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 May 21, 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 May 21, 2015



Summary of Benefits and Coverage

Accusated Walter - AV Calculation Repaired selegin michigated and delicitable Integrated Enably Michigated Individual delicitable Integrated	Member Cost Share amounts describe the Enrollee's out of pocket costs.		Platinu Coinsurane		Platinum Copay Plan	
	Actuarial Value	e - AV Calculator	88.59	6		
Interpretable So						
Solidary						
Indicated block-of-pocket maximum \$ 8,000 \$ 9,000 \$ 9,	Individual o	deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0		\$0 / \$0 /	
Section Sect	Family ded	uctible, NOT integrated: Medical / Pharmacy / Dental				
NA NA NA NA NA NA NA NA	Individual Out- Family Out-of-	-or-pocket maximum pocket maximum				
Member Cost Share Service Type Primary care visit to treat an injury, illness, or condition Service Type Primary care visit to treat an injury, illness, or condition Service Type Primary care visit to treat an injury, illness, or condition Service Type Primary care visit to treat an injury, illness, or condition Primary care visit to treat an injury, illness, or condition Primary care visit to treat an injury, illness, or condition Primary care visit to treat an injury, illness, or condition Primary care visit to treat an injury, illness, or condition Primary care visit to treat an injury, illness, or condition Primary care visit to treat an injury, illness, or condition Primary care visit to treat an injury, illness, or condition Primary care visit to treat an injury, illness, or condition Primary care visit to treat an injury, illness, or condition Primary care visit to treat an injury, illness, or condition Primary care visit to treat an injury, illness, or condition Primary care visit to treat an injury, illness, or condition Primary care visit to treat an injury, illness, or condition Primary care visit to treat an injury, illness, or condition Primary care visit to treat an injury, illness, or condition Primary care visit to the	HSA plan: Self	-only coverage deductible	N/A		N/A	
Primary care visit to treat an injury, threas, or condition \$20	HSA family pla	n: Individual deductible	N/A		N/A	
Primary care visit to treat an injury, libress, or condition Pleash care provider at the provider of the prov	Medical					Deductible
Check Companies Companie	Event	Service Type	Share	Applies	Share	Applies
Percentine care Septiminary Septiminar		Primary care visit to treat an injury, illness, or condition	\$20		\$20	
Preventive care' screening immunization	provider's office or	Other practitioner office visit	\$20		\$20	
Laboratory Tests		Specialist visit	\$40		\$40	
Test						
Imaging (CT/PET scans, MRIs) 10% \$150	Tests	Laboratory Tests X-rays and Diagnostic Imaging				_
Time						
Tier 3 Tier 3 Tier 4 Tier 5 Tier 4 Tier 5 Tier 4 Tier 5 Tier 4 Tier 5 Tier 4 Tier 6 Tier 6 Tier 6 Tier 7 Tier 8 Tier 8 Tier 8 Tier 8 Tier 9 Ti		Tier 1	\$5		\$5	
Tier 4	Drugs to treat	Tier 2	\$15		\$15	
Ter 4	illness or	Tier 3	\$25		\$25	
Surgery lacility lee (e.g., ASC)						
Dispation of the previous of the property of t		Het 4				
Substance Use disorder other outpatient family fee (e.g. hospital room) Mental/Behavioral health inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient physician/surgeon fee 10% Substance Use disorder outpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee 10% Substance use disorder in	Outpatient					
Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted) I great care \$40 \$40 \$40 \$40 \$40 \$40 \$40 \$40 \$40 \$4						_
Emergency room physician fee (walved if admitted) 10% No charge						
Emergency medical transportation \$150						
Immediate attention Urgent care Hospital stay Facility fee (e.g. hospital room) Physician/surgeon fee Mental/Behavioral health other outpatient office visits Mental/Behavioral health other outpatient terms and services Mental/Behavioral health inpatient facility fee (e.g. hospital room) Substance Use disorder outpatient office visits Substance Use disorder outpatient items and services Substance Use disorder outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance Use disorder outpatient items and services Substance Use disorder inpatient physician/surgeon fee Pregnancy Pregnancy Delivery and all inpatient services Substance Use disorder inpatient facility fee (e.g. hospital room) Delivery and all inpatient services Delivery and all inpatient physician/surgeon fee Hop to 5 days Professional Hospital Hospital Delivery and all inpatient services Substance Use disorder outpatient inpatient services Substance Use disorder inpatient physician/surgeon fee 10% Substance Use disorder outpatient items and services Substance Use disorder outpatient inpatient se	Need		10%			
Hospital stay Facility fee (e.g. hospital room) Physician/surgeon fee Mental/Behavioral health outpatient office visits Mental/Behavioral health outpatient office visits Mental/Behavioral health outpatient office visits Mental/Behavioral health inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient physician/surgeon fee 10% Substance Use disorder outpatient office visits Substance Use disorder outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance Use inpatient facility fee (e.g. hospital room) Substance Use inpatient facility fee (e.g. hospital room) Delivery and all inpatient physician/surgeon fee Pregnancy Pergnancy Delivery and all inpatient physician/surgeon fee Hope to disorder inpatient physician/surgeon fee Hope to disorder inpatient physician/surgeon fee Hope to disorder inpatient physician/surgeon fee Presental care and preconception visits No charge Pregnancy Delivery and all inpatient physician/surgeon fee Hope to disorder inpatient physician/surgeon fee Home health care Hope to disorder inpatient physician/surgeon fee Hope to disorder inpatient physician/surgeon fee 10% Substance Use inpatient facility fee (e.g. hospital room) 10% Substance Use inpatient facility fee (e.g. hospital room) 10% Substance Use inpatient facility fee (e.g. hospital room) 10% Substance Use inpatient facility fee (e.g. hospital room) 10% Substance Use inpatient facility fee (e.g. hospital room) 10% Substance Use inpatient facility fee (e.g. hospital room) 10% Substance Use disorder inpatient physician/surgeon fee 10% Substance Use inpatient facility fee (e.g. hospital room) 10% Substance Use disorder inpatient physician/surgeon fee 10% Substance Use disorder inpatient physician/surgeon fee 10% Substance Use disorder inpatient physician/surgeon fee 10% Substance Use disor	immediate	Emergency medical transportation	\$150		\$150	
Heapital stay Physician/surgeon fee	attention	Urgent care	\$40		\$40	
Mental/Behavioral health outpatient office visits \$20 \$20 Mental/Behavioral health outpatient items and services \$20 \$20 Mental/Behavioral health inpatient facility fee (e.g. hospital room) 10% \$250 per day up to 5 days to 5 days \$40 Mental/Behavioral health inpatient physician/surgeon fee 10% \$40 Substance Use disorder outpatient office visits \$20 \$20 Substance Use disorder outpatient items and services \$20 \$20 Substance Use inpatient facility fee (e.g. hospital room) 10% \$250 per day up to 5 days \$250 per day up to 5 days \$20 Substance Use inpatient physician/surgeon fee 10% \$40 Pregnancy Substance use disorder inpatient physician/surgeon fee 10% \$40 Pregnancy Delivery and all inpatient physician/surgeon fee 10% \$40 Pregnancy Delivery and all inpatient physician/surgeon fee 10% \$250 per day up to 5 days \$250 per day up to 5 da	Hospital stay	Facility fee (e.g. hospital room)	10%			
Mental/Behavioral health other outpatient items and services Mental/Behavioral health inpatient facility fee (e.g.hospital room) Mental/Behavioral health inpatient facility fee (e.g.hospital room) Mental/Behavioral health inpatient physician/surgeon fee behavioral health, or substance substance abuse needs Substance Use disorder outpatient office visits Substance Use disorder outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Pregnancy Pregnancy Pregnancy Pregnancy Pregnancy Pregnancy Delivery and all inpatient Home health care Durpatient Rehabilitation services Substance use disorder inpatient physician/surgeon fee Help Outpatient Habilitation services Substance use disorder inpatient physician/surgeon fee Help Outpatient Habilitation services Substance use disorder inpatient physician/surgeon fee Home health care Durpatient Rehabilitation services Substance use disorder inpatient physician/surgeon fee Home health care Durpatient Rehabilitation services Substance use disorder inpatient physician/surgeon fee Hop Colupatient Habilitation services Substance use disorder inpatient physician/surgeon fee Home health care Durpatient Rehabilitation services Substance use disorder inpatient physician/surgeon fee 10% Substance use disorder inpatient physician/surgeon fee 10% Substance use disorder outpatient physician/surgeon fee 10% Substanc		Physician/surgeon fee	10%		\$40	
Mental health, beath, behavioral health inpatient facility fee (e.g.hospital room) Mental/Behavioral health inpatient physician/surgeon fee behavioral health, or substance use disorder outpatient office visits Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Substance use disorder inpatient physician/surgeon fee Pregnancy Pregnancy Pregnancy Pregnancy Prenatal care and preconception visits No charge Professional Hospital Hospital Hospital Hospital 10% S250 per day up to 5 days No charge Professional 10% S250 per day Professional 10% S250 per day Professional 10% S250 per day Professional 10% S40 Home health care Outpatient Rehabilitation services S20 S20 Outpatient Rehabilitation services S20 S20 Outpatient Habilitation services S20 S20 No charge No charge Preventive Preventive Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Root Canal-Molar Ginglivectomy per Quad Major Services Root Canal-Molar Ginglivectomy per Quad Madically necessary orthodonorics S100 Modically necessary orthodonorics S100 Modically necessary orthodonorics S100 Modically necessary orthodonorics		Mental/Behavioral health outpatient office visits	\$20		\$20	
Mental bealth Mental/Behavioral health inpatient statisty fee (e.g. incsphal 100h) 10% \$40		Mental/Behavioral health other outpatient items and services	\$20		\$20	
Mental health, behavioral health inpatient physician/surgeon fee		Mental/Behavioral health inpatient facility fee (e.g.hospital room	10%			
behavioral health, or substance abuse needs Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Pregnancy Prenatal care and preconception visits No charge Pregnancy Delivery and all inpatient services Frofessional Home health care Outpatient Ababilitation services Substance use disorder inpatient physician/surgeon fee Home health care 10% \$250 per day up to 5 days Professional 10% \$250 per day up to 5 days Professional 10% \$20 Outpatient Ababilitation services \$20 \$20 \$20 S20 S20 S20 S20 S20	ou.					
Substance Use disorder outpatient office visits Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Prenatal care and preconception visits No charge Pregnancy Prenatal care and preconception visits No charge Pregnancy Prenatal care and preconception visits No charge Professional Hospital Professional Home health care 10% \$40 Uutpatient Habilitation services \$20 \$20 \$20 Uutpatient Rehabilitation services \$20 \$20 \$20 Uutpatient Rehabilitation services \$20 \$20 \$20 Sulted nursing care Sulted nursing care 10% \$150 per day up to 5 days \$10 per day 10% \$150 per day up to 5 days 10% \$150 per day up to 5 days 10% \$150 per day 10% 10% 10% 10% 10% 10% 10% 10	behavioral	wertarbenavioral nealth inpatient physician/surgeon ree	10%		\$40	_
Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Prenatal care and preconception visits No charge Prenatal care and preconception visits No charge Delivery and all inpatient services Professional Hospital Hospital 10% \$250 per day up to 5 days Professional 10% \$220 Qualtation services \$20 \$20 Qualtation services No charge No charge No charge No charge Qualtation services No charge No charge No charge No charge Preventive - Cleaning Root Canal- Molar Child Dental Major Sarvices Root Canal- Molar	substance	Substance Use disorder outpatient office visits	\$20		\$20	
Substance use disorder inpatient physician/surgeon fee Pregnancy Pregnancy Delivery and all inpatient services Hospital 10% Help 100 Unpatient Rehabilitation services Outpatient Rehabilitation services S20 S20 Outpatient Habilitation services S20 S20 Outpatient Habilitation services S20 S20 S20 S20 Outpatient Habilitation services S20 S20 S20 S20 Outpatient Habilitation services S20 S20 S20 S20 S20 S20 S20 Child eye Care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge Preventive - Cleaning Preventive - Cleaning Preventive - Cleaning Preventive - Space Maintainers - Fixed Child Dental Basic Amalgam Fill - 1 Surface Root Canal-Molar Gingivectomy per Quad Sarrices Root Canal-Molar Gingivectomy per Quad Sarrices Sarvices Sarvices Substance visits No charge No charge Sarvices Root Canal-Molar Gingivectomy per Quad Sarvices Sarvices Sarvices Sarvices Substance visits No charge No charge Sarvices Root Canal-Molar Si 150 Sarvices Sarvices Sarvices Sarvices Sarvices Sarvices Sarvices Substance visits No charge Sarvices Sarvices Substance visits No charge Sarvices Sarvices Substance visits No charge No charge No charge No charge No charge No charge Sarvices Sarvices Savices		Substance Use disorder other outpatient items and services	\$20		\$20	
Substance use disorder inpatient physician/surgeon fee 10% \$40 Prenatal care and preconception visits No charge S250 per day up to 5 days Professional 10% \$20 Outpatient Habilitation services \$20 \$25 Outpatient Habilitation services \$20 \$25 Outpatient Habilitation services \$20 \$25 Outpatient Habilitation services \$20 \$20 Outpatient Habilitation services \$20 Outpatient Habilitat		Substance Use inpatient facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
Prenatal care and preconception visits		Substance use disorder inpatient physician/surgeon fee	10%			
Pregnancy Delivery and all inpatient Hospital 10% \$250 per day up to 5 days		Prenatal care and preconception visits	No charge			
Services	Pregnancy				\$250 per day	
Home health care	,	services				_
Outpatient Habilitation services \$20 \$20 \$20 \$20 \$20 \$20 \$20 \$20 \$20 \$20		Home health care			\$20	
Second S						
No charge No charge	recovering or					
Durable medical equipment 10% 10% 10% 10% Hospice service No charge No charge No charge No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge No charge No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge No charge No charge Preventive - Cheaning Preventive - Cheaning Preventive - Cheaning Preventive - Cheaning No charge No charge No charge Preventive - Cheaning Preventive - Cheaning No charge No charge No charge Sealants per Tooth No charge No charge Sealants per Tooth No charge No charge Sealants per Tooth No charge No charge No charge No charge Sealants per Tooth No charge No charg					to 5 days	
Eye exam						
1 pair of glasses per year (or contact lenses in lieu of glasses) No charge	Child eve					
Preventive - Cleaning Preventive - X-ray No charge No charge		1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Diagnostic and sand Preventive - X-ray No charge No charge Preventive and Space Maintainers - Fixed Sealants per Tooth Sealants per Tooth Child Dental Basic Services Amalgam Fill - 1 Surface 20% \$25 Root Canal- Molar Ginglivectomy per Quad \$300 \$300 Child Dental Major Extraction- Single Tooth Exposed Root or Erupted 50% \$65 Services Porcelain with Metal Crown \$300 \$300 Child Medically necessary orthodostics 50% \$100						
Sealants per Tooth			_			
Topical Fuoride Application Space Maintainers - Fixed	and				No charge	
Child Dental Basic		Topical Fluoride Application				
Basic Amalgam Fill - 1 Surface 20% \$25 Services Root Canal- Molar \$300 Child Dental Major \$150 \$150 Extraction- Single Tooth Exposed Root or Erupted 50% \$65 Services Extraction- Complete Bony \$160 Porcelain with Metal Crown \$300 Child Medically necessary orthodoptics \$100		Space Maintainers - Fixed				
Root Canal- Molar \$300	Basic	Amalgam Fill - 1 Surface	20%		\$25	
Major Extraction- Single Tooth Exposed Root or Erupted 50% \$65 Services Extraction- Complete Bony \$160 Porcelain with Metal Crown \$300 Child Medically necessary orthodoptics 5.0% \$1.000						
Services Extraction- Complete Bony Porcelain with Metal Crown \$160 Child Medically necessary orthodontics 5094 \$1,000			50%			
Child Medically necessary orthodontics 5.0% \$1.000		Extraction- Complete Bony	2270		\$160	
		Porcelain with Metal Crown			\$300	
		Medically necessary orthodontics	50%		\$1,000	

