## 2016 Standard Benefit Plan Designs

May 21, 2015 Final OAL-approved



Summary of	f Benefits and Coverage			₩тм		
Member Cost S	Share amounts describe the Er	nrollee's out of pocket costs.	Platinu Coinsurand		Platinu Copay P	
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 /	
Individual Out	luctible, NOT integrated: Me –of–pocket maximum	dical / Pharmacy / Dental	\$0 / \$0 / \$4,00		\$0 / \$0 / \$4,00	
Family Out-of-	pocket maximum f-only coverage deductible		\$8,00 N/A	0	\$8,00 N/A	)
	an: Individual deductible		N/A		N/A	
Common Medical Event	So	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Literin	36	Nice Type	Citaro	rippiloo	Citaro	replico
Health care	Primary care visit to treat an in	njury, illness, or condition	\$20		\$20	
provider's office or clinic visit	Other practitioner office visit		\$20		\$20	
	Specialist visit		\$40		\$40	
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge \$20		No charge \$20	
Tests	X-rays and Diagnostic Imagin		\$40		\$40	
	Imaging (CT/PET scans, MR	S)	10%		\$150	
	Tier 1	Tier 1			\$5	
Drugs to treat illness or condition	Tier 2		\$15		\$15	
condition	Tier 3		\$25		\$25	
	Tier 4		10% up to \$250 per script		10% up to \$250 per script	
Quality of the set	Surgery facility fee (e.g., ASC	)	10%		\$250	
Outpatient services	Physician/surgeon fees		10%		\$40	
	Outpatient visit	unived if admitted)	10% \$150		10% \$150	
	Emergency room facility fee (					
Need	Emergency room physician fe	10%		No charge		
immediate attention	Emergency medical transport	ation	\$150		\$150	
attention	Urgent care		\$40		\$40	
	Facility fee (e.g. hospital roon	0	10%		\$250 per day up	
Hospital stay	Physician/surgeon fee	''	10%		to 5 days \$40	
	Mental/Behavioral health outp	patient office visits	\$20		\$20	
	Mental/Behavioral health othe	r outpatient items and services	\$20		\$20	
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	10%		\$250 per day up	
Mental health.	Mental/Behavioral health inpa		10%		to 5 days \$40	
behavioral health, or		tient physician/surgeon tee	10%		\$40	
substance abuse needs	Substance Use disorder outp	atient office visits	\$20		\$20	
	Substance Use disorder othe	r 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		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 Outpatient Rehabilitation serve		10% \$20		\$20 \$20	
Help recovering or	Outpatient Habilitation service		\$20 \$20		\$20	
other special	Skilled nursing care		10%		\$150 per day up to 5 days	
health needs	Durable medical equipment		10%		10%	
Child eye	Hospice service Eye exam		No charge No charge		No charge No charge	
care	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge		No charge	
Child Da	Oral Exam					
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray		No obarra		No charge	
and Preventive	Sealants per Tooth Topical Fluoride Application		No charge		No charge	
Child Dental	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 Expe	osed Root or Erupted	50%		\$65	
Services	Extraction- Complete Bony Porcelain with Metal Crown				\$160 \$300	
Child Orthodontics	Medically necessary orthodor	tics	50%		\$1,000	

Date: May 21, 2015 Summary of Benefits and Co

Member Cost Share amounts describe the Enrollee's out of pocket costs.		nrollee's out of pocket costs.	Gold Coinsurand		Gold Copay F	
	e - AV Calculator		80.2%	6	81.0%	
	cludes a deductible? Individual deductible		No		No \$0	
	Family deductible		\$0 \$0		\$0	
	deductible, NOT integrated: luctible, NOT integrated: Mo	Medical / Pharmacy / Dental	\$0 / \$0 / \$0 / \$0 /		\$0 / \$0 / \$0 / \$0 /	
	-of-pocket maximum	fulcal / Filalinacy / Dental	\$6,20	0	\$6,20	0
Family Out-of-	pocket maximum f-only coverage deductible		\$12,40 N/A	00	\$12,40 N/A	00
	an: Individual deductible		N/A		N/A	
Common						
Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an i	njury, illness, or condition	\$35		\$35	
Health care provider's office or	Other practitioner office visit		\$35		\$35	
clinic visit	Specialist visit		\$55		\$55	
	Preventive care/ screening/ in	nmunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagir	a	\$35 \$50		\$35 \$50	_
	Imaging (CT/PET scans, MR		20%		\$250	
	Tier 1		\$15		\$15	
Drugs to treat	Tier 2	\$50		\$50		
illness or condition	Tier 3	\$70		\$70		
	Tier 4		20% up to \$250 per script		20% up to \$250 per script	
Outpatient	Surgery facility fee (e.g., ASC)		20%		\$600	
services	Physician/surgeon fees Outpatient visit		20%		\$55 20%	_
	Emergency room facility fee	waived if admitted)	\$250		\$250	
	Emergency room physician fee (waived if admitted)					
Need	Emergency medical transpor	20% \$250		No charge \$250		
immediate attention	Urgent care		\$60		\$60	
	Facility fee (e.g. hospital roor	n)	20%		\$600 per day up	
Hospital stay	Physician/surgeon fee	"/	20%		to 5 days \$55	
	Mental/Behavioral health outpatient office visits		\$35		\$35	
	Mental/Behavioral health other outpatient items and services		\$35		\$35	
	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	20%		\$600 per day up	
Mental health,	Mental/Behavioral health inn	atient physician/surgeon fee	20%		to 5 days \$55	
behavioral health, or substance abuse needs	Mental/Behavioral health inpatient physician/surgeon fee Substance Use disorder outpatient office visits		\$35		\$35	
	Substance Use disorder other outpatient items and services		\$35		\$35	
	Substance Use inpatient faci	ity fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Substance use disorder inpa	tient physician/surgeon fee	20%		\$55	
	Prenatal care and preconcep	tion visits	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 service	ices	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	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	
Child Dental	Oral Exam Preventive - Cleaning					
Diagnostic	Preventive - X-ray		No charge		No charge	
and Preventive	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed		i to sharge			
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%		\$25	
	Root Canal- Molar				\$300	
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Exp	osed Root or Frupted	50%		\$150 \$65	
Services	Extraction- Complete Bony		5070		\$160	
	Porcelain with Metal Crown				\$300	
Child						

## 2016 Standard Benefit Plan Designs 10.0 EHB Date: May 21, 2015 Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs. Actuarial Value - AV Calculat Plan design includes a deductible? Integrated Individual deductible? Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum Family Out-of-pocket maximum HSA plan: Self-only coverage deductible HSA family plan: Individual deductible Medical Event Primary care visit to treat an injury, illness, or condition Health care provider's office or clinic visit Other practitioner office visit Specialist visit Preventive care/ screening/ immunization No charge Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) Tests Tier 1 Tier 2 Drugs to treat illness or condition Tier 3 20% up to \$250 per script after pharmacy deductible Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fees Outpatient services Outpatient visit Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted) ed hmediate Emergency medical transportation Urgent care

Individual

Silver Plan

70.4%

Yes, Medical/Pharmacy es, Medical/Pharmacy N/A \$2,250 / \$250 / \$0 \$4,500 / \$500 / \$0 \$6,250 \$12,500

N/A N/A

\$45

\$45

\$70

\$35 \$65 \$250

\$15

\$50

\$70

20% 20%

20%

\$250

\$50

\$250

\$90

50%

Deductibl Applies

Pharmacy deductible

Pharmacy deductible

Pharmacy deductible

х

х

Х

Hospital stay	Facility fee (e.g. hospital room	)	20%	х
	Physician/surgeon fee		20%	Х
	Mental/Behavioral health outp	atient office visits	\$45	
	Mental/Behavioral health othe	r outpatient items and services	\$45	
Mental	Mental/Behavioral health inpa	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 outp	atient office visits	\$45	
	Substance Use disorder othe	r outpatient items and services	\$45	
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%	х
	Substance use disorder inpat	ent physician/surgeon fee	20%	х
	Prenatal care and preconcept	ion visits	No charge	
Pregnancy	Delivery and all inpatient services	Hospital	20%	х
		Professional	20%	х
	Home health care		\$45	
Help	Outpatient Rehabilitation serv Outpatient Habilitation service		\$45 \$45	
recovering or		5		
other special	Skilled nursing care		20%	х
health needs	Durable medical equipment		20%	
	Hospice service		No charge	
Child eye	Eye exam		No charge	
care	1 pair of glasses per year (or c	ontact lenses in lieu of glasses)	No charge	
	Oral Exam			
Child Dental	Preventive - Cleaning			
Diagnostic	Preventive - X-ray		No charge	
and Preventive	Sealants per Tooth		i to ondigo	
Preventive	Topical Fluoride Application Space Maintainers - Fixed			
Child Dental Basic	Amalgam Fill - 1 Surface		20%	
Services	Deat Oracel Males			
Child Dental	Root Canal- Molar Gingivectomy per Quad			
Major	Extraction- Single Tooth Expo	sed Root or Erupted	50%	
Services	Extraction- Complete Bony		/0	
	Porcelain with Metal Crown			
Child				

