#### Title 10, California Code of Regulations

Re-adopt Section 6432:

#### 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 29, 2015 which are 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 29, 2015



Member Cost Share amounts describe the Enrollee's out of pocket costs.			Platinum Coinsurance Plan		Platinum Copay Plan	
Actuarial Valu	e - AV Calculator		88.5%		89.5%	
	cludes a deductible?		No so		No \$0	
	Individual deductible Family deductible		\$0 \$0		\$0	
Individual	deductible, NOT integrated:		\$0 / \$0 /		\$0 / \$0 / \$0 \$0 / \$0 / \$0	
Family ded	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum			\$0 / \$0 / \$0 \$4,000		
Family Out-of-	pocket maximum		\$8,00		\$4,00 \$8,00	
	f-only coverage deductible an: Individual deductible		N/A N/A		N/A N/A	
	an. marviadar deductible		1974		TUPA	
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	\$20		\$20	
Health care provider's office or clinic visit	Other practitioner office visit		\$20		\$20	
	Specialist visit		\$40		\$40	
	Preventive care/ screening/ in	nmunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagin	ıa.	\$20 \$40		\$20 \$40	
16313	Imaging (CT/PET scans, MRI		10%		\$150	
	Generic drugs Tier 1		\$5		\$5	
Drugs to treat	Preferred brand drugs Tier 2		\$15		\$15	
illness or condition	Non-preferred brand drugs Ti	er <u>3</u>	\$25		\$25	
	Specialty drugs Tier 4		10%		10%	
Outpatient	Surgery facility fee (e.g., ASC	:)	10%		\$250	
services	Physician/surgeon fees Outpatient visit		10%		\$40	
	Outpatient visit	unived if admitted)	10%		10%	
	Emergency room facility fee (	<u> </u>	\$150		\$150	
Need	Emergency room physician fe	10%		No charge		
immediate	Emergency medical transport	\$150		\$150		
attention	Urgent care		\$40		\$40	
Hospital stay	Facility fee (e.g. hospital roon	n)	10%		\$250 per day up	
Hospital stay	Physician/surgeon fee		10%		to 5 days \$40	
	Mental/Behavioral health outp	\$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	
health,	Mental/Behavioral health inpa	itient physician/surgeon fee	10%		\$40	
behavioral health, or substance abuse needs	Substance Use disorder outpa	\$20		\$20		
	Substance Use disorder other	\$20		\$20		
	Substance Use inpatient facili	ity fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Substance use disorder inpati	ient physician/surgeon fee	10%		to 5 days \$40	
	Prenatal care and preconcept		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	
Help	Outpatient Rehabilitation service Outpatient Habilitation service		\$20		\$20	
recovering or		N	\$20		\$20 \$150 per day up	
other special health 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	
care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge		No charge	
OLUMB .	Oral Exam					
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray		No. 1		No. 1	
and Preventive	Sealants per Tooth ventive Topical Fluoride Application		No charge		No charge	
Child Dental Basic Services	Space Maintainers - Fixed  Amalgam Fill - 1 Surface		20%		\$25	
	Root Canal- Molar				\$300	
Child Dental	Gingivectomy per Quad	and Post or Frunted	500/		\$150	
Major Services	Extraction- Single Tooth Expo Extraction- Complete Bony Porcelain with Metal Crown	sed Noot of Etupted	50%		\$65 \$160 \$300	
Child Orthodontics	Medically necessary orthodor	itics	50%		\$1,000	
Orthodontics						

	F Benefits and Coverage Share amounts describe the Er		Coincurant		Gold Copay P	
Actuarial Valu	e - AV Calculator		Coinsurance Plan 80.2%		81.0%	
Plan design in	cludes a deductible?		No		No	
Integrated	Individual deductible		\$0		\$0	
	Family deductible deductible, NOT integrated:	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		\$6,20 \$12,40		\$6,20 \$12,40	
HSA plan: Self	f-only coverage deductible		N/A		N/A	
	an: Individual deductible		N/A		N/A	
Common Medical Event	Sei	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an	injury, illness, or condition	\$35		\$35	
Health care provider's office or clinic visit	Other practitioner office visit		\$35		\$35	
	Specialist visit		\$55		\$55	
	Preventive care/ screening/ in	mmunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagir	na	\$35 \$50		\$35 \$50	
	Imaging (CT/PET scans, MR		20%		\$250	
	Generic drugs Tier 1		\$15		\$15	
Drugs to treat	Preferred brand drugs Tier 2		\$50		\$50	
illness or condition	Non-preferred brand drugs Ti	er 3	\$70		\$70	
	Specialty drugs Tier 4		20%		20%	
	Surgery facility fee (e.g., ASC	<u>'</u>	20%		\$600	
Outpatient	Physician/surgeon fees	·1	20%		\$55	
services	Outpatient visit		20%		20%	
	Emergency room facility fee	(waived if admitted)	\$250		\$250	
	Emergency room physician fe	20%		No charge		
Need immediate	Emergency medical transpor	\$250		\$250		
attention	Urgent care		\$60		\$60	
Hospital stay	Facility fee (e.g. hospital roor Physician/surgeon fee	n)	20%		\$600 per day up to 5 days \$55	
	Mental/Behavioral health out	\$35		\$35		
	Mental/Behavioral health other	\$35		\$35		
Mental	Mental/Behavioral health inpa	20%		\$600 per day up to 5 days		
health, behavioral	Mental/Behavioral health inpa	20%		\$55		
health, or substance abuse needs	Substance Use disorder outp	\$35		\$35		
	Substance Use disorder othe	\$35		\$35		
	Substance Use inpatient facil	20%		\$600 per day up to 5 days		
	Substance use disorder inpat		20%		\$55	L
	Prenatal care and preconcep		No charge		No charge	
Pregnancy	Delivery and all inpatient services	Hospital	20%		\$600 per day up to 5 days	
		Professional	20%		\$55	
Hala	Home health care Outpatient Rehabilitation sen	vices	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	prostic Preventive - X-ray Sealants per Tooth					
and Preventive			No charge		No charge	
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%		\$25	
Child Dental	Root Canal- Molar Gingivectomy per Quad				\$300 \$150	
Major	Extraction- Single Tooth Expo	osed Root or Erupted	50%		\$65	
Services	Extraction- Complete Bony Porcelain with Metal Crown				\$160 \$300	
Child	Medically necessary orthodor	ntics	50%		\$1,000	
Orthodontics	,		55/0		ψ.,σσσ	