Actuarial Valu	Share amounts describe the En	rollee's out of pocket costs.	Gold Coinsurand	ce Plan	Gold Copay Plan	
	e - AV Calculator		80.29	6	81.0%	6
	cludes a deductible?		No		No	
Integrated	Individual deductible Family deductible		\$0 \$0		\$0 \$0	
Individual	deductible, NOT integrated: ductible, NOT integrated: Me	Medical / Pharmacy / Dental	\$0 / \$0 / \$0 / \$0 /		\$0 / \$0 / \$0 / \$0 /	
Individual Out	-of-pocket maximum	ulcai / Filailliacy / Delitai	\$6,20	0	\$6,200	0
	-pocket maximum f-only coverage deductible		\$12,40 N/A	00	\$12,40 N/A	00
HSA family pla	an: Individual deductible		N/A		N/A	
Common						
Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductibl Applies
	Primary care visit to treat an in	jury, 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/ im	munization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	2	\$35 \$50		\$35 \$50	
16313	Imaging (CT/PET scans, MRI		20%		\$250	
	Tier 1		\$15		\$15	
Drugs to treat	Tier 2		\$50		\$50	
illness or condition	Tier 3					
			\$70 20% up to \$250		\$70 20% up to \$250	
	Tier 4		per script		per script	
Outpatient	Surgery facility fee (e.g., ASC)		20%		\$600	
services	Physician/surgeon fees Outpatient visit		20%		\$55 20%	
	Emergency room facility fee (v	vaived if admitted)	\$250		\$250	
	Emergency room physician fee (waived if admitted)					
Need	Emergency medical transportation		20% \$250		No charge \$250	
immediate attention	Emorgency medical transport	unor	φ∠ου		φ∠ΟU	
	Urgent care		\$60		\$60	
Hospital stay	Facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Physician/surgeon fee		20%		\$55	
	Mental/Behavioral health outp	atient office visits	\$35		\$35	
	Mental/Behavioral health other outpatient items and services		\$35		\$35	
	Mental/Behavioral health inna	tient facility fee (e.g.hospital room)	20%		\$600 per day up	
Mental health,	Mental/Behavioral health inpar		20%		to 5 days	
behavioral	ivienta/benavioral nealth inpa	lient physician/surgeon ree	20%		\$55	
health, or substance abuse needs	Substance Use disorder outpa	atient office visits	\$35		\$35	
	Substance Use disorder other	outpatient items and services	\$35		\$35	
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Substance use disorder inpati	ent physician/surgeon fee	20%		\$55	
	Prenatal care and preconcept	. ,	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		\$35 \$35		\$35 \$35	
recovering or other special	Skilled nursing care		20%		\$300 per day up	
health needs	Durable medical equipment		20%		to 5 days 20%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam 1 pair of glasses per year (or c	ontact lenses in lieu of alasses)	No charge No charge		No charge	
-2.0	Oral Exam		ino charge		No charge	
	Preventive - Cleaning					
Child Dental	Preventive - X-ray Sealants per Tooth		No charge		No charge	
Diagnostic and	Topical Fluoride Application					
Diagnostic	Space Maintainers - Fixed					
Diagnostic and Preventive Child Dental Basic			20%		\$25	
Diagnostic and Preventive Child Dental Basic Services	Space Maintainers - Fixed		20%		\$25 \$300	
Diagnostic and Preventive Child Dental Basic Services Child Dental	Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad	ssed Root or Frinted			\$300 \$150	
Diagnostic and Preventive Child Dental Basic Services	Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal-Molar Gingivectomy per Quad Extraction - Single Tooth Expo Extraction - Complete Bony	sed Root or Erupted	20%		\$300 \$150 \$65 \$160	
Diagnostic and Preventive Child Dental Basic Services Child Dental Major	Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal-Molar Gingivectomy per Quad Extraction- Single Tooth Expo	sed Root or Erupted			\$300 \$150 \$65	

Member Cost S	Benefits and Coverage hare amounts describe the El		Individua Silver Plai	
		itoliee's out of pocket costs.		'
	e - AV Calculator		70.4%	
	cludes a deductible? Individual deductible		Yes, Medical/Pha N/A	armacy
	Family deductible		N/A	
		Medical / Pharmacy / Dental	\$2,250 / \$250	
	luctible, NOT integrated: Me -of-pocket maximum	edical / Pharmacy / Dental	\$4,500 / \$500 \$6,250	/ \$0
Family Out-of-	pocket maximum		\$12,500	
HSA plan: Self HSA family pla	i-only coverage deductible in: Individual deductible		N/A N/A	
Common				
Medical				Deductible
Event	Se	rvice Type	Member Cost Share	Applies
	Primary care visit to treat an i	niury illness or condition	\$45	
	i iiiiaiy oalo vok to troat air i	njary, miroso, or containon	Ψ-3	
Health care				
orovider's office or	Other practitioner office visit		\$45	
linic visit				
	Specialist visit		\$70	
	Preventive care/ screening/ ir	nmunization	No charge	
	Laboratory Tests	IIIIuiizatioii	No charge \$35	
Tests	X-rays and Diagnostic Imagir		\$65	
	Imaging (CT/PET scans, MR	IS)	\$250	
	Tier 1		\$15	
				-
Orugs to treat	Tier 2		\$50	Pharmac deductibl
liness or				
condition	Tier 3		\$70	Pharmac deductibl
			20% up to \$250 per	
	Tier 4		script after pharmacy	Pharmacy deductible
	Surgery facility fee (e.g., ASC	3)	deductible 20%	
Outpatient services	Physician/surgeon fees	7	20%	
services	Outpatient visit		20%	
	Emergency room facility fee (waived if admitted)	\$250	х
	Emergency room physician fe	ee (waived if admitted)	\$50	х
Need immediate	Emergency medical transportation		\$250	X
attention			72.0	
	Urgent care		\$90	
	Facility fee (e.g. hospital room	n)	20%	х
Hospital stay	Physician/surgeon fee	<u>′</u>	20%	Х
	, and a second			
	Mental/Behavioral health outp	patient office visits	\$45	
	Mental/Behavioral health other	er outpatient items and services	\$45	
		,	Ţ.0	
	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	20%	Х
Mental health,	Mental/Behavioral health inpa	stient abuninian/ausean fon		.,
behavioral	ivienta/benavioral nealth inpa	atient physician/surgeon ree	20%	Х
health, or substance	Substance Use disorder outp	allows affine state		
abuse needs	Substance use disorder out	valient office visits	\$45	
	Substance Use disorder other	er outpatient items and services	\$45	
	Substance Use inpatient facil	ity fee (e.g. hospital room)	20%	Х
	Substance use disorder inpar	tient physician/surgeon fee	20%	Х
	Prenatal care and preconcep	* * * *	No charge	<u> </u>
Pregnancy	Delivery and all inpatient	Hospital	20%	Х
-g .	services			X
	Home health care	Professional	20% \$45	
Help	Outpatient Rehabilitation serv		\$45	
ecovering or	Outpatient Habilitation service	#S	\$45	
other special nealth needs	Skilled nursing care		20%	Х
	Durable medical equipment Hospice service		20% No charge	
Child eye	Eye exam		No charge	
care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge	
Objid Day	Oral Exam			
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray			
and	Sealants per Tooth		No charge	
Preventive				
Child Dental	== acc mantaners = rixed			
Basic	Amalgam Fill - 1 Surface		20%	
Services	Root Canal- Molor			
Child Dental	Root Canal- Molar Gingivectomy per Quad			
Major	Extraction- Single Tooth Exp	osed Root or Erupted	50%	
Services	Extraction- Complete Bony Porcelain with Metal Crown			
Child				
	Medically necessary orthodor	TUCS	50%	