Services hild

Medically necessary orthodontics

Date: May	21, 2015					
Summary of	f Benefits and Coverage		SHOP		SHOP	
Member Cost S	Share amounts describe the Er	rollee's out of pocket costs.	Silver Coinsurance	Plan	Silver Copay Pla	n
Actuarial Valu	e - AV Calculator		71.6%		71.3%	
	ncludes a deductible?		Yes, Medical/Pha	armacy	Yes, Medical/Pha	armacy
	Individual deductible Family deductible		N/A N/A		N/A N/A	
Individual	deductible, NOT integrated:	Medical / Pharmacy / Dental	\$1,500 / \$250		\$1,500 / \$250	
	ductible, NOT integrated: Me t–of–pocket maximum	dical / Pharmacy / Dental	\$3,000 / \$500 \$6,500	/\$0	\$3,000 / \$500 \$6,500	/\$0
Family Out-of-	-pocket maximum		\$13,000		\$13,000	
	f-only coverage deductible an: Individual deductible		N/A N/A		N/A N/A	
Common						
Medical Event	Se	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an ir	jury, illness, or condition	\$45		\$45	
Health care provider's office or clinic visit	Other practitioner office visit		\$45		\$45	
chine visit	Specialist visit		\$70		\$70	
	Preventive care/ screening/ in	munization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagin	q	\$35 \$65		\$35 \$65	
	Imaging (CT/PET scans, MRI		20%	Х	\$250	
	Tier 1		\$15		\$15	
Drugs to treat illness or	s or		\$55	Pharmacy deductible	\$55	Pharmacy deductible
condition	Tier 3		\$75	Pharmacy deductible	\$75	Pharmacy deductible
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20% up to \$250 per script after pharmacy deductible	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		\$50	x	\$50	х
Need	Emergency medical transport		\$50 \$250	X	\$50 \$250	X
immediate attention	Emergency medical transport	2001	\$250		\$250	
	Urgent care		\$90		\$90	
	Facility fee (e.g. hospital room	)	20%	х	20%	х
Hospital stay	Physician/surgeon fee	,	20%	X	20%	X
	Mental/Behavioral health outp	atient office visits	\$45		\$45	
	Mental/Behavioral health othe	r outpatient items and services	\$45		\$45	
	Mental/Behavioral health inna	tient facility fee (e.g.hospital room)	20%	х	20%	x
Mental health,						
behavioral	Mental/Behavioral health inpa	tient physician/surgeon fee	20%	X	20%	Х
health, or substance abuse needs	Substance Use disorder outp	atient office visits	\$45		\$45	
	Substance Use disorder othe	r outpatient items and services	\$45		\$45	
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%	х	20%	х
	Substance use disorder inpat	ient physician/surgeon fee	20%	х	20%	х
	Prenatal care and preconcep	tion visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	х	20%	х
	services	Professional	20%	X	20%	X
Unin	Home health care Outpatient Rehabilitation serv	ices	20% \$45		\$45 \$45	
Help recovering or	Outpatient Habilitation service		\$45		\$45	
other special	Skilled nursing care		20%	х	20%	х
health needs	Durable medical equipment		20%		20%	
	Hospice service Eye exam		No charge No charge		No charge No charge	
Child eye care	1 pair of glasses per year (or o	contact lenses in lieu of classes)	No charge No charge		No charge No charge	
	Oral Exam		no sharge			
Child Dental	Preventive - Cleaning					
Diagnostic and	Preventive - X-ray Sealants per Tooth		No charge		No charge	
Preventive	Topical Fluoride Application					
Child Dental Basic	Space Maintainers - Fixed Amalgam Fill - 1 Surface		20%		\$25	
Services	Deet Concl. Mala					
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						
Orthodontics	Medically necessary orthodor	tics	50%		\$1,000	

Date: May				
-	Benefits and Coverage		SHOP Silver	
	hare amounts describe the En	rollee's out of pocket costs.	HSA Pla 70.5%	in
	cludes a deductible?		Yes, integra	ated
Integrated	Individual deductible Family deductible		\$2,000 integ \$4,000 integ	rated
Individual	deductible, NOT integrated:	Medical / Pharmacy / Dental	N/A	rateu
Family ded	luctible, NOT integrated: Me -of-pocket maximum	dical / Pharmacy / Dental	N/A \$6,250	
Family Out-of- HSA plan: Self	pocket maximum -only coverage deductible		\$12,500 \$2,000	
HSA family pla	n: Individual deductible		\$2,600	
Common Medical Event	Service Type		Member Cost Share	Doductible An
Event	Primary care visit to treat an in		20%	Deductible App
Health care provider's	Other practitioner office visit		20%	x
office or clinic visit	Specialist visit		20%	x
	Preventive care/ screening/ in Laboratory Tests		No charge 20%	X
Tests	X-rays and Diagnostic Imagin Imaging (CT/PET scans, MRI		20% 20%	X X
	Tier 1	/	20%	x
Drugs to treat	Tier 2		20%	x
illness or condition	Tier 3	20%	x	
	Tier 4	20%	x	
	Surgery facility fee (e.g., ASC	)	20%	x
Outpatient services	Physician/surgeon fees		20%	Х
	Outpatient visit	unional if admitted)	20%	X
	Emergency room facility fee (waived if admitted)		20%	X
Need	Emergency room physician fe Emergency medical transport		20%	X
immediate attention	Urgent care		20%	x
Hospital stay	Facility fee (e.g. hospital room	)	20%	x
	Physician/surgeon fee		20%	Х
	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, behavioral	Mental/Behavioral health inpa	tient physician/surgeon fee	20%	х
benavioral health, or substance abuse needs	Substance Use disorder outpa	20%	x	
	Substance Use disorder other	outpatient items and services	20%	x
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%	x
	Substance use disorder inpati		20%	х
	Prenatal care and preconcept		No charge	
Pregnancy	Delivery and all inpatient services	Hospital	20%	X
	Home health care	Professional	20% 20%	X
Help	Outpatient Rehabilitation service		20% 20%	X
ecovering or other special	Skilled nursing care		20%	x
	Durable medical equipment		20%	X
nealth needs	Hospice service		0% No charge	Х
health needs	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge	
health needs Child eye	1 pair of glasses per year (or c	ontact lenses in lieu of glasses)	~	
health needs Child eye care	Oral Exam	ontact lenses in lieu of glasses)		
health needs Child eye care Child Dental		ontact lenses in lieu of glasses)	No to	
health needs Child eye care Child Dental Diagnostic and	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	ontact lenses in lieu of glasses)	No charge	
health needs Child eye care Child Dental Diagnostic and	Oral Exam Preventive - Cleaning Preventive - X-ray	ontact lenses in lieu of glasses)	No charge	
health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application	ontact lenses in lieu of glasses)	No charge	
health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar	ontact lenses in lieu of glasses)		
health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major Services	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface			