Summary o	f Benefits and Coverage	,	Individ	lual		
Member Cost S	Share amounts describe the Er	nrollee's out of pocket costs.	Silver I	Plan		
Actuarial Valu	e - AV Calculator		70.49	%		
	icludes a deductible?		Yes, Medical/ N/A			
Integrated	Individual deductible Family deductible		N/A			
	deductible, NOT integrated: ductible, NOT integrated: Me	Medical / Pharmacy / Dental	\$2,250 / \$2 \$4,500 / \$5			
Individual Out	t-of-pocket maximum	dicar / Harmacy / Dentar	\$6,25	50		
	-pocket maximum f-only coverage deductible		\$12,5 N/A			
	an: Individual deductible		N/A			
Common						
Medical Event	Sei	rvice Type	Member Cost Share	Deductible Applies		
	Primary care visit to treat an	injury, illness, or condition	\$45			
Health care provider's	Other practitioner office visit		\$45			
office or						
clinic visit						
	Specialist visit		\$70			
	Preventive care/ screening/ ir	mmunization	No charge			
	Laboratory Tests		\$35			
Tests	X-rays and Diagnostic Imagin Imaging (CT/PET scans, MR		\$65 \$250			
	Generic drugs Tier 1		\$15			
Drugs to treat	Preferred brand drugs Tier 2		\$50	Pharmacy deductible		
illness or condition	Non-preferred brand drugs Ti	ier 3	\$70	Pharmacy		
condition				Pharmacy		
	Specialty drugs <u>Tier 4</u> Surgery facility fee (e.g., ASC	2)	20%	deductible		
Outpatient	Physician/surgeon fees	<i>'</i> )	20%			
services	Outpatient visit		20%			
	Emergency room facility fee	(waived if admitted)	\$250	Х		
	Emergency room physician for	ee (waived if admitted)	<del>20%</del> \$50	х		
Need immediate	Emergency medical transport	tation	\$250	Х		
attention						
	Urgent care	\$90				
Hospital stay	Facility fee (e.g. hospital roor	m)	20%	Х		
	Physician/surgeon fee		20%	Х		
	Mental/Behavioral health out	natient office visits	\$45			
	montal Bonavioral nearly out	ΨΤΟ				
	Mental/Behavioral health other	er outpatient items and services	\$45			
	Mantal/Dehavioral health inne	ationt facility for (a a boonital room)	000/			
Mental		atient facility fee (e.g.hospital room)	20%	Х		
health, behavioral	Mental/Behavioral health inpa	atient physician/surgeon fee	20%	Х		
health, or substance	Cubatanaa I laa diaardar auta	ations office visits	0.45			
abuse needs	Substance Use disorder outp	attent office visits	\$45			
	Substance Use disorder othe	er outpatient items and services	\$45			
	Substance Use inpatient facil	ity fee (e.g. hospital room)	20%	Х		
	Substance use disorder inpat	tient physician/surgeon fee	20%	х		
	Prenatal care and preconcept	tion visits	No charge			
Pregnancy	Delivery and all inpatient	Hospital	20%	х		
	services	Professional	20%	X		
Uele	Home health care Outpatient Rehabilitation serv	vices	\$45 \$45			
Help recovering or	Outpatient Habilitation service		\$45			
other special health needs	Skilled nursing care		20%	Х		
Juliu. Hoods	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					
	Space Maintainers - Fixed					
Child Dental Basic	Amalgam Fill - 1 Surface		20%			
Services			2070			
Child Dental	Root Canal- Molar Gingivectomy per Quad					
Major	Extraction- Single Tooth Expo	osed Root or Erupted	50%			
	Extraction- Complete Bony					
Services	Porcelain with Metal Crown	Child				
Services Child Orthodontics		ntics	50%			

-	f Benefits and Coverage	vallagia aut of pagintt-		IOP ver	SHO Silve		
	Share amounts describe the Er	rollee's out of pocket costs.	Coinsurance Plan 71.7%		Copay Plan 71.4%		
	e - AV Calculator			al/Pharmacy	Yes, Medical/		
Integrated	Individual deductible		N	/A	N/A N/A		
Individual	Family deductible deductible, NOT integrated:		\$1,500 /	/A \$500 / \$0	\$1,500 / \$5	600 / \$0	
	luctible, NOT integrated: Me -of-pocket maximum	dical / Pharmacy / Dental		51,000 / \$0 500	\$3,000 / \$1, \$6,50		
amily Out-of-	pocket maximum f-only coverage deductible			,000 /A	\$13,0 N/A		
SA family plan: Individual deductible			/A	N/A			
Common Medical			Member Cost		Member Cost		
Event	Ser	vice Type	Share	Deductible Applies	Share	Deductible Applies	
	Primary care visit to treat an i	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		
Гests	Laboratory Tests X-rays and Diagnostic Imagin		\$35 \$65		\$35 \$65		
	Imaging (CT/PET scans, MRI		20%	X	\$250 \$15		
	Generic drugs Tier 1  Preferred brand drugs Tier 2		\$15 \$55	Pharmacy	\$15 \$55	Pharmacy	
Orugs to treat liness or		0		deductible Pharmacy		deductible	
condition	Non-preferred brand drugs Ti	e <u>r 3</u>	\$75	deductible	\$75	deductible	
	Specialty drugs Tier 4		20%	Pharmacy deductible	20%	Pharmacy 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	
	Emergency room physician fe	<del>20%</del> \$50	Х	<del>20%</del> \$50	Х		
leed mmediate	Emergency medical transport		\$250	X	\$250	X	
ittention	Urgent care		\$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 outpatient office visits		\$45		\$45		
	Mental/Behavioral health other outpatient items and services		\$45		\$45		
Mental	Mental/Behavioral health inpa	20%	х	20%	х		
nealth, pehavioral	Mental/Behavioral health inpa	tient physician/surgeon fee	20%	Х	20%	х	
nealth, or substance abuse needs	Substance Use disorder outpatient office visits		\$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	ion visits	No charge		No charge		
Pregnancy	Delivery and all inpatient services	Hospital	20%	Х	20%	Х	
	Home health care	Professional	20%	X	20% \$45	X	
lelp	Outpatient Rehabilitation serv		\$45		\$45		
ecovering or	Outpatient Habilitation service	25	\$45	V	\$45		
other special nealth needs	Skilled nursing care  Durable medical equipment		20%	Х	20%	Х	
	Hospice service		20% No charge		20% No charge		
Child eye	Eye exam		No charge		No charge		
are	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge		No charge		
Child Dental	Oral Exam Preventive - Cleaning						
Diagnostic and	Preventive - X-ray Sealants per Tooth		No charge		No charge		
Preventive	Topical Fluoride Application						
Child Dental	Space Maintainers - Fixed  Amalgam Fill - 1 Surface		20%		\$25		
Services	Root Canal- Molar				\$300		
Child Dental	Gingivectomy per Quad	and Doot or Equated	E00/		\$150		
Major	Extraction- Single Tooth Expo	seu Root or Erupted	50%		\$65 \$160		
Services	Extraction- Complete Bony						
	Porcelain with Metal Crown				\$300		

Member Cost S	Benefits and Coverage		SHOI Silve HSA PI	r an
	e - AV Calculator		70.5%	
	cludes a deductible? Individual deductible		Yes, integ \$2,000 inte	
Integrated	Family deductible		\$4,000 inte	
		Medical / Pharmacy / Dental	N/A	
	luctible, NOT integrated: Me –of–pocket maximum	dical / Pharmacy / Dental	N/A \$6.25	0
Family Out-of-	pocket maximum		\$12,50	00
	f-only coverage deductible an: Individual deductible		\$2,00 See endi	
	an. marviduar deddetible		occ chui	lote
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Appli
	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	
Tests	Laboratory Tests	20	20%	X
10313	X-rays and Diagnostic Imaging (CT/PET scans, MR		20% 20%	X
	Generic drugs Tier 1		20%	X
Drugs to treat	Preferred brand drugs Tier 2		20%	х
illness or	Non-preferred brand drugs T	er 3	20%	х
condition				
	Specialty drugs Tier 4		20%	Х
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	C)	20%	X
services	Outpatient visit		20%	X
	Emergency room facility fee	(waived if admitted)	20%	X
			***	
Need	Emergency room physician f		20%	Х
mmediate	Emergency medical transportation		20%	Х
attention	Urgent care		20%	х
Hospital stay	Facility fee (e.g. hospital room)		20%	х
	Physician/surgeon fee		20%	X
	Mental/Behavioral health outpatient office visits		20%	х
	Mental/Behavioral health other outpatient items and services		20%	х
Mental	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	Х
health,	Mental/Behavioral health inpatient physician/surgeon fee		20%	×
behavioral health, or substance abuse needs	Substance Use disorder outpatient office visits		20%	х
	Substance Use disorder other outpatient items and services		20%	х
	Substance Use inpatient facil	ity fee (e.g. hospital room)	20%	х
	Substance use disorder inpat	ient physician/surgeon fee	20%	х
	Prenatal care and preconcep	tion visits	No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	х
	services	Professional	20%	Х
	Home health care Outpatient Rehabilitation serv	vines	20% 20%	X
Help	Outpatient Habilitation service		20%	X
recovering or other special	Skilled nursing care		20%	Х
health needs	Durable medical equipment		20%	X
	Hospice service		0%	X
Child eye	Eye exam		No charge	
care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge	
Child Dental	Oral Exam Preventive - Cleaning			
Diagnostic	Preventive - X-ray		No charge	
and Preventive	Sealants per Tooth Topical Fluoride Application		90	
Child Dental	Space Maintainers - Fixed			
Basic Services	Amalgam Fill - 1 Surface  Root Canal- Molar		20%	
Child Dental	Gingivectomy per Quad			
Major Services	Extraction- Single Tooth Exp Extraction- Complete Bony Porcelain with Metal Crown	osed Root or Erupted	50%	
Child Orthodontics	Medically necessary orthodor	ntics	50%	

