



Summary of Benefits and Coverage		Platinum		Platinum		
	Share amounts describe the E	nrollee's out of pocket costs.	Coinsuranc	e Plan	Copay P	lan
	e - AV Calculator		89.7% <u>91</u>	.2%	90.3%88	<u>.1%</u>
	cludes a deductible? ndividual deductible		No \$0		No \$0	
Integrated I	Family deductible leductible, NOT integrated: I	Andinal / Pharmany / Dantal	\$0 \$0 / \$0 /	ф О	\$0 \$0 / \$0 /	' ¢0
	uctible, NOT integrated: Med		\$0 / \$0 /		\$0 / \$0 /	
	of-pocket maximum pocket maximum		\$4,000 <u>\$3</u> \$8,000 <u>\$6</u>		\$4,000 <u>\$3</u> \$8,000 <u>\$6</u>	
HSA plan: Self	f-only coverage deductible		N/A	,700	N/A	,700
HSA family pla	an: Individual deductible		N/A		N/A	
Common Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an i		\$15		\$15	
Health care provider's office or clinic visit	Other practitioner office visit	\$15		\$ 15		
Cillic Visit	Specialist visit		\$40 <u>\$30</u>		\$40 <u>\$30</u>	
	Preventive care/ screening/ in	nmunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagin	g	\$20 <u>\$15</u> \$40 <u>\$30</u>		\$20 <u>\$15</u> \$40 <u>\$30</u>	
	Imaging (CT/PET scans, MRI	s)	10%		\$150 <u>\$75</u>	
	Tier 1		\$5		\$5	
Drugs to treat illness or	Tier 2	Tier 2			\$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 <u>\$100</u> \$40 <u>\$25</u>		
services	Outpatient visit		10%		10%	
	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fe	No charge		No charge		
Need immediate	Emergency medical transport	\$150		\$150		
attention	Urgent care		\$15		\$15	
	Facility fee (e.g. hospital roon	N	400/		\$250 per day up	
Hospital stay	Physician/surgeon fee	')	10%		to 5 days \$40No charge	
	Mental/Behavioral health outpatient office visits		10% \$15		\$15	
	Mental/Behavioral health othe	\$15		\$15		
	Mental/Behavioral health inpa	10%		\$250 per day up		
Mental health,	Mental/Behavioral health inpa	400/		to 5 days		
behavioral	wertal/beriavioral fleatiff inpa	10%		\$40No charge		
health, or substance abuse needs	Substance Use disorder outp	\$15		\$15		
	Substance Use disorder othe	\$15		\$15		
	Substance Use inpatient facil	ity fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Substance use disorder inpat	ient physician fee	10%		\$40No charge	
	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%		\$40No charge	
	Home health care (cost share Outpatient Rehabilitation serv		10% \$15		\$20 \$15	
Help recovering or	Outpatient Habilitation service		\$15		\$15	
other special	Skilled nursing care		10%		\$150 per day up to 5 days	
health needs	Durable medical equipment		10%		10%	
	Hospice service Eye exam		No charge No charge		No charge No charge	
Child eye care	_	contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam					
Child Dental	Preventive - Cleaning					
Diagnostic and	Preventive - X-ray Sealants per Tooth		Not Covered		Not Covered	
Preventive	Topical Fluoride Application Space Maintainers - Fixed					
Child Dental	Restorative Procedures					
Basic Services	Periodontal Maintenance Ser	vices	Not Covered		Not Covered	
	Crowns and Casts				Not Covered	
Child Dental	Endodontics Periodontics (other than main	tononco)	Not Carrage		Not Covered	
Major Services	Periodontics (other than mair Prosthodontics Oral Surgery	непапсе)	Not Covered		Not Covered Not Covered Not Covered	
Child Orthodontics	Medically necessary orthodor	ntics	Not Covered		Not Covered	
Junouontics						

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Date: June 16, 2016March 14, 2017

Member Cost S	share amounts describe the Enrollee's out of pocket costs.	Gold Coinsurand	-	Gold Copay P	lan
Actuarial Value - AV Calculator		80.9% <u>81.8%</u>		81.2% 78.4%	
	cludes a deductible? ndividual deductible	No \$0		No \$0	