Summary of	f Benefits and Coverage						
Member Cost S	Share amounts describe the En	rollee's out of pocket costs.	Silver F 100%-150		Silver Plan 150%-200% F		
Actuarial Valu	e - AV Calculator		93.89		86.8%		
	cludes a deductible?		Yes, Medical/	Pharmacy	Yes, Medical/Pharmacy		
	Individual deductible Family deductible		N/A N/A		N/A N/A		
Individual	deductible, NOT integrated: ductible, NOT integrated: Me		\$75 / \$0		\$550 / \$50 / \$		
Individual Out	-of-pocket maximum	lical / Pharmacy / Dental	\$150 / \$0 \$2,25		\$1,100 / \$100 / \$2,250	\$U	
	pocket maximum f-only coverage deductible		\$4,50 N/A	0	\$4,500 N/A		
	an: Individual deductible		N/A		N/A N/A		
Common							
Medical			Member Cost Share	Deductible	Mambar Cast Share	Deductible	
Event	Ser	vice Туре	Share	Applies	Member Cost Share	Applies	
	Primary care visit to treat an in	jury, illness, or condition	\$5		\$15		
Health care provider's office or	Other practitioner office visit		\$5		\$15		
clinic visit	Specialist visit		\$8		\$25		
	Preventive care/ screening/ im	munization	No charge		No charge		
Tests	Laboratory Tests X-rays and Diagnostic Imaging	1	\$8 \$8		\$15 \$25		
	Imaging (CT/PET scans, MRI		\$50		\$100		
	Tier 1		\$3		\$5		
Drugs to treat illness or	Tier 2		\$10		\$20	Pharmacy deductible	
condition	Tier 3		\$15		\$35	Pharmacy deductible	
	Tier 4		10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharmacy deductible	
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees		10% 10%		15% 15%		
services	Outpatient visit		10%		15%		
	Emergency room facility fee (v	vaived if admitted)	\$30	x	\$75	x	
	Emergency room physician fe	(waived if admitted)		x		v	
Need	Emergency medical transporta	, ,	\$25 \$30	X	\$40 \$75	X	
immediate attention	Emergency medical transporta	non	\$30	^	\$15	^	
	Urgent care		\$6		\$30		
	Facility fee (e.g. hospital room	)	10%	x	15%	x	
Hospital stay	Physician/surgeon fee		10%	X	15%	X	
	Mental/Behavioral health outp	atient office visits	\$5		\$15		
	Mental/Behavioral health othe	outpatient items and services	\$5		\$15		
	Mental/Behavioral booth inner	ient facility fee (e.g.hospital room)	10%	x	15%	x	
Mental							
health, behavioral	Mental/Behavioral health inpat	ient physician/surgeon fee	10%	X	15%	X	
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 facilit	y fee (e.g. hospital room)	10%	х	15%	х	
	Substance use disorder inpati	ent physician/surgeon fee	10%	x	15%	х	
	Prenatal care and preconcept		No charge		No charge		
Pregnancy	Delivery and all inpatient	Hospital	10%	х	15%	х	
	services	Professional	10%	X	15%	х	
	Home health care		\$3		\$15		
Help	Outpatient Rehabilitation servi Outpatient Habilitation service:		\$5 \$5		\$15 \$15		
	Skilled nursing care		10%	х	15%	х	
health needs	Durable medical equipment		10%		15%		
	Hospice service		No charge		No charge		
Child eye care	Eye exam	notact langes in liqu of alagoon)	No charge		No charge		
Jure	1 pair of glasses per year (or o Oral Exam	under rended in lieu of glasses)	No charge		No charge		
Child Dental	Preventive - Cleaning						
Diagnostic and	Preventive - X-ray		No charge		No charge		
and Preventive	Sealants per Tooth Topical Fluoride Application				-		
	Space Maintainers - Fixed						
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%		20%		
Child Dental	Root Canal- Molar Gingivectomy per Quad						
Major	Extraction- Single Tooth Expo	sed Root or Erupted	50%		50%		
Services	Extraction- Complete Bony Porcelain with Metal Crown						
Child		ilee.					
Orthodontics	Medically necessary orthodon	acs	50%		50%		

	share amounts describe the E	nrollee's out of pocket costs.	Silver Plan 200%-250% FPL			
Actuarial Valu	e - AV Calculator		72.8%			
	cludes a deductible?		Yes, Medical/Pha	rmacy		
	Individual deductible Family deductible		N/A N/A			
Individual	deductible, NOT integrated	: Medical / Pharmacy / Dental	\$1,900 / \$250 /			
	luctible, NOT integrated: M –of–pocket maximum	edical / Pharmacy / Dental	\$3,800 / \$500 / \$5,450	\$0		
Family Out-of-	pocket maximum		\$10,900			
HSA plan: Self	f-only coverage deductible		N/A			
	an: Individual deductible		N/A			
Common Medical				Deducti		
Event	Se	ervice Type	Member Cost Share	Applie		
Health care	Primary care visit to treat an	injury, illness, or condition	\$40			
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	na	\$35 \$50			
	Imaging (CT/PET scans, MR		\$250			
	Tier 1		\$15			
Drugs to treat	Tier 2		\$45	Pharma deducti		
illness or condition	Tier 3		\$70	Pharma deducti		
	Tier 4	20% up to \$250 per script after pharmacy	Pharma			
		deductible	deducti			
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		
	Emergency room physician f			v		
leed	Emergency medical transpor	\$50 \$250	X			
mmediate attention			\$250	~		
	Urgent care		\$80			
lospital stay	Facility fee (e.g. hospital roor	n)	20%	х		
	Physician/surgeon fee		20%	Х		
	Mental/Behavioral health out	\$40				
	Mental/Behavioral health other outpatient items and services		\$40			
	Montal/Pohavioral boatth inp	ationst facility foo (o a boonital room)	20%			
Mental		atient facility fee (e.g.hospital room)	20%	х		
nealth, behavioral	Mental/Behavioral health inp	atient physician/surgeon fee	20%	Х		
nealth, or substance abuse needs	Substance Use disorder out	patient office visits	\$40			
	Substance Use disorder othe	er outpatient items and services	\$40			
	Substance Use inpatient faci	ility fee (e.g. hospital room)	20%	х		
	Substance use disorder inpa		20%	х		
	Prenatal care and preconcept	otion visits	No charge			
Pregnancy	Delivery and all inpatient services	Hospital	20%	x		
	Home health care	Professional	20% \$40	X		
lelp	Outpatient Rehabilitation ser		\$40			
ecovering or	Outpatient Habilitation servic	03	\$40			
other special nealth needs	Skilled nursing care		20%	х		
	Durable medical equipment Hospice service		20% No charge			
Child eye	Eye exam		No charge			
are	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge			
	Oral Exam					
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray					
ind	Sealants per Tooth		No charge			
Preventive	Topical Fluoride Application Space Maintainers - Fixed					
Child Dental Basic	Amalgam Fill - 1 Surface		20%			
Services	Root Canal- Molar			_		
Child Dental	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted			-		
Major	Extraction- Single Tooth Exp	osed Root or Erupted	50%			
		osed Root or Erupted	50%			

