2016 2017 Standard Benefit Plan Designs 10.0 EHB





Member Cost S	hare amounts describe the Enr	ollee's out of pocket costs.	Platinum Coinsurance Plan		Platinum Copay Plan		
Actuarial Value	e - AV Calculator		88.5 <u>89.7</u>		89.5 <u>90.4</u>		
	cludes a deductible?		No		No		
	Individual deductible Family deductible		\$0 \$0		\$0 \$0		
Individual	deductible, NOT integrated: N		\$0 / \$0 /		\$0 / \$0 /		
Family ded	luctible, NOT integrated: Med -of-pocket maximum	ical / Pharmacy / Dental	\$0 / \$0 / \$4,00		\$0 / \$0 / \$4,00		
Family Out-of-	pocket maximum		\$8,00		\$8,00		
HSA plan: Self	only coverage deductible in: Individual deductible		N/A N/A		N/A N/A		
noa railily pia	iii. iiidividdai deddcdbie		IV/A		IN/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	\$20 <u>\$15</u>		\$20 <u>\$15</u>		
Health care provider's office or	Other practitioner office visit		\$20 <u>\$15</u>		\$20 <u>\$15</u>		
clinic visit	Specialist visit		\$40		\$40		
	Preventive care/ screening/ im	munization	No charge		No charge		
	Laboratory Tests		\$20		\$20		
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs		\$40 10%		\$40 \$150		
		1					
	Tier 1		\$5		\$5		
Drugs to treat	Tier 2	\$15		\$15			
condition	Tier 3		\$25		\$25		
	Tier 4	10% up to \$250		10% up to \$250			
			per script		per script		
Outpatient	Surgery facility fee (e.g., ASC)		10%		\$250		
services	Physician/surgeon fees Outpatient visit		10%		\$40 10%		
	Emergency room combined facility and physician fee (waived if		\$150		\$150		
	admitted)						
Need	Emergency room physician fee (waived if admitted)		10%		No charge		
immediate	Emergency medical transportation		\$150		\$150		
attention	Urgent care		\$40 <u>\$15</u>		\$40 <u>\$15</u>		
Hospital stay	Facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days		
	Physician/surgeon fee		10%		\$40		
	Mental/Behavioral health outpatient office visits		\$20 <u>\$15</u>		\$20 <u>\$15</u>		
	Mental/Behavioral health other outpatient items and services		\$20 <u>\$15</u>		\$20 <u>\$15</u>		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		10%		\$250 per day up		
Mental health,	Mental/Behavioral health inpat		10%		to 5 days \$40		
behavioral health, or	Mental/Benavioral nealth inpai	ient pnysician/surgeon tee	10%		\$40		
substance abuse needs	Substance Use disorder outpa	\$20 <u>\$15</u>		\$20 <u>\$15</u>			
	Substance Use disorder other	\$20 <u>\$15</u>		\$20 <u>\$15</u>			
	Substance Use inpatient facilit	y fee (e.g. hospital room)	10%		\$250 per day up to 5 days		
	Substance use disorder inpati	ent physician/surgeon fee	10%		\$40		
	Prenatal care and preconcepti	on visits	No charge		No charge		
Pregnancy	Delivery and all inpatient	Hospital	10%		\$250 per day up		
	services	Professional	10%		to 5 days \$40		
	Home health care		10%		\$20		
Help	Outpatient Rehabilitation servi		\$20 \$15		\$20 \$15		
recovering or	Outpatient Habilitation service		\$20 \$15		\$20 \$15 \$150 per day up		
other special health needs	Skilled nursing care		10%		to 5 days		
	Durable medical equipment Hospice service		10% No charge		10% No charge		
	Eye exam		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						
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray		1				
and	Sealants per Tooth		No charge		No charge		
Preventive	Topical Fluoride Application						
Child Dental Basic	Space Maintainers - Fixed Amalgam Fill - 1 Surface		20%		\$25		
Services			• • •				
Child Dental	Root Canal- Molar Gingivectomy per Quad				\$300		
Major	Gingivectomy per Quad Extraction- Single Tooth Expo	sed Root or Erupted	50%		\$150 \$65		
Services	Extraction- Complete Bony				\$160		
	Porcelain with Metal Crown				\$300		
Child Orthodontics	Medically necessary orthodon	ics	50%		\$1,000		