Integrated F	Family deductible	\$0		\$0	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental		/ \$0 / \$0	\$0 / \$0 / \$0 \$0 / \$0 / \$0	
	of-pocket maximum	\$6,750 <u>\$6</u> \$13,500 <u>\$</u> 1		\$6,750 <u>\$6</u> \$13,500 <u>\$</u> 1	
HSA plan: Self	-only coverage deductible	N/A		N/A	2,000
	nn: Individual deductible	N/A		N/A	
Common Medical		Member Cost	Deductible	Member Cost	Deductib
Event	Service Type	Share	Applies	Share	Applies
	Primary care visit to treat an injury, illness, or condition	\$30 <u>\$25</u>		\$30 <u>\$25</u>	
Health care					
provider's	Other practitioner office visit	\$30 <u>\$25</u>		\$30 <u>\$25</u>	
office or clinic visit					
	Specialist visit	\$55		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$35 \$55		\$35 \$55	
	Imaging (CT/PET scans, MRIs)	20%		\$275	
	Tier 1	\$15		\$15	
Drugs to treat	Tier 2	\$55		\$55	
illness or condition	Tier 3	\$75		\$75	
		Ψισ		Ψισ	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
Outpatient	Surgery facility fee (e.g., ASC)	20%		\$600 <u>\$300</u>	
services	Physician/surgeon fees Outpatient visit	20% 20%		\$55 <u>\$40</u> 20%	
	Emergency room facility fee (waived if admitted)	\$325		\$325	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate	Emergency medical transportation	\$250		\$250	
attention					
	Urgent care	\$30 <u>\$25</u>		\$30 <u>\$25</u>	
	Facility fee (e.g. hospital room)	20%		\$600 per day up	
Hospital stay	Physician/surgeon fee	20%		to 5 days \$55No charge	
	Thysiolanion geoffice	2070		\$00 140 charge	
	Mental/Behavioral health outpatient office visits	\$30 <u>\$25</u>		\$30 <u>\$25</u>	
	Mental/Behavioral health other outpatient items and services	\$30 <u>\$25</u>		\$30 <u>\$25</u>	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%		\$600 per day up	
Mental health,	Mental/Behavioral health inpatient physician fee	20%		to 5 days \$55No charge	
behavioral health, or	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2070		φοσ <u>ινο σπαιασ</u>	
substance abuse needs	Substance Use disorder outpatient office visits	\$30 <u>\$25</u>		\$30 <u>\$25</u>	
abuse neeus					
	Substance Use disorder other outpatient items and services	\$30 <u>\$25</u>		\$30 \$25	
				#C00 === d=	
	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	L
	Prenatal care and preconception visits	No charge		No charge \$600 per day	
Pregnancy	Delivery and all inpatient Hospital services	20%		up to 5 days	
	Professional Home health care (cost share per visit)	20%		\$55No charge \$30	
Help	Outpatient Rehabilitation services	\$30 <u>\$25</u>		\$30 <u>\$25</u>	
recovering or	Outpatient Habilitation services	\$30 <u>\$25</u>		\$30 <u>\$25</u> \$300 per day up	
other special health needs	Skilled nursing care Durable medical equipment	20%		to 5 days	
	Hospice service	No charge		No charge	
Child eye care	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
-aro	Oral Exam	No charge		No charge	
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray				
and Preventive	Sealants per Tooth	Not Covered		Not Covered	
	Topical Fluoride Application Space Maintainers - Fixed				
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered	
Services	Periodontal Maintenance Services Crowns and Casts			Not Course 1	
Child Dental	Crowns and Casts Endodontics			Not Covered Not Covered	
Major	Periodontics (other than maintenance)	Not Covered		Not Covered	
Services	Prosthodontics Oral Surgery			Not Covered Not Covered	
Child		Not Covered			
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

Member Cost S	hare amounts describe the Er	rollee's out of pocket costs.	Silver Plai	n
	e - AV Calculator	71.5%71.9%		
	cludes a deductible?			