	- 10 <u>may 21</u> , 2013					
Summary of	Benefits and Coverage	9	SHOP Silver		SHOP Silver	
Member Cost S	Share amounts describe the E	nrollee's out of pocket costs.	Coinsurance Plan		Copay Plan	
Actuarial Valu	e - AV Calculator		71.7% <u>71.6</u>	<u>%</u>	71.4% <u>71.3</u>	<u>%</u>
	cludes a deductible?		Yes, Medical/Pha	armacy	Yes, Medical/Pha	armacy
Integrated Integrated	Individual deductible Family deductible		N/A N/A		N/A N/A	
Individual	deductible, NOT integrated:	Medical / Pharmacy / Dental	\$1,500 / \$500 <u>\$2</u>		\$1,500 / \$500 <u>\$2</u>	
Individual Out	luctible, NOT integrated: Mo -of-pocket maximum	edical / Pharmacy / Dental	\$3,000 / \$1,000 <u>\$</u> \$6,500	500 / \$0	\$3,000 / \$1,000 <u>\$</u> \$6,500	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	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an i		\$45		\$45	
Health care provider's	Other practitioner office visit	njury, iiiness, or contaition	\$45		\$45 \$45	
office or clinic visit	Specialist visit		\$70		\$70	
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge \$35		No charge \$35	
Tests	X-rays and Diagnostic Imagir	ig .	\$65		\$65	
	Imaging (CT/PET scans, MR	ls)	20%	X	\$250	
	Tier 1		\$15		\$15	
Drugs to treat illness or	Tier 2		\$55	Pharmacy deductible	\$55	Pharmacy deductible
condition	Tier 3		\$75	Pharmacy deductible	\$75	Pharmacy deductible
	Tier 4 Surgery facility fee (e.g., ASC		20% up to \$250 per script after pharmacy deductible 20%	Pharmacy deductible	20% up to \$500 per script after pharmacy deductible 20%	Pharmacy deductible
Outpatient services	Physician/surgeon fees	,	20%		20%	
Services	Outpatient visit		20%		20%	
	Emergency room facility fee (waived if admitted)	\$250	Х	\$250	Х
	Emergency room physician f	ee (waived if admitted)	\$50	Х	\$50	Х
Need immediate	Emergency medical transpor	tation	\$250	Х	\$250	X
attention						
	Urgent care		\$90		\$90	
Hospital stay	Facility fee (e.g. hospital roon	n)	20%	×	20%	х
	Physician/surgeon fee		20%	X	20%	X
	Mental/Behavioral health out	patient office visits	\$45		\$45	
	Mental/Behavioral health other	er outpatient items and services	\$45		\$45	
Mental	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	20%	х	20%	х
Mental health,	Mental/Behavioral health inpa	atient physician/surgeon fee	20%	Х	20%	Х
behavioral health, or substance abuse needs	Substance Use disorder outp	.,,	\$45	~	\$45	·
	Substance Use disorder other	er outpatient items and services	\$45		\$45	
		•			·	
	Substance Use inpatient faci		20%	X	20%	X
	Substance use disorder inpa		20%	Х	20%	Х
	Prenatal care and preconcep		No charge		No charge	
Pregnancy	Delivery and all inpatient services	Hospital	20%	X	20%	X
	Home health care	Professional	20% 20%	X	20% \$45	X
Help	Outpatient Rehabilitation sen		\$45		\$45	
recovering or other special	Outpatient Habilitation service	50	\$45		\$45	
health needs	Skilled nursing care		20%	Х	20%	Х
	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 Diagnostic	Oral Exam Preventive - Cleaning Preventive - X-ray		No charge		No charge	
and Preventive	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed		onarge		go	
Child Dental Basic	Amalgam Fill - 1 Surface		20%		\$25	
Services	Root Canal- Molar				\$300	
Child Dental	Gingivectomy per Quad				\$150	
Major Services	Extraction- Single Tooth Exp Extraction- Complete Bony	osed Root or Erupted	50%		\$65 \$160	
_0.7.063	Porcelain with Metal Crown				\$300	
Child Orthodontics	Medically necessary orthodo	ntics	50%		\$1,000	
Janouontics						

Member Cost S	Benefits and Coverage that amounts describe the E		SHOF Silver HSA PL	r an
	e - AV Calculator		70.5%	
	cludes a deductible? Individual deductible		Yes, integr \$2,000 integration	
Integrated	Family deductible		\$4,000 inte	
	deductible, NOT integrated: luctible, NOT integrated: Mo	Medical / Pharmacy / Dental	N/A N/A	
Individual Out-	-of-pocket maximum	alour / Humaoy / Domai	\$6,250	
	pocket maximum -only coverage deductible		\$12,50 \$2,000	
HSA family pla	n: Individual deductible		See endnote	
Common				
Medical Event	Se	rvice Type	Member Cost Share	Deductible Applie
	Primary care visit to treat an i	njury, illness, or condition	20%	х
Health care provider's office or	Other practitioner office visit		20%	х
clinic visit	Specialist visit		20%	х
	Preventive care/ screening/ in	nmunization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagir	ia .	20%	X
	Imaging (CT/PET scans, MR		20%	X
	Tier 1		20%	х
Drugs to treat	Tier 2		20%	х
illness or condition	Tier 3		20%	х
	Tier 4		20%	х
Outpatient	Surgery facility fee (e.g., ASC	3)	20%	Х
services	Physician/surgeon fees Outpatient visit		20%	X
		in a line of the advantage of the advant	20%	X
	Emergency room facility fee (waived if admitted)		20%	Х
Need	Emergency room physician f	*	20%	Х
immediate	Emergency medical transportation		20%	X
attention	Urgent care		20%	х
Hospital stay	Facility fee (e.g. hospital roor	n)	20%	Х
	Physician/surgeon fee Mental/Behavioral health outpatient office visits		20%	×
		er outpatient items and services	20%	x
	Mental/Rehavioral health inna	atient facility fee (e.g.hospital room)	20%	X
Mental health,			2070	- 1
behavioral health, or	Mental/Behavioral health inpa		20%	Х
substance abuse needs	Substance Use disorder outp	patient office visits	20%	Х
	Substance Use disorder other	er outpatient items and services	20%	х
	Substance Use inpatient faci		20%	Х
	Substance use disorder inpa	.,	20%	Х
	Prenatal care and preconcep		No charge	
Pregnancy	Delivery and all inpatient services	Hospital	20%	Х
	Home health care	Professional	20% 20%	X
Help	Outpatient Rehabilitation sen		20%	Х
recovering or	Outpatient Habilitation service		20%	Х
other special health needs	Skilled nursing care		20%	Х
Jai necus	Durable medical equipment Hospice service		20% 0%	X X
Child eye	Eye exam		No charge	^
care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge	
	Oral Exam			
Child Dental 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		20%	
Services	Root Canal- Molar			
Child Dental	Gingivectomy per Quad			
Major Services	Extraction- Single Tooth Exp Extraction- Complete Bony Porcelain with Metal Crown	osed Root or Erupted	50%	
Child		- Line	5500	
Orthodontics	Medically necessary orthodo	iuos	50%	

Summary of	Renefits and	Coverage

Summary of	Benefits and Coverage					
Member Cost S	ember Cost Share amounts describe the Enrollee's out of pocket costs.			lan % FDI	Silver Plan 150%-200% FPL	
Actuarial Value	e - AV Calculator		93.89		86.8%	
	cludes a deductible?		Yes, Medical/I	Pharmacy	Yes, Medical/Phar	rmacv
Integrated	Individual deductible		N/A		N/A	
	Family deductible deductible, NOT integrated:	Medical / Pharmacy / Dental	N/A \$75 / \$0	/\$0	N/A \$550 / \$50 / \$	60
Family ded	luctible, NOT integrated: Me		\$150 / \$0	0 / \$0	\$1,100 / \$100 /	
	of-pocket maximum		\$2,25 \$4,50		\$2,250 \$4,500	
HSA plan: Self	f-only coverage deductible		N/A		N/A	
HSA family pla	n: 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		\$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	,	\$8		\$15	
16212	Imaging (CT/PET scans, MRI		\$8 \$50		\$25 \$100	
	Tier 1		\$3		\$5	
Drugs to treat	Tier 2		\$10		\$20	Pharmacy deductible
illness or 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)		10%		15%	
Services	Physician/surgeon fees		10%		15%	
	Outpatient visit		10%		15%	
	Emergency room facility fee (v	vaived if admitted)	\$30	Х	\$75	Х
Need	Emergency room physician fe	e (waived if admitted)	\$25	х	\$40	Х
immediate	Emergency medical transporta	ation	\$30	Х	\$75	Х
attention						
	Urgent care		\$6		\$30	
Hospital stay	Facility fee (e.g. hospital room)	10%	х	15%	Х
1103pitai stay	Physician/surgeon fee		10%	Х	15%	Х
	Mental/Behavioral health outp	atient office visits	\$5		\$15	
	Mental/Behavioral health other	outpatient items and services	\$5		\$15	
	Mental/Behavioral health innat	ient facility fee (e.g.hospital room)	10%	х	15%	х
Mental health,						
behavioral	Mental/Behavioral health inpat	ient physician/surgeon fee	10%	Х	15%	Х
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%	х	15%	х
	Prenatal care and preconcept		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 servi		\$3 \$6		\$15	
Help recovering or	Outpatient Rehabilitation services		\$5 \$5		\$15 \$15	
other special	Skilled nursing care		10%	Х	15%	х
health needs	Durable medical equipment		10%		15%	
	Hospice service		No charge		No charge	
Office Cyc	L pair of alasses per year (or a	potent longer in liqu of glasses)	No charge		No charge	
care	1 pair of glasses per year (or o Oral Exam	macrenses in ieu of glasses)	No charge		No charge	
	Preventive - Cleaning					
Diagnostic and	Preventive - X-ray		No charge		No charge	
Preventive	Sealants per Tooth Topical Fluoride Application					
Child Dental	Space Maintainers - Fixed					
Basic Services	Amalgam Fill - 1 Surface Root Canal- Molar		20%		20%	
Child Dental	Gingivectomy per Quad	and Doot or Francis d	500/		500/	
Major Services	Extraction- Single Tooth Expo Extraction- Complete Bony Porcelain with Metal Crown	seu noot or Erupted	50%		50%	
Child Orthodontics	Medically necessary orthodon	ics	50%		50%	

