam Preventive - Cleaning			
Diagnostic	Preventive - X-ray		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application		5576160	
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered	
	Root Canal- Molar			
Child Dental	Gingivectomy per Quad Extraction- Single Tooth Expo	Not Covered		
Major Services	Extraction- Complete Bony Porcelain with Metal Crown			

-	Benefits and Coverage share amounts describe the Enrollee's out of pocket costs.	Sil	IOP ver ance Plan	SHO Silve Copay	er
	e - AV Calculator	71.	77%	71.45	%
	cludes a deductible? Individual deductible		al/Pharmacy /A	Yes, Medical/ N/A	
Integrated	Family deductible	N	/A	N/A	
	deductible, NOT integrated: Medical / Pharmacy / Dental		\$500 / \$0	\$1,500 / \$5	
	luctible, NOT integrated: Medical / Pharmacy / Dental -of-pocket maximum		51,000 / \$0 500	\$3,000 / \$1, \$6,50	
Family Out-of-	pocket maximum		,000	\$13,0	
HSA plan: Self HSA family pla	-only coverage deductible In: Individual deductible		/A /A	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	\$45		\$45	
Health care provider's office or clinic visit	Other practitioner office visit	\$45		\$45	
	Specialist visit	\$70		\$70	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$35 \$65		\$35 \$65	
	Imaging (CT/PET scans, MRIs)	20%	X	\$250	
	Generic drugs	\$15		\$15	Dhorre
Drugs to treat	Preferred brand drugs	\$55	Pharmacy deductible	\$55	Pharmacy deductible
liness or	Non-preferred brand drugs	\$75	Pharmacy	\$75	Pharmacy
condition			deductible Pharmacy		deductible Pharmacy
	Specialty drugs	20%	deductible	20%	deductible
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees	20%		20%	
services	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$250	х	\$250	Х
Need	Emergency room physician fee (waived if admitted)	20%	X	20%	X
mmediate attention	Emergency medical transportation Urgent care	\$250 \$90	X	\$250 \$90	X
Hospital stay	Facility fee (e.g. hospital room)	20%	Х	20%	Х
	Physician/surgeon fee	20%	X	20%	Х
	Mental/Behavioral health outpatient office visits	\$45		\$45	
	Mental/Behavioral health other outpatient items and services	\$45		\$45	
Mental	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	Х	20%	Х
nealth,	Mental/Behavioral health inpatient physician/surgeon fee	20%	х	20%	Х
behavioral health, or substance abuse needs	Substance Use disorder outpatient office visits	\$45		\$45	
	Substance Use disorder other outpatient items and services	\$45		\$45	
	Substance Use inpatient facility fee (e.g. hospital room)	20%	х	20%	Х
	Substance use disorder inpatient physician/surgeon fee	20%	Х	20%	Х
	Prenatal care and preconception visits	No charge		No charge	
Pregnancy	Delivery and all inpatient services Hospital	20%	Х	20%	Х
	Professional Home health care	20%	X	20% \$45	X
deln	Outpatient Rehabilitation services	\$45		\$45	
Help recovering or	Outpatient Habilitation services	\$45		\$45	
other special	Skilled nursing care	20%	Х	20%	Х
health needs	Durable medical equipment	20%		20%	
26.11.4	Hospice service Eye exam	No charge No charge		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	margo		snargo	
Child Dental	Preventive - Cleaning				
Diagnostic and	Preventive - X-ray Sealants per Tooth	Not Covered		Not Covered	
Preventive	Topical Fluoride Application				
Child Dental	Space Maintainers - Fixed Amalgam Fill - 1 Surface	Not Covered		Not Covered	
Services	Root Canal- Molar			Not Covered	
Child Dental	Gingivectomy per Quad			Not Covered	
Major Services	Extraction- Single Tooth Exposed Root or Erupted	Not Covered		Not Covered	
J. 11063	Extraction- Complete Bony Porcelain with Metal Crown			Not Covered Not Covered	
Child					