Integrated I	ndividual deductible		Yes, Medical/Pha N/A	armacy
	Family deductible eductible, NOT integrated: N	fedical / Pharmacy / Dental	N/A \$2,500/ \$250 \$13	30 / \$0
Family dedu	uctible, NOT integrated: Med		\$5,000/ \$500 <u>\$26</u>	<u>30</u> / \$0
	-of-pocket maximum pocket maximum		\$6800 <u>\$7,00</u> \$13,600\$14,0	
HSA plan: Self	only coverage deductible		N/A	
	n: Individual deductible		N/A	
Common Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an i	njury, illness, or condition	\$35	
Health care provider's office or	Other practitioner office visit		\$35	
clinic visit	Specialist visit		\$ 70 \$75	
	Preventive care/ screening/ ir	nmunization	No charge	
Tooto	Laboratory Tests		\$35	
Tests	X-rays and Diagnostic Imagin Imaging (CT/PET scans, MRI:		\$70 <u>\$75</u> \$300	
	Tier 1		¢1E	Pharmacy
	Tier 2		\$15	deductible
Drugs to treat illness or condition			\$55	deductible
	Tier 3		\$80 20% up to \$250 per	deductible
			script after pharmacy deductible	deductible
Outpatient services	Surgery facility fee (e.g., ASC Physician/surgeon fees Outpatient visit)	20% 20% 20%	
	Emergency room facility fee (waived if admitted)	\$350	
	Emergency room physician fe	No charge		
Need immediate	Emergency medical transportation		\$250	X
attention	Urgent care		\$35	
Hospital stay	Facility fee (e.g. hospital room	n)	20%	Х
	Physician/surgeon fee		20%	Х
	Mental/Behavioral health outpatient office visits		\$35	
	Mental/Behavioral health othe	\$35		
	Mental/Behavioral health inpa	itient facility fee (e.g.hospital room)	20%	х
Mental health,	Mental/Behavioral health inpa	itient physician fee	20%	Х
behavioral health, or substance	Substance Use disorder outp	atient office visits	\$35	
abuse needs				
	Substance Use disorder othe	\$35		
	Substance Use inpatient facil Substance use disorder inpat		20%	X
	Prenatal care and preconcep		No charge	^
Pregnancy	Delivery and all inpatient	Hospital	20%	Х
	services	Professional	20%	X
	Home health care (cost share	per visit)	\$45	
Help	Outpatient Rehabilitation service Outpatient Habilitation service		\$35 \$35	
recovering or 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	contact lenses in lieu of glasses)	No charge	
	Oral Exam	<u> </u>	<u>_</u>	
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray			
and Preventive	Sealants per Tooth Topical Fluoride Application		Not Covered	
Child Dental	Space Maintainers - Fixed			
Basic	Restorative Procedures		Not Covered	
Services	Periodontal Maintenance Ser Crowns and Casts	vices		
Child Dental	Endodontics			
Major	Periodontics (other than main	tenance)	Not Covered	
Services	Prosthodontics			
	Oral Surgery			
Child		itics	Not Covered	

Summary of	Benefits and Coverage	CCSB		CCSB			
Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.		Silver		Silver			
	Actuarial Value - AV Calculator		Coinsurance Plan 71.6%71.9%		Copay Plan 71.3%71.4%		
	e - AV Calculator cludes a deductible?	Yes, Medical/Ph		Yes, Medical/Ph	_		
Integrated I	ndividual deductible	N/A	атпасу	N/A	armacy		
Individual d	Family deductible leductible, NOT integrated: Medical / Pharmacy / Dental	N/A \$2,000/ \$250 <u>\$1</u>		N/A \$2,000/ \$ 250 \$1			
	uctible, NOT integrated: Medical / Pharmacy / Dental -of-pocket maximum	\$4,000 / \$ 500 <u>\$2</u> \$ 6800 \$7,0		\$4,000 / \$500 <u>\$2</u> \$6800\$7,0			
Family Out-of-	pocket maximum	\$13,600 <u>\$14</u> ,		\$13,600 <u>\$14,</u>			
	f-only coverage deductible an: Individual deductible	N/A N/A		N/A N/A			
Common							
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies		
	Cervice Type						
	Primary care visit to treat an injury, illness, or condition	\$45		\$45			