2016 2017 Standard Benefit Plan Designs 10.0 EHB

Summary of	of Benefits	and Coverage

	hare amounts describe the Enrollee's out of pocket costs.	Coinsurant 80.2 80.	ce Plan	Gold Copay P 81.0 81.5	lan
	cludes a deductible?	No		No	
Integrated	Individual deductible	\$0		\$0	
Individual	Family deductible deductible NOT integrated: Medical / Pharmacy / Dental	\$0 \$0 / \$0		\$0 \$0 / \$0 /	
Family ded ndividual Out-	luctible, NOT integrated: Medical / Pharmacy / Dental -of-pocket maximum	\$0 / \$0 / \$ 6,200 6		\$0 / \$0 / \$ 6,200 6	
amily Out-of-	pocket maximum	\$ 12,400 <u>1</u>		\$ 12,400 1	
	-only coverage deductible in: Individual deductible	N/A N/A		N/A N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductil Applies
	Primary care visit to treat an injury, illness, or condition	\$35 <u>\$30</u>		\$35 <u>\$30</u>	
Health care provider's office or	Other practitioner office visit	\$36 <u>\$30</u>		\$35 <u>\$30</u>	
clinic visit	Specialist visit	\$55		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$35 \$60 <u>\$55</u>		\$35 \$60 <u>\$55</u>	
	Imaging (CT/PET scans, MRIs)	20%		\$250 \$275	
	Tier 1	\$15		\$15	
Drugs to treat	Tier 2	\$50 <u>\$55</u>		\$ 50 <u>\$55</u>	
condition	Tier 3	\$70 <u>\$75</u>		\$70 <u>\$75</u>	
	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%		\$600 \$55	
services	Outpatient visit	20%		20%	
	Emergency room combined facility and physician fee (waived if admitted)	\$250 \$325		\$250 <u>\$325</u>	
	Emergency room physician fee (waived if admitted)	20%		No charge	
Need mmediate	Emergency medical transportation	\$250		\$250	
attention	Urgent care	\$ 60 <u>\$30</u>		\$60 <u>\$30</u>	
Hospital stay	Facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Physician/surgeon fee	20%		\$55	
	Mental/Behavioral health outpatient office visits	\$35 <u>\$30</u>		\$35 <u>\$30</u>	
	Mental/Behavioral health other outpatient items and services	\$35 <u>\$30</u>		\$35 <u>\$30</u>	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%		\$600 per day up	
Mental health,	Mental/Behavioral health inpatient physician/surgeon fee	20%		to 5 days \$55	
behavioral health, or	wentai/benavioral nealth inpatient physician/surgeon ree	20%		\$55	
substance abuse needs	Substance Use disorder outpatient office visits	\$35 <u>\$30</u>		\$35 <u>\$30</u>	
	Substance Use disorder other outpatient items and services	\$35 <u>\$30</u>		\$35 <u>\$30</u>	
	Substance Use inpatient facility 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 preconception visits	No charge		No charge	
Pregnancy	Delivery and all inpatient Hospital	20%		\$600 per day up	
	services Professional	20%		to 5 days \$55	
	Home health care	20%		\$30	
Help	Outpatient Rehabilitation services Outpatient Habilitation services	\$35 \$30 \$35 \$30		\$35 \$30 \$35 \$30	
ecovering or other special	Skilled nursing care	20%		\$300 per day up	
nealth needs	Durable medical equipment	20%		to 5 days 20%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam 1 pair of alassas par year (or centest lances in lieu of alassas)	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	No charge		No charge	
Child Dental	Preventive - Cleaning	1			
Diagnostic and	Preventive - X-ray Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
Child Dental	Space Maintainers - Fixed Amalgam Fill - 1 Surface	200/		enr	
Basic Services	Amalgam Fill - 1 Surface	20%		\$25	
	Root Canal- Molar			\$300	
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted	50%		\$150 \$65	
Services	Extraction- Complete Bony			\$160	
Child	Porcelain with Metal Crown			\$300	
	Medically necessary orthodontics	50%		\$1,000	