	Share amounts describe the Er	rollee's out of pocket costs.	Bronze Pla	n	Bron	ze
Actuarial Value					HSA P	lan
	e - AV Calculator		61.9%		61.1	%
	cludes a deductible?		Yes, Medical/Pha	irmacy	Yes, integ	
Integrated	Individual deductible Family deductible		N/A N/A		\$4,500 inte \$9,000 inte	
	deductible, NOT integrated: luctible, NOT integrated: Me	Medical / Pharmacy / Dental	\$6,000 / \$500 \$12,000 / \$1,00		N/A N/A	
Individual Out-	–of–pocket maximum		\$6,500	-,	\$6,50	00
	pocket maximum f-only coverage deductible		\$13,000 N/A		\$13,0 \$4,50	
	an: Individual deductible		N/A		\$4,50	00
Common Medical Event	Se	vice Туре	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an ir		\$70	After 1st three non-preventive visits	40%	x
Health care provider's office or	Other practitioner office visit		\$70	After 1st three non-preventive visits	40%	x
clinic visit	Specialist visit		\$90	After 1st three non-preventive visits	40%	х
	Preventive care/ screening/ in	munization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagin	q	\$40 100%	X	40% 40%	X
	Imaging (CT/PET scans, MRI		100%	X	40%	X
	Tier 1		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40%	х
Drugs to treat illness or	Tier 2		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40%	x
condition	Tier 3		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40%	х
	Tier 4		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40%	х
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	)	100% 100%	X X	40% 40%	X X
services	Outpatient visit		100%	X	40%	X
	Emergency room facility fee (	vaived if admitted)	100%	х	40%	х
	Emergency room physician fe	e (waived if admitted)	100%	х	40%	х
Need immediate	Emergency medical transport		100%	X	40%	X
attention	Urgent care		\$120	After 1st three non-preventive visits	40%	x
	Facility fee (e.g. hospital room	)	100%	x	40%	x
Hospital stay	Physician/surgeon fee	,	100%	X	40%	X
	Mental/Behavioral health outp	atient office visits	\$70	After 1st three non-preventive visits	40%	x
	Mental/Behavioral health othe	r outpatient items and services	\$70	After 1st three non-preventive visits	40%	x
Mental	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	100%	х	40%	х
health,	Mental/Behavioral health inpa	tient physician/surgeon fee	100%	x	40%	x
behavioral health, or substance abuse needs	Substance Use disorder outp		\$70	After 1st three non-preventive visits	40%	x
	Substance Use disorder othe	r outpatient items and services	\$70	After 1st three non-preventive	40%	x
	Substance Use inpatient facili		100%	visits X	40%	x
				x	40%	x
	Substance use disorder inpat Prenatal care and preconcept		100% No charge	^	40% No charge	
Pregnancy	Delivery and all inpatient services	Hospital	100%	х	40%	х
	Home health care	Professional	<u>100%</u> 100%	<u> </u>	40% 40%	X
Help	Outpatient Rehabilitation serv		\$70		40%	Х
recovering or	Outpatient Habilitation service	S	\$70		40%	X
other special health needs	Skilled nursing care		100%	X	40%	X
	Durable medical equipment Hospice service		100% No charge	X	40% 0%	X X
onnueye	Eye exam		No charge		No charge	
care	1 pair of glasses per year (or o Oral Exam	contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application		No charge		No charge	
Child Dental Basic	Space Maintainers - Fixed Amalgam Fill - 1 Surface		20%		20%	
Child Dental	Root Canal- Molar Gingivectomy per Quad					
Major Services	Extraction- Single Tooth Expo Extraction- Complete Bony Porcelain with Metal Crown	ised Root or Erupted	50%		50%	
Child Orthodontics	Medically necessary orthodor	tics	50%		50%	

	hare amounts describe the En	rollee's out of pocket costs.	Catastro	ohic Plan
	e - AV Calculator			
	cludes a deductible? Individual deductible		Yes, int \$6,850 ir	egrated
Integrated	Family deductible		\$6,850 ir \$13,700 i	
		Medical / Pharmacy / Dental	N	
Family ded Individual Out-	luctible, NOT integrated: Me –of–pocket maximum	dical / Pharmacy / Dental	N. \$6,	
Family Out-of-	pocket maximum		\$13	700
HSA plan: Self	f-only coverage deductible an: Individual deductible		N	
			IN.	A
Common Medical Event			Member Cost Share	Deductible
Lvent		vice Type		Applies After 1st three
Health care	Primary care visit to treat an in	ijury, iliness, or condition	0%	non-preventive visits After 1st three
provider's office or clinic visit	Other practitioner office visit		0%	non-preventive visits
	Specialist visit	0%	х	
	Preventive care/ screening/ in Laboratory Tests	Indrization	No charge 0%	х
Tests	X-rays and Diagnostic Imagin	g	0%	X
	Imaging (CT/PET scans, MRI	s)	0%	Х
	Tier 1		0%	х
Drugs to treat illness or	Tier 2		0%	х
condition	Tier 3	0%	х	
	Tier 4	0%	х	
Outpatient	Surgery facility fee (e.g., ASC)	)	0%	X
services	Physician/surgeon fees Outpatient visit		0%	X
	Emergency room facility fee (v	vaived if admitted)	0%	x
			0%	^
Need	Emergency room physician fe		0%	х
mmediate	Emergency medical transport	ation	0%	Х
attention	Urgent care		0%	After 1st three non-preventive visits
Hospital stay	Facility fee (e.g. hospital room	)	0%	х
,	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/Behavioral health inpa	tient facility fee (e.g.hospital room)	0%	х
Mental health,	Manata UB at an Assart to a still. Some	the state of the s		
behavioral	Mental/Behavioral health inpa	tient physician/surgeon fee	0%	X
health, or substance abuse needs	Substance Use disorder outpa	atient 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 facili	ty fee (e.g. hospital room)	0%	х
	Substance use disorder inpati		0%	х
	Prenatal care and preconcept	ion visits	No charge	
Pregnancy	Delivery and all inpatient	Hospital	0%	х
	services	Professional	0%	х
	Home health care		0%	X
Help	Outpatient Rehabilitation service Outpatient Habilitation service		0%	X
recovering or other special	Skilled nursing care		0%	x
health needs	Durable medical equipment		0%	X
	Hospice service		0%	X
onnu eye	Eye exam		No charge	
care	1 pair of glasses per year (or c	ontact lenses in lieu of glasses)	0%	х
Child Dental	Oral Exam Preventive - Cleaning			
Diagnostic	Preventive - Cleaning Preventive - X-ray			
and	Sealants per Tooth		No charge	
Preventive	Topical Fluoride Application Space Maintainers - Fixed			
Child Dental Basic	Amalgam Fill - 1 Surface		0%	x
	Root Canal- Molar			X
Services	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted			
Services Child Dental				X
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Expo	sed Root or Erupted	0%	Х
Child Dental	Gingivectomy per Quad	sed Root or Erupted	0%	
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Expo Extraction- Complete Bony		0%	X X





Member Cost S	hare amounts describe the En	rollee's out of pocket costs.	Platinu Coinsurano		Platinu Copay P	
Actuarial Value	e - AV Calculator		88.5%		89.5%	
Plan design in	cludes a deductible?		No		No	
Integrated	Individual deductible		\$0		\$0	
Integrated	Family deductible deductible, NOT integrated:	Medical / Pharmacy / Dental	\$0 \$0 / \$0 /	\$0	\$0 \$0 / \$0 /	\$0
	luctible, NOT integrated: Med		\$0 / \$0 /		\$0 / \$0 /	
Individual Out-	–of–pocket maximum		\$4,00	0	\$4,000	0
	pocket maximum f-only coverage deductible		\$8,00 N/A	0	\$8,000 N/A	D
HSA family pla	an: Individual deductible		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 in	jury, illness, or condition	\$20		\$20	
office or	Other practitioner office visit		\$20		\$20	
clinic visit	Specialist visit		\$40		\$40	
	Preventive care/ screening/ im	munization	No charge		No charge	
Teete	Laboratory Tests	-	\$20		\$20	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs	) \$)	\$40 10%		\$40 \$150	
		,				
	Tier 1		\$5		\$5	
illness or	Tier 2		\$15		\$15	
condition	Tier 3		\$25		\$25	
	Tier 4	10% up to \$250		10% up to \$250		
			per script		per script	
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees		10%		\$250	
services	Physician/surgeon fees Outpatient visit		10% 10%		\$40 10%	
	Emergency room facility fee (w	vaived if admitted)	\$150		\$150	
			_			
Need	Emergency room physician fee (waived if admitted)		10%		No charge	
immediate	Emergency medical transportation		\$150		\$150	
attention	Urgent care		\$40		\$40	
Hospital 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/Behavioral health inpatient facility fee (e.g.hospital room)		10%		\$250 per day	
Mental health,					up to 5 days	
behavioral	Mental/Behavioral health inpatient 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 facilit	y fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Substance use disorder inpati	ent physician/surgeon fee	10%		\$40	
	Prenatal care and preconcepti		No charge		No charge	
	Delivery and all inpatient	Hospital	10%		\$250 per day	
	services		10%		up to 5 days	
	Home health care	Professional	10%		\$40 \$20	
Help	Outpatient Rehabilitation servi		\$20		\$20	
recovering or	Outpatient Habilitation services	3	\$20		\$20 \$150 per day	
health needs	Skilled nursing care		10%		\$150 per day up to 5 days	
	Durable medical equipment		10%		10%	
	Hospice service Eye exam		No charge No charge		No charge No charge	
Child eye care	1 pair of glasses per year (or cr	ontact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam					
	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	
	Root Canal- Molar				Not Covered Not Covered	
	Gingivectomy por Quad					
Child Dental	Extraction- Single Tooth Exposed Root or Erupted		Not Covered		Not Covered	
Child Dental	Extraction- Complete Bony	sed Root or Erupted	Not Covered		Not Covered Not Covered	
Child Dental Major	Extraction- Single Tooth Expo	sed Root or Erupted	Not Covered		Not Covered	