Summary of	f Benefits and Coverage					
Member Cost S	Share amounts describe the Er	nrollee's out of pocket costs.	Silver I 100%-150		Silver 1 150%-200	
<b>Actuarial Valu</b>	e - AV Calculator		93.8%		86.8%	
	cludes a deductible?		Yes, Medical/		Yes, Medical	
	Individual deductible Family deductible		N/A N/A		N/A	
Individual	deductible, NOT integrated:	Medical / Pharmacy / Dental	\$75 / \$0	) / \$0	\$550 / \$5	50 / \$0
Family dec	ductible, NOT integrated: Me -of-pocket maximum	dical / Pharmacy / Dental	\$150 / \$0 \$2,25		\$1,100 / \$1 \$2,25	100 / \$0 50
Family Out-of-	-pocket maximum		\$4,50	00	\$4,50	00
	f-only coverage deductible an: Individual deductible		N/A		N/A N/A	
Common Medical			Member Cost	Deductible	Member Cost	Deductible
Event	Sei	vice Type	Share	Applies	Share	Applies
	Primary care visit to treat an	injury, illness, or condition	\$5		\$15	
Health care provider's	Other practitioner office visit		\$5		\$15	
office or						
clinic visit	Specialist visit		\$8		\$25	
	Preventive care/ screening/ ir	nmunization	No charge		No charge	
Tanto	Laboratory Tests		\$8		\$15	
Tests	X-rays and Diagnostic Imagir Imaging (CT/PET scans, MR		\$8 \$50		\$25 \$100	
	Generic drugs Tier 1		\$3		\$5	Dharman
Drugs to treat	Preferred brand drugs Tier 2		\$10		\$20	Pharmacy deductible
illness or condition	Non-preferred brand drugs Ti	er 3	\$15		\$35	Pharmacy
Condition	Specialty drugs Tier 4					deductible Pharmacy
	Surgery facility fee (e.g., ASC	3)	10%		15% 15%	deductible
Outpatient	Physician/surgeon fees	7	10%		15%	
services	Outpatient visit		10%		15%	
	Emergency room facility fee	waived if admitted)	\$30	Х	\$75	Х
	Emergency room physician for	<del>10%</del> \$25	х	<del>15%</del> \$40	Х	
Need immediate	Emergency medical transpor	\$30	Х	\$75	Х	
attention	Urgent care		\$6		\$30	
Hospital stay	Facility fee (e.g. hospital roor	n)	10%	×	15%	х
	Physician/surgeon fee		10%	X	15%	X
	Mental/Behavioral health out	\$5		\$15		
	Mental/Behavioral health other	\$5		\$15		
Mental	Mental/Behavioral health inpa	10%	Х	15%	Х	
health, behavioral	Mental/Behavioral health inpa	10%	х	15%	х	
health, or substance abuse needs	Substance Use disorder outp	\$5		\$15		
	Substance Use disorder othe	\$5		\$15		
	Substance Use inpatient facil	10%	х	15%	х	
	Substance use disorder inpat	ient physician/surgeon fee	10%	х	15%	х
	Prenatal care and preconcept	ion visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	10%	х	15%	х
	services	Professional	10%	Х	15%	Х
	Home health care Outpatient Rehabilitation serv	rices	\$3 \$5		\$15 \$15	
Help recovering or	Outpatient Habilitation service		\$5		\$15	
other special	Skilled nursing care		10%	х	15%	х
health needs	Durable medical equipment		10%		15%	
Child arm	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					
and	Sealants per Tooth		No charge		No charge	
Preventive	Topical Fluoride Application Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%		20%	
	Root Canal- Molar					
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Expo	osed Root or Frunted	50%		50%	
Services	Extraction- Single Footh Expo Extraction- Complete Bony Porcelain with Metal Crown		55,5		33,4	
Child Orthodontics	Medically necessary orthodor	ntics	50%		50%	

#### 2016 Standard Benefit Plan Designs 10.0 EHB

Date: Apri	l 16, 2015			
Summary of	Benefits and Coverage		011	N
Member Cost S	Share amounts describe the Er	nrollee's out of pocket costs.	Silver F 200%-250	
Actuarial Valu	e - AV Calculator		72.89	6
Plan design in	cludes a deductible? Individual deductible		Yes, Medical/I	Pharmacy
Integrated	Family deductible		N/A	
	deductible, NOT integrated: luctible, NOT integrated: Me	Medical / Pharmacy / Dental dical / Pharmacy / Dental	\$1,900 / \$2 \$3,800 / \$5	
Individual Out	of-pocket maximum		\$5,45 \$10,90	
HSA plan: Self	f-only coverage deductible		N/A	50
	an: Individual deductible		N/A	
Common Medical			Member Cost	Deductible
Event	Se	rvice Type	Share	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/ in	mmunization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagin	ng	\$35 \$50	
	Imaging (CT/PET scans, MR		\$250	
	Generic drugs Tier 1		\$15	Pharmacy
Drugs to treat	Preferred brand drugs Tier 2		\$45	deductible
illness or condition	Non-preferred brand drugs T	er 3	\$70	Pharmacy deductible
	Specialty drugs Tier 4		20%	Pharmacy
	Surgery facility fee (e.g., ASC	C)	20%	deductible
Outpatient services	Physician/surgeon fees		20%	
	Outpatient visit	(continued of a description)	20%	
	Emergency room facility fee		\$250	Х
Need	Emergency room physician f	<del>20%</del> <u>\$50</u>	Х	
immediate	Emergency medical transpor	\$250	Х	
attention	Urgent care		\$80	
	Facility fee (e.g. hospital room)		20%	×
Hospital stay	Physician/surgeon fee		20%	Х
	Mental/Behavioral health out	\$40		
	Mental/Behavioral health other	er outpatient items and services	\$40	
	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	20%	х
Mental health,	Mental/Behavioral health inpa	20%	×	
behavioral health, or substance	Substance Use disorder outp	\$40	^	
abuse needs				
	Substance Use disorder other	r outpatient items and services	\$40	
	Substance Use inpatient facil		20%	х
	Substance use disorder inpat		20%	Х
	Prenatal care and preconcep		No charge	
Pregnancy	Delivery and all inpatient services	Hospital	20%	Х
	Home health care	Professional	20% \$40	X
Help	Outpatient Rehabilitation service Outpatient Habilitation service		\$40	
recovering or other special	Skilled nursing care	co .	\$40 20%	×
health needs	Durable medical equipment		20%	^
	Hospice service		No charge	
Child eye care	Eye exam 1 pair of glasses per year (or	contact language in lines of old	No charge	
Vale	Oral Exam	contact lenses in lieu or gidSSeS)	No charge	
Child Dental	Preventive - Cleaning			
Diagnostic and	Preventive - X-ray Sealants per Tooth		No charge	
Preventive	Topical Fluoride Application			
Child Dental Basic	Space Maintainers - Fixed  Amalgam Fill - 1 Surface		20%	
Services	Root Canal- Molar			
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Exp	osed Root or Frunted	50%	
Services	Extraction- Complete Bony	Took of Erapica	30 /4	
Child	Porcelain with Metal Crown			