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	Benefits and Coverage hare amounts describe the Enrollee's out of pocket costs.	Silver Pla	1
	· · · · · · · · · · · · · · · · · · ·		
	e - AV Calculator	70.4 <u>71.53</u> °	
	cludes a deductible?	Yes, Medical/Pha	armacy
Integrated	Individual deductible Family deductible	N/A N/A	
Individual	deductible, NOT integrated: Medical / Pharmacy / Dental	\$ 2,250 2,500/ \$2	
	uctible, NOT integrated: Medical / Pharmacy / Dental	\$ 4,500 <u>5,000</u> / \$5 \$ 6250 6,80	
Family Out-of-	pocket maximum	\$ 12,500 <u>13,6</u>	
	-only coverage deductible In: Individual deductible	N/A N/A	
nox raining pra	iii. Iiidividdal deddedbie	IVA	
Common			Deductible
Medical Event	Service Type	Member Cost Share	Applies
	Primary care visit to treat an injury, illness, or condition	\$45 \$35	
		VIO GOO	
Health care provider's	Other practitioner office visit	\$45 \$35	
office or clinic visit	<u> </u>		
cimic visit	Specialist visit	\$70	
	Specialist vol.	\$10	
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$35 \$65 <u>\$70</u>	
	Imaging (CT/PET scans, MRIs)	\$250 \$300	
	Tier 1	\$15	
	··	\$10	
Drugs to treat	Tier 2	\$ 50 <u>\$55</u>	Pharmac
illness or			deductible
condition	Tier 3	\$70 <u>\$80</u>	Pharmac; deductible
		20% up to \$250 per	Pharmacy
	Tier 4	script after pharmacy deductible	deductible
Outpatient	Surgery facility fee (e.g., ASC)	20%	
services	Physician/surgeon fees Outpatient visit	20%	
	Emergency room combined facility and physician fee (waived if	\$250 \$350	×
	admitted)		
Need	Emergency room physician fee (waived if admitted)	\$50	×
immediate attention	Emergency medical transportation	\$250	×
attention	Urgent care	\$90 <u>\$35</u>	
	organic date	\$50 <u>\$55</u>	
	Facility fee (e.g. hospital room)	20%	Х
Hospital stay	Physician/surgeon fee	20%	X
	Triyonamourgoon too	2070	^
	Mental/Behavioral health outpatient office visits	\$45 <u>\$35</u>	
	Mental/Behavioral health other outpatient items and services	\$45 \$35	
	'	V-1	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	х
Mental health,	Mental/Behavioral health inpatient physician/surgeon fee	20%	×
behavioral health, or	wertan behavioral nealth inpatient physician surgeon ree	20%	Α
substance	Substance Use disorder outpatient office visits	\$45 <u>\$35</u>	
abuse needs	Substance decided outpatient office visits	910 <u>933</u>	
	Substance Use disorder other outpatient items and services	\$45 <u>\$35</u>	
	Substance Use inpatient facility fee (e.g. hospital room)	0537	.,
	Substance Use inpatient facility fee (e.g. hospital foom)	20%	Х
	Substance use disorder inpatient physician/surgeon fee	20%	х
	Prenatal care and preconception visits	No charge	
Pregnancy	Delivery and all inpatient Hospital	20%	х
	services Professional	20%	X
	Home health care Outpatient Rehabilitation services	\$45 \$45 <u>\$35</u>	
Help recovering or	Outpatient Habilitation services	\$45 <u>\$35</u>	
other special	Skilled nursing care	20%	х
health needs	Durable medical equipment	20%	
	Hospice service	No charge	
Child eye care	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge No charge	
	Oral Exam	o craige	
Child Dental	Preventive - Cleaning		
Diagnostic and	Preventive - X-ray Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
Child Device	Space Maintainers - Fixed		
Child Dental Basic	Amalgam Fill - 1 Surface	20%	
Services	Rest Canal Malar		
Child Dental	Root Canal- Molar Gingivectomy per Quad		
Major	Extraction- Single Tooth Exposed Root or Erupted	50%	
	Extraction- Complete Bony		
Services	Porcelain with Metal Crown		

