



Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

		Platinum Coinsurance Plan	Platinum Copay Plan
Actuarial Value - AV Calculator		89.7% 91.2%	90.3% 88.1%
Plan design includes a deductible?		No	No
Integrated Individual deductible		\$0	\$0
Integrated Family deductible		\$0	\$0
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0	\$0 / \$0 / \$0
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0	\$0 / \$0 / \$0
Individual Out-of-pocket maximum		\$4,000 \$3,350	\$4,000 \$3,350
Family Out-of-pocket maximum		\$8,000 \$6,700	\$8,000 \$6,700
HSA plan: Self-only coverage deductible		N/A	N/A
HSA family plan: Individual deductible		N/A	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
	Other practitioner office visit	\$15		\$15	
	Specialist visit	\$40 \$30		\$40 \$30	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$20 \$15		\$20 \$15	
	X-rays and Diagnostic Imaging	\$40 \$30		\$40 \$30	
	Imaging (CT/PET scans, MRIs)	10%		\$150 \$75	
Drugs to treat illness or condition	Tier 1	\$5		\$5	
	Tier 2	\$15		\$15	
	Tier 3	\$25		\$25	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	10%		\$250 \$100	
	Physician/surgeon fees	10%		\$40 \$25	
	Outpatient visit	10%		10%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Emergency medical transportation	\$150		\$150	
	Urgent care	\$15		\$15	
Hospital stay	Facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Physician/surgeon fee	10%		\$40 No charge	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$15		\$15	
	Mental/Behavioral health other outpatient items and services	\$15		\$15	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%		\$250 per day up to 5 days	
	Mental/Behavioral health inpatient physician fee	10%		\$40 No charge	
	Substance Use disorder outpatient office visits	\$15		\$15	
	Substance Use disorder other outpatient items and services	\$15		\$15	
	Substance Use inpatient facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Substance use disorder inpatient physician fee	10%		\$40 No charge	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	Hospital	10%	\$250 per day up to 5 days	
		Professional	10%	\$40 No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	10%		\$20	
	Outpatient Rehabilitation services	\$15		\$15	
	Outpatient Habilitation services	\$15		\$15	
	Skilled nursing care	10%		\$150 per day up to 5 days	
	Durable medical equipment	10%		10%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam				
	Preventive - Cleaning				
	Preventive - X-ray	Not Covered		Not Covered	
	Sealants per Tooth				
	Topical Fluoride Application				
Child Dental Basic Services	Space Maintainers - Fixed				
	Restorative Procedures	Not Covered		Not Covered	
Child Dental Major Services	Periodontal Maintenance Services				
	Crowns and Casts			Not Covered	
	Endodontics			Not Covered	
	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics			Not Covered	
Child Orthodontics	Oral Surgery			Not Covered	
	Medically necessary orthodontics	Not Covered		Not Covered	