Health care							
provider's office or	Other practitioner office visit	\$45		\$45			
clinic visit	Consistint visit	Ф7 Б		67 5			
	Specialist visit	\$75		\$75			
	Preventive care/ screening/ immunization Laboratory Tests	No charge \$40		No charge \$40			
	X-rays and Diagnostic Imaging	\$70		\$70			
	Imaging (CT/PET scans, MRIs)	20%		\$300			
	Tier 1	\$15	Pharmacy deductible	\$15	Pharmac deductible		
			Pharmacy		Pharmacy		
Drugs to treat	Tier 2	\$55	deductible	\$55	deductible		
condition	Tier 3	\$85	Pharmacy	\$85	Pharmac		
			deductible		deductible		
	Tier 4	20% up to \$250 per script after pharmacy	Pharmacy deductible	20% up to \$250 per script after pharmacy	Pharmacy deductible		
	Surgery facility fee (e.g., ASC)	deductible 20%	- COGGOUDIE	deductible 20%			
Outpatient services	Physician/surgeon fees	20%		20%			
	Outpatient visit Emergency room facility fee (waived if admitted)	20%		20%			
		\$350		\$350			
Need	Emergency room physician fee (waived if admitted) Emergency medical transportation	No charge \$250	X	No charge \$250	X		
immediate attention	Emergency medical transportation	Ψ230		Ψ250			
	Urgent care	\$45		\$45			
Hospital stay	Facility fee (e.g. hospital room)	20%	Х	20%	х		
	Physician/surgeon fee	20%	X	20%	X		
	Mental/Behavioral health outpatient office visits	\$45		\$45			
	Mental/Behavioral health other outpatient items and services	\$45		\$45			
		ψ.0		\$ 1.0			
Mental	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	х	20%	х		
health,	Mental/Behavioral health inpatient physician fee	20%	Х	20%	х		
behavioral health, or							
substance abuse needs	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%	Х	20%	Х		
	Substance use disorder inpatient physician fee	20%	Х	20%	Х		
	Prenatal care and preconception visits	No charge		No charge			
Pregnancy	Delivery and all inpatient services Hospital	20%	Х	20%	Х		
	Professional Home health care (cost share per visit)	20%	X	20% \$45	X		
Help	Outpatient Rehabilitation services Outpatient Habilitation services	\$45 \$45		\$45 \$45			
recovering or 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	, , ,					
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray	Not Covered		Not Covered			
and Preventive	Sealants per Tooth Topical Fluoride Application	Not Covered		INOL Covered			
	Space Maintainers - Fixed						
Child Dental Basic	Restorative Procedures	Not Covered		Not Covered			
Services	Periodontal Maintenance Services						
Child Dental	Crowns and Casts Endodontics			Not Covered Not Covered			
Major	Periodontics (other than maintenance)	Not Covered		Not Covered			
Services	Prosthodontics Oral Surgery	-		Not Covered Not Covered			
Child	Medically necessary orthodontics						
		Not Covered		Not Covered			

Summary of	f Benefits and Coverage		CCSE	1
Member Cost S	Share amounts describe the En	rollee's out of pocket costs.	Silver HDHP P	
	e - AV Calculator		71.3% <u>71.</u>	<u>7%</u>
	cludes a deductible? ndividual deductible		Yes, integr \$2,000 integr	
	Family deductible leductible, NOT integrated: N	ledical / Pharmacy / Dental	\$4,000 integ N/A	grated
Family dedu	uctible, NOT integrated: Med -of-pocket maximum		N/A \$6,550	1
Family Out-of-	pocket maximum		\$13,10	0
	f-only coverage deductible and individual deductible		\$2,000 \$2,600	
Common				
Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an ir	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 Imaging	g	20% 20%	X
	Imaging (CT/PET scans, MRIs	3)	20%	Х
	Tier 1		20% up to \$250 per script	х
Drugs to treat illness or	Tier 2		20% up to \$250 per script	Х
condition	Tier 3		20% up to \$250 per script	Х