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Member Cost S Actuarial Valu Plan design in Integrated	f Benefits and Coverage		SHOP CCS	8 <u>B</u>	SHOP CCS	B
Actuarial Valu Plan design ir Integrated	Share amounts describe the Enrollee's out of p	ocket costs	Silver		Silver	
Plan design in Integrated	·	ookot oooko.	Coinsurance 71.6 71.56		Copay Pla 71.3 71.259	
Integrated						
Integrated	ncludes a deductible?		Yes, Medical/Pha	armacy	Yes, Medical/Pha N/A	armacy
	Family deductible		N/A		N/A	
Individual	deductible, NOT integrated: Medical / Pharr ductible, NOT integrated: Medical / Pharmac	macy / Dental	\$ 1,500 <u>2,000</u> / \$2 \$ 3,000 4 <u>,000</u> / \$5		\$ 1,500 <u>2,000</u> / \$2 \$ 3,000 4,000 / \$5	
Individual Out	t-of-pocket maximum	Jy / Dentai	\$6,500 6,80		\$6,500 6,80	
	-pocket maximum		\$ 13,000 <u>13,6</u>	<u>800</u>	\$ 13,000 <u>13,6</u>	000
	f-only coverage deductible an: Individual deductible		N/A N/A		N/A N/A	
Common Medical Event	t Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
	Primary care visit to treat an injury, illness, or	r condition	\$45		\$45	
Health care provider's office or	Other practitioner office visit		\$45		\$45	
clinic visit	Specialist visit	\$70 <u>\$75</u>		\$70 <u>\$75</u>		
	Proventive core/ coreoning/ immunitation		No obose		No ob one	
	Preventive care/ screening/ immunization Laboratory Tests		No charge \$35 \$40		No charge \$35 \$40	
Tests	X-rays and Diagnostic Imaging		\$65 <u>\$70</u>		\$65 <u>\$70</u>	
	Imaging (CT/PET scans, MRIs)		20%	×	\$250 <u>\$300</u>	
	Tier 1		\$15		\$15	
Drugs to treat	Tier 2		\$55	Pharmacy deductible	\$55	Pharmad
illness or condition	Tier 3		\$76 <u>\$85</u>	Pharmacy deductible	\$76 <u>\$85</u>	Pharmad deductib
	Tier 4		20% up to \$250 per script after pharmacy	Pharmacy deductible	20% up to \$250 per script after pharmacy	Pharmadeductib
	Surgery facility fee (e.g., ASC)		deductible 20%		deductible 20%	
Outpatient services	Physician/surgeon fees		20%		20%	
iervices	Outpatient visit	ining for Assets of if	20%		20%	
	Emergency room combined facility and physical admitted)	iciari lee (walved li	\$250 <u>\$350</u>	×	\$250 <u>\$350</u>	×
	Emergency room physician fee (waived if adr	mitted)	\$50	×	\$50	×
Need mmediate	Emergency medical transportation		\$250	×	\$250	×
attention	Urgent care		\$ 90 <u>\$45</u>		\$ 90 <u>\$45</u>	
Hospital stay	Facility fee (e.g. hospital room)		20%	×	20%	Х
iospitai stay	Physician/surgeon fee		20%	Х	20%	х
	Mental/Behavioral health outpatient office visi	\$45		\$45		
	Mental/Behavioral health other outpatient iter	\$45		\$45		
	Mental/Behavioral health inpatient facility fee	(e.g.hospital room)	20%	х	20%	х
Mental health, behavioral	Mental/Behavioral health inpatient physician/	surgeon fee	20%	Х	20%	х
health, or substance abuse needs	Substance Use disorder outpatient office visit	ts	\$45		\$45	
	Substance Use disorder other outpatient item	\$45		\$45		
	Substance Use inpatient facility fee (e.g. hos	spital room)	20%	х	20%	х
	Substance use disorder inpatient physician/s	surgeon fee	20%	х	20%	х
	Prenatal care and preconception visits		No charge	- "	No charge	
Pregnancy	Delivery and all inpatient Hospital		20%	х	20%	х
	services Professional		20%	Х	20%	х
	Home health care		20%		\$45	
Help	Outpatient Rehabilitation services Outpatient Habilitation services		\$45 \$45		\$45 \$45	
				V		v
	Skilled nursing care Durable medical equipment		20%	Х	20%	Х
other special	Hospice service		20% No charge		20% No charge	
ther special	Eye exam		No charge		No charge	
other special nealth needs		lieu of glasses)	No charge		No charge	
other special nealth needs	1 pair of glasses per year (or contact lenses in l					
other special nealth needs Child eye care	Oral Exam					
other special nealth needs Child eye care	i pair or grasses per year (or contact ienses in i		No. 1		N	
other special nealth needs Child eye care Child Dental Diagnostic	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth		No charge		No charge	
other special nealth needs Child eye care Child Dental Diagnostic	pain of glasses per year (or contact tenses in to Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application		No charge		No charge	
other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth		No charge		No charge	
other special nealth needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic	pair or glasses per year for conact enses in Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface				\$25	
child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services	pair or glasses per year for conact erises in 1 Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed				\$25 \$300	
recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major	Pari or grasses per year for conact erises in Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or En.	upted			\$25 \$300 \$150 \$65	
other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental	Pari or glasses per year for conact enses in Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or En. Extraction- Complete Bony	upted	20%		\$25 \$300 \$150 \$65 \$160	
other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major	Pari or grasses per year for conact erises in Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or En.	upted	20%		\$25 \$300 \$150 \$65	

Summary of	Benefits and Coverage	SHOP CO	SB			
Member Cost S	hare amounts describe the Enrollee's out of pocket costs.	Silver HSA HDHP				
Actuarial Value	- AV Calculator	70.5 71.16%				
Plan design in	cludes a deductible?	Yes, integr	ated			
	Individual deductible	\$2,000 integ				
	Family deductible	\$4,000 integ	ırated			
	deductible, NOT integrated: Medical / Pharmacy / Dental uctible, NOT integrated: Medical / Pharmacy / Dental	N/A N/A				
	-of-pocket maximum	\$6.250 6.	650			
	pocket maximum	\$ 12,500 13				
	only coverage deductible	\$2,000				
HSA family pla	n: Individual deductible	\$2,600	1			
Common Medical Event	Service Type	Member Cost Share	Deductible Applie			
	Primary care visit to treat an injury, illness, or condition	20%	x			
Health care provider's office or	Other practitioner office visit	20%	x			
clinic visit	Specialist visit	20%	х			
	Preventive care/ screening/ immunization	No charge				
	Laboratory Tests	20%	X			
Tests	X-rays and Diagnostic Imaging	20%	Х			
	Imaging (CT/PET scans, MRIs)	20%	X			
	Tier 1	20% <u>up to \$250 per</u> <u>script</u>	х			
Drugs to treat	Tier 2	20% <u>up to \$250 per</u> <u>script</u>	х			
condition	Tier 3	20% <u>up to \$250 per</u> <u>script</u>	х			
	Tier 4	20% <u>up to \$250 per</u> <u>script</u>	х			
Outpatient	Surgery facility fee (e.g., ASC)	20%	X			
services	Physician/surgeon fees	20%	Х			
	Outpatient visit	20%	Х			
	Emergency room combined facility and physician fee (waived if admitted)	20%	Х			
	Emergency room physician for (unived if admitted)	000/				