20172018 Patient-Centered Benefit Plan Designs

9.5 EHB

Date: June 16, 2016 January 26, 2017

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

		Gold Coinsurance Plan		Gold Copay Plan	
Actuarial Value - AV Calculator		80.9%81.9%		81.2%78.4%	
Plan design includes a deductible?		No		No	
Integrated Individual deductible		\$0		\$0	
Integrated Family deductible		\$0		\$0	
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0		\$0 / \$0 / \$0	
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0		\$0 / \$0 / \$0	
Individual Out-of-pocket maximum		\$6,750\$6,000		\$6,750\$6,000	
Family Out-of-pocket maximum		\$13,500\$12,000		\$13,500\$12,000	
HSA plan: Self-only coverage deductible		N/A		N/A	
HSA family plan: Individual deductible		N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$30\$25		\$30\$25	
	Other practitioner office visit	\$30\$25		\$30\$25	
	Specialist visit	\$55		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$35		\$35	
	X-rays and Diagnostic Imaging	\$55		\$55	
	Imaging (CT/PET scans, MRIs)	20%		\$275	
Drugs to treat illness or condition	Tier 1	\$15		\$15	
	Tier 2	\$55		\$55	
	Tier 3	\$75		\$75	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	20%		\$600\$300	
	Physician/surgeon fees	20%		\$55\$40	
	Outpatient visit	20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$325		\$325	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Emergency medical transportation	\$250		\$250	
	Urgent care	\$30		\$30	
Hospital stay	Facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Physician/surgeon fee	20%		\$55No charge	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$30\$25		\$30\$25	
	Mental/Behavioral health other outpatient items and services	\$30\$25		\$30\$25	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%		\$600 per day up to 5 days	
	Mental/Behavioral health inpatient physician fee	20%		\$55No charge	
	Substance Use disorder outpatient office visits	\$30\$25		\$30\$25	
	Substance Use disorder other outpatient items and services	\$30\$25		\$30\$25	
	Substance Use inpatient facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Substance use disorder inpatient physician fee	20%		\$55No charge	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	Hospital	20%	\$600 per day up to 5 days	
		Professional	20%	\$55No charge	
Help recovering or other special health needs	Home health care (cost share per visit)	20%		\$30	
	Outpatient Rehabilitation services	\$30\$25		\$30\$25	
	Outpatient Habilitation services	\$30\$25		\$30\$25	
	Skilled nursing care	20%		\$300 per day up to 5 days	
	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam				
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth	Not Covered		Not Covered	
	Topical Fluoride Application				
Child Dental Basic Services	Space Maintainers - Fixed				
	Restorative Procedures	Not Covered		Not Covered	
Child Dental Major Services	Periodontal Maintenance Services				
	Crowns and Casts			Not Covered	
	Endodontics			Not Covered	
	Periodontics (other than maintenance)	Not Covered		Not Covered	
	Prosthodontics			Not Covered	
Child Orthodontics	Oral Surgery			Not Covered	
	Medically necessary orthodontics	Not Covered		Not Covered	

2017-2018 Patient-Centered Benefit Plan Designs

9.5 EHB

Date: June 16, 2016/January 26, 2017

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Individual
	Silver Plan
Actuarial Value - AV Calculator	71.5%/71.9%
Plan design includes a deductible?	Yes, Medical/Pharmacy
Integrated Individual deductible	N/A
Integrated Family deductible	N/A
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,500/ \$250/\$100 / \$0
Family deductible, NOT integrated: Medical / Pharmacy / Dental	\$5,000/ \$500/\$200 / \$0
Individual Out-of-pocket maximum	\$6800/\$7,000
Family Out-of-pocket maximum	\$13,600/\$14,000
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$35		
	Other practitioner office visit	\$35		
	Specialist visit	\$70		
	Preventive care/ screening/ immunization	No charge		
Tests	Laboratory Tests	\$35		
	X-rays and Diagnostic Imaging	\$70		
	Imaging (CT/PET scans, MRIs)	\$300		
Drugs to treat illness or condition	Tier 1	\$15	Pharmacy deductible	
	Tier 2	\$55	Pharmacy deductible	
	Tier 3	\$80	Pharmacy deductible	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	
Outpatient services	Surgery facility fee (e.g., ASC)	20%		
	Physician/surgeon fees	20%		
	Outpatient visit	20%		
Need immediate attention	Emergency room facility fee (waived if admitted)	\$350		
	Emergency room physician fee (waived if admitted)	No charge		
	Emergency medical transportation	\$250	X	
	Urgent care	\$35		
Hospital stay	Facility fee (e.g. hospital room)	20%	X	
	Physician/surgeon fee	20%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$35		
	Mental/Behavioral health other outpatient items and services	\$35		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	
	Mental/Behavioral health inpatient physician fee	20%	X	
	Substance Use disorder outpatient office visits	\$35		
	Substance Use disorder other outpatient items and services	\$35		
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X	
	Substance use disorder inpatient physician fee	20%	X	
Pregnancy	Prenatal care and preconception visits	No charge		
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care (cost share per visit)	\$45		
	Outpatient Rehabilitation services	\$35		
	Outpatient Habilitation services	\$35		
	Skilled nursing care	20%	X	
	Durable medical equipment	20%		
	Hospice service	No charge		
Child eye care	Eye exam	No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
Child Dental Diagnostic and Preventive	Oral Exam			
	Preventive - Cleaning			
	Preventive - X-ray	Not Covered		
	Sealants per Tooth			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures	Not Covered		
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts			
	Endodontics			
	Periodontics (other than maintenance)	Not Covered		
	Prosthodontics			
Child Orthodontics	Oral Surgery			
	Medically necessary orthodontics	Not Covered		