	Tier 4		20% up to \$250 per script	Х
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees)	20% 20%	X
services	Outpatient visit		20%	X
	Emergency room facility fee (v	waived if admitted)	20%	Х
Nood	Emergency room physician fe	e (waived if admitted)	0%	Х
Need immediate	Emergency medical transport	ation	20%	X
attention	Urgent care		20%	х
Hospital stay	Facility fee (e.g. hospital room	ı)	20%	х
	Physician/surgeon fee		20%	X
	Mental/Behavioral health outpatient office visits		20%	х
	Mental/Behavioral health othe	er outpatient items and services	20%	х
Mental	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	Х
health,	Mental/Behavioral health inpa	tient physician fee	20%	Х
behavioral health, or substance abuse needs	Substance Use disorder outpa	atient office visits	20%	х
	Substance Use disorder other	r outpatient items and services	20%	х
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%	X
	Substance use disorder inpati	ient physician fee	20%	Х
	Prenatal care and preconcept		No charge	*
Pregnancy	Delivery and all inpatient	Hospital	20%	Х
	services	Professional	20%	X
	Home health care (cost share Outpatient Rehabilitation serv		20% 20%	X
Help recovering or	Outpatient Habilitation service		20%	X
other special health needs	Skilled nursing care		20%	Х
	Durable medical equipment Hospice service		20% 0%	X
	Eye exam		No charge	
Child eye		1 pair of glasses per year (or contact lenses in lieu of glasses)		
Child eye care	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge	
Child Dental	1 pair of glasses per year (or of Oral Exam Preventive - Cleaning	contact lenses in lieu of glasses)	No charge	
	1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - X-ray	contact lenses in lieu of glasses)	No charge	
Child Dental Diagnostic	1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application	contact lenses in lieu of glasses)		
Child Dental Diagnostic and	1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	contact lenses in lieu of glasses)		
Child Dental Diagnostic and Preventive Child Dental Basic	1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures			
Child Dental Diagnostic and Preventive Child Dental	1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Sen Crowns and Casts		Not Covered	
Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental	1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Sen Crowns and Casts Endodontics	/ices	Not Covered Not Covered	
Child Dental Diagnostic and Preventive Child Dental Basic	1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Sen Crowns and Casts Endodontics Periodontics (other than main Prosthodontics	/ices	Not Covered	
Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major	1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Sen Crowns and Casts Endodontics Periodontics (other than main	vices tenance)	Not Covered Not Covered	

Member Cost Share amounts describe the Enrollee's out of pocket costs. Actuarial Value - AV Calculator		Silver F 100%-150 94.1%93	% FPL	Silver Plan 150%-200% FPL	
	e - AV Calculator	Yes, Medical/		87.5% <u>87.9%</u> Yes, Medical/Pha	
Integrated I	Individual deductible Family deductible	N/A N/A		N/A N/A	imacy
Individual d	leductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0	/ \$0	\$650 / \$50 / \$	
	uctible, NOT integrated: Medical / Pharmacy / Dental –of–pocket maximum	\$150 / \$0 \$2,350 \$		\$1,300 / \$100 \$ 2,350 \$2,45	
Family Out-of-	-pocket maximum	\$4,700 <u>\$2</u>	2,000	\$4,700 <u>\$4,90</u>	
	f-only coverage deductible an: Individual deductible	N/A N/A		N/A N/A	
Common					
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$5		\$10	