Actuarial Value		rollee's out of pocket costs.	Silver HSA Pla	
riotaariar varao	- AV Calculator		70.50%	
	cludes a deductible?		Yes, integr	rated
	ndividual deductible Family deductible		\$2,000 inte	
Individual d	leductible, NOT integrated:	Medical / Pharmacy / Dental	N/A	grated
	uctible, NOT integrated: Me -of-pocket maximum	dical / Pharmacy / Dental	N/A \$6,250)
Family Out-of-p	oocket maximum		\$12,50	
	only coverage deductible n: Individual deductible		\$2,000 See endr	
	ii. iiidividdai deddciibie		See enui	iote
Common Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an	injury, illness, or condition	20%	х
Health care provider's office or clinic visit	Other practitioner office visit		20%	х
	Specialist visit		20%	Х
	Preventive care/ screening/ in	nmunization	No charge	
	Laboratory Tests X-rays and Diagnostic Imagir	g	20% 20%	X
	Imaging (CT/PET scans, MRI		20%	X
	Generic drugs		20%	X
Drugs to treat	Preferred brand drugs		20%	Х
illness or condition	Non-preferred brand drugs		20%	Х
l i	Specialty drugs		20%	Х
	Surgery facility fee (e.g., ASC	3	20%	X
Outpatient	Physician/surgeon fees	,	20%	×
services	Outpatient visit		20%	X
	Emergency room facility fee (waived if admitted)	20%	х
	Emergency room physician fe	ee (waived if admitted)	20%	х
Need immediate	Emergency medical transport	ation	20%	Х
attention	Urgent care		20%	х
Hospital Stay	Facility fee (e.g. hospital roor	n)	20% 20%	X X
	Mental/Behavioral health outpatient office visits		20%	×
	Mental/Behavioral health other outpatient items and services Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	х
			20%	х
Mental			20%	X
behavioral health, or	Mental/Behavioral health inpatient physician/surgeon fee Substance Use disorder outpatient office visits		20%	x
	Substance Use disorder other outpatient items and services		20%	х
	Substance Use inpatient facility fee (e.g. hospital room)		20%	X
	Substance use disorder inpat	ient physician/surgeon fee	20%	х
	Prenatal care and preconcept	ion visits	No charge	
	Delivery and all inpatient	Hospital	20%	Х
	services	Professional	20%	Х
l i	Home health care Outpatient Rehabilitation serv	ices	20% 20%	X
	Outpatient Renabilitation service		20%	X
other special	Skilled nursing care		20%	Х
	Durable medical equipment		20%	X
	Hospice service		0%	X
Crina eye	Eye exam 1 pair of glasses per year (or	contact lenses in lieu of plasses)	No charge No charge	
	Oral Exam			
Child Dental	Preventive - Cleaning			
	Preventive - X-ray Sealants per Tooth		Not Covered	
Preventive	Topical Fluoride Application			
Child Dental Basic	Space Maintainers - Fixed Amalgam Fill - 1 Surface		Not Covered	
Services	Root Canal- Molar			
Child Dental	Gingivectomy per Quad		2	
	Extraction- Single Tooth Expo Extraction- Complete Bony Porcelain with Metal Crown	sed Root or Erupted	Not Covered	
	Occidin with Netal Crown			