Medically necessary orthodontics

50%

	Share amounts describe the Er	nrollee's out of pocket costs.	Bronze		Bron: HSA P	lan
	e - AV Calculator		61.2		61.19	
	Individual deductible?		Yes, inte \$6,500 int	grated	Yes, integ \$4,500 inte	
Integrated	Family deductible		\$13,000 in		\$9,000 inte	
		Medical / Pharmacy / Dental	N/A		N/A N/A	
ramily dec	ductible, NOT integrated: Me -of-pocket maximum	dical / Pharmacy / Dental	\$6.5		\$6,50	
Family Out-of-	-pocket maximum		\$13,0	000	\$13,0	00
	f-only coverage deductible an: Individual deductible		N//		\$4,50 \$4,50	
	an. murviduai deductible		19//	`	φ4,30	
Common Medical Event	Sei	vice Type	Member Cost Share	Deductible Applies After 1st	Member Cost Share	Deductibl Applies
	Primary care visit to treat an	injury, illness, or condition	\$70	three non- preventive visits	40%	Х
Health care provider's office or clinic visit	Other practitioner office visit		\$70	After 1st three non- preventive visits	40%	х
cimio visit	Specialist visit		\$90	After 1st three non- preventive visits	40%	х
	Preventive care/ screening/ in	nmunization	No charge		No charge	V
Tests	Laboratory Tests X-rays and Diagnostic Imagir	ng	\$40 0%	X	40% 40%	X
	Imaging (CT/PET scans, MR		0%	X	40%	X
	Generic drugs Tier 1		0%	Х	40%	Х
Drugs to treat	Preferred brand drugs Tier 2		0%	Х	40%	Х
illness or condition	Non-preferred brand drugs Ti	er 3	0%	х	40%	х
Januarion	Specialty drugs Tier 4		0%	х	40%	Х
	Surgery facility fee (e.g., ASC	:)	0%	X	40%	X
Outpatient services	Physician/surgeon fees		0%	X	40%	X
ser vices	Outpatient visit		0%	Х	40%	Х
	Emergency room facility fee (	waived if admitted)	0%	Х	40%	х
	Emergency room physician fe	ee (waived if admitted)	0%	х	40%	Х
Need	Emergency medical transport		0%	X	40%	X
immediate attention	Urgent care		\$120	After 1st three non- preventive visits	40%	x
Unovital stay	Facility fee (e.g. hospital roor	n)	0%	Х	40%	х
Hospital stay	Physician/surgeon fee		0%	X	40%	Х
	Mental/Behavioral health outpatient office visits		\$70	After 1st three non- preventive visits	40%	х
	Mental/Behavioral health other	\$70	After 1st three non- preventive visits	40%	х	
Mental	Mental/Behavioral health inpa	0%	Х	40%	Х	
health,	Mental/Behavioral health inpa	itient 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%	x
	Substance Use disorder othe	\$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	ient physician/surgeon fee	0%	х	40%	х
	Prenatal care and preconcept	ion visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	0%	х	40%	Х
	services	Professional	0%	Х	40%	Х
	Home health care		0%	X	40%	Х
Help	Outpatient Rehabilitation service Outpatient Habilitation service		\$70 \$70		40% 40%	X
recovering or				V		
other special health needs	Skilled nursing care		0%	X	40%	X
	Durable medical equipment Hospice service		0% No charge	X	40% 0%	X
Child eye	Eye exam		No charge		No charge	
care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge	<u></u>	No charge	
Child Dental	Oral Exam Preventive - Cleaning					
Diagnostic	Preventive - X-ray		No charge		No charge	
and Preventive	Sealants per Tooth Topical Fluoride Application		go			
Child Dental Basic	Space Maintainers - Fixed  Amalgam Fill - 1 Surface		20%		20%	
Services Child Dental	Root Canal- Molar Gingivectomy per Quad				FOX	
					50%	
Major Services	Extraction- Single Tooth Expo Extraction- Complete Bony Porcelain with Metal Crown	sea Root or Eruptea	50%		30 %	

Summary of	Benefits and Coverage		
Member Cost S	hare amounts describe the Enrollee's out of pocket costs.	Catastrop	hic Plan
Actuarial Value	e - AV Calculator		
Plan design in	cludes a deductible?	Yes, inte	grated
	Individual deductible	\$6,850 int	
	Family deductible	\$13,700 in	
	deductible, NOT integrated: Medical / Pharmacy / Dental	N/A N/A	
	luctible, NOT integrated: Medical / Pharmacy / Dental	\$6.8	
	pocket maximum	\$13,7	
	-only coverage deductible	Ψ15,7 N/A	
	an: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
	COLLISC Type		After 1st
	Primary care visit to treat an injury, illness, or condition	0%	three non- preventive visits
Health care provider's office or	Other practitioner office visit	0%	After 1st three non- preventive visits
clinic visit	Specialist visit	0%	х
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	Х
Tests	X-rays and Diagnostic Imaging	0%	Х
	Imaging (CT/PET scans, MRIs)	0%	Х
	Generic drugs Tier 1	0%	Х
Drugs to treat	Preferred brand drugs Tier 2	0%	Х
condition	Non-preferred brand drugs Tier 3	0%	Х
	Specialty drugs Tier 4	0%	х
Outpatient	Surgery facility fee (e.g., ASC)	0%	Х
services	Physician/surgeon fees	0%	Х
J. 11003	Outpatient visit	0%	Х
	Emergency room facility fee (waived if admitted)	0%	Х
Need	Emergency room physician fee (waived if admitted)	0%	х
immediate	Emergency medical transportation	0%	Х
attention			After 1st



Member Cost Share amounts describe the Enrollee's out of pocket costs.			Platinum Coinsurance Plan		Platinum Copay Plan	
Actuarial Valu	e - AV Calculator		88.5%		89.5%	
	cludes a deductible?		No		No	
	Individual deductible Family deductible		\$0 \$0		\$0 \$0	
Individual	deductible, NOT integrated:	Medical / Pharmacy / Dental	\$0 / \$0 /		\$0 / \$0 /	
Family ded	Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum			\$0 / \$0 / \$0 \$4,000		\$0
Family Out-of-	-pocket maximum		\$8,00		\$8,00	
	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	injury, illness, or condition	\$20		\$20	
Health care	Other practitioner office visit		200		200	
provider's office or	Other practitioner office visit		\$20		\$20	
clinic visit						
	Specialist visit		\$40		\$40	
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge \$20		No charge \$20	
Tests	X-rays and Diagnostic Imagir		\$40		\$40	
	Imaging (CT/PET scans, MRI Generic drugs <u>Tier 1</u>	s)	10% \$5		\$150 \$5	
Drugs to treat	Preferred brand drugs Tier 2		\$15		\$15	
illness or	Non-preferred brand drugs Ti	er 3	\$25		\$25	
condition	, , ,					
	Specialty drugs Tier 4		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 fe	10%		No charge		
Need immediate	Emergency medical transport	\$150		\$150		
attention						
	Urgent care		\$40		\$40	
Hospital stay	Facility fee (e.g. hospital roon	n)	10%		\$250 per day up to 5 days	
riospitai stay	Physician/surgeon fee		10%		\$40	
	Mental/Behavioral health outp	\$20		\$20		
	Mental/Behavioral health other outpatient items and services		\$20		\$20	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		10%		\$250 per day up	
Mental health,	Mental/Behavioral health inpatient physician/surgeon fee				to 5 days	
behavioral	wentai/Benavioral nealth inpa	atient physician/surgeon ree	10%		\$40	
health, or substance abuse needs	Substance Use disorder outpo	\$20		\$20		
	Substance Use disorder other outpatient items and services		***			
	Substance Use disorder other	\$20		\$20		
	Substance Use inpatient facil	ity fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Substance use disorder inpat		10%		\$40	
	Prenatal care and preconcept		No charge		No charge	
Pregnancy	Delivery and all inpatient services	Hospital	10%		\$250 per day up to 5 days	
	Home health care	Professional	10%		\$40 \$20	
Help	Outpatient Rehabilitation serv		\$20		\$20	
recovering or	Outpatient Habilitation service	es	\$20		\$20 \$150 per day up	
other special health 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	
care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Oral Exam Preventive - Cleaning					
Diagnostic	Preventive - X-ray		Not Covered		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Child Dental	Root Canal- Molar				Not Covered	
Major	Gingivectomy per Quad Extraction- Single Tooth Expo	osed Root or Erupted	Not Covered		Not Covered Not Covered	
Services	Extraction- Complete Bony Porcelain with Metal Crown				Not Covered Not Covered	
Child	Medically necessary orthodor	ntics	Not Covered		Not Covered	
Orthodontics						