Health care provider's office or	Other practitioner office visit	\$5		\$10	
clinic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$8 \$8		\$15 \$25	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1	\$3		\$5	
Drugs to treat illness or	Tier 2	\$10		\$20	Pharmac deductible
condition	Tier 3	\$15		\$35	Pharmac deductible
	Tier 4	10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharmacy deductible
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees	10%		15% 15%	
services	Outpatient visit	10%		15%	
	Emergency room facility fee (waived if admitted)	\$50		\$100	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need	Emergency medical transportation	\$30	X	\$75	Х
immediate attention	Urgent care	\$5		\$10	
Hospital stay	Facility fee (e.g. hospital room)	10%	X	15%	Х
	Physician/surgeon fee	10%	X	15%	Х
	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%	Х	15%	х
Mental health,	Mental/Behavioral health inpatient physician fee	10%	Х	15%	Х
behavioral health, or substance abuse needs	Substance Use disorder outpatient office visits	\$5	^	\$10	
	Substance Use disorder other outpatient items and services	\$5		\$10	
	Substance Use innationt facility for (a.g. beanite! ream)	100/	v	15%	X
	Substance Use inpatient facility fee (e.g. hospital room)	10%	Х	10%	Х
	Substance use disorder inpatient physician fee	10%	Х	15%	Х
	Prenatal care and preconception visits	No charge		No charge	
Pregnancy	Delivery and all inpatient Hospital services	10%	Х	15%	Х
	Professional Home health care (cost share per visit)	10% \$3	X	15% \$15	X
Help	Outpatient Rehabilitation services	\$5		\$10	
recovering or	Outpatient Habilitation services	\$5		\$10	
other special health needs	Skilled nursing care	10%	Х	15%	Х
	Durable medical equipment Hospice service	10% No charge		15% No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	No charge		No charge	
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray	N-+ C '		N-4 0	
and	Sealants per Tooth	Not Covered		Not Covered	
Preventive	Topical Fluoride Application Space Maintainers - Fixed				
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	Not Covered		Not Covered	
	Crowns and Casts				
Child Dental	Endodontics	Not O		Net O	
Major Services	Periodontics (other than maintenance) Prosthodontics Oral Surgery	Not Covered		Not Covered	
		_			

Member Cost Share amounts describe the Enrollee's out of pocket costs.		Silver Plan 200%-250% FPL		
	e - AV Calculator	73.7% <u>73.9%</u>		
	ncludes a deductible? Individual deductible	Yes, Medical/Phai	macy	
Integrated	Family deductible	N/A		
	deductible, NOT integrated: Medical / Pharmacy / Dental uctible, NOT integrated: Medical / Pharmacy / Dental	\$2,200 / \$ 250 \$13 \$4,400 / \$500 \$26		
Individual Out	-of-pocket maximum	\$5,700 \$5,85	<u>)</u>	
	-pocket maximum f-only coverage deductible	\$11,400 <u>\$11,7</u> 0 N/A	<u>00</u>	
	an: Individual deductible	N/A		
Common				
Medical Event	Service Type	Member Cost Share	Deductible Applies	
Haalib aana	Primary care visit to treat an injury, illness, or condition	\$30		
Health care provider's office or clinic visit	Other practitioner office visit	\$30		
Cimio Viole	Specialist visit	\$55 \$75		
	Preventive care/ screening/ immunization Laboratory Tests	No charge \$35		
Tests	X-rays and Diagnostic Imaging	\$65 <u>\$75</u>		
	Imaging (CT/PET scans, MRIs)	\$300		
	Tier 1	\$15	Pharmacy deductible	
Drugs to treat	Tier 2	\$50	Pharmacy deductible	
condition	Tier 3	\$75	Pharmacy deductible	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees	20%		
services	Outpatient visit	20%		
	Emergency room facility fee (waived if admitted)	\$350		