Summary of Benefits and Coverage

	Benefits and Coverage thare amounts describe the En		Silver Plan 200%-250% Fl	PL
	e - AV Calculator		72.8%	
	cludes a deductible? Individual deductible		Yes, Medical/Phar N/A	macy
	Family deductible		N/A N/A	
Individual	deductible, NOT integrated:	Medical / Pharmacy / Dental	\$1,900 / \$250 /	
	luctible, NOT integrated: Me -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 in: Individual deductible		N/A N/A	
noa taminy pia	in: individual deductible		IN/A	
Common Medical				Deductible
Event	Se	rvice Type	Member Cost Share	Applies
	Primary care visit to treat an in	njury, illness, or condition	\$40	
Health care				
provider's	Other practitioner office visit		\$40	
office or clinic visit				
CIIIIIC VISIL	Specialist visit		\$55	
	Opodalot voit		ψοσ	
	Preventive care/ screening/ in	nmunization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagin	ng .	\$35	
16313	Imaging (CT/PET scans, MR		\$50 \$250	
		•		
	Tier 1		\$15	
				Phormac
Drugs to treat	Tier 2		\$45	Pharmacy deductible
illness or				
Continue	Tier 3		\$70	Pharmacy deductible
			20% up to \$250 per	
	Tier 4		20% up to \$250 per script after pharmacy	Pharmacy deductible
	Surgery facility fee (e.g. ASC	·\	deductible	deductible
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	·1	20% 20%	
services	Outpatient visit		20%	
	Emergency room facility fee (waived if admitted)	\$250	Х
	Emergency room physician fo	050	x	
Need		\$50	- 11	
immediate attention	Emergency medical transport	\$250	Х	
attention	Urgent core	Urgent care		
	orgeni care		\$80	
Hospital stay	Facility fee (e.g. hospital roon	n)	20%	Х
	Physician/surgeon fee		20%	X
	Mental/Behavioral health outpatient office visits			
	Mental/Benavioral nealth out	patient office visits	\$40	
	Mental/Behavioral health other outpatient items and services		\$40	
	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	20%	Х
Mental health.	Mental/Behavioral health inpa	ationt physician/surgoon foo	20%	×
behavioral	ivierita/beriavioral riealur iripa	alent physician/surgeon ree	20%	
health, or substance	Substance Use disorder outp			
abuse needs	Substance Use disorder outp	\$40		
	Substance Use disorder other	er outpatient items and services	\$40	
	222 2.00,00, 00,0	,	V .0	
	Substance Use inpatient facil	lity fee (e.g. hospital room)	20%	х
	Substance use disorder inpar		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	inas	\$40 \$40	
Help	Outpatient Renabilitation service		\$40 \$40	
recovering or other special	Skilled nursing care		20%	X
health needs	Durable medical equipment		20%	_
	Hospice service		No charge	
Child eye	Eye exam		No charge	
care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge	
Child Dental	Oral Exam Preventive - Cleaning			
Diagnostic	Preventive - X-ray		No charge	
and Preventive	Sealants per Tooth		140 charge	
i revenuve	Topical Fluoride Application Space Maintainers - Fixed		1	
Child Dental				
Basic	Amalgam Fill - 1 Surface		20%	
Services	Root Canal- Molar			
Child Dental	Gingivectomy per Quad			
	Extraction- Single Tooth Expe	osed Root or Erupted	50%	
Major	Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony			
Major Services			1	
	Extraction- Complete Bony Porcelain with Metal Crown Medically necessary orthodor		50%	