2017-2018 Patient-Centered Benefit Plan Designs

9.5 EHB

Date: June 16, 2016/January 26, 2017

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

		CCSB		CCSB		
		Silver Coinsurance Plan		Silver Copay Plan		
Actuarial Value - AV Calculator		71.6%71.8%		71.3%71.4%		
Plan design includes a deductible?		Yes, Medical/Pharmacy		Yes, Medical/Pharmacy		
Integrated Individual deductible		N/A		N/A		
Integrated Family deductible		N/A		N/A		
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$2,000/ \$250\$100 / \$0		\$2,000/ \$250\$100 / \$0		
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$4,000 / \$500\$200 / \$0		\$4,000 / \$500\$200 / \$0		
Individual Out-of-pocket maximum		\$6,800		\$6,800		
Family Out-of-pocket maximum		\$13,600		\$13,600		
HSA plan: Self-only coverage deductible		N/A		N/A		
HSA family plan: Individual deductible		N/A		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$45		\$45		
	Other practitioner office visit	\$45		\$45		
	Specialist visit	\$75		\$75		
	Preventive care/ screening/ immunization	No charge		No charge		
Tests	Laboratory Tests	\$40		\$40		
	X-rays and Diagnostic Imaging	\$70		\$70		
	Imaging (CT/PET scans, MRIs)	20%		\$300		
Drugs to treat illness or condition	Tier 1	\$15	Pharmacy deductible	\$15	Pharmacy deductible	
	Tier 2	\$55	Pharmacy deductible	\$55	Pharmacy deductible	
	Tier 3	\$85	Pharmacy deductible	\$85	Pharmacy deductible	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	
Outpatient services	Surgery facility fee (e.g., ASC)	20%		20%		
	Physician/surgeon fees	20%		20%		
	Outpatient visit	20%		20%		
Need immediate attention	Emergency room facility fee (waived if admitted)	\$350		\$350		
	Emergency room physician fee (waived if admitted)	No charge		No charge		
	Emergency medical transportation	\$250	X	\$250	X	
	Urgent care	\$45		\$45		
Hospital stay	Facility fee (e.g. hospital room)	20%	X	20%	X	
	Physician/surgeon fee	20%	X	20%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$45		\$45		
	Mental/Behavioral health other outpatient items and services	\$45		\$45		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	20%	X	
	Mental/Behavioral health inpatient physician fee	20%	X	20%	X	
	Substance Use disorder outpatient office visits	\$45		\$45		
	Substance Use disorder other outpatient items and services	\$45		\$45		
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X	20%	X	
	Substance use disorder inpatient physician fee	20%	X	20%	X	
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Delivery and all inpatient services	Hospital	20%	X	20%	X
		Professional	20%	X	20%	X
Help recovering or other special health needs	Home health care (cost share per visit)	20%		\$45		
	Outpatient Rehabilitation services	\$45		\$45		
	Outpatient Habilitation services	\$45		\$45		
	Skilled nursing care	20%	X	20%	X	
	Durable medical equipment	20%		20%		
	Hospice service	No charge		No charge		
Child eye care	Eye exam	No charge		No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
Child Dental Diagnostic and Preventive	Oral Exam					
	Preventive - Cleaning					
	Preventive - X-ray	Not Covered		Not Covered		
	Sealants per Tooth					
	Topical Fluoride Application					
Child Dental Basic Services	Space Maintainers - Fixed					
	Restorative Procedures	Not Covered		Not Covered		
Child Dental Major Services	Periodontal Maintenance Services					
	Crowns and Casts			Not Covered		
	Endodontics			Not Covered		
	Periodontics (other than maintenance)	Not Covered		Not Covered		
	Prosthodontics			Not Covered		
Child Orthodontics	Oral Surgery			Not Covered		
	Medically necessary orthodontics	Not Covered		Not Covered		