	Emergency room physician fee (waived if admitted)	No charge		
Need	Emergency medical transportation	\$250	X	
immediate attention	Urgent care	\$30		
Hospital stay	Facility fee (e.g. hospital room)	20%	х	
	Physician/surgeon fee	20%	X	
	Mental/Behavioral health outpatient office visits	\$30		
	Mental/Behavioral health other outpatient items and services	\$30		
Mental	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	Х	
health,	Mental/Behavioral health inpatient physician fee	20%	Х	
behavioral health, or substance abuse needs	Substance Use disorder outpatient office visits	\$30		
abase needs	Substance Use disorder other outpatient items and services	\$30		
	Substance Use inpatient facility fee (e.g. hospital room)	20%	Х	
	Substance use disorder inpatient physician fee	20%	Х	
	Prenatal care and preconception visits	No charge		
Pregnancy	Delivery and all inpatient Hospital services	20%	х	
	Professional	20%	X	
Halm	Home health care (cost share per visit) Outpatient Rehabilitation services	\$40 \$30		
Help recovering or	Outpatient Habilitation services	\$30		
other special health needs	Skilled nursing care	20%	Х	
	Durable medical equipment Hospice service	20%		
Child eye	Eye exam	No charge No charge		
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
01:11:4.7	Oral Exam			
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray	N-4 0		
and	Sealants per Tooth	Not Covered		
Preventive	Topical Fluoride Application Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures	Not Covered		
Services	Periodontal Maintenance Services			
	Crowns and Casts Endodontics			
	Periodontics (other than maintenance)	Not Covered		
Child Dental Major				
	Prosthodontics Oral Surgery			
Major	Prosthodontics Oral Surgery Medically necessary orthodontics	Not Covered		

Member Cost Share amounts describe the Enrollee's out of pocket costs.		Bronze Pla	Bronze HDHP Plan			
Actuarial Value	e - AV Calculator	61.9%60.89	<u>%</u>	62.0% <u>61.4%</u>		
	cludes a deductible?	Yes, Medical/Pha	armacy	Yes, integ		
	Individual deductible Family deductible	N/A N/A		\$4,800 inte \$9,600 inte		
	leductible, NOT integrated: Medical / Pharmacy / Dental uctible, NOT integrated: Medical / Pharmacy / Dental	\$6,300 / \$500 \$12,600 / \$1,00		N/A N/A		
Individual Out	of-pocket maximum	\$6,800 \$7,00	00	\$6,550		
	pocket maximum f-only coverage deductible	\$13,600<u>\$</u>14, 0 N/A	<u> </u>	\$13,10 \$4,80		
HSA family pla	an: Individual deductible	N/A		\$4,800	0	
Common				Mamban Cast		
Medical Event	Service Type	Member Cost Share	Deductible Applies After 1st three	Member Cost Share	Deductible Applies	
	Primary care visit to treat an injury, illness, or condition	\$75	non-preventive visits	40%	Х	
Health care provider's office or	Other practitioner office visit	\$75	After 1st three non-preventive visits	40%	Х	
clinic visit	Specialist visit	\$105	After 1st three non-preventive visits	40%	х	
	Preventive care/ screening/ immunization	No charge		No charge		
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$40 100%	Х	40% 40%	X	
	Imaging (CT/PET scans, MRIs)	100%	X	40%	Х	
	Tier 1	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х	
Drugs to treat illness or	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	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%	X	40%	X	
	Emergency room facility fee (waived if admitted)	100%	Х	40%	х	
	Emergency room physician fee (waived if admitted)	No charge		0%	Х	
Need immediate	Emergency medical transportation	100%	Х	40%	Х	
attention	Urgent care	\$ 75	After 1st three non-preventive visits	40%	х	
Hospital stay	Facility fee (e.g. hospital room)	100%	Х	40%	Х	