20%

20%

20%

20%

20%

20%

20%

20%

20%

20%

No charge

20%

20% 20% 20%

20%

20%

0% No charge

No charge

No charge

20%

50%

50%

Х

Х

Х

Х

Х

Х

x

Emergency medical transportation

Facility fee (e.g. hospital room)

Mental/Behavioral health outpatient office visits

Substance Use disorder outpatient office visits

Mental/Behavioral health other outpatient items and services

Mental/Behavioral health inpatient facility fee (e.g.hospital room)

Mental/Behavioral health inpatient physician/surgeon fee

Substance Use disorder other outpatient items and services

Substance Use inpatient facility fee (e.g. hospital room)

Substance use disorder inpatient physician/surgeon fee

1 pair of glasses per year (or contact lenses in lieu of glasses)

Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony Porcelain with Metal Crown

Professional

Prenatal care and preconception visits

Delivery and all inpatient Hospital services

Home health care
Outpatient Rehabilitation services

Outpatient Habilitation services
Skilled nursing care

Durable medical equipment

Oral Exam
Preventive - Cleaning
Preventive - X-ray
Sealants per Tooth
Topical Fluoride Application
Space Maintainers - Fixed

Amalgam Fill - 1 Surface

Medically necessary orthodontics

Hospice service Eye exam

Child eye care

Child Dental

Child Dental Basic Services

Child Dental

hild

Physician/surgeon fee

Urgent care

Date: May 21, 2015 January 21, 2016

Summary of Benefits and Coverage

Summary of	Benefits and Coverage					
Member Cost S	hare amounts describe the Enr	ollee's out of pocket costs.	Silver F 100%-150		Silver Plan 150%-200% FF	
Actuarial Value	e - AV Calculator		93.8 94.	12%	86.8 <u>87.48</u> %	
	cludes a deductible?		Yes, Medical/I	Pharmacy	Yes, Medical/Phar	rmacy
	Individual deductible Family deductible		N/A N/A		N/A N/A	
Individual	deductible, NOT integrated: N	ledical / Pharmacy / Dental	\$75 / \$0		\$ 550 <u>650</u> / \$50	
Individual Out-	luctible, NOT integrated: Med -of-pocket maximum	ical / Pharmacy / Dental	\$150 / \$0 / \$0 \$ 2,250 <u>2,350</u>		\$ 1,100 <u>1,300</u> / \$10 \$ 2,250 <u>2,350</u>	
Family Out-of-	pocket maximum -only coverage deductible		\$ 4,500 <u>4,700</u>		\$4,500 4,700 N/A	
	n: Individual deductible		N/A N/A		N/A N/A	
Common Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an in	jury, illness, or condition	\$5		\$15 <u>\$10</u>	
Health care provider's office or clinic visit	Other practitioner office visit		\$5		\$15 <u>\$10</u>	
	Specialist visit		\$8		\$25	
	Preventive care/ screening/ im	munization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	1	\$8		\$15 \$25	
	Imaging (CT/PET scans, MRIs		\$50		\$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 Outpatient visit		10% 10%		15% 15%	
	Emergency room combined facility and physician fee (waived if		\$30 \$50	×	\$75 \$100	*
	admitted)	(univad if admitted)		×		
Need	Emergency room physician fer Emergency medical transporta		\$ 25 \$30	×	\$40 \$75	*
immediate attention	Emergency medical transports	non	\$30		φ13	
	Urgent care		\$6 <u>\$5</u>		\$30 <u>\$10</u>	
	Facility fee (e.g. hospital room)	10%	х	15%	x
Hospital stay	Physician/surgeon fee		10%	х	15%	Х
	Mental/Behavioral health outp	atient office visits	\$5		\$15 <u>\$10</u>	
	Mental/Behavioral health other	r outpatient items and services	\$5		\$15 <u>\$10</u>	
	Mental/Behavioral health inpat	tient facility fee (e.g.hospital room)	10%	х	15%	х
Mental health, behavioral	Mental/Behavioral health inpat		10%	×	15%	X
health, or	montal bonavioral ribatin input	ion priyoloanioargoon too	1076	^	1576	^
substance abuse needs	Substance Use disorder outpa	tient office visits	\$5		\$15 <u>\$10</u>	
	Substance Use disorder other	outpatient items and services	\$5		\$15 <u>\$10</u>	
	Substance Use inpatient facilit	ry fee (e.g. hospital room)	10%	х	15%	х
	Substance use disorder inpati	ent physician/surgeon fee	10%	х	15%	х
	Prenatal care and preconcepti	on visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	10%	х	15%	х
	services	Professional	10%	Х	15%	X
Hala	Home health care Outpatient Rehabilitation servi	ces	\$3 \$5		\$15 \$15 <u>\$10</u>	
Help recovering or	Outpatient Habilitation service		\$5		\$15 <u>\$10</u>	
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					
and	Sealants per Tooth		No charge		No charge	
Preventive	Topical Fluoride Application Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%		20%	
	Root Canal- Molar					
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Expos	sed Root or Frunted	50%		50%	
Services	Extraction- Single Tooth Expos Extraction- Complete Bony Porcelain with Metal Crown	1000 or Erupteu	JU /6		3070	
Child Orthodontics	Medically necessary orthodon	tics	50%		50%	