Summary of	f Benefits and Coverage					
	Share amounts describe the En	rollee's out of pocket costs.	Silver Plan 100%-150% FPL		Silver P 150%-2009	% FPL
	e - AV Calculator		93.93		86.89°	
	Individual deductible?		Yes, Medical/ N/A	Pharmacy	Yes, Medical/F N/A	Pharmacy
	Family deductible deductible, NOT integrated:	Medical / Pharmacy / Dental	N/A \$75 / \$0		N/A \$550 / \$50	0 / \$0
Family dec	ductible, NOT integrated: Me		\$150 / \$0) / \$0	\$1,100 / \$1	00 / \$0
Family Out-of-	-of-pocket maximum -pocket maximum		\$2,25 \$4,50		\$2,25 \$4,50	
	f-only coverage deductible an: Individual deductible		N/A N/A		N/A N/A	
Common						
Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an i	njury, illness, or condition	\$5		\$15	
Health care provider's office or clinic visit	Other practitioner office visit		\$5		\$15	
	Specialist visit		\$8		\$25	
	Preventive care/ screening/ in	nmunization	No charge \$8		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagin		\$8		\$15 \$25	
	Imaging (CT/PET scans, MRI Generic drugs	s)	\$50 \$3		\$100 \$5	
Drugs to treat	Preferred brand drugs		\$10		\$20	Pharmacy deductible
illness or	Non-preferred brand drugs		\$15		\$35	Pharmacy
condition	Specialty drugs					deductible Pharmacy
	Surgery facility fee (e.g., ASC	:)	10%		15% 15%	deductible
Outpatient services	Physician/surgeon fees	,	10%		15%	
3CI VICC3	Outpatient visit		10%		15%	
	Emergency room facility fee (waived if admitted)	\$30	Х	\$75	Х
Need	Emergency room physician fe		10%	Х	15%	Х
immediate attention	Emergency medical transport	ation	\$30	Х	\$75	X
attention	Urgent care		\$6		\$30	
Hospital stay	Facility fee (e.g. hospital room	n)	10%	Х	15%	Х
nospital stay	Physician/surgeon fee		10%	X	15%	X
	Mental/Behavioral health outp	patient office visits	\$5		\$15	
	Mental/Behavioral health other	er outpatient items and services	\$5		\$15	
Mental	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	10%	х	15%	х
health,	Mental/Behavioral health inpa	itient physician/surgeon fee	10%	х	15%	Х
behavioral health, or substance abuse needs	Substance Use disorder outpa	atient office visits	\$5		\$15	
	Substance Use disorder other	outpatient items and services	\$5		\$15	
	Substance Use inpatient facili	ity fee (e.g. hospital room)	10%	х	15%	х
	Substance use disorder inpati	ent physician/surgeon fee	10%	х	15%	х
	Prenatal care and preconcept		No charge		No charge	
Pregnancy	Delivery and all inpatient services	Hospital	10%	Х	15%	Х
	Home health care	Professional	10% \$3	X	15% \$15	X
Help	Outpatient Rehabilitation service Outpatient Habilitation service		\$5 \$5		\$15 \$15	
recovering or other special	Skilled nursing care	-	10%	х	15%	х
health needs	Durable medical equipment		10%		15%	
Obilid area	Hospice service Eye exam		No charge No charge		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					
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray		Not Covered		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application		Not Covered		Not Covered	
Child Dental Basic	Space Maintainers - Fixed Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Services Child Dental Major	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Expo	sed Root or Erupted	Not Covered		Not Covered	
Services	Extraction- Complete Bony Porcelain with Metal Crown					
Child Orthodontics	Medically necessary orthodor	atics	Not Covered		Not Covered	