20172018 Patient-Centered Benefit Plan Designs

9.5 EHB

Date: June 16, 2016 January 26, 2017

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

		CCSB		
		Silver HDHP Plan		
Actuarial Value - AV Calculator		71.3%71.7%		
Plan design includes a deductible?		Yes, integrated		
Integrated Individual deductible		\$2,000 integrated		
Integrated Family deductible		\$4,000 integrated		
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		
Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		
Individual Out-of-pocket maximum		\$6,550		
Family Out-of-pocket maximum		\$13,100		
HSA plan: Self-only coverage deductible		\$2,000		
HSA family plan: Individual deductible		\$2,600		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	20%	X	
	Other practitioner office visit	20%	X	
	Specialist visit	20%	X	
	Preventive care/ screening/ immunization	No charge		
Tests	Laboratory Tests	20%	X	
	X-rays and Diagnostic Imaging	20%	X	
	Imaging (CT/PET scans, MRIs)	20%	X	
Drugs to treat illness or condition	Tier 1	20% up to \$250 per script	X	
	Tier 2	20% up to \$250 per script	X	
	Tier 3	20% up to \$250 per script	X	
	Tier 4	20% up to \$250 per script	X	
Outpatient services	Surgery facility fee (e.g., ASC)	20%	X	
	Physician/surgeon fees	20%	X	
	Outpatient visit	20%	X	
Need immediate attention	Emergency room facility fee (waived if admitted)	20%	X	
	Emergency room physician fee (waived if admitted)	0%	X	
	Emergency medical transportation	20%	X	
	Urgent care	20%	X	
Hospital stay	Facility fee (e.g. hospital room)	20%	X	
	Physician/surgeon fee	20%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	20%	X	
	Mental/Behavioral health other outpatient items and services	20%	X	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	
	Mental/Behavioral health inpatient physician fee	20%	X	
	Substance Use disorder outpatient office visits	20%	X	
	Substance Use disorder other outpatient items and services	20%	X	
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X	
	Substance use disorder inpatient physician fee	20%	X	
Pregnancy	Prenatal care and preconception visits	No charge		
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care (cost share per visit)	20%	X	
	Outpatient Rehabilitation services	20%	X	
	Outpatient Habilitation services	20%	X	
	Skilled nursing care	20%	X	
	Durable medical equipment	20%	X	
	Hospice service	0%	X	
Child eye care	Eye exam	No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
Child Dental Diagnostic and Preventive	Oral Exam	Not Covered		
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures	Not Covered		
	Periodontal Maintenance Services			
Child Dental Major Services	Crowns and Casts	Not Covered		
	Endodontics			
	Periodontics (other than maintenance)			
	Prostodontics			
Child Orthodontics	Oral Surgery	Not Covered		
	Medically necessary orthodontics			

2017/2018 Patient-Centered Benefit Plan Designs

9.5 EHB

Date: June 16, 2016/January 26, 2017

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

		Silver Plan 100%-150% FPL		Silver Plan 150%-200% FPL	
Actuarial Value - AV Calculator		94.1% 93.9%		87.5% 87.9%	
Plan design includes a deductible?		Yes, Medical/Pharmacy		Yes, Medical/Pharmacy	
Integrated Individual deductible		N/A		N/A	
Integrated Family deductible		N/A		N/A	
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$75 / \$0 / \$0		\$650 / \$50 / \$0	
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$150 / \$0 / \$0		\$1,300 / \$100 / \$0	
Individual Out-of-pocket maximum		\$2,360 \$1,000		\$2,360 \$2,450	
Family Out-of-pocket maximum		\$4,700 \$2,000		\$4,700 \$4,900	
HSA plan: Self-only coverage deductible		N/A		N/A	
HSA family plan: Individual deductible		N/A		N/A	