Summary of	f Benefits and Coverage					
	Share amounts describe the En	rollee's out of pocket costs.	Bronze Pla	n	Bronz HSA P	
Actuarial Valu	e - AV Calculator		61.2% 61.99	<u>%</u>	61.19	
Plan design in	cludes a deductible?		Yes, integrated Medica	al/Pharmacy	Yes, integ	rated
	Individual deductible		\$6,500 integrate		\$4,500 inte	egrated
	Family deductible		\$13,000 integrate		\$9,000 inte	
	deductible, NOT integrated:		N/A\$6,000 / \$50	00 / \$0	N/A	
	ductible, NOT integrated: Med -of-pocket maximum	dicar/ Pharmacy / Dentai	N/A\$12,000 / \$1,0 \$6,500	<u> </u>	N/A \$6.50	
Family Out-of-	-pocket maximum		\$13,000		\$13,0	
HSA plan: Sel	f-only coverage deductible		N/A		\$4,50	
HSA family pia	an: Individual deductible		N/A		\$4,50	00
Common Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an in		\$70	After 1st 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/ im	munization	No charge		No charge	
	Laboratory Tests		\$40		40%	Х
Tests	X-rays and Diagnostic Imaging		0% 100%	X	40%	X
	Imaging (CT/PET scans, MRIs	s)	0% 100% 0% 100% up to \$500 per	X	40%	X
	Tier 1		script after pharmacy deductible	XPharmacy Deductible	40%	Х
Drugs to treat	Tier 2		9%100% up to \$500 per script after pharmacy deductible	XPharmacy Deductible	40%	Х
condition	Tier 3		9%100% up to \$500 per script after pharmacy deductible 9%100% up to \$500 per	XPharmacy Deductible	40%	х
	Tier 4 Surgery facility fee (e.g., ASC)		script after pharmacy deductible 9%100%	XPharmacy Deductible	40%	X
Outpatient	Physician/surgeon fees		0% 100%	X	40%	X
services	Outpatient visit		0% 100%	X	40%	Х
	Emergency room facility fee (v	vaived if admitted)	0% 100%	Х	40%	х
Need	Emergency room physician fee (waived if admitted)		0% 100%	Х	40%	Х
immediate	Emergency medical transporta	ation	0% 100%	Х	40%	Х
attention	Urgent care		\$120	After 1st three non-preventive visits	40%	х
Hospital stay	Facility fee (e.g. hospital room)	0% 100%	х	40%	х
	Physician/surgeon fee		0% 100%	X	40%	Х
	Mental/Behavioral health outp	atient office visits	\$70	After 1st three non-preventive visits	40%	х
	Mental/Behavioral health other outpatient items and services		\$70	After 1st three non-preventive visits	40%	х
	Mental/Behavioral health innet	tient facility fee (e.g.hospital room)	0% 100%	Х	40%	Х
Mental			0.7010076	^	40%	^
health, behavioral						
	Mental/Behavioral health inpat	tient physician/surgeon fee	0% 100%	Х	40%	х
health, or substance abuse needs	Mental/Behavioral health inpat		0%100% \$70	After 1st three non-preventive visits	40%	x
substance		atient office visits		After 1st three non-preventive		
substance	Substance Use disorder outpa	atient office visits outpatient items and services	\$70	After 1st three non-preventive visits After 1st three non-preventive	40%	х
substance	Substance Use disorder outpa	atient office visits outpatient items and services by fee (e.g. hospital room)	\$70 \$70	After 1st three non-preventive visits After 1st three non-preventive visits	40%	x
substance	Substance Use disorder outpet Substance Use disorder other Substance Use inpatient facilit Substance use disorder inpati	outpatient office visits outpatient items and services ty fee (e.g. hospital room) ent physician/surgeon fee	\$70 \$70 0%100% 0%100%	After 1st three non-preventive visits After 1st three non-preventive visits X	40% 40% 40% 40%	x x
substance abuse needs	Substance Use disorder output Substance Use disorder other Substance Use inpatient facilit Substance use disorder inpati Prenatal care and preconcept	outpatient office visits outpatient items and services by fee (e.g. hospital room) ent physician/surgeon fee ion visits	\$70 \$70 0%100% 0%100% No charge	After 1st three non-preventive visits After 1st three non-preventive visits X X	40% 40% 40% No charge	x x x
substance abuse needs	Substance Use disorder outpet Substance Use disorder other Substance Use inpatient facilit Substance use disorder inpati	outpatient office visits outpatient items and services by fee (e.g. hospital room) ent physician/surgeon fee ion visits Hospital	\$70 \$70 #100% 9%100% No charge 9%100%	After 1st three non-preventive visits After 1st three non-preventive visits X X	40% 40% 40% No charge 40%	x x x x x
substance abuse needs	Substance Use disorder outpater of the Substance Use disorder other Substance Use inpatient facilities Substance use disorder inpatient Substance use disorder inpatient prenatal care and preconcept Delivery and all inpatient services	outpatient office visits outpatient items and services by fee (e.g. hospital room) ent physician/surgeon fee ion visits	\$70 \$70 9%100% 9%100% No charge 9%100% 9%100%	After 1st three non-preventive visits After 1st three non-preventive visits X X X X	40% 40% 40% 40% No charge 40% 40%	x x x x x x x
substance abuse needs	Substance Use disorder outpool Substance Use disorder other Substance Use inpatient facilit Substance use disorder inpati Prenatal care and preconcept Delivery and all inpatient	outpatient items and services by fee (e.g. hospital room) ent physician/surgeon fee ion visits Hospital Professional	\$70 \$70 #100% 9%100% No charge 9%100%	After 1st three non-preventive visits After 1st three non-preventive visits X X	40% 40% 40% 40% No charge 40% 40% 40%	x x x x x
substance abuse needs Pregnancy	Substance Use disorder output Substance Use disorder other Substance Use inpatient facilit Substance use disorder inpati Prenatal care and preconcept Delivery and all inpatient services Home health care	outpatient office visits outpatient items and services ty fee (e.g. hospital room) ent physician/surgeon fee ion visits Hospital Professional ces	\$70 \$70 0%100% 0%100% No charge 9%100% 9%100% 9%100%	After 1st three non-preventive visits After 1st three non-preventive visits X X X X	40% 40% 40% 40% No charge 40% 40%	x x x x x x x x x x x x x x x x x x x
substance abuse needs Pregnancy	Substance Use disorder outper Substance Use disorder other Substance Use inpatient facilit Substance use disorder inpati Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Rehabilitation servi	outpatient office visits outpatient items and services ty fee (e.g. hospital room) ent physician/surgeon fee ion visits Hospital Professional ces	\$70 \$70 9%100% 9%100% No charge 9%100% 9%100% 9%100% 9%100% \$70 \$70	After 1st three non-preventive visits After 1st three non-preventive visits X X X X	40% 40% 40% 40% No charge 40% 40% 40%	X X X X X X X X X X X X X X X X X X X
Pregnancy Help recovering or other special	Substance Use disorder output Substance Use disorder other Substance Use inpatient facilit Substance use disorder inpati Prenatal care and preconcept belivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care	outpatient office visits outpatient items and services ty fee (e.g. hospital room) ent physician/surgeon fee ion visits Hospital Professional ces	\$70 \$70 9%100% 9%100% No charge 9%100% 9%100% 9%100% \$70 \$70 9%100%	After 1st three non-preventive visits After 1st three non-preventive visits X X X X X X X	40% 40% 40% 40% No charge 40% 40% 40% 40% 40%	x x x x x x x x x x x x x x x x x x x
substance abuse needs Pregnancy Help recovering or other special	Substance Use disorder output Substance Use disorder other Substance Use inpatient facilit Substance use disorder inpati Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment	outpatient office visits outpatient items and services ty fee (e.g. hospital room) ent physician/surgeon fee ion visits Hospital Professional ces	\$70 \$70 6%100% 0%100% No charge 9%100% 9%100% 9%100% \$70 \$70 9%100% 9%100%	After 1st three non-preventive visits After 1st three non-preventive visits X X X X X X X	40% 40% 40% 40% No charge 40% 40% 40% 40% 40%	x x x x x x x x x x x x x x x x x x x
Pregnancy Help recovering or other special health needs	Substance Use disorder output Substance Use disorder other Substance Use inpatient facilit Substance use disorder inpati Prenatal care and preconcept belivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care	outpatient office visits outpatient items and services ty fee (e.g. hospital room) ent physician/surgeon fee ion visits Hospital Professional ces	\$70 \$70 9%100% 9%100% No charge 9%100% 9%100% 9%100% \$70 \$70 9%100%	After 1st three non-preventive visits After 1st three non-preventive visits X X X X X X X	40% 40% 40% No charge 40% 40% 40% 40% 40% 40% 40%	x x x x x x x x x x x x x x x x x x x
Pregnancy Help recovering or other special health needs Child eye	Substance Use disorder outpater Substance Use disorder other Substance Use inpatient facilif Substance use disorder inpati Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service	outpatient items and services ty fee (e.g. hospital room) ent physician/surgeon fee ion visits Hospital Professional ces	\$70 \$70 9%100% 9%100% No charge 9%100% 9%100% 9%100% \$70 \$70 9%100% 9%100% 0%400% 0%400% 0%400%	After 1st three non-preventive visits After 1st three non-preventive visits X X X X X X X	40% 40% 40% 40% No charge 40% 40% 40% 40% 40% 40% 60%	x x x x x x x x x x x x x x x x x x x
Pregnancy Help recovering or other special	Substance Use disorder outpet Substance Use disorder other Substance Use inpatient facilit Substance use disorder inpati Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam	outpatient items and services ty fee (e.g. hospital room) ent physician/surgeon fee ion visits Hospital Professional ces	\$70 \$70 9%100% 9%100% No charge 9%100% \$400% 9%100% \$70 \$70 9%100% 9%100% No charge No charge	After 1st three non-preventive visits After 1st three non-preventive visits X X X X X X X	40% 40% 40% No charge 40% 40% 40% 40% 40% 40% No charge	x x x x x x x x x x x x x x x x x x x
Pregnancy Help recovering or other special health needs Child eye care	Substance Use disorder outpet Substance Use disorder other Substance Use inpatient facilit Substance use disorder inpati Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Rehabilitation servio Outpatient Healthilation servio Outpatient Healthilation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning	outpatient items and services ty fee (e.g. hospital room) ent physician/surgeon fee ion visits Hospital Professional ces	\$70 \$70 9%100% 9%100% No charge 9%100% \$400% 9%100% \$70 \$70 9%100% 9%100% No charge No charge	After 1st three non-preventive visits After 1st three non-preventive visits X X X X X X X	40% 40% 40% No charge 40% 40% 40% 40% 40% 40% No charge	x x x x x x x x x x x x x x x x x x x
Pregnancy Help recovering or other special health needs Child Dental Diagnostic	Substance Use disorder output Substance Use disorder other Substance Use inpatient facilit Substance use disorder inpati Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Rehabilitation servi Outpatient Habilitation service: Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or or Oral Exam Preventive - Cleaning Preventive - X-ray	outpatient items and services ty fee (e.g. hospital room) ent physician/surgeon fee ion visits Hospital Professional ces	\$70 \$70 9%100% 9%100% No charge 9%100% 9%100% \$70 \$70 9%100% 9%100% No charge No charge	After 1st three non-preventive visits After 1st three non-preventive visits X X X X X X X	40% 40% 40% No charge 40% 40% 40% 40% 40% 40% No charge No charge	x x x x x x x x x x x x x x x x x x x
Pregnancy Help recovering or other special health needs Child eye care Child Dental Diagnostic and	Substance Use disorder output Substance Use disorder other Substance Use inpatient facilit Substance use disorder inpati Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	outpatient items and services ty fee (e.g. hospital room) ent physician/surgeon fee ion visits Hospital Professional ces	\$70 \$70 9%100% 9%100% No charge 9%100% \$400% 9%100% \$70 \$70 9%100% 9%100% No charge No charge	After 1st three non-preventive visits After 1st three non-preventive visits X X X X X X X	40% 40% 40% No charge 40% 40% 40% 40% 40% 40% No charge	x x x x x x x x x x x x x x x x x x x
Pregnancy Help recovering or other special health needs Child eye care Child Dental Diagnostic and	Substance Use disorder output Substance Use disorder other Substance Use inpatient facilit Substance use disorder inpati Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or or Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - Cray Sealants per Tooth Topical Fluoride Application	outpatient items and services ty fee (e.g. hospital room) ent physician/surgeon fee ion visits Hospital Professional ces	\$70 \$70 9%100% 9%100% No charge 9%100% 9%100% \$70 \$70 9%100% 9%100% No charge No charge	After 1st three non-preventive visits After 1st three non-preventive visits X X X X X X X	40% 40% 40% No charge 40% 40% 40% 40% 40% 40% No charge No charge	x x x x x x x x x x x x x x x x x x x
Pregnancy Help recovering or other special health needs Child Dental Diagnostic and Preventive Child Dental Basic	Substance Use disorder output Substance Use disorder other Substance Use inpatient facilit Substance use disorder inpati Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	outpatient items and services ty fee (e.g. hospital room) ent physician/surgeon fee ion visits Hospital Professional ces	\$70 \$70 9%100% 9%100% No charge 9%100% 9%100% \$70 \$70 9%100% 9%100% No charge No charge	After 1st three non-preventive visits After 1st three non-preventive visits X X X X X X X	40% 40% 40% No charge 40% 40% 40% 40% 40% 40% No charge No charge	x x x x x x x x x x x x x x x x x x x
Pregnancy Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental	Substance Use disorder output Substance Use disorder other Substance Use inpatient facilit Substance use disorder inpati Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Rehabilitation service Use in the services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per 1 Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface	outpatient items and services ty fee (e.g. hospital room) ent physician/surgeon fee ion visits Hospital Professional ces	\$70 \$70 \$400% 6%100% No charge 9%100% 9%100% \$70 \$70 9%100% No charge No charge No charge No charge	After 1st three non-preventive visits After 1st three non-preventive visits X X X X X X X	40% 40% 40% No charge 40% 40% 40% 40% 40% 50% No charge No charge	x x x x x x x x x x x x x x x x x x x
Pregnancy Help recovering or other special health needs Child Dental Diagnostic and Preventive Child Dental Basic	Substance Use disorder outpet Substance Use disorder other Substance Use inpatient facilit Substance use disorder inpati Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Abelibilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or or Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - Cleaning Preventive - Footh Topical Fluoride Application Space Maintainers - Fixed	outpatient items and services ty fee (e.g. hospital room) ent physician/surgeon fee ion visits Hospital Professional ces	\$70 \$70 \$400% 6%100% No charge 9%100% 9%100% \$70 \$70 9%100% No charge No charge No charge No charge	After 1st three non-preventive visits After 1st three non-preventive visits X X X X X X X	40% 40% 40% No charge 40% 40% 40% 40% 40% 50% No charge No charge	x x x x x x x x x x x x x x x x x x x
Pregnancy Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major	Substance Use disorder output Substance Use disorder other Substance Use inpatient facilit Substance use disorder inpati Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Abelitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or or Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - Cleaning Preventive - National Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Expo	outpatient items and services outpatient items and services ty fee (e.g. hospital room) ent physician/surgeon fee ion visits Hospital Professional ces s ontact lenses in lieu of glasses)	\$70 \$70 \$400% 6%100% No charge 9%100% 9%100% \$70 \$70 9%100% No charge No charge No charge No charge	After 1st three non-preventive visits After 1st three non-preventive visits X X X X X X X	40% 40% 40% No charge 40% 40% 40% 40% 40% 50% No charge No charge	x x x x x x x x x x x x x x x x x x x
Pregnancy Help recovering or other special health needs Child Opental Diagnostic and Preventive Child Dental Basic Services Child Dental Child Dental Child Opental Child Opental Child Opental Child Dental Chil	Substance Use disorder outpater Substance Use disorder other Substance Use inpatient facilit Substance use disorder inpati Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Rehabilitation servic Outpatient Rehabilitation servic Skilled nursing care Durable medical equipment Hospice service Eye exam 1 the preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal-Molar Gingivectomy per Quad Extraction - Single Tooth Expo Extraction - Single Tooth Expo Extraction - Complete Bony	outpatient items and services outpatient items and services ty fee (e.g. hospital room) ent physician/surgeon fee ion visits Hospital Professional ces s ontact lenses in lieu of glasses)	\$70 \$70 9%100% 9%100% No charge 9%100% 9%100% \$70 \$70 \$70 \$400% 9%100% No charge No charge No charge	After 1st three non-preventive visits After 1st three non-preventive visits X X X X X X X	40% 40% 40% No charge 40% 40% 40% 40% 40% 40% No charge No charge No charge	x x x x x x x x x x x x x x x x x x x
Pregnancy Help recovering or other special health needs Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Services Child Dental Services	Substance Use disorder output Substance Use disorder other Substance Use inpatient facilit Substance use disorder inpati Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Abelitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or or Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - Cleaning Preventive - National Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Expo	outpatient items and services outpatient items and services ty fee (e.g. hospital room) ent physician/surgeon fee ion visits Hospital Professional ces s ontact lenses in lieu of glasses)	\$70 \$70 9%100% 9%100% No charge 9%100% 9%100% \$70 \$70 \$70 \$400% 9%100% No charge No charge No charge	After 1st three non-preventive visits After 1st three non-preventive visits X X X X X X X	40% 40% 40% No charge 40% 40% 40% 40% 40% 40% No charge No charge No charge	x x x x x x x x x x x x x x x x x x x
Pregnancy Help recovering or other special health needs Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major	Substance Use disorder outpater Substance Use disorder other Substance Use inpatient facilit Substance use disorder inpati Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Rehabilitation servic Outpatient Rehabilitation servic Skilled nursing care Durable medical equipment Hospice service Eye exam 1 the preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal-Molar Gingivectomy per Quad Extraction - Single Tooth Expo Extraction - Single Tooth Expo Extraction - Complete Bony	atient office visits outpatient items and services by fee (e.g. hospital room) ent physician/surgeon fee ion visits Hospital Professional ces s ontact lenses in lieu of glasses)	\$70 \$70 9%100% 9%100% No charge 9%100% 9%100% \$70 \$70 \$70 \$400% 9%100% No charge No charge No charge	After 1st three non-preventive visits After 1st three non-preventive visits X X X X X X X	40% 40% 40% No charge 40% 40% 40% 40% 40% 40% No charge No charge No charge	x x x x x x x x x x x x x x x x x x x

Member Cost S	hare amounts describe the Er	rollee's out of pocket costs.	Catastro	phic Plan
Actuarial Valu	e - AV Calculator			
Plan design in	cludes a deductible?		Yes, int	egrated
	Individual deductible		\$6,850 ir	ntegrated
Integrated	Family deductible	Madical / Pharmany / Dantal		integrated
Family dec	deductible, NOT integrated: luctible, NOT integrated: Me	Medical / Pharmacy / Dental dical / Pharmacy / Dental		/A /A
	of-pocket maximum	alout, i hamaoy, bomar	\$6,	850
	pocket maximum			,700
	f-only coverage deductible			/A /A
noa ranniy pia	n: Individual deductible		IN.	A
Common Medical			Member Cost	Deductible
Event	Primary care visit to treat an in	njury, illness, or condition	Share 0%	Applies After 1st three non-preventive
Health care provider's	Other practitioner office visit		0%	visits After 1st three non-preventive
office or clinic visit	Specialist visit		0%	visits
	Preventive care/ screening/ in	nmunization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagin	g	0%	X
10313	Imaging (CT/PET scans, MRI		0%	X
	Tier 1	•	0%	Х
Drugs to treat	Tier 2		0%	Х
illness or condition	Tier 3		00/	
			0%	X
	Tier 4 Surgery facility fee (e.g. ASC		0%	X
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	1	0%	X
services	Outpatient visit		0%	X
	Emergency room facility fee (waived if admitted)	0%	X
	Emergency room raciity ree (waived ii admitted)	0%	^
	Emergency room physician fee (waived if admitted)		0%	×
Need immediate	Emergency medical transportation		0%	Х
attention	Urgent care		0%	After 1st three non-preventive visits
	Facility fee (e.g. hospital room	1)	0%	Х
Hospital stay		7		
	Physician/surgeon fee		0%	X
	Mental/Behavioral health outp	atient 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 inpa	tient facility fee (e.g.hospital room)	0%	х
health,	Mental/Behavioral health inpa	tient physician/surgeon fee	0%	Х
behavioral health, or	montal Bonarioral nodili inpa	aon priyotola rourgoon too	078	After 1st three
substance abuse needs	Substance Use disorder outp	atient office visits	0%	non-preventive
	Substance Use disorder othe	r 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 inpat		0%	х
	Prenatal care and preconcept	tion visits	No charge	
Pregnancy	Delivery and all inpatient	Hospital	0%	х
	services	Professional	0%	X
	Home health care		0%	X
Help	Outpatient Rehabilitation serv		0%	Х
recovering or	Outpatient Habilitation service	S	0%	Х
other special	Skilled nursing care		0%	Х
health needs	Durable medical equipment		0%	Х
	Hospice service		0%	X
Child eye care	Eye exam 1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge 0%	Х
	Oral Exam			
Child Dental	Preventive - Cleaning		l .	
Diagnostic and Preventive	Preventive - X-ray Sealants per Tooth Topical Fluoride Application		No charge	
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		0%	х
OUI VILES	Root Canal- Molar			X
	Gingivectomy per Quad		1	X
		and Deed on Female 4	0%	X
Child Dental Major Services	Extraction- Single Tooth Expo Extraction- Complete Bony Porcelain with Metal Crown	sea Root or Eruptea		X



Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.		Platinum Coinsurance Plan		Platinum Copay Plan		
	e - AV Calculator cludes a deductible?		88.59 No	fo	89.59 No	ъ
	Individual deductible		\$0		\$0	
Integrated	Family deductible	Medical / Pharmacy / Dental	\$0	/ © O	\$0	r ¢ n
Family ded	luctible, NOT integrated: Me		\$0 / \$0 / \$0 / \$0 /	/\$0	\$0 / \$0 / \$0 / \$0 /	\$0
Individual Out-	of-pocket maximum		\$4,00 \$8,00	0	\$4,00 \$8,00	0
HSA plan: Self	-only coverage deductible		\$8,00 N/A	U	\$6,00 N/A	U
HSA family pla	n: 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		\$20		\$20	
Health care provider's office or	Other practitioner office visit		\$20		\$20	
clinic visit	Specialist visit		\$40		\$40	
	Preventive care/ screening/ ir	nmunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging		\$20 \$40		\$20 \$40	
10313	Imaging (CT/PET scans, MR		10%		\$150	
	Tier 1		\$5		\$5	
Drugs to treat	Tier 2		\$15		\$15	
condition	Tier 3		\$25		\$25	
	Tier 4		10% up to \$250 per script		10% up to \$250 per script	
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 for	ee (waived if admitted)	10%		No charge	
Need immediate	Emergency medical transpor	,	\$150		\$150	
attention	, , , , , , , , , , , , , , , , , , , ,					
	Urgent care		\$40		\$40	
Hospital stay	Facility fee (e.g. hospital room	1)	10%		\$250 per day	
nospitai stay	Physician/surgeon fee		10%		up to 5 days \$40	
	Mental/Behavioral health outpatient office visits		\$20		\$20	
	Mental/Behavioral health other outpatient items and services		\$20		\$20	
	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	10%		\$250 per day	
Mental health.					up to 5 days	
behavioral	Mental/Behavioral health inpa	itient physician/surgeon ree	10%		\$40	
health, or substance abuse needs	Substance Use disorder outp	atient office visits	\$20		\$20	
	Substance Use disorder other	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 inpar	ient physician/surgeon fee	10%		\$40	
	Prenatal care and preconcep	tion visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	10%		\$250 per day up to 5 days	
	services	Professional	10%		\$40	
	Home health care Outpatient Rehabilitation serv	rices	10% \$20		\$20 \$20	
Help recovering or	Outpatient Habilitation service		\$20		\$20	
other special	Skilled nursing care		10%		\$150 per day up to 5 days	
health needs	Durable medical equipment		10%		10%	
01.11.1	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		7.5		11.51	
Child Dental Diagnostic and Preventive	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application		Not Covered		Not Covered	
Child Dental Basic	Space Maintainers - Fixed Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Services	Root Canal- Molar				Not Covered	
Child Dental	Gingivectomy per Quad				Not Covered	
Major	Extraction- Single Tooth Exp	osed Root or Erupted	Not Covered		Not Covered	
	Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony					
Services	Extraction- Complete Bony Porcelain with Metal Crown				Not Covered Not Covered	

Member Cost S	hare amounts describe the En	rollee's out of pocket costs.	Gold Coinsuran		Gold Copay Plan	
Actuarial Value	e - AV Calculator		80.29		81.09	
	cludes a deductible?		No		No	
	Individual deductible Family deductible		\$0 \$0		\$0 \$0	
Individual	deductible, NOT integrated:	Medical / Pharmacy / Dental	\$0 / \$0.		\$0 / \$0	
	luctible, NOT integrated: Me -of-pocket maximum	dical / Pharmacy / Dental	\$0 / \$0 . \$6.20		\$0 / \$0 / \$6,20	
Family Out-of-	pocket maximum		\$12,40		\$12,40	
HSA plan: Self HSA family pla	f-only coverage deductible an: Individual deductible		N/A N/A		N/A N/A	
	in. marviduai deductible		IWA		INFA	
Common Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deduct Appli
	Primary care visit to treat an in	jury, 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/ im	munization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagin		\$35 \$50		\$35 \$50	_
	Imaging (CT/PET scans, MRI		20%		\$250	
	Tier 1		\$15		\$15	
Drugs to treat illness or condition	Tier 2		\$50		\$50	
	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) Physician/surgeon fees		20% 20%		\$600 \$55	
services	Outpatient visit		20%		20%	
	Emergency room facility fee (v	vaived if admitted)	\$250		\$250	
Need	Emergency room physician fee (waived if admitted)		20%		No charge	
	Emergency medical transportation		\$250		\$250	
	Emergency modical danaport	34011	Ψ230		9230	
	Urgent care		\$60		\$60	
Unamital atau	Facility fee (e.g. hospital room)	20%		\$600 per day	
Hospital stay	Physician/surgeon fee		20%		up to 5 days \$55	
	Mental/Behavioral health outpatient office visits		\$35		\$35	
	Mental/Behavioral health othe	r outpatient items and services	\$35		\$35	
	Mental/Rehavioral health inna	tient facility fee (e.g.hospital room)	20%		\$600 per day	
Mental nealth,					up to 5 days	
oehavioral	Mental/Behavioral health inpa	tient physician/surgeon fee	20%		\$55	
nealth, or substance abuse needs	Substance Use disorder outpo	atient office visits	\$35		\$35	
	Substance Use disorder other outpatient items and services		\$35		\$35	
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Substance use disorder inpatient physician/surgeon fee		20%		\$55	
	Prenatal care and preconcept	ion 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 servi	ces	20% \$35		\$30 \$35	
lelp ecovering or	Outpatient Habilitation service		\$35		\$35	
ther special	Skilled nursing care		20%		\$300 per day up to 5 days	
nealth needs	Durable medical equipment		20%		20%	
hild	Hospice service Eye exam		No charge No charge		No charge No charge	
Child eye care	1 pair of glasses per year (or o	ontact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam		Ť			
Child Dental	Preventive - Cleaning					
Diagnostic and	Preventive - X-ray Sealants per Tooth		Not Covered		Not Covered	
Preventive	Topical Fluoride Application					
Child Dental Basic	Space Maintainers - Fixed Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Services	Poot Conal Malar				Net Comment	
Child Dental	Root Canal- Molar Gingivectomy per Quad				Not Covered Not Covered	
Major Services	Extraction- Single Tooth Expo	sed Root or Erupted	Not Covered		Not Covered	
JOI VICES	Extraction- Complete Bony				Not Covered Not Covered	
	Porcelain with Metal Crown					

	Benefits and Coverage hare amounts describe the Er		Individua Silver Pla	
	e - AV Calculator	noise 3 out of pocket costs.	70.4%	
	cludes a deductible?			
Integrated	Individual deductible		Yes, Medical/Pha N/A	arriacy
	Family deductible	Medical / Pharmacy / Dental	N/A \$2,250 / \$250	/80
Family ded	luctible, NOT integrated: Me		\$4,500 / \$500	
	-of-pocket maximum		\$6,250 \$12,500	
HSA plan: Self	pocket maximum f-only coverage deductible		N/A	
HSA family pla	n: Individual deductible		N/A	
Common Medical				Dodustible
Event	Se	rvice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an in	njury, illness, or condition	\$45	
Health care provider's office or	Other practitioner office visit		\$45	
clinic visit	Specialist visit		\$70	
		and the state of		
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge \$35	
Tests .	X-rays and Diagnostic Imagin		\$65	
	Imaging (CT/PET scans, MR	s)	\$250	
	Tier 1		\$15	
Drugs to treat illness or condition	Tier 2		\$50	Pharmac; deductible
	Tier 3	\$70	Pharmac; deductible	
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC Physician/surgeon fees)	20% 20%	
services	Outpatient visit		20%	
	Emergency room facility fee (waived if admitted)	\$250	х
Need immediate attention	Emergency room physician fe	ee (waived if admitted)	\$50	х
	Emergency medical transport	ation	\$250	Х
	Urgent care		\$90	
Hospital stay	Facility fee (e.g. hospital roon	n)	20%	Х
,	Physician/surgeon fee		20%	Х
	Mental/Behavioral health outp	patient office visits	\$45	
	Mental/Behavioral health other	er outpatient items and services	\$45	
	Mental/Behavioral health inna	tient facility fee (e.g.hospital room)	20%	Х
Mental nealth,				
behavioral	Mental/Behavioral health inpa	tient physician/surgeon fee	20%	Х
nealth, or substance abuse needs	Substance Use disorder outp	atient office visits	\$45	
	Substance Use disorder other	r outpatient items and services	\$45	
	Substance Use inpatient facil	ity fee (e.g. hospital room)	20%	Х
	Substance use disorder inpat		20%	х
	Prenatal care and preconcep			
Pregnancy	Delivery and all inpatient	Hospital	No charge	X
,,	services	Professional	20%	X
	Home health care		\$45	_^
lelp .	Outpatient Rehabilitation service Outpatient Habilitation service		\$45 \$45	
ecovering or other special	Skilled nursing care		20%	Х
nealth needs	Durable medical equipment		20%	
	Hospice service		No charge	
Child eye care	Eye exam 1 pair of glasses per year (or or	contact lenses in lieu of plasses)	No charge No charge	
	Oral Exam	s. ronoco in ilidu or grasses)	140 Charge	
Child Dental	Preventive - Cleaning]	
Diagnostic and	Preventive - X-ray Sealants per Tooth		Not Covered	
Preventive	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered	
	Root Canal- Molar			
Child Dental Major Services	Gingivectomy per Quad Extraction- Single Tooth Expe Extraction- Complete Bony Porcelain with Metal Crown	osed Root or Erupted	Not Covered	
	Euroeiain with ivietal Crown			
Child				