Summary	of	Benefits	and	Coverage	

	share amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL		
Actuarial Value	e - AV Calculator	72.91%		
	cludes a deductible?	Yes, Medical/I	Pharmacy	
Integrated	Individual deductible Family deductible	N/A		
	deductible, NOT integrated: Medical / Pharmacy / Dental luctible, NOT integrated: Medical / Pharmacy / Dental	\$1,900 / \$2 \$3,800 / \$5	50 / \$0	
Individual Out	of-pocket maximum pocket maximum	\$5,45 \$10,90	0	
HSA plan: Self	-only coverage deductible	N/A	50	
	an: Individual deductible	N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
	Primary care visit to treat an injury, illness, or condition	\$40		
Health care provider's office or clinic visit	Other practitioner office visit	\$40		
	Specialist visit	\$55		
	Preventive care/ screening/ immunization	No charge		
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$35 \$50		
	Imaging (CT/PET scans, MRIs) Generic drugs	\$250 \$15		
D	Preferred brand drugs	\$45	Pharmacy	
Drugs to treat illness or condition	Non-preferred brand drugs	\$70	Pharmacy deductible	
	Specialty drugs	20%	Pharmacy deductible	
Outpatient	Surgery facility fee (e.g., ASC)	20%	GOGGOLDIO	
services	Physician/surgeon fees Outpatient visit	20%		
	Emergency room facility fee (waived if admitted)	\$250	Х	
	Emergency room physician fee (waived if admitted)	20%	Х	
Need immediate	Emergency medical transportation	\$250	X	
attention	Urgent care	\$80		
Hospital stay	Facility fee (e.g. hospital room)	20%	Х	
	Physician/surgeon fee	20%	X	
	Mental/Behavioral health outpatient office visits	\$40		
	Mental/Behavioral health other outpatient items and services	\$40		
Mental	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	Х	
health,	Mental/Behavioral health inpatient physician/surgeon fee	20%	Х	
behavioral health, or substance abuse needs	Substance Use disorder outpatient office visits	\$40		
	Substance Use disorder other outpatient items and services	\$40		
	Substance Use inpatient facility fee (e.g. hospital room)	20%	х	
	Substance use disorder inpatient physician/surgeon fee	20%	х	
	Prenatal care and preconception visits	No charge		
Pregnancy	Delivery and all inpatient Hospital	20%	х	
	services Professional	20%	X	
Holp	Home health care Outpatient Rehabilitation services	\$40 \$40		
Help recovering or	Outpatient Habilitation services	\$40		
other special health needs	Skilled nursing care	20%	Х	
	Durable medical equipment Hospice service	20% No charge		
Child eye	Eye exam	No charge		
care	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	No charge		
Child Dental	Preventive - Cleaning			
Diagnostic and				
Preventive	Topical Fluoride Application Space Maintainers - Fixed			
Child Dental Basic	Amalgam Fill - 1 Surface	Not Covered		
Services	Root Canal- Molar			
Child Dental Major Services	Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony Porcelain with Metal Crown	Not Covered		
Child Orthodontics	Medically necessary orthodontics	Not Covered		