	Benefits and Coverage Chare amounts describe the Er		Gold		Gold	
	e - AV Calculator		Coinsurance 80.29		Copay P 81.0%	
	cludes a deductible?		No		No	
	Individual deductible		\$0		\$0	
	Family deductible		\$0		\$0	
	deductible, NOT integrated: luctible, NOT integrated: Me	Medical / Pharmacy / Dental	\$0 / \$0 / \$0 / \$0 /		\$0 / \$0 / \$0 / \$0 /	
Individual Out-	of-pocket maximum	dicar / i Harmacy / Demar	\$6,20		\$6,200	
	pocket maximum		\$12,40	00	\$12,40	0
	i-only coverage deductible an: Individual deductible		N/A N/A		N/A N/A	
Common						
Medical Event	Ser	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an	injury, illness, or condition	\$35		\$35	
Health care provider's office or clinic visit	Other practitioner office visit		\$35		\$35	
	Specialist visit		\$55		\$55	
	Preventive care/ screening/ ir	mmunization	No charge		No charge	
	Laboratory Tests X-rays and Diagnostic Imagir	na	\$35 \$50		\$35 \$50	
	Imaging (CT/PET scans, MR		20%		\$250	
	Generic drugs Tier 1		\$15		\$15	
Drugs to treat	Preferred brand drugs Tier 2		\$50		\$50	
illness or	Non-preferred brand drugs Ti	er 3	\$70		\$70	
condition	, ,	<del>_</del>			-	
	Specialty drugs Tier 4		20%		20%	
	Surgery facility fee (e.g., ASC Physician/surgeon fees	<u> </u>	20% 20%		\$600 \$55	
	Outpatient visit		20%		20%	
	Emergency room facility fee	(waived if admitted)	\$250		\$250	
			φ230		φ230	
Need	Emergency room physician fe	ee (waived if admitted)	20%		No charge	
immediate	Emergency medical transpor	tation	\$250		\$250	
attention	Urgent care		\$60		\$60	
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 out	\$35		\$35		
	Mental/Behavioral health other outpatient items and services		\$35		\$35	
Mental	Mental/Behavioral health inpa	20%		\$600 per day up to 5 days		
health,	Mental/Behavioral health inpa	atient physician/surgeon fee	20%		\$55	
behavioral health, or substance abuse needs	Substance Use disorder outp	\$35		\$35		
	Substance Use disorder othe	\$35		\$35		
	Substance Use inpatient facil	ity foo (o.g. hospital room)	000/		\$600 per day up	
	Substance use disorder inpat		20%		to 5 days \$55	
	Prenatal care and preconcept	tion visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%		\$600 per day	
	services	Professional	20%		up to 5 days \$55	
	Home health care		20%		\$30	
Help	Outpatient Rehabilitation service Outpatient Habilitation service		\$35		\$35	
recovering or		co	\$35		\$35 \$300 per day up	
hoalth noode	Skilled nursing care		20%		to 5 days	
	Durable medical equipment Hospice service		20% No charge		20% No charge	
	Eye exam		No charge		No charge	
care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam					
	Preventive - Cleaning					
	Preventive - X-ray Sealants per Tooth Topical Fluoride Application		Not Covered		Not Covered	
Preventive	Space Maintainers - Fixed				Not Covered	
Preventive Child Dental		Amalgam Fill - 1 Surface				
Preventive  Child Dental  Basic  Services	Amalgam Fill - 1 Surface		Not Covered			
Preventive  Child Dental Basic Services  Child Dental	Amalgam Fill - 1 Surface  Root Canal- Molar Gingivectomy per Quad				Not Covered Not Covered	
Preventive  Child Dental Basic Services  Child Dental Major	Amalgam Fill - 1 Surface  Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Expe	osed Root or Erupted	Not Covered  Not Covered		Not Covered Not Covered Not Covered	
Preventive  Child Dental Basic Services  Child Dental Major Services	Amalgam Fill - 1 Surface  Root Canal- Molar Gingivectomy per Quad	osed Root or Erupted			Not Covered Not Covered	

Summary of	f Benefits and Coverage		Individ	lual	
Member Cost S	Share amounts describe the En	rollee's out of pocket costs.	Silver I	Plan	
Actuarial Valu	e - AV Calculator		70.4%		
	cludes a deductible?		Yes, Medical/	Pharmacy	
Integrated	Individual deductible		N/A		
	Family deductible	Madical / Dharmany / Dantal	N/A \$2,250 / \$2		
	deductible, NOT integrated: ductible, NOT integrated: Me		\$4,500 / \$5		
Individual Out	-of-pocket maximum		\$6,25	60	
	-pocket maximum f-only coverage deductible		\$12,5 N/A		
	an: Individual deductible		N/A		
Common					
Medical			Member Cost	Deductible	
Event	Ser	vice Type	Share	Applies	
	Primary care visit to treat an i	njury, 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	-	\$35		
16515	X-rays and Diagnostic Imagin Imaging (CT/PET scans, MRI		\$65 \$250		
	Generic drugs Tier 1	,	\$15		
Druge to treet	Preferred brand drugs Tier 2		\$50	Pharmacy deductible	
Drugs to treat illness or		0		Pharmacy	
condition	Non-preferred brand drugs Ti	e <u>r 3</u>	\$70	deductible	
	Specialty drugs Tier 4		20%	Pharmacy	
	Surgery facility fee (e.g., ASC	:)	20%	deductible	
Outpatient services	Physician/surgeon fees		20%		
Sei Vices	Outpatient visit		20%		
	Emergency room facility fee (	waived if admitted)	\$250	Х	
	Emergency room physician fe	ee (waived if admitted)	<del>20%</del> \$50	Х	
Need	Emergency medical transport		\$250	X	
immediate attention	Emergency medical transport	ation	φ230		
	Urgent care		\$90		
	Facility fee (e.g. hospital roon	n)	20%	Х	
Hospital stay	Physician/surgeon fee	<u>′</u>	20%	X	
	Mental/Behavioral health outp	\$45	_^		
	Mental/Behavioral health other	er outpatient items and services	\$45		
Mental		tient facility fee (e.g.hospital room)	20%	х	
health, behavioral	Mental/Behavioral health inpa	tient physician/surgeon fee	20%	Х	
health, or substance abuse needs	Substance Use disorder outpa	atient office visits	\$45		
	Substance Use disorder other	outpatient items and services	\$45		
	Substance Use inpatient facili	ity fee (e.g. hospital room)	20%	х	
	Substance use disorder inpati	ient physician/surgeon fee	20%	х	
	Prenatal care and preconcept	ion visits	No charge		
Pregnancy	Delivery and all inpatient	Hospital	20%	х	
	services	Professional	20%	Х	
	Home health care		\$45		
Help	Outpatient Rehabilitation service Outpatient Habilitation service		\$45 \$45		
recovering or other special	Skilled nursing care		20%	×	
health needs	Durable medical equipment			^	
	Hospice service		20% No charge		
Child eye	Eye exam		No charge		
care	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge		
Child Day	Oral Exam				
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray				
and	Sealants per Tooth	Not Covered			
Preventive	Topical Fluoride Application Space Maintainers - Fixed				
Child Device	орасе манцанеть - гіхей				
Child Dental Basic Services	Amalgam Fill - 1 Surface  Root Canal- Molar		Not Covered		
Child Dental	Gingivectomy per Quad				
Major	Extraction- Single Tooth Expo	sed Root or Erupted	Not Covered		
Services	Extraction- Complete Bony Porcelain with Metal Crown				
Child Orthodontics	Medically necessary orthodor	atics	Not Covered		