	Benefits and Coverage		Gold	1	Gold	
	hare amounts describe the Ei	nrollee's out of pocket costs.	Coinsuran		Copay F	
			80.29	6	81.0%	0
	cludes a deductible? Individual deductible		No \$0		No \$0	
Integrated	Family deductible		\$0		\$0	
Family ded	deductible, NOT integrated: luctible, NOT integrated: Me	Medical / Pharmacy / Dental	\$0 / \$0 \$0 / \$0		\$0 / \$0 / \$0 / \$0 /	
Individual Out	–of–pocket maximum		\$6,20	0	\$6,20	0
	pocket maximum f-only coverage deductible		\$12,40 N/A	00	\$12,40 N/A	0
	an: Individual deductible		N/A		N/A	
Common			Marrison Cont		Mambar Card	
Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primony corro visit to troot on i	aiun, illages, or condition	\$35		\$35	
	Primary care visit to treat an in	jury, miless, or conductr	<b>\$</b> 35		\$30	
Health care						
provider's office or	Other practitioner office visit		\$35		\$35	
clinic visit						
	Specialist visit		\$55		\$55	
	Preventive care/ screening/ in	nmunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagin	q	\$35 \$50		\$35 \$50	
	Imaging (CT/PET scans, MR		20%		\$250	
	Tier 1		\$15		\$15	
Drugs to treat	Tier 2		\$50		\$50	
illness or				_		
condition	Tier 3	\$70		\$70		
	Tier 4		20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC	)	20%		\$600	
Outpatient services	Physician/surgeon fees	/	20%		\$55	
	Outpatient visit		20%		20%	
	Emergency room facility fee (	waived if admitted)	\$250		\$250	
Need	Emergency room physician fe	e (waived if admitted)	20%		No charge	
immediate	Emergency medical transport	ation	\$250		\$250	
attention						
	Urgent care		\$60		\$60	
					\$600 per day	
Hospital stay	Facility fee (e.g. hospital roon	1)	20%		up to 5 days	
	Physician/surgeon fee		20%		\$55	
	Mental/Behavioral health outp	patient office visits	\$35		\$35	
	· · · · · · · · · · · · · · · · · · ·					
	Mental/Behavioral health other outpatient items and services		\$35		\$35	
		•				
Mental	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%		\$600 per day up to 5 days	
health,	Mental/Behavioral health inpa	tient physician/surgeon fee	20%		\$55	
behavioral health, or						
substance	Substance Use disorder outp	atient office visits	\$35		\$35	
abuse needs						
	Substance Lise disorder othe	r outpatient items and services	\$35		\$35	
	Substance use disorder othe	i oupatient tients and services	<b>\$</b> 35		\$30	
	Substance Use inpatient facil	ity fee (e.g. hospital room)	20%		\$600 per day	
					up to 5 days	
	Substance use disorder inpat		20%		\$55	
Pregnancy	Prenatal care and preconcep Delivery and all inpatient		No charge	_	No charge \$600 per day	
. regnancy	services	Hospital Professional	20%		up to 5 days	
	Home health care	•	20%		\$55 \$30	
Help	Outpatient Rehabilitation service		\$35		\$35	
recovering or other special	Skilled nursing care	10	\$35		\$35 \$300 per day	
health needs	Durable medical equipment		20%		up to 5 days 20%	
	Hospice service		No charge		No charge	
Child eye	Eye exam	nontrat langua la Vere et ete a	No charge		No charge	
care	1 pair of glasses per year (or Oral Exam	contact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Preventive - Cleaning		1			
Diagnostic and	Preventive - X-ray Sealants per Tooth		Not Covered		Not Covered	
Preventive	Topical Fluoride Application					
Child Dental	Space Maintainers - Fixed					
Basic	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 Expe Extraction- Complete Bony	osea Koot or Erupted	Not Covered		Not Covered Not Covered	
	Porcelain with Metal Crown				Not Covered	
Child Orthodontics	Medically necessary orthodor	ntics	Not Covered		Not Covered	
- Alloaonnio 5						_

Member Cost S Actuarial Valu Plan design ir	f Benefits and Coverage	9	Individua	d .
Plan design ir	Share amounts describe the E		Silver Pla	
	e - AV Calculator		70.4%	
	ncludes a deductible? Individual deductible		Yes, Medical/Pha N/A	armacy
Integrated	Family deductible		N/A	
Individual Family dee	deductible, NOT integrated: ductible, NOT integrated: Me	Medical / Pharmacy / Dental	\$2,250 / \$250 \$4,500 / \$500	
Individual Out	–of–pocket maximum -pocket maximum		\$6,250 \$12,500	
HSA plan: Sel	f-only coverage deductible		N/A	
	an: Individual deductible		N/A	
Common Medical			Marrhan Cast Share	Deductib
Event	Primary care visit to treat an i	rvice Type njury, illness, or condition	Member Cost Share \$45	Applies
Health care provider's	Other practitioner office visit		\$45	
office or clinic visit	Specialist visit		\$70	
	Preventive care/ screening/ in Laboratory Tests	nnunization	No charge \$35	
Tests	X-rays and Diagnostic Imagir Imaging (CT/PET scans, MR	ng Is)	\$65 \$250	
	Tier 1		\$15	
Drugs to treat	Tier 2		\$50	Pharma
illness or condition	Tier 3			
	Tier 4	\$70 20% up to \$250 per script after pharmacy	deductib Pharmac deductib	
	Surgery facility fee (e.g., ASC	3	deductible 20%	deductib
Outpatient services	Physician/surgeon fees	20%		
	Outpatient visit		20%	
	Emergency room facility fee (	\$250	Х	
Need	Emergency room physician fe		\$50	Х
immediate attention	Emergency medical transpor	lation	\$250	X
Hospital stay	Facility fee (e.g. hospital room	n)	20%	x
	Physician/surgeon fee		20%	X
	Mental/Behavioral health out	\$45		
	Mental/Behavioral health othe	\$45		
Mental	Mental/Behavioral health inpa	20%	х	
health,	Mental/Behavioral health inpa	20%	х	
behavioral health, or substance abuse needs	Substance Use disorder outp	\$45		
	Substance Use disorder othe	er outpatient items and services	\$45	
	Substance Use inpatient faci	ity fee (e.g. hospital room)	20%	x
	Substance use disorder inpa	tient physician/surgeon fee	20%	х
	Prenatal care and preconcep		No charge	^
Pregnancy	Delivery and all inpatient	Hospital	20%	х
	services	Professional	20%	х
Help	Home health care Outpatient Rehabilitation service		\$45 \$45	
recovering or	Outpatient Habilitation service	95	\$45	
other special health needs	Skilled nursing care Durable medical equipment		20%	x
	Hospice service		20% No charge	
	Eye exam	nontrast langua in How of sta	No charge	
Child eye	1 pair of glasses per year (or Oral Exam	contact lenses in lieu of glasses)	No charge	
Child eye	Oral Exam Preventive - Cleaning			
Child eye care Child Dental	nd Preventive - X-ray Sealants per Tooth		Not Covered	
Child eye care Child Dental Diagnostic and	Preventive - X-ray Sealants per Tooth		Not Concidu	
Child eye care Child Dental Diagnostic and	Preventive - X-ray			
Child eye care Child Dental Diagnostic and Preventive Child Dental Basic	Preventive - X-ray Sealants per Tooth Topical Fluoride Application		Not Covered	
Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services	Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed			
Child eye care Child Dental Diagnostic and Preventive Child Dental Basic	Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface	osed Root or Erupted		