		escribe the Enrollee's out of pocket costs. Bronze Plan		Bron HSA P	lan	
	e - AV Calculator		61.1		61.06	%
	cludes a deductible?		Yes, inte		Yes, inte	
	Individual deductible Family deductible		\$6,500 in \$13,000 ir		\$4,500 into \$9,000 into	
Individual o	deductible, NOT integrated:	Medical / Pharmacy / Dental	N/a	A	N/A	
	luctible, NOT integrated: Me -of-pocket maximum	dical / Pharmacy / Dental	N// \$6,5		N/A \$6,50	
Family Out-of-	pocket maximum		\$13,0	000	\$13,0	00
HSA plan: Self	i-only coverage deductible in: Individual deductible		N/A		\$4,50 \$4,50	
	in. marviduai deductible		19//	`	φ4,υ	10
Common Medical Event	Sei	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an	injury, illness, or condition	\$70	After 1st three non- preventive visits	40%	×
Health care provider's office or clinic visit	Other practitioner office visit		\$70	After 1st three non- preventive visits	40%	х
	Specialist visit		\$90	After 1st three non- preventive visits	40%	х
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge \$40		No charge 40%	X
	X-rays and Diagnostic Imagir		0%	Х	40%	Х
	Imaging (CT/PET scans, MR	s)	0%	X	40%	X
	Generic drugs		0%	X	40%	X
Drugs to treat	Preferred brand drugs		0%	Х	40%	Х
illness or condition	Non-preferred brand drugs		0%	Х	40%	х
	Specialty drugs		0%	Х	40%	х
	Surgery facility fee (e.g., ASC	:)	0%	X	40%	X
Outpatient	Physician/surgeon fees		0%	Х	40%	Х
	Outpatient visit		0%	X	40%	X
	Emergency room facility fee (waived if admitted)	0%	Х	40%	Х
	Emergency room physician fe	ee (waived if admitted)	0%	Х	40%	х
Need immediate	Emergency medical transport	ation	0%	Х	40%	Х
attention	Urgent care		\$120	After 1st three non- preventive visits	40%	х
Hospital stay	Facility fee (e.g. hospital roor Physician/surgeon fee	n)	0%	х	40%	х
	Mental/Behavioral health outpatient office visits		\$70	After 1st three non- preventive visits	40%	X
	Mental/Behavioral health other outpatient items and services		\$70	After 1st three non- preventive visits	40%	х
Mental	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	0%	Х	40%	Х
health,	Mental/Behavioral health inpa	atient physician/surgeon fee	0%	Х	40%	Х
behavioral health, or substance abuse needs	Substance Use disorder outpatient office visits		\$70	After 1st three non- preventive visits	40%	х
	Substance Use disorder other outpatient items and services		\$70	After 1st three non- preventive visits	40%	х
	Substance Use inpatient facil	ity fee (e.g. hospital room)	0%	х	40%	Х
	Substance use disorder inpat		0%	Х	40%	Х
	Prenatal care and preconcept	ion visits	No charge		No charge	
Pregnancy	Delivery and all inpatient services	Hospital	0%	Х	40%	Х
	Home health care	Professional	0%	X	40% 40%	X
Holp	Outpatient Rehabilitation serv		\$70	^	40%	X
Help recovering or	Outpatient Habilitation service		\$70		40%	Х
other special	Skilled nursing care		0%	Х	40%	х
health needs	Durable medical equipment		0%	X	40%	X
	Hospice service Eye exam		No charge No charge		No charge	X
Child eye care	1 pair of glasses per year (or Oral Exam	contact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Preventive - Cleaning					
Diagnostic and	Preventive - X-ray		Not Covered		Not Covered	
Preventive	Sealants per Tooth Topical Fluoride Application					
Child Dental	Space Maintainers - Fixed					
Basic Services	Amalgam Fill - 1 Surface Root Canal- Molar		Not Covered		Not Covered	
	Gingivectomy per Quad	need Root or Frunted	Not Covered		Not Covered	
Major Services	Extraction- Single Tooth Expo Extraction- Complete Bony Porcelain with Metal Crown	Noted Root of Erupted	INUL Covered		NUL Covered	
Child	Medically necessary orthodor		Not Covered		Not Covered	