•	f Benefits and Coverage			ЮР	sно	
Member Cost S	Share amounts describe the Er	rollee's out of pocket costs.		ver ance Plan	Silver Copay Plan	
	e - AV Calculator		71.	.7%	71.4%	
	Individual deductible?			al/Pharmacy I/A	Yes, Medical/I	
Integrated	Family deductible	Madical (Discussion (Daniel	N	I/A	N/A	
Family ded	deductible, NOT integrated: ductible, NOT integrated: Me			\$500 / \$0 \$1,000 / \$0	\$1,500 / \$5 \$3,000 / \$1,	
Individual Out- Family Out-of-	t-of-pocket maximum -pocket maximum		\$6,500 \$13,000		\$6,50 \$13,00	
HSA plan: Self	f-only coverage deductible		N	I/A I/A	N/A N/A	
	an: Individual deductible		IN	IA.	IN/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	\$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	g	\$35 \$65		\$35 \$65	
	Imaging (CT/PET scans, MRI Generic drugs Tier 1		20% \$15	X	\$250	
	Preferred brand drugs Tier 2		\$15 \$55	Pharmacy	\$15 \$55	Pharmacy
Drugs to treat illness or				deductible Pharmacy		deductible Pharmacy
condition	Non-preferred brand drugs Ti	\$75	deductible	\$75	deductible	
	Specialty drugs Tier 4		20%	Pharmacy 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 fe	<del>20%</del> \$50	х	<del>20%</del> <u>\$50</u>	х	
immediate	Emergency medical transport	ation	\$250	Х	\$250	X
attention	Urgent care		\$90		\$90	
Hospital stay	Facility fee (e.g. hospital room	1)	20%	х	20%	×
	Physician/surgeon fee	20%	X	20%	X	
	Mental/Behavioral health outp	\$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 outpa	\$45		\$45		
	Substance Use disorder other	\$45		\$45		
	Substance Use inpatient facil	20%	x	20%	х	
	Substance use disorder inpat	ent physician/surgeon fee	20%	х	20%	х
	Prenatal care and preconcept	ion visits	No charge		No charge	
Pregnancy	Delivery and all inpatient services	Hospital	20%	Х	20%	Х
	Home health care	Professional	20%	X	20% \$45	X
Help	Outpatient Rehabilitation serv		\$45		\$45	
recovering or	Outpatient Habilitation service	es	\$45		\$45	
other special health needs	Skilled nursing care  Durable medical equipment		20%	Х	20%	Х
	Hospice service		20% No charge		20% No charge	
Cilia eye	Eye exam		No charge		No charge	
care	1 pair of glasses per year (or or Oral Exam	contact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Preventive - Cleaning					
Diagnostic and	Preventive - X-ray Sealants per Tooth		Not Covered		Not Covered	
Preventive	Topical Fluoride Application Space Maintainers - Fixed					
Child Dental Basic	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Services	Root Canal- Molar				Not Covered	
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Expo	sed Root or Erupted	Not Covered		Not Covered Not Covered	
Services	Extraction- Complete Bony		5010100		Not Covered	
	Porcelain with Metal Crown				Not Covered	
Child	Medically necessary orthodor		Not Covered		Not Covered	

Member Cost S	F Benefits and Coverage Share amounts describe the En		SHOF Silver HSA PI	r an
	e - AV Calculator		70.5%	
	cludes a deductible? Individual deductible		Yes, integ \$2,000 inte	
Integrated	Family deductible		\$4,000 inte	
		Medical / Pharmacy / Dental	N/A	
	luctible, NOT integrated: Me –of–pocket maximum	dicai / Pharmacy / Dentai	N/A \$6,250	)
Family Out-of-	pocket maximum		\$12,50	
	f-only coverage deductible an: Individual deductible		\$2,000 See endr	
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/ in	nmunization	No charge	
Tests	Laboratory Tests	20	20%	X
10313	X-rays and Diagnostic Imaging (CT/PET scans, MR		20% 20%	X
	Generic drugs Tier 1		20%	X
Drugs to treat	Preferred brand drugs Tier 2		20%	Х
illness or	Non-preferred brand drugs T	er 3	20%	Х
condition			=1,1	
	Specialty drugs Tier 4		20%	Х
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	0)	20%	X
services	Outpatient visit		20%	X
	Emergency room facility fee	(waived if admitted)	20%	X
			***	
Need	Emergency room physician f		20%	Х
immediate	Emergency medical transpor	tation	20%	X
attention	Urgent care		20%	х
Hospital stay	Facility fee (e.g. hospital room Physician/surgeon fee	n)	20% 20%	X X
	Mental/Behavioral health outpatient office visits		20%	x
	Mental/Behavioral health other outpatient items and services		20%	х
Mental	Mental/Behavioral health inpatient 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 outpatient office visits		20%	х
	Substance Use disorder other	r outpatient items and services	20%	х
	Substance Use inpatient facil	ity fee (e.g. hospital room)	20%	х
	Substance use disorder inpat	ient physician/surgeon fee	20%	х
	Prenatal care and preconcep	tion visits	No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	Х
	services	Professional	20%	X
	Home health care Outpatient Rehabilitation serv	vices	20% 20%	X
Help recovering or	Outpatient Habilitation service		20%	X
other special	Skilled nursing care		20%	Х
health needs	Durable medical equipment		20%	Х
	Hospice service		0%	X
Child eye care	Eye exam 1 pair of glasses per year (or	contact language in lices of alar	No charge	
out o	Oral Exam	oonwor renees at tieu of gidSSeS)	No charge	
Child Dental	Preventive - Cleaning			
Diagnostic	Preventive - X-ray		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application			
Child Dental Basic	Space Maintainers - Fixed  Amalgam Fill - 1 Surface		Not Covered	
Services	Root Canal- Molar		oovered	
Child Dental	Gingivectomy per Quad	and Deet or Franked	Not Comm.	
Major Services	Extraction- Single Tooth Expr Extraction- Complete Bony Porcelain with Metal Crown	osea Root or Erupted	Not Covered	

	Share amounts describe the Er	rollee's out of pocket costs.	Silver F 100%-150' 93.89	% FPL	Silver F 150%-200 86.89	% FPL
	cludes a deductible?		Yes, Medical/I		Yes, Medical/	
Integrated	Individual deductible		N/A		N/A	
	Family deductible deductible, NOT integrated:	Medical / Pharmacy / Dental	N/A \$75 / \$0 / \$0		N/A \$550 / \$50 / \$0	
Family ded	luctible, NOT integrated: Me		\$150 / \$0	0 / \$0	\$1,100 / \$1	00 / \$0
	-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	
	- Harriaga adadonsio		147		107	
Common Medical Event	Sei	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an	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/ ir	nmunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagir	ıa	\$8 \$8		\$15 \$25	
	Imaging (CT/PET scans, MR		\$50		\$100	
	Generic drugs Tier 1		\$3		\$5	Pharmac
Drugs to treat	Preferred brand drugs Tier 2		\$10		\$20	deductible
Ilness or condition	Non-preferred brand drugs Ti	er 3	\$15		\$35	Pharmac deductible
	Specialty drugs Tier 4	10%		15%	Pharmac	
Outmoticut	Surgery facility fee (e.g., ASC	10%		15%	deductible	
Outpatient services	Physician/surgeon fees		10%		15%	
	Outpatient visit		10%		15%	
	Emergency room facility fee	waived if admitted)	\$30	Х	\$75	Х
Need	Emergency room physician fe	<del>10%</del> <u>\$25</u>	Х	<del>15%</del> <u>\$40</u>	Х	
mmediate	Emergency medical transpor	\$30	Х	\$75	Х	
attention	Urgent care		\$6		\$30	
Hospital stay	Facility fee (e.g. hospital roor	n)	10%	×	15%	Х
	Physician/surgeon fee	10%	X	15%	X	
	Mental/Behavioral health outpatient 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, behavioral	Mental/Behavioral health inpa	itient physician/surgeon fee	10%	х	15%	×
health, or substance abuse needs	Substance Use disorder outp	atient office visits	\$5		\$15	
	Substance Use disorder othe	outpatient items and services	\$5		\$15	
	Substance Use inpatient facil	10%	х	15%	х	
	Substance use disorder inpat	ent physician/surgeon fee	10%	х	15%	х
	Prenatal care and preconcept	ion visits	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
Heln	Outpatient Rehabilitation serv		\$5		\$15	
Help recovering or	Outpatient Habilitation service		\$5		\$15	
other special health needs	Skilled nursing care		10%	Х	15%	Х
	Durable medical equipment Hospice service		10% No charge		15% 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					
Diagnostic	Preventive - Cleaning Preventive - X-ray		Not Covered		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application		0046160		00+6160	
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Child Dental	Root Canal- Molar Gingivectomy per Quad					
Child Dental Major Services	Extraction- Single Tooth Expo Extraction- Complete Bony Porcelain with Metal Crown	osed Root or Erupted	Not Covered		Not Covered	
Child Orthodontics	Medically necessary orthodor	itics	Not Covered		Not Covered	