	21, 2015					
Summary of	Benefits and Coverage		SHOP Silver		SHOP Silver	
Member Cost S	Share amounts describe the E	nrollee's out of pocket costs.	Coinsurance	Plan	Copay Plai	n
Actuarial Valu	e - AV Calculator		71.6%		71.3%	
	cludes a deductible? Individual deductible		Yes, Medical/Pha N/A	irmacy	Yes, Medical/Pha N/A	rmacy
Integrated	Family deductible		N/A N/A		N/A	
Individual Eamily dec	deductible, NOT integrated: luctible, NOT integrated: Me	Medical / Pharmacy / Dental	\$1,500 / \$250 \$3,000 / \$500		\$1,500 / \$250 \$3,000 / \$500	
Individual Out	–of–pocket maximum	Salcar / Filamacy / Dental	\$6,500	7.40	\$6,500	, ψυ
	pocket maximum f-only coverage deductible		\$13,000 N/A		\$13,000 N/A	
HSA family pla	an: Individual deductible		N/A		N/A	
Common						
Medical Event	S.		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Litoint		rvice Type		Applied		Abbues
	Primary care visit to treat an i	njury, illness, or condition	\$45		\$45	
Health care						
provider's office or	Other practitioner office visit		\$45		\$45	
clinic visit						
	Specialist visit		\$70		\$70	
	Preventive care/ screening/ ir	nmunization	No charge		No charge	
_	Laboratory Tests		\$35		\$35	
Tests	X-rays and Diagnostic Imagir Imaging (CT/PET scans, MR		\$65 20%	X	\$65 \$250	
		,				
	Tier 1		\$15		\$15	
				Pharmacy		Pharmacy
Drugs to treat illness or	Tier 2		\$55	deductible	\$55	deductible
condition	Tion 2			Pharmacy	A	Pharmacy
	Tier 3		\$75	deductible	\$75	deductible
	Tier 4		20% up to \$250 per	Pharmacy	20% up to \$250 per	Pharmacy
	1161 4		script after pharmacy deductible	deductible	script after pharmacy deductible	deductible
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	i)	20% 20%		20% 20%	
services	Outpatient visit		20%		20%	
	Emergency room facility fee (	waived if admitted)	\$250	х	\$250	х
	Emergency room physician fee (waived if admitted)		\$50	x	\$50	х
Need immediate	Emergency medical transpor		\$250	X	\$250	X
attention						
	Urgent care		\$90		\$90	
Hospital stay	Facility fee (e.g. hospital room	n)	20%	х	20%	х
	Physician/surgeon fee		20%	Х	20%	х
	Mental/Rehavioral boolth outpatient office visits		<b>6</b> 45		0.45	
	Mental/Behavioral health outpatient office visits		\$45		\$45	
	Mental/Behavioral health other outpatient items and services		\$45		\$45	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	x	20%	x
Mental health,						
behavioral	Mental/Behavioral health inpa	atient physician/surgeon fee	20%	X	20%	X
health, or substance	Substance Use disorder outpatient office visits		¢ 45		¢ 45	
abuse needs	oubstance ose disorder out		\$45		\$45	
	Substance Use disorder othe	r outpatient items and services	\$45		\$45	
	Substance Use inpatient faci	ity fee (e.g. hospital room)	20%	x	20%	x
	Substance use disorder inpa	tient physician/surgeon fee	20%	х	20%	х
	Prenatal care and preconcep	tion visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	х	20%	х
	services Home health care	Professional	20%	X	20%	<u> </u>
Help	Outpatient Rehabilitation service		20% \$45		\$45 \$45	
recovering or	Outpatient Habilitation service		\$45		\$45	
other special health needs	Skilled nursing care		20%	x	20%	x
	Durable medical equipment 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 Preventive - Cleaning					
Diagnostic	Preventive - X-ray		Not Covered		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Services						
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		1		Not Covered Not Covered	
Child		ation	NH 0			
Orthodontics	Medically necessary orthodor	1000	Not Covered		Not Covered	

-	21, 2015			
-	Benefits and Coverage		SHOI	
	hare amounts describe the Ei	nrollee's out of pocket costs.	HSA PI 70.5%	
	cludes a deductible?		Yes, integ	
Integrated	Individual deductible		\$2,000 inte	grated
Individual of	Family deductible deductible, NOT integrated:	Medical / Pharmacy / Dental	\$4,000 inte N/A	grateu
Family ded Individual Out-	uctible, NOT integrated: Me -of-pocket maximum	edical / Pharmacy / Dental	N/A \$6,25	D
Family Out-of- HSA plan: Self	pocket maximum -only coverage deductible		\$12,50 \$2,00	
HSA family pla	n: Individual deductible		\$2,60	D
Common Medical				
Event	Se	rvice Type	Member Cost Share	Deductible App
Health care	Primary care visit to treat an i	njury, illness, or condition	20%	x
provider's office or clinic visit	Other practitioner office visit		20%	x
	Specialist visit		20%	x
	Preventive care/ screening/ in Laboratory Tests		No charge 20%	x
Fests	X-rays and Diagnostic Imagir Imaging (CT/PET scans, MR	lg Is)	20%	X X
	Tier 1		20%	X
Drugs to treat illness or condition			20%	X
	Tier 3		20%	x
	Tier 4		20%	x
Outpatient services	Surgery facility fee (e.g., ASC Physician/surgeon fees	·/	20% 20%	X X
SULLES	Outpatient visit		20%	X
	Emergency room facility fee (	waived if admitted)	20%	х
Need	Emergency room physician fe		20%	X
mmediate attention	Emergency medical transportation		20%	x
Hospital stay	Facility fee (e.g. hospital roon	n)	20%	x
	Physician/surgeon fee		20%	Х
	Mental/Behavioral health outpatient office visits		20%	х
	Mental/Behavioral health other outpatient items and services		20%	х
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	x
Mental nealth,	Mental/Behavioral health inpa		20%	x
pehavioral nealth, or substance	Substance Use disorder outp	., .	20%	x
abuse needs				<u> </u>
	Substance Use disorder othe	er outpatient items and services	20%	x
	Substance Use inpatient facil	ity fee (e.g. hospital room)	20%	x
	Substance use disorder inpar		20%	х
	Prenatal care and preconcep		No charge	
Pregnancy	Delivery and all inpatient services	Hospital Professional	20%	X
	Home health care		20%	X
Help recovering or	Outpatient Rehabilitation service		20% 20%	X
other special	Skilled nursing care		20%	х
nealth needs	Durable medical equipment		20%	X
	Hospice service Eye exam		0% No charge	X
are	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			
Child Dental	Space Maintainers - Fixed			
unu Dentai	Amalgam Fill - 1 Surface		Not Covered	
Basic Services				
Services	Root Canal- Molar Gingiyectomy per Quad			
Services Child Dental Major Services	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exp Extraction- Complete Bony Porcelain with Metal Crown	osed Root or Erupted	Not Covered	

	Share amounts describe the Er	nrollee's out of pocket costs.	Silver P 100%-1509	% FPL	Silver Plan 150%-200% FPL	
	e - AV Calculator Includes a deductible?		93.8%		86.8% Yes, Medical/Pharmacy	
Integrated	Individual deductible		Yes, Medical/F N/A	marmacy	N/A	Imacy
	Family deductible deductible, NOT integrated:	Medical / Pharmacy / Dental	N/A \$75 / \$0	/\$0	N/A \$550 / \$50 / \$	\$0
	luctible, NOT integrated: Me –of–pocket maximum	dical / Pharmacy / Dental	\$150 / \$0 \$2,25		\$1,100 / \$100 / \$2,250	\$0
Family Out-of-	pocket maximum		\$4,50		\$4,500	
HSA plan: Sel HSA family pla	f-only coverage deductible an: Individual deductible		N/A N/A		N/A N/A	
Common						
Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an in	njury, illness, or condition	\$5		\$15	
Health care provider's			05		045	
office or	Other practitioner office visit		\$5		\$15	
clinic visit	Specialist visit		\$8		\$25	
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge \$8		No charge \$15	
Tests	X-rays and Diagnostic Imagin Imaging (CT/PET scans, MR		\$8 \$50		\$25 \$100	
		3)	\$50		\$100	
	Tier 1		\$3		\$5	
						Pharmacy
Drugs to treat illness or	Tier 2		\$10		\$20	deductible
condition	Tier 3		\$15		\$35	Pharmacy
			φio			deductible
	Tier 4		10% up to \$150		15% up to \$150 per script after pharmacy	Pharmacy deductible
	Surgery facility fee (e.g., ASC)		per script 10%		deductible 15%	deddclibie
Outpatient services	Physician/surgeon fees	,	10%		15%	
	Outpatient visit		10%		15%	
	Emergency room facility fee (waived if admitted)		\$30	X	\$75	X
Need	Emergency room physician fee (waived if admitted) Emergency medical transportation		\$25	X	\$40	X
immediate attention	Emergency medical transportation		\$30	X	\$75	X
	Urgent care		\$6		\$30	
Hospital stay	Facility fee (e.g. hospital roon	1)	10%	х	15%	х
noopna olay	Physician/surgeon fee		10%	X	15%	Х
	Mental/Behavioral health outpatient office visits		\$5		\$15	
	wentarbenavioral nealth outpatient once visits		φJ		\$1J	
	Mantel/Debasianel backbackar extensions items and any issue					
	Mental/Behavioral health other outpatient items and services		\$5		\$15	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		10%	x	15%	х
Mental health,	Mental/Behavioral health inpatient physician/surgeon fee		10%	x	15%	x
behavioral health, or			10,0	~	10,0	~
substance abuse needs	Substance Use disorder outpatient office visits		\$5		\$15	
abuse neeus						
	Substance Use disorder other outpatient items and services		\$5		\$15	
					• •	
	Substance Use inpatient facil	ity fee (e.g. hospital room)	10%	х	15%	х
	Substance use disorder inpat	ient physician/surgeon fee	10%	х	15%	х
	Prenatal care and preconcep	tion visits	No charge		No charge	
Pregnancy	Delivery and all inpatient services	Hospital	10%	х	15%	х
	Home health care	Professional	10% \$3	<u> </u>	15% \$15	X
Help	Outpatient Rehabilitation serv	ices	\$3 \$5		\$15	
recovering or	Outpatient Habilitation service	25	\$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 Preventive - Cleaning					
Diagnostic	Preventive - X-ray		Not Covered		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental Basic	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Services	Root Conol Malar					
Child Dental	Gingivectomy per Quad					
	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Expr Extraction- Complete Bony	osed Root or Erupted	Not Covered		Not Covered	
Child Dental Major	Gingivectomy per Quad	osed Root or Erupted	Not Covered		Not Covered	