Member Cost S	hare amounts describe the En	Catastrophic Plan				
Actuarial Value - AV Calculator						
	cludes a deductible?		Yes, inte			
	Individual deductible Family deductible		\$6,850 int \$13,700 in			
Individual	deductible, NOT integrated:		N/A N/A	١		
Individual Out	luctible, NOT integrated: Med -of-pocket maximum	dicai / Pharmacy / Dentai	\$6,8	50		
	pocket maximum -only coverage deductible		\$13,7 N/A			
	n: Individual deductible		N/A			
Common Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies		
	Primary care visit to treat an i		0%	After 1st three non- preventive		
Health care provider's office or clinic visit	Other practitioner office visit		0%	visits After 1st three non- preventive visits		
	Specialist visit		0%	х		
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge 0%	X		
Tests	X-rays and Diagnostic Imagin	g	0%	Х		
	Imaging (CT/PET scans, MRI Generic drugs	s)	0%	X		
	Preferred brand drugs		0%	X		
Drugs to treat illness or condition	Non-preferred brand drugs		0%	х		
	Specialty drugs		0%	х		
Outpatient	Surgery facility fee (e.g., ASC)	0%	X		
services	Physician/surgeon fees Outpatient visit		0% 0%	X		
	Emergency room facility fee (waived if admitted)	0%	X		
Need	Emergency room physician fe Emergency medical transport		0%	X		
immediate attention	Emergency medical transport	078	After 1st			
	Urgent care	0%	three non- preventive visits			
Hospital stay	Facility fee (e.g. hospital room	1)	0%	Х		
riospitai stay	Physician/surgeon fee		0%	Х		
	Mental/Behavioral health outp	0%	After 1st three non- preventive visits			
	Mental/Behavioral health othe	0%	After 1st three non- preventive visits			
Mental	Mental/Behavioral health inpa	0%	Х			
health, behavioral	Mental/Behavioral health inpa	0%	Х			
health, or substance abuse needs	Substance Use disorder outpa	0%	After 1st three non- preventive visits			
	Substance Use disorder other	0%	After 1st three non- preventive			
	Substance Use inpatient facili	ty fee (e.g. hospital room)	0%	visits		
	Substance use disorder inpati	ent physician/surgeon fee	0%	х		
	Prenatal care and preconcept		No charge			
Pregnancy	Delivery and all inpatient	Hospital	0%	х		
	services	Professional	0%	Х		
	Home health care Outpatient Rehabilitation serv	ices	0% 0%	X		
Help recovering or	Outpatient Habilitation service		0%	X		
other special health needs	Skilled nursing care		0%	Х		
nealth needs	Durable medical equipment Hospice service		0%	X		
Child eye	Eye exam		0% No charge			
care	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	0%	Х		
Child Dental	Oral Exam Preventive - Cleaning					
Diagnostic	Preventive - X-ray	Not Covered				
and Preventive	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed					
Child Dental	Amalgam Fill - 1 Surface		Not Covered			
Basic Services	Root Canal- Molar		Not Covered			
Child Dental	Gingivectomy per Quad	and Doot or Frients 1	Net Co			
Major Services	Extraction- Single Tooth Expo Extraction- Complete Bony Porcelain with Metal Crown	эва коогої стартва	Not Covered			
Child Orthodontics	Medically necessary orthodon	tics	Not Covered			

Endnotes to 2016 Standard Benefit Plan Designs

Notes:

- 1) Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. Innetwork services include services provided by an out-of-network provider but are approved as in-network by the carrier.
- 2) For covered out of network services in a PPO plan, these Standard 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) 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 carrier pays all costs for covered services for all family members.
- 5) For HDHPs linked to HSAs, in other than self-only coverage, each individual in the family must meet a deductible of [insert IRS-determined amount for an individual in other than self-only coverage for the 2016 Plan Year] until the family as a whole meets the family deductible. For HDHPs linked to HSAs, in other than self-only coverage, each individual in the family must meet the individual out of pocket maximum amount that is the same as that for self-only coverage until the family as a whole meets the family out of pocket maximum amount.
- 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. Note that a benefit may be considered illusory if the co-payment covers most of the plan's cost of the service.
- 7) For the Bronze and Catastrophic plans, the deductible is waived for the first three non-preventive visits, which may include urgent care visits or outpatient Mental Health/Substance Use Disorder visits.
- 8) Member cost-share for oral anti-cancer drugs shall not exceed \$200 per month per state law.
- 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 coinsurance applies to the prescription supply. For example, if the prescription is for a month's supply, one co-pay or co-insurance amount can be collected. If the prescription is written for a 90 day supply, a single cost-share amount applies. Nothing in this note precludes a carrier from offering mail order prescriptions at a reduced cost.

- 11) As applicable, for the child dental portion of the benefit design, a carrier may choose the copay or coinsurance child dental Standard Benefit Plan Design, regardless of whether the carrier selects the copay or the coinsurance design for the non-child dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.
- 12) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Standard Benefit Plan Designs.
- 13) Mental Health/Substance Use Disorder Outpatient Items and Services include post-discharge ancillary care services, such as counseling and other outpatient support services, which may be provided as part of the offsite recovery component of a residential treatment plan.
- 14) 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.
- 15) Specialists include 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 (28 CCR § 1300.51(I)(1)).
- 16) The Other Practitioner category includes Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors and other practitioners included in 28 CCR § 1300.67(a)(1).
- 17) 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.
- 18) Cost-sharing for services subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) may be less than those listed in these standard benefit plan designs if necessary for compliance with MHPAEA.