Summary of Benefits and Coverage	
Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Plan 200%-250% FPL
Actuarial Value - AV Calculator	72.8%
Plan design includes a deductible?	V 11 11 11 11 11 11 11 11 11 11 11 11 11
	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A
Integrated Family deductible	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$1,900 / \$250 / \$0
Family deductible NOT integrated: Medical / Pharmacy / Dental	\$3.800 / \$500 / \$0

Integrated	Individual deductible		Yes, Medical/I	
Integrated	Family deductible		N/A	
Individual	deductible, NOT integrated: Me		\$1,900 / \$2	
	luctible, NOT integrated: Medic -of-pocket maximum	al / Pharmacy / Dental	\$3,800 / \$5 \$5.45	
Family Out-of	pocket maximum		\$10,90	
HSA plan: Sel	-only coverage deductible		N/A	
HSA family pla	n: Individual deductible		N/A	
Common				
Medical			Member Cost	Deductible
Event	Servic	е Туре	Share	Applies
	Primary care visit to treat an inju	ry, illness, or condition	\$40	
Health care provider's office or clinic visit	Other practitioner office visit		\$40	
	Specialist visit		\$55	
	Preventive care/ screening/ immi	unization	No charge	
<b>-</b>	Laboratory Tests		\$35	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)		\$50 \$250	
	Generic drugs Tier 1		\$15	
	Preferred brand drugs Tier 2			Pharmacy
Drugs to treat	Treicired brand drugs <u>Hei Z</u>		\$45	deductible
illness or condition	Non-preferred brand drugs Tier 3	<u>1</u>	\$70	Pharmacy deductible
	Specialty drugs Tier 4		20%	Pharmacy
	Surgery facility fee (e.g., ASC)		20%	deductible
Outpatient	Physician/surgeon fees		20%	
services	Outpatient visit		20%	
	Emergency room facility fee (wai	ived if admitted)	\$250	х
			Ψ200	^
Need	Emergency room physician fee (	waived if admitted)	<del>20%</del> \$50	Х
immediate	Emergency medical transportation	on	\$250	Х
attention	Urgent care		\$80	
	Escility foo (o.g. boenital room)		20%	
Hospital stay	Facility fee (e.g. hospital room)		20%	Х
	Physician/surgeon fee		20%	X
	Mental/Behavioral health outpation	\$40		
	Mental/Behavioral health other o	utpatient items and services	\$40	
Mental	Mental/Behavioral health inpatier	nt facility fee (e.g.hospital room)	20%	х
health,	Mental/Behavioral health inpatier	nt physician/surgeon fee	20%	х
behavioral health, or substance	Substance Use disorder outpatie		\$40	^
abuse needs	Substance Use disorder other ou	thatient items and services	\$40	
	Substance Use inpatient facility f	·	20%	х
	Substance use disorder inpatient		20%	Х
	Prenatal care and preconception	visits	No charge	
Pregnancy		ospital	20%	х
	services Pr	ofessional	20%	Х
	Home health care		\$40	
Help	Outpatient Rehabilitation service	S	\$40	
recovering or	Outpatient Habilitation services		\$40	
other special health needs	Skilled nursing care		20%	Х
	Durable medical equipment		20%	
	Hospice service Eye exam		No charge No charge	
Child eye		act langue in liqu of alassas)		
care	1 pair of glasses per year (or cont	actienises in lieu of glasses)	No charge	
Child Dental	Oral Exam Preventive - Cleaning			
Diagnostic	Preventive - X-ray		Not Covered	
and	Sealants per Tooth		Not Covered	
Preventive	Topical Fluoride Application Space Maintainers - Fixed			
Child Dental Basic	Amalgam Fill - 1 Surface		Not Covered	
Services	Root Canal- Molar			
Child Dental	Gingivectomy per Quad		Not Covered	
Major	Extraction- Single Tooth Exposed	140t GOVERCO		
	Extraction- Single Tooth Exposed Extraction- Complete Bony	Troot of Eraptoa	Not Govered	
Major	Extraction- Single Tooth Exposed	Troot of Eraptod	Not Govered	

	Share amounts describe the Er	nrollee's out of pocket costs.	Bronze		Bron: HSA P	lan
	e - AV Calculator		61.2	2%	61.19	%
	cludes a deductible?		Yes, inte		Yes, integ	grated
	Individual deductible Family deductible			,500 integrated \$4,500 integr 3,000 integrated \$9,000 integr		
Individual	deductible, NOT integrated:	Medical / Pharmacy / Dental	N/a	Ą	N/A	
	luctible, NOT integrated: Me –of–pocket maximum	dical / Pharmacy / Dental	N// \$6.5		N/A \$6.50	
amily Out-of-	pocket maximum		\$13,0		\$13,0	
	f-only coverage deductible an: Individual deductible		N/A		\$4,50 \$4,50	
Common						
Medical Event	Set	vice Type	Member Cost Share	Deductible Applies After 1st	Member Cost Share	Deductib Applies
	Primary care visit to treat an	injury, illness, or condition	\$70	three non- preventive visits	40%	х
Health care provider's office or	Other practitioner office visit		\$70	After 1st three non- preventive visits	40%	х
clinic visit	Specialist visit		\$90	After 1st three non- preventive visits	40%	х
	Preventive care/ screening/ ir	nmunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagir	na	\$40 0%	X	40% 40%	X
-313	Imaging (CT/PET scans, MR		0%	X	40%	X
	Generic drugs Tier 1		0%	Х	40%	Х
Orugs to treat	Preferred brand drugs Tier 2		0%	Х	40%	Х
liness or	Non-preferred brand drugs Ti	er 3	0%	х	40%	х
condition			V	400/		
	Specialty drugs Tier 4	4	0%	X	40%	X
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	•)	0%	X	40% 40%	X
ervices	Outpatient visit		0%	X	40%	X
	Emergency room facility fee (	waived if admitted)	0%	Х	40%	Х
	Emergency room physician fe		00/	X	400/	Х
leed	Emergency medical transport		0%	X	40%	X
mmediate ittention	Urgent care	auon	\$120	After 1st three non- preventive visits	40%	х
Hospital stay	Facility fee (e.g. hospital roor Physician/surgeon fee	n)	0%	X X	40%	X
	Mental/Behavioral health out	\$70	After 1st three non- preventive visits	40%	x	
	Mental/Behavioral health other	\$70	After 1st three non- preventive visits	40%	х	
Mental	Mental/Behavioral health inpa	0%	х	40%	Х	
nealth,	Mental/Behavioral health inpa	atient physician/surgeon fee	0%	X	40%	Х
pehavioral nealth, or substance abuse needs	Substance Use disorder outp	\$70	After 1st three non- preventive visits	40%	х	
	Substance Use disorder othe	\$70	After 1st three non- preventive visits	40%	х	
	Substance Use inpatient facil	0%	X	40%	х	
	Substance use disorder inpat	ient physician/surgeon fee	0%	х	40%	х
	Prenatal care and preconcept	ion visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	0%	х	40%	Х
	services	Professional	0%	Х	40%	Х
	Home health care Outpatient Rehabilitation serv	rices	0% \$70	Х	40% 40%	X
lelp ecovering or	Outpatient Habilitation service		\$70		40%	X
ther special	Skilled nursing care		0%	х	40%	х
nealth needs	Durable medical equipment		0%	Х	40%	Х
	Hospice service Eye exam		No charge		0%	Х
Child eye care	1 pair of glasses per year (or	contact laneae in liqu of alacces)	No charge		No charge	
	Oral Exam	Someon remote in incu or glasses)	No charge		No charge	
Child Dental	Preventive - Cleaning					
Diagnostic	Preventive - X-ray		Not Covered		Not Covered	
ind Preventive	Sealants per Tooth Topical Fluoride Application					
Child Dental	Space Maintainers - Fixed		N+4 O		Not 0	
Basic Bervices	Amalgam Fill - 1 Surface  Root Canal- Molar		Not Covered		Not Covered	
Child Dental	Gingivectomy per Quad	and Post or Frunted	Not Covered		Not Course	
Major Services	Extraction- Single Tooth Expo Extraction- Complete Bony Porcelain with Metal Crown	seu Root or Erupted	Not Covered		Not Covered	
Child	Medically necessary orthodor	ntics	Not Covered		Not Covered	