	Benefits and Coverage		SHOP Silver		SHOP Silver	
	share amounts describe the E	nrollee's out of pocket costs.	Coinsurance Plan		Copay Plan	
	e - AV Calculator		71.7% <u>71.69</u>		71.4% <u>71.39</u>	
	cludes a deductible? Individual deductible		Yes, Medical/Pha N/A	rmacy	Yes, Medical/Pha N/A	irmacy
Integrated	Family deductible		N/A	/0-	N/A	/
	deductible, NOT integrated luctible, NOT integrated: M	: Medical / Pharmacy / Dental edical / Pharmacy / Dental	\$1,500 / \$500 <u>\$2</u> \$3,000 / \$1,000 <u>\$5</u>		\$1,500 / \$500 <u>\$2</u> \$3,000 / \$1,000 <u>\$5</u>	
ndividual Out	of-pocket maximum		\$6,500		\$6,500	
	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	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an	njury, illness, or condition	\$45		\$45	
Health care provider's office or	Other practitioner office visit		\$45		\$45	
clinic visit	Specialist visit		\$70		\$70	
	Preventive care/ screening/ in	mmunization	No charge		No charge	
	Laboratory Tests		\$35		\$35	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MR		\$65 20%	X	\$65 \$250	
		,				
	Tier 1		\$15		\$15	
Drugs to treat illness or condition	Tier 2		\$55	Pharmacy deductible	\$55	Pharmac deductibl
	Tier 3		\$75	Pharmacy deductible	\$75	Pharmac deductible
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20% up to \$500 per script after pharmacy deductible	Pharmac deductibl
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 f	ee (waived if admitted)	\$50	х	\$50	Х
Need	Emergency medical transpor		\$250	X	\$250	X
immediate attention			\$2.00		Ψ200	Α
	Urgent care		\$90		\$90	
Hospital stay	Facility fee (e.g. hospital roor	n)	20%	Х	20%	Х
	Physician/surgeon fee		20%	X	20%	X
	Mental/Behavioral health out	patient office visits	\$45		\$45	
	Mental/Behavioral health oth	er outpatient items and services	\$45		\$45	
	Mental/Behavioral health inn	atient facility fee (e.g.hospital room)	20%	х	20%	Х
Mental health,					***	
behavioral health, or	Mental/Behavioral health inp	atient physician/surgeon ree	20%	Х	20%	Х
substance abuse needs	Substance Use disorder out	patient office visits	\$45		\$45	
	Substance Use disorder other	er outpatient items and services	\$45		\$45	
	Substance Use inpatient faci	lity fee (e.g. hospital room)	20%	х	20%	х
	Substance use disorder inpa	tient physician/surgeon fee	20%	х	20%	Х
	Prenatal care and preconcep	otion visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	х	20%	х
	services	Professional	20%	Х	20%	Х
	Home health care Outpatient Rehabilitation ser	vices	20% \$45		\$45 \$45	
Help recovering or	Outpatient Habilitation service		\$45 \$45		\$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	contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam		90		90	
Child Dental	Preventive - Cleaning					
Diagnostic and Preventive	Preventive - X-ray Sealants per Tooth Topical Fluoride Application		Not Covered		Not Covered	
Child Dental	Space Maintainers - Fixed					
Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Child Dental	Root Canal- Molar Gingivectomy per Quad				Not Covered Not Covered	
Major	Extraction- Single Tooth Exp	osed Root or Erupted	Not Covered		Not Covered	
Services	Extraction- Complete Bony Porcelain with Metal Crown		-		Not Covered Not Covered	
Child						
Orthodontics	Medically necessary orthodo	HUCS	Not Covered		Not Covered	

Summary of	f Benefits and Coverage		SHOP	
	Share amounts describe the En	rollee's out of pocket costs.	Silver HSA Pla	an
	e - AV Calculator		70.5%	
	Individual deductible?		Yes, integr \$2,000 integr	rated
Integrated	Family deductible deductible, NOT integrated:	Modical / Pharmacy / Dontal	\$4,000 integ N/A	
Family ded	ductible, NOT integrated: Me		N/A	
	of-pocket maximum pocket maximum		\$6,250 \$12,50	
HSA plan: Sel	f-only coverage deductible an: Individual deductible		\$2,000 See endnote	
	an. muividuai deductible		occ chanote	<u>\$2,000</u>
Common Medical				
Event	Ser	vice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an in	jury, illness, or condition	20%	х
	Other practitioner office visit		20%	х
	Specialist visit		20%	х
	Preventive care/ screening/ im Laboratory Tests	munization	No charge 20%	×
Tests	X-rays and Diagnostic Imagin		20%	Х
	Imaging (CT/PET scans, MRI	5)	20%	X
	Tier 1		20%	х
Drugs to treat	Tier 2		20%	х
condition	Tier 3		20%	Х
	Tier 4		20%	Х
Outpatient	Physician/surgeon rees		20% 20%	X
services	Outpatient visit		20%	X
	Emergency room facility fee (waived if admitted)		20%	х
Need immediate attention	Emergency room physician fe	e (waived if admitted)	20%	х
	Emergency medical transport	ation	20%	X
	Urgent care		20%	х
	Facility fee (e.g. hospital room)	20%	X
Hospital stay	Physician/surgeon fee)	20%	X
	Mental/Behavioral health outpatient office visits		20%	x
	Mental/Behavioral health other outpatient items and services		20%	х
Mental	Mental/Behavioral health inpar	ient facility fee (e.g.hospital room)	20%	Х
health,	Mental/Behavioral health inpar	ient physician/surgeon fee	20%	х
behavioral health, or substance	Substance Use disorder outpatient office visits		20%	х
abuse needs	Substance Use disorder other outnatient items and services			v
	Substance Use disorder other outpatient items and services		20%	X
	Substance Use inpatient facili		20%	Х
	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%	X
Help	Outpatient Rehabilitation servi Outpatient Habilitation service		20% 20%	X
recovering or other special	Skilled nursing care		20%	X
health needs	Durable medical equipment		20%	X
	Hospice service Eye exam		0%	X
Child eye care	1 pair of glasses per year (or c	ontact lenses in lieu of placeae)	No charge No charge	
	Oral Exam		onlarge	
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			
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Expo	sed Root or Frunted	Not Covered	
Services	Extraction- Single Footh Expo Extraction- Complete Bony Porcelain with Metal Crown	occ noot of Etupieu	1401 Coveled	
Child Orthodontics	Medically necessary orthodon	tics	Not Covered	

Summary of	Benefits and Coverage					
	share amounts describe the En	rollee's out of pocket costs.	Silver Plan 100%-150% FPL		Silver Plan 150%-200% F	PL
	e - AV Calculator		93.89		86.8%	
	cludes a deductible? Individual deductible		Yes, Medical/F N/A	Pharmacy	Yes, Medical/Phar N/A	macy
Integrated	Family deductible deductible, NOT integrated:	Medical / Pharmacy / Dental	N/A \$75 / \$0	/\$0	N/A \$550 / \$50 / \$	0
Family dec	luctible, NOT integrated: Me		\$150 / \$0	/\$0	\$1,100 / \$100 /	
	of-pocket maximum		\$2,25 \$4,50		\$2,250 \$4,500	
HSA plan: Sel	f-only coverage deductible an: Individual deductible		N/A N/A		N/A N/A	
	in. marviduai deddetible		1074		1471	
Common Medical			Member Cost	Deductible	Mambas Cast Share	Deductible
Event	Ser	vice Type	Share	Applies	Member Cost Share	Applies
Health care	Primary care visit to treat an in	jury, illness, or condition	\$5		\$15	
provider's office or clinic visit	Other practitioner office visit		\$5		\$15	
	Specialist visit		\$8		\$25	
	Preventive care/ screening/ im Laboratory Tests	munization	No charge \$8		No charge \$15	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRI)	\$8 \$50		\$25 \$100	
		2)	\$50		\$100	
	Tier 1		\$3		\$5	
Drugs to treat illness or condition	Tier 2		\$10		\$20	Pharmacy deductible
condition	Tier 3		\$15		\$35 15% up to \$150 per	Pharmacy deductible
	Tier 4		10% up to \$150 per script		script after pharmacy deductible	Pharmacy deductible
Outpatient	Surgery facility fee (e.g., ASC)		10%		15%	
services	Physician/surgeon fees Outpatient visit		10%		15% 15%	
	Emergency room facility fee (v	vaived if admitted)	\$30	Х	\$75	Х
	Emergency room physician fe	e (waived if admitted)	\$25	Х	\$40	Х
Need immediate	Emergency medical transporta		\$30	X	\$75	X
attention						
	Urgent care		\$6		\$30	
Hospital stay	Facility fee (e.g. hospital room)		10%	х	15%	х
	Physician/surgeon fee		10%	X	15%	X
	Mental/Behavioral health outp	atient office visits	\$5		\$15	
	Mental/Behavioral health othe	r outpatient items and services	\$5		\$15	
Mental	Mental/Behavioral health inpat	ient facility fee (e.g.hospital room)	10%	х	15%	х
health,	Mental/Behavioral health inpat	ient physician/surgeon fee	10%	х	15%	х
behavioral health, or substance abuse needs	Substance Use disorder outpa	atient office visits	\$5		\$15	
abuse needs	Substance Use disorder other	outpatient items and conject	ø.c.		\$15	
			\$5		*	
	Substance Use inpatient facilit		10%	Х	15%	Х
	Substance use disorder inpati	· · ·	10%	Х	15%	Х
Description	Prenatal care and preconcept		No charge		No charge	
Pregnancy	Delivery and all inpatient services	Hospital Professional	10%	X	15%	X
	Home health care		10% \$3	^	15% \$15	_^
Help	Outpatient Rehabilitation servi Outpatient Habilitation service		\$5 \$5		\$15 \$15	
recovering or other special	Skilled nursing care		10%	х	15%	х
health needs	Durable medical equipment		10%		15%	
	Hospice service Eye exam		No charge No charge		No charge No charge	
Child eye care	1 pair of glasses per year (or c	ontact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam					
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray		Not Covered		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application		INUL COVERED		Not Covered	
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
	Root Canal- Molar					
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Expo	sed Root or Erupted	Not Covered		Not Covered	
Services	Extraction- Complete Bony Porcelain with Metal Crown					
Child		u				
Orthodontics	Medically necessary orthodon	ucs	Not Covered		Not Covered	

	Benefits and Coverage		Silver Plan	
	hare amounts describe the E	nrollee's out of pocket costs.	200%-250% FP	L
	e - AV Calculator		72.8%	
	cludes a deductible? Individual deductible		Yes, Medical/Pharm N/A	nacy
Integrated	Family deductible		N/A	
	deductible, NOT integrated: luctible, NOT integrated: Me	Medical / Pharmacy / Dental	\$1,900 / \$250 / \$ \$3,800 / \$500 / \$	
Individual Out-	-of-pocket maximum		\$5,450	_
	pocket maximum f-only coverage deductible		\$10,900 N/A	
HSA family pla	n: Individual deductible		N/A	
Common				
Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an i	njury, illness, or condition	\$40	
Health care provider's office or clinic visit	Other practitioner office visit		\$40	
	Specialist visit		\$55	
	Preventive care/ screening/ ir	mmunization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagir	ng.	\$35 \$50	
16515	Imaging (CT/PET scans, MR		\$250	
	Tier 1		\$15	
Druge to treat	Tier 2		\$45	Pharmacy
Drugs to treat illness or condition	Tion 2			deductible
	Tier 3		\$70	deductible
	Surgery facility fee (e.g., ASC) 20%		after pharmacy deductible	Pharmacy
Outpatient services	Physician/surgeon fees	7	20%	
30,11000	Outpatient visit		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)		\$250	Х
	Emergency room physician for	ee (waived if admitted)	\$50	х
	Emergency medical transpor	tation	\$250	Х
	Urgent care		\$80	
Hospital stay	Facility fee (e.g. hospital roon	n)	20%	Х
	Physician/surgeon fee		20%	X
	Mental/Behavioral health outpatient office visits		\$40	
	Mental/Behavioral health other outpatient items and services		\$40	
Mental	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	х
health,	Mental/Behavioral health inpatient physician/surgeon fee		20%	х
behavioral health, or substance	Substance Use disorder outpatient office visits		\$40	
abuse needs				
	Substance Use disorder other outpatient items and services		\$40	
	Substance Use inpatient facility fee (e.g. hospital room)		20%	Х
	Substance use disorder inpa	· · ·	20%	Х
December	Prenatal care and preconcep		No charge	
Pregnancy	Delivery and all inpatient services	Hospital Professional	20%	X
	Home health care	Professional	20% \$40	X
Help	Outpatient Rehabilitation service		\$40 \$40	
recovering or other special	Outpatient Habilitation service Skilled nursing care	~	20%	X
health needs	Durable medical equipment		20%	^
	Hospice service		No charge	
Child eye	Eye exam	contact langue in liqui of al	No charge	
care	1 pair of glasses per year (or Oral Exam	contact renses in neu or glasses)	No charge	
Child Dental	Preventive - Cleaning			
Diagnostic and	Preventive - X-ray Sealants per Tooth		Not Covered	
Preventive	Topical Fluoride Application			
Child Daniel	Space Maintainers - Fixed			_
Child Dental Basic	Amalgam Fill - 1 Surface		Not Covered	
Services				
	Root Canal- Molar Gingivectomy per Quad			
Child Dental Major Services	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exp Extraction- Complete Bony	osed Root or Erupted	Not Covered	