2016 2017 Standard Benefit Plan Designs 10.0 EHB

Summary of	of Benefits	and Coverage	

	hare amounts describe the En	rollee's out of pocket costs.	Silver Plan 200%-250% FP	L
	e - AV Calculator		72.8 <u>73.67</u> %	
	cludes a deductible?		Yes, Medical/Pharm	macy
Integrated	Family deductible		N/A	
Individual	deductible, NOT integrated: I	Medical / Pharmacy / Dental	\$1,900 2,200 / \$250	
ramily ded Individual Out-	uctible, NOT integrated: Med -of-pocket maximum	icai / Pharmacy / Dentai	\$3,800 <u>4,400</u> / \$500 \$ 5,450 5,700	0 / \$0
Family Out-of-	pocket maximum		\$ 10,900 <u>11,40</u>	0
	only coverage deductible n: Individual deductible		N/A N/A	
non raining pro	II. IIIdividdai deductible		IVA	
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an ir	njury, illness, or condition	\$40 <u>\$30</u>	
Health care provider's office or	Other practitioner office visit		\$40 <u>\$30</u>	
clinic visit	Specialist visit		\$55	
	Preventive care/ screening/ in	munization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	n	\$35 \$60 <u>\$65</u>	
	Imaging (CT/PET scans, MRIs		\$250 <u>\$300</u>	
	Tier 1		\$15	
Drugs to treat	Tier 2		\$45 <u>\$50</u>	Pharmacy
illness or condition	Tier 3		\$70 \$75	Pharmac
	1.0.0		20% up to \$250 per script	Pharmac
	Tier 4 Surgery facility fee (e.g., ASC)	after pharmacy deductible 20%	deductible
Outpatient	Physician/surgeon fees	,	20%	
services	Outpatient visit		20%	
	Emergency room combined fa admitted)	cility and physician fee (waived if	\$250 \$350	×
	Emergency room physician fe	e (waived if admitted)	\$50	×
Need immediate	Emergency medical transport	\$250	×	
attention	·		\$200	
	Urgent care		\$ 80 \$ <u>30</u>	
Hospital stay	Facility fee (e.g. hospital room	n)	20%	х
	Physician/surgeon fee		20%	Х
	Mental/Behavioral health outp	atient office visits	\$40 <u>\$30</u>	
	Mental/Behavioral health othe	\$40 <u>\$30</u>		
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	х
Mental health, behavioral	Mental/Behavioral health inpa	tient physician/surgeon fee	20%	Х
health, or substance abuse needs	Substance Use disorder outpa	atient office visits	\$40 <u>\$30</u>	
	Substance Use disorder other	outpatient items and services	\$40 <u>\$30</u>	
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%	
	Substance use disorder inpati		20%	X
	Prenatal care and preconcept			^
D			No charge	
Pregnancy	Delivery and all inpatient services	Hospital	20%	X
	Home health care	Professional	20% \$40	Х
Help	Outpatient Rehabilitation serv		\$40 \$40 <u>\$30</u>	
recovering or	Outpatient Habilitation service	es .	\$40 <u>\$30</u>	
other special	Skilled nursing care		20%	х
health needs	Durable medical equipment		20%	
	Hospice service Eye exam		No charge No charge	
Child eye care	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge	
	Oral Exam	31 gauded)	. so salarge	
Child Dental	Preventive - Cleaning			
Diagnostic and	Preventive - X-ray Sealants per Tooth		No charge	
Preventive	Topical Fluoride Application			
Child Dental	Space Maintainers - Fixed Amalgam Fill - 1 Surface		20%	
			2076	
	Root Canal- Molar			
Basic Services Child Dental				
Services Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Expo	sed Root or Erupted	50%	
Services Child Dental	Gingivectomy per Quad	sed Root or Erupted	50%	