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$5		\$10		
	Other practitioner office visit	\$5		\$10		
	Specialist visit	\$8		\$25		
	Preventive care/ screening/ immunization	No charge		No charge		
Tests	Laboratory Tests	\$8		\$15		
	X-rays and Diagnostic Imaging	\$8		\$25		
	Imaging (CT/PET scans, MRIs)	\$50		\$100		
Drugs to treat illness or condition	Tier 1	\$3		\$5		
	Tier 2	\$10		\$20	Pharmacy deductible	
	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 services	Surgery facility fee (e.g., ASC)	10%		15%		
	Physician/surgeon fees	10%		15%		
	Outpatient visit	10%		15%		
Need immediate attention	Emergency room facility fee (waived if admitted)	\$50		\$100		
	Emergency room physician fee (waived if admitted)	No charge		No charge		
	Emergency medical transportation	\$30	X	\$75	X	
	Urgent care	\$5		\$10		
Hospital stay	Facility fee (e.g. hospital room)	10%	X	15%	X	
	Physician/surgeon fee	10%	X	15%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$5		\$10		
	Mental/Behavioral health other outpatient items and services	\$5		\$10		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%	X	15%	X	
	Mental/Behavioral health inpatient physician fee	10%	X	15%	X	
	Substance Use disorder outpatient office visits	\$5		\$10		
	Substance Use disorder other outpatient items and services	\$5		\$10		
	Substance Use inpatient facility fee (e.g. hospital room)	10%	X	15%	X	
	Substance use disorder inpatient physician fee	10%	X	15%	X	
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Delivery and all inpatient services	Hospital	10%	X	15%	X
		Professional	10%	X	15%	X
Help recovering or other special health needs	Home health care (cost share per visit)	\$3		\$15		
	Outpatient Rehabilitation services	\$5		\$10		
	Outpatient Habilitation services	\$5		\$10		
	Skilled nursing care	10%	X	15%	X	
	Durable medical equipment	10%		15%		
	Hospice service	No charge		No charge		
Child eye care	Eye exam	No charge		No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
Child Dental Diagnostic and Preventive	Oral Exam					
	Preventive - Cleaning					
	Preventive - X-ray	Not Covered		Not Covered		
	Sealants per Tooth					
	Topical Fluoride Application					
Child Dental Basic Services	Space Maintainers - Fixed					
	Restorative Procedures	Not Covered		Not Covered		
Child Dental Major Services	Periodontal Maintenance Services					
	Crowns and Casts					
	Endodontics					
	Periodontics (other than maintenance)	Not Covered		Not Covered		
	Prosthodontics					
Child Orthodontics	Oral Surgery					
	Medically necessary orthodontics	Not Covered		Not Covered		

2017-2018 Patient-Centered Benefit Plan Designs

9.5 EHB

Date: June 16, 2016/January 26, 2017

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

		Silver Plan 200%-250% FPL		
Actuarial Value - AV Calculator		73.7%/73.9%		
Plan design includes a deductible?		Yes, Medical/Pharmacy		
Integrated Individual deductible		N/A		
Integrated Family deductible		N/A		
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$2,200 / \$250/\$100 / \$0		
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$4,400 / \$500/\$200 / \$0		
Individual Out-of-pocket maximum		\$5,700/\$5,850		
Family Out-of-pocket maximum		\$11,400/\$11,700		
HSA plan: Self-only coverage deductible		N/A		
HSA family plan: Individual deductible		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$30		
	Other practitioner office visit	\$30		
	Specialist visit	\$55/\$65		
	Preventive care/ screening/ immunization	No charge		
Tests	Laboratory Tests	\$35		
	X-rays and Diagnostic Imaging	\$65/\$70		
	Imaging (CT/PET scans, MRIs)	\$300		
Drugs to treat illness or condition	Tier 1	\$15	Pharmacy deductible	
	Tier 2	\$50	Pharmacy deductible	
	Tier 3	\$75	Pharmacy deductible	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	
Outpatient services	Surgery facility fee (e.g., ASC)	20%		
	Physician/surgeon fees	20%		
	Outpatient visit	20%		
Need immediate attention	Emergency room facility fee (waived if admitted)	\$350		
	Emergency room physician fee (waived if admitted)	No charge		
	Emergency medical transportation	\$250	X	
	Urgent care	\$30		
Hospital stay	Facility fee (e.g. hospital room)	20%	X	
	Physician/surgeon fee	20%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$30		
	Mental/Behavioral health other outpatient items and services	\$30		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	
	Mental/Behavioral health inpatient physician fee	20%	X	
	Substance Use disorder outpatient office visits	\$30		
	Substance Use disorder other outpatient items and services	\$30		
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X	
	Substance use disorder inpatient physician fee	20%	X	
Pregnancy	Prenatal care and preconception visits	No charge		
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care (cost share per visit)	\$40		
	Outpatient Rehabilitation services	\$30		
	Outpatient Habilitation services	\$30		
	Skilled nursing care	20%	X	
	Durable medical equipment	20%		
	Hospice service	No charge		
Child eye care	Eye exam	No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
Child Dental Diagnostic and Preventive	Oral Exam			
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth	Not Covered		
	Topical Fluoride Application			
Child Dental Basic Services	Space Maintainers - Fixed			
	Restorative Procedures	Not Covered		
Child Dental Major Services	Periodontal Maintenance Services			
	Crowns and Casts			
	Endodontics			
	Periodontics (other than maintenance)	Not Covered		
	Prosthodontics			
Child Orthodontics	Oral Surgery			
	Medically necessary orthodontics	Not Covered		