	share amounts describe the Er	rollee's out of pocket costs.	Silver Plan 200%-250% FP	L
Actuarial Valu	e - AV Calculator		72.8%	
	cludes a deductible?		Yes, Medical/Pharm	nacy
Integrated	Individual deductible Family deductible		N/A N/A	
Individual	deductible, NOT integrated:	Medical / Pharmacy / Dental	\$1,900 / \$250 / \$ \$3,800 / \$500 / \$	
	ductible, NOT integrated: Me –of–pocket maximum	dical / Pharmacy / Dental	\$3,800 / \$500 / \$ \$5,450	0
Family Out-of-	pocket maximum		\$10,900	
	f-only coverage deductible an: Individual deductible		N/A N/A	
Common				
Medical				Deductibl
Event	Ser	rvice Type	Member Cost Share	Applies
	Primary care visit to treat an ir	ijury, illness, or condition	\$40	
Health care provider's	Other practitioner office visit		\$40	
office or clinic visit	· · · · · · · · · · · · · · · · · · ·			
cimic visit	Specialist visit		\$55	
			<b>\$</b> 00	
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge \$35	
Tests	X-rays and Diagnostic Imagin		\$50	
	Imaging (CT/PET scans, MRI	s)	\$250	_
	Tier 1		\$15	
Drugs to treat	Tier 2		\$45	Pharmac
illness or			÷	deductibl
condition	Tier 3		\$70	Pharmac
			÷.•	deductibl
	Tier 4		20% up to \$250 per script	Pharmac
			after pharmacy deductible	deductibl
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees		20%	
services	Outpatient visit		20%	
	Emergency room facility fee (	waived if admitted)	\$250	х
	Emergency room physician fee (waived if admitted)		\$50	х
Need immediate	Emergency medical transportation		\$250	X
attention				
	Urgent care		\$80	
	Facility fee (e.g. hospital room	1)	20%	х
Hospital stay	Physician/surgeon fee	·	20%	х
	Mental/Behavioral health outp	atient office visits	\$40	
	Mental/Behavioral health othe	r outpatient items and services	\$40	
Mental	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	х
health,	Mental/Behavioral health inpa	tient physician/surgeon fee	20%	х
behavioral health. or			2070	~
substance	Substance Use disorder outp	atient office visits	\$40	
abuse needs	· · · · · ·			
	Substance Use disorder othe	r outpatient items and services	\$40	
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%	Х
	Substance use disorder inpat	ient physician/surgeon fee	20%	х
	Prenatal care and preconcept	tion visits	No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	х
	services	Professional	20%	х
	Home health care Outpatient Rehabilitation serv	icos	\$40 \$40	
Help recovering or	Outpatient Habilitation service		\$40	
other special	Skilled nursing care		20%	х
health needs	Durable medical equipment		20%	
	Hospice service Eye exam		No charge No charge	
	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge	
Child eye care				
care	Oral Exam	Preventive - Cleaning		
care Child Dental	Preventive - Cleaning			
care			Not Covered	
care Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application		Not Covered	
care Child Dental Diagnostic and Preventive	Preventive - Cleaning Preventive - X-ray Sealants per Tooth		Not Covered	
care Child Dental Diagnostic and	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application		Not Covered	
care Child Dental Diagnostic and Preventive Child Dental	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface			
care Child Dental Diagnostic and Preventive Child Dental Basic	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar			
care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingtivectomy per Quad Extraction - Single Tooth Exped	sed Root or Erupted		
care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad	used Root or Erupted	Not Covered	

Summary of	f Benefits and Coverage	)			Dura	
Member Cost S	Share amounts describe the E	nrollee's out of pocket costs.	Bronze Plan	n	Bron HSA P	
	e - AV Calculator		61.9%		61.1	%
	cludes a deductible? Individual deductible		Yes, Medical/Pha N/A	rmacy	Yes, integ \$4,500 inte	grated
Integrated	Family deductible		N/A		\$9,000 inte	egrated
	deductible, NOT integrated: luctible, NOT integrated: Me	Medical / Pharmacy / Dental	\$6,000 / \$500 / \$12,000 / \$1000		N/A N/A	
Individual Out	–of–pocket maximum pocket maximum		\$6,500 \$13,000		\$6,50 \$13,0	00
HSA plan: Sel	f-only coverage deductible		N/A		\$4,50	00
HSA family pla	an: Individual deductible		N/A		\$4,50	00
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an i	njury, illness, or condition	\$70	After 1st three non-preventive visits	40%	x
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/ in Laboratory Tests	nmunization	No charge \$40		No charge 40%	X
Tests	X-rays and Diagnostic Imagir		100%	x	40%	X
	Imaging (CT/PET scans, MR	ls)	100%	X	40%	X
	Tier 1		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40%	x
Drugs to treat illness or	Tier 2		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40%	x
condition	Tier 3		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40%	x
	Tier 4		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40%	х
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	;)	100% 100%	X X	40% 40%	X
services	Outpatient visit		100%	x	40%	X
	Emergency room facility fee (	waived if admitted)	100%	х	40%	х
	Emergency room physician f	ee (waived if admitted)	100%	x	40%	х
Need immediate	Emergency medical transportation		100%	x	40%	X
attention	Urgent care		\$120	After 1st three non-preventive visits	40%	x
	Facility fee (e.g. hospital roor	n)	100%	x	40%	x
Hospital stay	Physician/surgeon fee	"'	100%	×	40%	X
	Mental/Behavioral health out	patient office visits	\$70	After 1st three non-preventive visits	40%	x
	Mental/Behavioral health oth	er outpatient items and services	\$70	After 1st three non-preventive visits	40%	x
	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	100%	х	40%	х
Mental health,	Mental/Behavioral health inpa	atient physician/surgeon fee	100%	х	40%	х
behavioral health, or substance abuse needs	Substance Use disorder outp		\$70	After 1st three non-preventive	40%	x
abuse neeus	Substance Use disorder othe	er outpatient items and services	\$70	Visits After 1st three non-preventive	40%	x
	Substance Use inpatient faci		100%	visits	40%	x
						_
	Substance use disorder inpa Prenatal care and preconcept		100%	X	40%	X
Pregnancy	Delivery and all inpatient services	Hospital	No charge 100%	x	No charge 40%	x
	Home health care	Professional	<u>100%</u> 100%	X	40% 40%	<u> </u>
Help	Outpatient Rehabilitation service		\$70		40%	Х
recovering or other special	Skilled nursing care	50	\$70	x	40%	x
health needs	Durable medical equipment		100%	X	40%	X
	Hospice service		No charge		0%	X
Child eye	Eye exam	contact long on in line of alar	No charge		No charge	_
care	1 pair of glasses per year (or Oral Exam	contact tenses in lieu or glasses)	No charge		No charge	
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray		Not Covered		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed				. NOT COVERED	
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Child Dental Major Services	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exp Extraction- Complete Bony	osed Root or Erupted	Not Covered		Not Covered	
Child	Porcelain with Metal Crown				1	
Orthodontics	Medically necessary orthodo	TUCS	Not Covered		Not Covered	