Medically necessary orthodontics

Not Covered

Summary of Benefits and Coverage

Summary of Benefits and Coverage				Bronze		
Member Cost S	share amounts describe the En	rollee's out of pocket costs.	Bronze Plan	n	HSA Plan	
Actuarial Value	e - AV Calculator		61.19% <u>61.9</u> °	<u>%</u>	61.1%	
	cludes a deductible?		Yes, integrated Medica		Yes, integ	
	Individual deductible Family deductible		\$6,500 integrate \$13,000 integrate		\$4,500 inte \$9,000 inte	
Individual	deductible, NOT integrated:	Medical / Pharmacy / Dental	N/A\$6,000 / \$50	0/\$0	N/A	
	luctible, NOT integrated: Me -of-pocket maximum	dical / Pharmacy / Dental	N/A <u>\$12,000 / \$10</u> \$6,500	00 / \$0	N/A \$6,500	
Family Out-of-	pocket maximum		\$13,000		\$13,000	
	f-only coverage deductible an: Individual deductible		N/A N/A		\$4,50 \$4,50	
Common						
Medical Event	Sei	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an ir	jury, illness, or condition	\$70	After 1st 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
	Specialist visit		\$90 After 1st three non-preventive visits		40%	х
	Preventive care/ screening/ in Laboratory Tests	munization	No charge \$40		No charge 40%	X
Tests	X-rays and Diagnostic Imagin		0% 100%	Х	40%	Х
	Imaging (CT/PET scans, MRI	s)	0% 100%	X	40%	X
	Tier 1		9%100% up to \$500 per script after pharmacy deductible	XPharmacy Deductible	40%	х
Drugs to treat illness or	Tier 2		9%100% up to \$500 per script after pharmacy deductible	XPharmacy Deductible	40%	х
condition	Tier 3		9%100% up to \$500 per script after pharmacy deductible	XPharmacy Deductible	40%	х
	Tier 4 Surgery facility fee (e.g., ASC)		9%100% up to \$500 per script after pharmacy deductible	XPharmacy Deductible	40%	х
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees		0% 100% 0% 100%	X	40% 40%	X
services	Outpatient visit		0% 100% 0% 100%	X	40%	X
	Emergency room facility fee (v	vaived if admitted)	0% 100%	х	40%	Х
	Emergency room physician fe	e (waived if admitted)		X	40%	x
Need	Emergency medical transport	· ,	0%100% 0% 100%	X	40%	X
immediate attention	Urgent care	care		After 1st three non-preventive visits	40%	х
Hospital stay	Facility fee (e.g. hospital room)		0% 100%	X	40%	Х
	Physician/surgeon fee		0% 100%	X	40%	Х
	Mental/Behavioral health outpatient office visits Mental/Behavioral health other outpatient items and services		\$70	After 1st three non-preventive visits	40%	х
			\$70	After 1st three non-preventive visits	40%	х
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		0% 100%	Х	40%	х
Mental health,	Mental/Rehavioral health inna	tient physician/surgeon fee		X	40%	X
behavioral	Mental/Behavioral health inpa	tient physician/surgeon ree	0% 100%		40%	_ ^
health, or substance abuse needs	Substance Use disorder outpatient office visits		\$70	After 1st three non-preventive visits	40%	х
	Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee		\$70	After 1st three non-preventive visits	40%	х
			0% 100%	Х	40%	Х
				Х	40%	х
	Prenatal care and preconcept		0%100%			^_
Pregnancy	Delivery and all inpatient	Hospital	No charge 0%100%	Х	No charge 40%	х
. /og.ianoy	services	Professional	0%100%	X	40%	X
	Home health care		0% 100% 0%100%	X	40%	X
Help	Outpatient Rehabilitation serv		\$70		40%	Х
recovering or	Outpatient Habilitation service	8	\$70		40%	X
other special health needs	Skilled nursing care		0%100%	X	40%	X
	Durable medical equipment Hospice service		0%100% No charge	X	40% 0%	X
Child eye	Eye exam		No charge		No charge	
care	1 pair of glasses per year (or o	ontact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Oral Exam					
Diagnostic			Not Covered		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed		Not covered		Not Govered	
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
	Root Canal- Molar					
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Expo	sed Root or Erupted	Not Covered		Not Covered	
Services	Extraction- Complete Bony Porcelain with Metal Crown	·				
Child Orthodontics	Medically necessary orthodon	tics	Not Covered		Not Covered	

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.			Catastrophic Plan		
Actuarial Valu	e - AV Calculator				
Plan design in	cludes a deductible?		Yes, int	egrated	
	Individual deductible		\$6,850 ir	itegrated	
	Family deductible deductible, NOT integrated:	Medical / Pharmacy / Dental	\$13,700 I	ntegrated A	
Family ded	luctible, NOT integrated: Med		N.	'A	
Individual Out-	-of-pocket maximum pocket maximum		\$6,8 \$13		
HSA plan: Self	f-only coverage deductible		N.		
HSA family pla	n: Individual deductible		N.		
Common					
Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies	
	Primary care visit to treat an in	jury, illness, or condition	0%	After 1st 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/ im	munization	No charge		
	Laboratory Tests		0%	X	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs		0%	X	
	illaging (CT/FET Scalls, Wikis	5)	0%	X	
	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		0%	X	
	Outpatient visit		0%	X	
	Emergency room facility fee (v	vaived if admitted)	0%	Х	
	Emergency room physician fe	0%	х		
Need immediate	Emergency medical transporta	0%	Х		
attention				After det three	
	Urgent care	0%	After 1st three non-preventive visits		
	Facility fee (e.g. hospital room)	0%	Х	
Hospital stay	Physician/surgeon fee		0%	X	
	i nysician/surgeon ree		078	After 1st three	
	Mental/Behavioral health outpatient office visits		0%	non-preventive visits	
	Mental/Behavioral health other outpatient items and services		0%	After 1st three non-preventive visits	
	Mental/Behavioral health inpat	ient facility fee (e.g.hospital room)	0%	Х	
Mental health,	Mental/Behavioral health inpat	ient physician/surgeon fee	0%	Х	
behavioral health, or	·	· · · · ·			
substance abuse needs	Substance Use disorder outpa	0%	After 1st three non-preventive visits		
	Substance Use disorder other	0%	After 1st three non-preventive visits		
	Substance Use inpatient facilit	0%	X		
	Substance use disorder inpati		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	
Help	Outpatient Rehabilitation services		0%	X	
recovering or	Outpatient Habilitation services	•	0%	X	
other special health needs	Skilled nursing care		0%	Х	
	Durable medical equipment Hospice service		0%	X	
Child eye	Eye exam		No charge		
care	1 pair of glasses per year (or co	ontact lenses in lieu of glasses)	0%	Х	
	Oral Exam				
Child Dental Diagnostic	Dental Preventive - Cleaning				
and	Sealants per Tooth		Not Covered		
Preventive	Topical Fluoride Application				
Child Dental Basic	Space Maintainers - Fixed Amalgam Fill - 1 Surface		Not Covered		
Services					
Child Dental	Root Canal- Molar Gingivectomy per Quad				
Major Services	Extraction- Single Tooth Expo Extraction- Complete Bony Porcelain with Metal Crown	sed Root or Erupted	Not Covered		
Child					
Orthodontics	Medically necessary orthodon	tics	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-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</u> plans <u>including except</u> 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, each individual in the family must meet the individual minimum deductible amount established by the Internal Revenue Service for the applicable Plan Year. 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 the <u>an up to 30-day</u> prescription supply. For example, if the prescription is for a month's supply, one co-pay or co-insurance 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-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. Qualified Health Plans may not cover non-Essential Health
 Benefits.
- 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.
2	1) Non-preferred generic drugs or;
12	2) Preferred brand name drugs or;

	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;
	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. Plan formularies must include at least one drug in Tiers 1 or 2 or 3 if all FDA-approved 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) 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. 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 statement that other drugs that are covered may not be listed on the formulary for tiers 1-3.
- 2322) 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: April 16 May 21, 2015

Summary of Benefits	Standalone Children's Dental Plan		Standalone Children's Dental Plan		
Member Cost Share amou costs.	nts describe the Enrollee's out of pocket	Pediatric Dental EHB Copay Plan		Pediatric Dental EHB Coinsurance Plan	
		Up to Age 19		Up to Aզ	je 19
Actuarial Value		83.09	%	86.89	6
Individual Deductible (waived for Diagnostic &	Preventive)	\$0		\$65 In Network/ \$65 Out of Network	
Family Deductible (Two of waived for Diagnostic &	Preventive)	\$0		\$130 In Network/ \$130 Out of Network	
Individual Out of Pocket		\$350		\$350	
Family Out of Pocket Ma	\$700		\$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)	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		0%	
	Topical Fluoride Application	\$0		0%	
	Space Maintainers - Fixed	\$0		0%	
Basic Services	Amalgam Fill - One Surface	\$25		20%	X
Major Services - Crowns	Root Canal - Molar Gingivectomy per Quad	\$300 \$150			
and Casts, Endodontics, Periodontics, Prosthodontics, Oral	Extraction- Single Tooth Exposed Root or Erupted	\$65		50%	х
Surgery	Extraction - Complete Bony	\$160			
	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: April 16 May 21, 2015

Summary of Benefits and Coverage		Family Dental Plan				
Member Cost Share amounts describe the Enrollee's out of pocket costs.		Pediatric Dental EHB Copay Plan		Adult Dental Copay Plan		
		Up to Age 19		Age 19 and Older		
Actuarial Value		83.0%		Not Calculated		
Individual Deductible (waived for Diagnostic & Preventive)		\$0		\$0		
Family Deductible (Two or more children) (waived for Diagnostic & Preventive)		\$0		\$0		
Individual Out of Pocket Maximum		\$350		Not Applicable		
Family Out of Pocket Maximum (Two or More Children)		\$700		Not Applicable		
Office Copay		\$0		\$0		
Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d)		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	
Diagnostic & Preventive	Oral Exam	\$0		\$0		
	Preventive - Cleaning	\$0		\$0		
	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: April 16 May 21, 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		
			Up to Age 19		Age 19 and Older	
Actuarial Value		86.8%		Not Calculated		
Individual Deductible (waived for Diagnostic & Preventive)		\$65 In Network/ \$65 Out of Network		\$50 In Network/ \$50 Out of Network		
Family Deductible (Two or more children) (waived for Diagnostic & Preventive)		\$130 In Network/ \$130 Out of Network		Not Applicable		
Individual Out of Pocket Maximum		\$350		Not Applicable		
Family Out of Pocket Maximum (Two or More Children)		\$700 \$0		Not Applicable \$0		
Office Copay 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		\$1,500		
Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Diagnostic & Preventive	Oral Exam	0%		0%		
	Preventive - Cleaning	0%		0%		
	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%	х	
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.
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- 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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- 8) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.