2017/2018 Patient-Centered Benefit Plan Designs

9.5 EHB

Date: June 16, 2016/January 26, 2017

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

		Bronze Plan	Bronze HDHP Plan
Actuarial Value - AV Calculator		61.9%/60.8%	62.0%/61.4%
Plan design includes a deductible?		Yes, Medical/Pharmacy	Yes, integrated
Integrated Individual deductible		N/A	\$4,800 integrated
Integrated Family deductible		N/A	\$9,600 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$6,300 / \$500 / \$0	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$12,600 / \$1,000 / \$0	N/A
Individual Out-of-pocket maximum		\$6,800/\$7,000	\$6,550
Family Out-of-pocket maximum		\$13,600/\$14,000	\$13,100
HSA plan: Self-only coverage deductible		N/A	\$4,800
HSA family plan: Individual deductible		N/A	\$4,800

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$75	After 1st three non-preventive visits	40%	X	
	Other practitioner office visit	\$75	After 1st three non-preventive visits	40%	X	
	Specialist visit	\$105	After 1st three non-preventive visits	40%	X	
	Preventive care/ screening/ immunization	No charge		No charge		
Tests	Laboratory Tests	\$40		40%	X	
	X-rays and Diagnostic Imaging	100%	X	40%	X	
	Imaging (CT/PET scans, MRIs)	100%	X	40%	X	
Drugs to treat illness or condition	Tier 1	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	X	
	Tier 2	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	X	
	Tier 3	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	X	
	Tier 4	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	X	
Outpatient services	Surgery facility fee (e.g., ASC)	100%	X	40%	X	
	Physician/surgeon fees	100%	X	40%	X	
	Outpatient visit	100%	X	40%	X	
Need immediate attention	Emergency room facility fee (waived if admitted)	100%	X	40%	X	
	Emergency room physician fee (waived if admitted)	No charge		0%	X	
	Emergency medical transportation	100%	X	40%	X	
	Urgent care	\$75	After 1st three non-preventive visits	40%	X	
Hospital stay	Facility fee (e.g. hospital room)	100%	X	40%	X	
	Physician/surgeon fee	100%	X	40%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$75	After 1st three non-preventive visits	40%	X	
	Mental/Behavioral health other outpatient items and services	\$75	After 1st three non-preventive visits	40%	X	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	100%	X	40%	X	
	Mental/Behavioral health inpatient physician fee	100%	X	40%	X	
	Substance Use disorder outpatient office visits	\$75	After 1st three non-preventive visits	40%	X	
	Substance Use disorder other outpatient items and services	\$75	After 1st three non-preventive visits	40%	X	
	Substance Use inpatient facility fee (e.g. hospital room)	100%	X	40%	X	
	Substance use disorder inpatient physician fee	100%	X	40%	X	
Pregnancy	Prenatal care and preconception visits	No charge		No charge		
	Delivery and all inpatient services	Hospital	100%	X	40%	X
		Professional	100%	X	40%	X
Help recovering or other special health needs	Home health care (cost share per visit)	100%	X	40%	X	
	Outpatient Rehabilitation services	\$75		40%	X	
	Outpatient Habilitation services	\$75		40%	X	
	Skilled nursing care	100%	X	40%	X	
	Durable medical equipment	100%	X	40%	X	
	Hospice service	No charge		0%	X	
Child eye care	Eye exam	No charge		No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
Child Dental Diagnostic and Preventive	Oral Exam					
	Preventive - Cleaning					
	Preventive - X-ray					
	Sealants per Tooth	Not Covered		Not Covered		
	Topical Fluoride Application					
Child Dental Basic Services	Space Maintainers - Fixed					
	Restorative Procedures	Not Covered		Not Covered		
Child Dental Major Services	Periodontal Maintenance Services					
	Crowns and Casts					
	Endodontics					
	Periodontics (other than maintenance)	Not Covered		Not Covered		
	Prosthodontics					
Child Orthodontics	Oral Surgery					
	Medically necessary orthodontics	Not Covered		Not Covered		