Summary	of	Benefits	and	Coverage

Member Cost S	Share amounts describe the Enrollee's out of pocket costs.	Catastrophic Plan		
Actuarial Value	e - AV Calculator			
	cludes a deductible?	Yes, inte		
	Individual deductible Family deductible	\$6,850 int \$13,700 in		
Individual	deductible, NOT integrated: Medical / Pharmacy / Dental	N/A	4	
	luctible, NOT integrated: Medical / Pharmacy / Dental –of–pocket maximum	N/A \$6,8		
	pocket maximum	\$13,7		
	f-only coverage deductible	N/A		
	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	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	
clinic visit	Specialist visit	0%	х	
	Preventive care/ screening/ immunization	No charge		
Tests	Laboratory Tests X-rays and Diagnostic Imaging	0%	X	
16363	Imaging (CT/PET scans, MRIs)	0%	X	
	Generic drugs Tier 1	0%	X	
Drugs to treat	Preferred brand drugs <u>Tier 2</u>	0%	Х	
illness or condition	Non-preferred brand drugs Tier 3	0%	х	
	Specialty drugs Tier 4	0%	х	
Outpotions	Surgery facility fee (e.g., ASC)	0%	Х	
Outpatient services	Physician/surgeon fees	0%	X	
	Outpatient visit	0%	X	
	Emergency room facility fee (waived if admitted)	0%	Х	
Need	Emergency room physician fee (waived if admitted)	0%	Х	
immediate	Emergency medical transportation	0%	Х	
attention	Urgent care	0%	After 1st three non- preventive visits	
Hospital stay	Facility fee (e.g. hospital room)	0%	Х	
riospitai stay	Physician/surgeon fee	0%	Х	
	Mental/Behavioral health outpatient office visits	0%	After 1st three non- preventive visits	
	Mental/Behavioral health other outpatient items and services	0%	After 1st three non- preventive visits	
Mental	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	0%	X	
health,	Mental/Behavioral health inpatient physician/surgeon fee	0%	Х	
behavioral health, or substance abuse needs	Substance Use disorder outpatient office visits	0%	After 1st three non- preventive visits	
	Substance Use disorder other outpatient items and services	0%	After 1st three non- preventive visits	
	Substance Use inpatient facility fee (e.g. hospital room)	0%	X	
	Substance use disorder inpatient physician/surgeon fee	0%	X	
Prognance	Prenatal care and preconception visits	No charge	V	
Pregnancy	Delivery and all inpatient services Hospital	0%	X	
	Professional Home health care	0%	X	
Help	Outpatient Rehabilitation services	0%	Х	
recovering or	Outpatient Habilitation services	0%	X	
other special health needs	Skilled nursing care  Durable medical equipment	0%	X	
	Hospice service	0% 0%	X	
Child eye	Eye exam	No charge		
care	1 pair of glasses per year (or 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	Govereu		
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface	Not Covered		
Child Dental	Root Canal- Molar			
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		
Orthodontics				

#### **Endnotes to 2016 Standard Benefit Plan Designs**

#### Notes:

- Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. Innetwork services include services provided by an out-of-network provider but are approved as in-network by the 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) For <u>all plans including HDHPs linked to that are not HSA plans</u>, 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 the individual minimum deductible amount established by the Internal Revenue Service for the applicable Plan Year. 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 benefit category.
- 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.
- 19) When a QHP operates an integrated health plan and generates a single bill for an enrollee's use of the emergency room, the only cost-share that applies is for the emergency room facility fee. No emergency room physician fee cost share applies unless a separate emergency room physician bill is received by the QHP. Drug tiers are defined as follows:

Tier	<u>Definition</u>
<u>1</u>	1) Most generic drugs and low cost preferred brands.
	1) Non-preferred generic drugs or;
	2) Preferred brand name drugs or:
<u>2</u>	3) Recommended by the plan's pharmaceutical and
	therapeutics (P&T) committee based on drug safety, efficacy
	and cost.
	1) Non-preferred brand name drugs or;
	2) Recommended by P&T committee based on drug safety,
<u>3</u>	efficacy and cost or;
	3) Generally have a preferred and often less costly
	therapeutic alternative at a lower tier.
	1) Food and Drug Administration (FDA) or drug
	manufacturer limits distribution to specialty pharmacies or:
<u>4</u>	2) Self administration requires training, clinical monitoring or;
	3) Drug was manufactured using biotechnology or:
	4) Plan cost (net of rebates) is >\$600.

- 20) If a drug would otherwise qualify for placement on tier 4 and at least 3 treatment options are available for that particular condition as determined by either a plan's pharmaceutical and therapeutics (P&T) committee or indicated by the Food and Drug Administration (FDA) or according to applicable treatment guidelines for that condition, one drug used to treat that condition must be placed on either tier 1,2 or 3.
- 21) All drugs covered in tier 4 must be expressly listed in the plan's formulary. All drugs placed in tiers 1 through 3 to treat the following conditions must be expressly listed in the plan's formulary: HIV/AIDs, hepatitis C, rheumatoid arthritis, multiple sclerosis, systemic lupus erythematosus.
- <u>A plan's formulary must include a statement that other drugs that are covered may not be listed on the formulary for tiers 1-3.</u>
- 23) A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary.



#### 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 (waived for Diagnostic & Preventive) \$65 Out of Network 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

\$300

\$350

50%

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

Orthodontia

Crown - Porcelain with Metal

Medically Necessary 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	Family Dental Plan				
Member Cost Share amou costs.	Member Cost Share amounts describe the Enrollee's out of pocket costs.			Adult Dental Copay Plan	
				Age 19 and	d Older
Actuarial Value		83.	0%	Not Calcu	ılated
Individual Deductible (waived for Diagnostic &	Individual Deductible (waived for Diagnostic & Preventive)		0	\$0	
Family Deductible (Two of waived for Diagnostic &	Preventive)		0	\$0	
	Maximum ximum (Two or More Children)	\$7	700	Not Appli Not Appli \$0	
			\$0 None		e
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
Diagnostic & Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	\$0 \$0 \$0 \$0 \$0 \$0		\$0 \$0 \$0 Not Covered Not Covered	
Basic Services	Amalgam Fill - One Surface	\$25		Not Covered \$25	
Major Services - Crowns and Casts, Endodontics, Periodontics, Prosthodontics, Oral	Root Canal - Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted	\$300 \$150 \$65		\$300 \$150 \$65	
Surgery	Extraction - Complete Bony Crown - Porcelain with Metal	\$160 \$300		\$160 \$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.
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- 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.
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#### 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 Coinsurance Plan		Adult Dental Coinsurance Plan			
			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 &	Preventive)	\$130 In Ne \$130 Out of	Network	Not Appli			
Individual Out of Pocket		\$350		Not Applicable			
	ximum (Two or More Children)	\$700		Not Applicable			
Office Copay		\$0		\$0			
(Waivered Condition provision, as	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%			
	Sealants per Tooth	0%		Not Covered			
	Topical Fluoride Application	0% 0%		Not Covered			
	Space Maintainers - Fixed			Not Covered			
Basic Services	Amalgam Fill - One Surface	20%	X	20%	X		
Major Convince Comme	Root Canal - Molar						
Major Services - Crowns and Casts, Endodontics,	Gingivectomy per Quad						
Periodontics,	Extraction- Single Tooth Exposed Root	50%	х	50%	Х		
Prosthodontics, Oral	or Erupted Extraction - Complete Bony	33 70	Λ	00 /0	^		
Surgery	Extraction - Complete bony						

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.

Crown - Porcelain with Metal

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.
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