2016 Dental Standard Benefit Plan Designs

Date: January 15, 2015 Summary of Benefits and Coverage Standalone Dental Plan Standalone Dental Plan **Pediatric Dental EHB Pediatric Dental EHB** Member Cost Share amounts describe the Enrollee's out of pocket Copay Plan **Coinsurance Plan** costs. Up to Age 19 Up to Age 19 **Actuarial Value** 83.0% 86.8% **Individual Deductible** \$65 In Network/ \$0 \$65 Out of Network (waived for Diagnostic & Preventive) Family Deductible (Two or more children) \$130 In Network/ \$0 (waived for Diagnostic & Preventive) \$130 Out of Network **Individual Out of Pocket Maximum** \$350 \$350 \$700 Family Out of Pocket Maximum (Two or More Children) \$700 \$0 \$0 Office Copay **Waiting Period** None Waivered Condition provision, as defined in Health & Safety Code None 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d) **Annual Benefit Limit** None None the maximum amount the dental plan will pay in the benefit year) Member Cost **Member Cost Deductible Deductible Service Type Procedure Category Share Share Applies** Oral Exam \$0 0% Preventive - Cleaning \$0 0% Preventive - X-ray \$0 0% **Diagnostic & Preventive** Sealants per Tooth \$0 0% Topical Fluoride Application \$0 0% Space Maintainers - Fixed \$0 0% **Basic Services** Amalgam Fill - One Surface \$25 20% х Root Canal - Molar \$300 **Major Services - Crowns** Gingivectomy per Quad \$150 and Casts, Endodontics, Extraction- Single Tooth Exposed Root \$65 50% Periodontics. Х or Erupted Prosthodontics, Oral Extraction - Complete Bony \$160 Surgery Crown - Porcelain with Metal \$300

\$350

50%

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Standalone Dental Plan or Family Dental Plan)

Medically Necessary Orthodontia

Orthodontia

- 1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.
- 2) Cost sharing payments made by each individual child for innetwork services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.

 3) In a plan with two or more children, cost sharing payments.
- 3) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family deductible, if applicable, as well as the family out-of-pocket maximum.
- 4) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.

Adult Dental Benefit Notes (only applicable to the Family Dental Plan)

- 5) Each adult is responsible for an individual deductible.
- 6) Families eligible to purchase a Family Dental Plan must include at least one adult who has purchased a Qualified Health Plan through the Exchange.
- 7) If a child is enrolled in the Family Dental Plan, all children in the family under age 19 years must be enrolled in the same Family Dental Plan.
- 8) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.



2016 Dental Standard Benefit Plan Designs

Date: January 15, 2015

Summary of Benefits	and Coverage	Family Dental Plan				
Member Cost Share amounts describe the Enrollee's out of pocket costs.		Pediatric Dental EHB Copay Plan		Adult Dental Copay Plan		
	Up to	Age 19	Age 19 and Older			
Actuarial Value		83.	0%	Not Calcu	ılated	
Individual Deductible (waived for Diagnostic &	Preventive)	\$	0	\$0		
Family Deductible (Two of waived for Diagnostic &	Preventive)	\$		\$0		
Individual Out of Pocket Family Out of Pocket Max	Maximum ximum (Two or More Children)		50 00	Not Appli Not Appli		
Office Copay		\$	0	\$0		
	Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d)		None		None	
Annual Benefit Limit (the maximum amount the dental	plan will pay in the benefit year)	None		None		
Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
	Oral Exam	\$0		\$0		
	Preventive - Cleaning	\$0		\$0		
Diagnostic & Preventive	Preventive - X-ray	\$0		\$0		
Diagnostic & Fleventive	Sealants per Tooth	\$0		Not Covered		
	Topical Fluoride Application	\$0		Not Covered		
	Space Maintainers - Fixed	\$0		Not Covered		
Basic Services	Amalgam Fill - One Surface	\$25		\$25		
	Root Canal - Molar	\$300		\$300		
Major Services - Crowns	Gingivectomy per Quad	\$150		\$150		
and Casts, Endodontics, Periodontics,	Extraction- Single Tooth Exposed Root or Erupted	\$65		\$65		
Prosthodontics, Oral	Extraction - Complete Bony	\$160		\$160		
Surgery	Crown - Porcelain with Metal	\$300		\$300		
Orthodontia	Medically Necessary Orthodontia	\$350		Not Covered		