2017-2018 Patient-Centered Benefit Plan Designs

9.5 EHB

Date: ~~June 16, 2016~~ January 26, 2017

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

		Catastrophic Plan		
Actuarial Value - AV Calculator				
Plan design includes a deductible?		Yes, integrated		
Integrated Individual deductible		\$7,150 \$7,350 integrated		
Integrated Family deductible		\$14,300 \$14,700 integrated		
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		
Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		
Individual Out-of-pocket maximum		\$7,150 \$7,350		
Family Out-of-pocket maximum		\$14,300 \$14,700		
HSA plan: Self-only coverage deductible		N/A		
HSA family plan: Individual deductible		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non-preventive visits	
	Other practitioner office visit	0%	After 1st three non-preventive visits	
	Specialist visit	0%	X	
	Preventive care/ screening/ immunization	No charge		
Tests	Laboratory Tests	0%	X	
	X-rays and Diagnostic Imaging	0%	X	
	Imaging (CT/PET scans, MRIs)	0%	X	
Drugs to treat illness or condition	Tier 1	0%	X	
	Tier 2	0%	X	
	Tier 3	0%	X	
	Tier 4	0%	X	
Outpatient services	Surgery facility fee (e.g., ASC)	0%	X	
	Physician/surgeon fees	0%	X	
	Outpatient visit	0%	X	
Need immediate attention	Emergency room facility fee (waived if admitted)	0%	X	
	Emergency room physician fee (waived if admitted)	No charge		
	Emergency medical transportation	0%	X	
	Urgent care	0%	After 1st three non-preventive visits	
Hospital stay	Facility fee (e.g. hospital room)	0%	X	
	Physician/surgeon fee	0%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	0%	After 1st three non-preventive visits	
	Mental/Behavioral health other outpatient items and services	0%	After 1st three non-preventive visits X	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	0%	X	
	Mental/Behavioral health inpatient physician fee	0%	X	
	Substance Use disorder outpatient office visits	0%	After 1st three non-preventive visits	
	Substance Use disorder other outpatient items and services	0%	After 1st three non-preventive visits X	
	Substance Use inpatient facility fee (e.g. hospital room)	0%	X	
	Substance use disorder inpatient physician fee	0%	X	
Pregnancy	Prenatal care and preconception visits	No charge		
	Delivery and all inpatient services	Hospital	0%	X
		Professional	0%	X
Help recovering or other special health needs	Home health care (cost share per visit)	0%	X	
	Outpatient Rehabilitation services	0%	X	
	Outpatient Habilitation services	0%	X	
	Skilled nursing care	0%	X	
	Durable medical equipment	0%	X	
	Hospice service	0%	X	
Child eye care	Eye exam	No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X	
Child Dental Diagnostic and Preventive	Oral Exam	Not Covered		
	Preventive - Cleaning			
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
Child Dental Basic Services	Space Maintainers - Fixed	Not Covered		
	Restorative Procedures			
Child Dental Major Services	Periodontal Maintenance Services	Not Covered		
	Crowns and Casts			
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
Child Orthodontics	Oral Surgery	Not Covered		
	Medically necessary orthodontics			