Summary	οf	Renefits	and	Coverage

Member Cost S	Benefits and Coverage hare amounts describe the En	rollee's out of pocket costs.	Bronze Pla	n	Bronz HSA HDHF	Plan
Actuarial Value	e - AV Calculator		61.9%		61.06 <u>61.</u>	<u>13</u> %
	cludes a deductible?		Yes, Medical/Pha	armacy	Yes, integ	
	Individual deductible Family deductible		N/A N/A		\$4,500 integ	
Individual	deductible, NOT integrated: I	Medical / Pharmacy / Dental	\$ 6,000 <u>6,300</u> / \$5	\$9,000 integrated N/A		
	luctible, NOT integrated: Med -of-pocket maximum	lical / Pharmacy / Dental	\$ 12,000 <u>12,600</u> / \$1	N/A \$ 6,500 6,	eeo.	
	pocket maximum		\$ 6,500 <u>6,800</u> \$ 13,000 <u>13,600</u>		\$1 3,000 <u>0</u> ,	
HSA plan: Self-	only coverage deductible		N/A		\$4,500)
HSA family pla	n: Individual deductible		N/A		\$4,500)
Common Medical Event	•	nica Tuna	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
medical Event	Primary care visit to treat an ir	rvice Type	\$70 \$75	After 1st three non-preventive	40%	Х
Health care	<u> </u>	yary, amooo, or container.		visits After 1st three		
office or clinic visit	Other practitioner office visit		\$70 <u>\$75</u>	non-preventive visits After 1st three	40%	Х
	Specialist visit Preventive care/ screening/ in	nmunization	\$90 \$105 No charge	non-preventive visits	40% No charge	Х
	Laboratory Tests		\$40		40%	X
Tests	X-rays and Diagnostic Imagin		100%	Х	40%	Х
	Imaging (CT/PET scans, MRIs	5)	100%	X	40%	X
	Tier 1		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	х
Drugs to treat	Tier 2		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	х
condition	Tier 3		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	х
	Tier 4	1	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	х
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees)	100% 100%	X	40% 40%	X
services	Outpatient visit		100%	х	40%	х
	Emergency room combined fa admitted)	acility and physician fee (waived if	100%	Х	40%	х
	Emergency room physician fe	e (waived if admitted)	100%	×	40%	×
Need	Emergency medical transport		100%	X	40%	X
immediate attention	Urgent care		\$120 <u>\$75</u>	After 1st three non-preventive visits	40%	×
Hamital atom	Facility fee (e.g. hospital room	n)	100%	х	40%	X
Hospital stay	Physician/surgeon fee		100%	X	40%	Х
	Mental/Behavioral health outp	atient office visits	\$70 <u>\$75</u>	After 1st three non-preventive visits	40%	х
	Mental/Behavioral health othe	er outpatient items and services	\$70 <u>\$75</u>	After 1st three non-preventive visits	40%	х
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	100%	Х	40%	х
Mental health,	Mental/Behavioral health inpa	tient physician/surgeon fee	100%	x	40%	×
behavioral health, or substance abuse needs	Substance Use disorder outpo		\$70 <u>\$75</u>	After 1st three non-preventive visits	40%	×
	Substance Use disorder other	outpatient items and services	\$70 <u>\$75</u>	After 1st three non-preventive	40%	×
	Substance Use inpatient facili	ity fee (e.g. hospital room)	100%	Visits	40%	х
	Substance use disorder inpat	ient physician/surgeon fee	100%	х	40%	х
	Prenatal care and preconcept		No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	100%	х	40%	х
gus y	services	Professional	100%	X	40%	×
	Home health care	i iordaaluridi	100%	X	40%	X
Help	Outpatient Rehabilitation serv		\$70 <u>\$75</u>		40%	Х
recovering or	Outpatient Habilitation service	es .	\$70 <u>\$75</u>		40%	Х
other special health needs	Skilled nursing care		100%	Х	40%	Х
	Durable medical equipment Hospice service		100%	Х	40% 0%	X
	Eye exam		No charge No charge		No charge	_^
Child eye care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam					
Child Dental Diagnostic	Preventive - Cleaning					
and	Preventive - X-ray Sealants per Tooth		No charge		No charge	
Preventive	Topical Fluoride Application Space Maintainers - Fixed					
Child Dental Basic	Amalgam Fill - 1 Surface		20%		20%	
Services	De don de Mil					
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	50%		50%	
Child Orthodontics	Medically necessary orthodon	tics	50%		50%	
C. thoublines						