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Standalone Dental Plan or Family Dental Plan)

- 1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.
- 2) Cost sharing payments made by each individual child for innetwork services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
- 3) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family deductible, if applicable, as well as the family out-of-pocket maximum.
- 4) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.

Adult Dental Benefit Notes (only applicable to the Family Dental Plan)

- 5) Each adult is responsible for an individual deductible.
- 6) Families eligible to purchase a Family Dental Plan must include at least one adult who has purchased a Qualified Health Plan through the Exchange.
- 7) If a child is enrolled in the Family Dental Plan, all children in the family under age 19 years must be enrolled in the same Family Dental Plan.
- 8) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.



2016 Dental Standard Benefit Plan Designs

Date: January 15, 20	15					
Summary of Benefits	and Coverage	Family Dental Plan				
Member Cost Share amounts describe the Enrollee's out of pocket costs.		Pediatric Dental EHB Coinsurance Plan		Adult Dental Coinsurance Plan		
	Up to Ag	je 19	Age 19 and	d Older		
Actuarial Value		86.8%	6	Not Calcu	ılated	
Individual Deductible (waived for Diagnostic &	Preventive)	\$65 In Net \$65 Out of N		\$50 In Ne \$50 Out of N		
Family Deductible (Two of waived for Diagnostic &	range and the second of the	\$130 In Ne \$130 Out of		Not Appli	cable	
Individual Out of Pocket		\$350		Not Appli		
	ximum (Two or More Children)	\$700)	Not Applicable		
Office Copay		\$0		\$0		
	Waiting Period Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d)			6 months for Major Services, Waived with Proof of Prior Coverage		
Annual Benefit Limit (the maximum amount the dental	plan will pay in the benefit year)	None		\$1,500		
Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
	Oral Exam	0%		0%		
	Preventive - Cleaning	0%		0%		
Diagnostic & Preventive	Preventive - X-ray	0%		0%		
Diagnostic a rieventive	Sealants per Tooth	0%		Not Covered		
	Topical Fluoride Application	0%		Not Covered		
	Space Maintainers - Fixed	0%		Not Covered		
Basic Services	Amalgam Fill - One Surface	20%	Х	20%	X	
Major Services - Crowns and Casts, Endodontics, Periodontics, Prosthodontics, Oral Surgery	Root Canal - Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction - Complete Bony Crown - Porcelain with Metal	50%	х	50%	x	

50%

Not Covered

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Standalone Dental Plan or Family Dental Plan)

Orthodontia

1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.

Medically Necessary Orthodontia

- 2) Cost sharing payments made by each individual child for innetwork services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
- 3) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family deductible, if applicable, as well as the family out-of-pocket maximum.
- 4) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.

Adult Dental Benefit Notes (only applicable to the Family Dental Plan)

- 5) Each adult is responsible for an individual deductible.
- 6) Families eligible to purchase a Family Dental Plan must include at least one adult who has purchased a Qualified Health Plan through the Exchange.
- 7) If a child is enrolled in the Family Dental Plan, all children in the family under age 19 years must be enrolled in the same Family Dental Plan.
- 8) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.