	hare amounts describe the Enrollee's out of pocket costs.	Catastro	phic Plan
Actuarial Value	e - AV Calculator		
	cludes a deductible?		tegrated
	Individual deductible Family deductible		ntegrated
Individual of	deductible, NOT integrated: Medical / Pharmacy / Dental	N	integrated /A
Family ded	luctible, NOT integrated: Medical / Pharmacy / Dental		/A
ndividual Out- Family Out-of-	-of-pocket maximum pocket maximum		850 ,700
HSA plan: Self	f-only coverage deductible	N	/A
HSA family pla	m: Individual deductible	N	/A
Common Medical		Member Cost	Deductible
Event	Service Type	Share	Applies
	Primary care visit to treat an injury, illness, or condition	0%	After 1st thre non-preventi visits
Health care provider's office or	Other practitioner office visit	0%	After 1st thre non-preventi visits
linic visit:	Specialist visit	0%	x
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	Х
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	0%	X
	Tier 1	0%	x
Drugs to treat Ilness or condition	Tier 2	0%	x
Shaluon	Tier 3	0%	x
	Tier 4	0%	х
Outpatient	Surgery facility fee (e.g., ASC)	0%	X
services	Physician/surgeon fees Outpatient visit	0%	X
	Emergency room facility fee (waived if admitted)	0%	X
Need	Emergency room physician fee (waived if admitted)	0%	X
mmediate	Emergency medical transportation	0%	X
attention	Urgent care	0%	After 1st thr non-prevent visits
Hospital stay	Facility fee (e.g. hospital room)	0%	х
	Physician/surgeon fee	0%	х
	Mental/Behavioral health outpatient office visits	0%	After 1st thr non-prevent visits
	Mental/Behavioral health other outpatient items and services	0%	After 1st thr non-prevent visits
	Mental/Behavioral health inpatient facility fee (e.g.hospital roo	m) 0%	X
Mental health,			
behavioral	Mental/Behavioral health inpatient physician/surgeon fee	0%	х
health, or substance abuse needs	Substance Use disorder outpatient office visits	0%	After 1st thr non-prevent visits
	Substance Use disorder other outpatient items and services	0%	After 1st thr non-prevent visits
	Substance Use inpatient facility fee (e.g. hospital room)	0%	х
	Substance use disorder inpatient physician/surgeon fee	0%	x
	Prenatal care and preconception visits	No charge	
Pregnancy	Delivery and all inpatient Hospital	0%	х
	services Professional	0%	X
	Home health care	0%	X
lelp	Outpatient Rehabilitation services Outpatient Habilitation services	0%	X
ecovering or other special			
nealth needs	Skilled nursing care Durable medical equipment	0%	X
	Durable medical equipment Hospice service	0%	X
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	х
Child Dented	Oral Exam	_	_
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray		
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		
			L
Child Dental Major Services	Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony	Not Covered	
		Not Covered	

## 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-ofpocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
- 3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
- 4) For plans except HDHPs linked to HSA plans, 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, an individual's payment toward a deductible, if required, must be the higher of the specified deductible amount for individual coverage or \$2600 for Plan Year 2016. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
- 6) Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the \$45 copayment, the lesser amount is the applicable cost-sharing amount.
- 7) 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 co-insurance applies to an up to 30-day prescription supply. Nothing in this note precludes a carrier from offering mail order prescriptions at a reduced cost-share.
- 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) Drug tiers are defined as follows:

Tier	Definition
1	1) Most generic drugs and low cost preferred brands.
	1) Non-preferred generic drugs or;
	2) Preferred brand name drugs or;
2	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,
3	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;
4	2) Self administration requires training, clinical monitoring or;
	3) Drug was manufactured using biotechnology or;
	4) Plan cost (net of rebates) is >\$600.

- 20) Plan formularies must include at least one drug in Tiers 1 or 2 or 3 if all FDAapproved drugs in the same drug class would otherwise qualify for Tier 4 and at least 3 drugs in that class are available as FDA-approved drugs.
- 21) Issuers must comply with 45 CFR Section 156.122(d) dated February 27, 2015 which requires the health plan to publish an up-to-date, accurate and complete list of all covered drugs on its formulary list including any tiering structure that is adopted.
- 22) 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.
- 23) For 2016, a carrier may offer a plan with two in-network facility tiers if the lowest-cost tier network (Tier 1), complies with the cost-sharing requirements in the standard benefit plan design, meets state network adequacy and timeliness standards as applied by the applicable regulator and the carrier demonstrates that the two in-network facility tiers are in the best interest of the consumer as determined by Covered California on a case-by-case basis, based on premium stability, price, quality, choice and value. For non-Qualified Health Plans, the applicable regulator will review.



### 2016 Dental Standard Benefit Plan Designs

### Date: May 21, 2015

Summary of Benefits and Coverage		Children's Dental Plan		Children's Dental Plan		
Member Cost Share amou costs.	Member Cost Share amounts describe the Enrollee's out of pocket costs.		Pediatric Dental EHB Copay Plan		ntal EHB ce Plan	
		Up to Age 19		Up to Age 19		
Actuarial Value		83.04	%	86.89	%	
Individual Deductible (waived for Diagnostic & Preventive)		\$0		\$65 In Ne \$65 Out of		
Family Deductible (Two of (waived for Diagnostic &	Preventive)	\$0		\$130 In Ne \$130 Out of	Network	
Individual Out of Pocket Family Out of Pocket Max	Maximum ximum (Two or More Children)	\$350 \$700		\$350 \$700		
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)	Non	e	Non	e	
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 d'Heventive	Sealants per Tooth	\$0		0%		
	Topical Fluoride Application	\$0		0%		
	Space Maintainers - Fixed	\$0		0%		
Basic Services	Amalgam Fill - One Surface	\$25		20%	<u>x</u>	
Major Services - Crowns	Root Canal - Molar Gingivectomy per Quad	\$300 \$150				
and Casts, Endodontics, Periodontics,	Extraction- Single Tooth Exposed Root or Erupted	\$65		50%	x	
Prosthodontics, Oral	Extraction - Complete Bony	\$160				
Surgery	Crown - Porcelain with Metal	\$300				
Orthodontia	Medically Necessary Orthodontia	\$350		50%	х	

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: May 21, 2015

Summary of Benefits	Family Dental Plan					
Member Cost Share amou costs.	Member Cost Share amounts describe the Enrollee's out of pocket costs.		Pediatric Dental EHB Copay Plan		ental Plan	
		Up to Age 19		Age 19 and Older		
Actuarial Value		83.	0%	Not Calcu	Ilated	
Individual Deductible (waived for Diagnostic &	Preventive)	\$	0	\$0		
Family Deductible (Two of (waived for Diagnostic &	Preventive)	\$	-	\$0		
Individual Out of Pocket		\$3		Not Appli		
	kimum (Two or More Children)	\$7		Not Appli	cable	
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		
	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: May 21, 2015

Summary of Benefits	and Coverage	Family Dental Plan			
Member Cost Share amou costs.	Member Cost Share amounts describe the Enrollee's out of pocket costs.			Adult Dental Coinsurance Plan	
		Up to Age 19		Age 19 and Older	
Actuarial Value		86.8%	6	Not Calcu	lated
Individual Deductible (waived for Diagnostic &	\$65 In Net \$65 Out of N		\$50 In Net \$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 \$700		Not Appli	
Family Out of Pocket Max Office Copay	Family Out of Pocket Maximum (Two or More Children)			Not Applicable \$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		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	e	\$1,50	0
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%		Not Covered	
	Space Maintainers - Fixed	0%		Not Covered	
Basic Services	Amalgam Fill - One Surface	20%	X	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%	x	50%	x
Orthodontia	Medically Necessary Orthodontia	50%	Х	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.