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Summary of Benefits and Coverage

Actuarial Value	hare amounts describe the En		Catastro	
	cludes a deductible?		Yes, int	egrated
	Individual deductible			0 integrated
Integrated	Family deductible		\$ 13,700 <u>14,3</u>	00 integrated
Individual	deductible, NOT integrated: Med	Medical / Pharmacy / Dental	N	
ramily ded Individual Out	luctible, NOT integrated: Med -of-pocket maximum	icai / Pharmacy / Dentai	N \$ 6,85 0	
Family Out-of-	pocket maximum		\$13,700	14,300
	only coverage deductible		N	
HSA family pla	n: Individual deductible		N	/A
Common Medical Event	Sei	rvice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an ir	njury, illness, or condition	0%	After 1st thre non-preventiv visits
Health care provider's office or	Other practitioner office visit		0%	After 1st thre non-preventiv visits
clinic visit	Specialist visit		0%	х
	Preventive care/ screening/ im	munization	No charge	
	Laboratory Tests		0%	Х
Tests	X-rays and Diagnostic Imaging		0%	Х
	Imaging (CT/PET scans, MRIs	3)	0%	Х
	Tier 1		0%	х
Drugs to treat	Tier 2		0%	х
illness or condition	Tier 3		0%	х
	Tier 4		0%	х
	Surgery facility fee (e.g., ASC	1	00/	X
Outpatient	Physician/surgeon fees		0%	X
services	Outpatient visit		0%	X
	Emergency room combined fa	cility and physician fee (waived if	0%	X
	admitted)		0.76	^
	Emergency room physician fee (waived if admitted)		0%	×
Need mmediate	Emergency medical transportation		0%	Х
attention	Urgent care		0%	After 1st three
Hospital stay	Facility fee (e.g. hospital room	1)	0%	Х
nospitai stay	Physician/surgeon fee		0%	Х
	Mental/Behavioral health outp	atient office visits	0%	After 1st three non-prevention visits
	Mental/Behavioral health other outpatient items and services		0%	After 1st thre non-preventiv visits
Mental health,	Mental/Behavioral health inpa	0%	х	
behavioral	Mental/Behavioral health inpa	tient physician/surgeon fee	0%	х
health, or substance abuse needs	Substance Use disorder outpa	atient office visits	0%	After 1st three
	Substance Use disorder other outpatient items and services		0%	After 1st thre
	Cubatana I las invationt facili	h. for (n n harrital resur)		visits
	Substance Use inpatient facili Substance use disorder inpati		0%	X
	Prenatal care and preconcept	ion visits	No charge	
D				
Pregnancy	Delivery and all inpatient services	Hospital	0%	Х
		Professional	0%	X
	Home health care Outpatient Rehabilitation serv	ices	0%	X
			0%	X
	Outpatient Habilitation service			
ecovering or			0%	¥
ecovering or other special	Skilled nursing care		0%	X
ecovering or other special	Skilled nursing care Durable medical equipment		0% 0%	Х
ecovering or other special realth needs	Skilled nursing care	_	0%	
ecovering or other special realth needs	Skilled nursing care Durable medical equipment Hospice service Eye exam		0%	X X
ecovering or other special nealth needs	Skilled nursing care Durable medical equipment Hospice service		0% 0% No charge	Х
ecovering or other special health needs Child eye care Child Dental	Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or c Oral Exam Preventive - Cleaning		0% 0% No charge	X X
ecovering or other special nealth needs Child eye care Child Dental Diagnostic	Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or c Oral Exam Preventive - Cleaning Preventive - X-ray		0% 0% No charge 0%	X X
ecovering or other special nealth needs Child eye care Child Dental Diagnostic and	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		0% 0% No charge	X X
ecovering or other special nealth needs Child eye care Child Dental Diagnostic and	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 Topical Fluoride Application		0% 0% No charge 0%	X X
recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic	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		0% 0% No charge 0%	X X
recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic	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 Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface		0% 0% No charge 0%	X X X
Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental	Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - Array Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar		0% 0% No charge 0%	x x x
recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental	Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - Cleaning Preventive - Laving Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad Extraction - Single Tooth Expo	contact lenses in lieu of glasses)	0% 0% No charge 0%	X X X
recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major	Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - Wary Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Expo Extraction- Complete Bony	contact lenses in lieu of glasses)	0% 0% No charge 0% No charge	X X X X X X X X X X X X X X X X X X X
recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic	Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - Cleaning Preventive - Laving Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad Extraction - Single Tooth Expo	contact lenses in lieu of glasses)	0% 0% No charge 0% No charge	X X X X X X X X X X