	Physician/surgeon fee	100%	X After 1st three	40%	X	
	Mental/Behavioral health outpatient office visits	\$75	non-preventive visits	40%	Х	
	Mental/Behavioral health other outpatient items and services	\$75	After 1st three- non-preventive- visitsX	40%	Х	
Mental	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	100%	Х	40%	х	
health,	Mental/Behavioral health inpatient physician fee	100%	Х	40%	х	
behavioral health, or substance abuse needs	Substance Use disorder outpatient office visits	\$75	After 1st three non-preventive visits	40%	Х	
	Substance Use disorder other outpatient items and services	\$75	After 1st three- non-preventive- visitsX	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	
	Prenatal care and preconception visits	No charge		No charge		
Pregnancy	Delivery and all inpatient Hospital	100%	Х	40%	Х	
	services Professional	100%	X	40%	Х	
	Home health care (cost share per visit) Outpatient Rehabilitation services	100% \$75	Х	40% 40%	X	
Help recovering or	Outpatient Habilitation services	\$75		40%	X	
other special	Skilled nursing care	100%	Х	40%	Х	
health needs	Durable medical equipment	100%	Х	40%	Х	
OL II.	Hospice service Eye exam	No charge No charge		0% No charge	X	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam	· ·				
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray					
and	Sealants per Tooth	Not Covered		Not Covered		
Preventive	Topical Fluoride Application Space Maintainers - Fixed					
Child Dental	Restorative Procedures					
Basic Services	Periodontal Maintenance Services Crowns and Casts	Not Covered		Not Covered		
	Endodontics					
Child Dontol		Not Covered		Not Covered		
Child Dental Major	Periodontics (other than maintenance)	Not Covered		Not Covered		
	Prosthodontics	Not Covered				
Major	, , , , , , , , , , , , , , , , , , ,	Not Covered				

	e - AV Calculator			
	cludes a deductible? ndividual deductible			egrated 0 integrated
Inimprated i	amil deductible		\$14,300 <u>\$14.7</u>	700 integrated
	leductible, NOT i∎I∎∎rated: l uctible, NOT i∎I∎∎rated: Med	Medical / Pharmung / Dental dical / Pharmung / Dental		/A /A
ndividual Oul				\$7.350
	muket maximum -only covernmed deductible			\$14.700 /A
ISA family pla	n: Individual deductible		N	/A
Common Medical			Member Cost	Deductible
Event	Se	rvice Type	Share	Applies
	Primary care visit to treat an	injury, illness, or condition	0%	After 1st thre non-preventiv visits
Health care provider's office or	Other practitioner office visit		0%	After 1st three non-prevention
linic visit	Specialist visit		0%	х
	Preventive care/ screening/ i	mmunization	No charge	
Γests	Laboratory Tests X-rays and Diagnostic Imagir	ora	0% 0%	X
esis	Imaging (CT/PET scans, MR		0%	X
	Tier 1		0%	х
Orugs to treat	Tier 2		0%	Х
liness or condition				
	Tier 3		0%	Х
	Tier 4		0%	Х
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	c)	0% 0%	X
ervices	Outpatient visit		0%	X
	Emergency room facility fee	(waived if admitted)	0%	х
	Emergency room physician fee (waived if admitted)		No charge	
leed mmediate	Emergency medical transportation		0%	Х
attention				After 1st thre
	Urgent care		0%	non-preventi visits
Hospital stay	Facility fee (e.g. hospital roor	n)	0%	х
	Physician/surgeon fee		0%	X
	Mental/Behavioral health outpatient office visits		0%	After 1st three non-preventing visits
	Mental/Behavioral health other outpatient items and services		0%	After-1st three non-prevention visitsX
	Mental/Behavioral health inp	atient facility fee (e.g.hospital room)	0%	Х
Mental nealth,	Mental/Behavioral health inp	atient physician fee	0%	Х
oehavioral nealth, or		, ,		After 1st thre
substance abuse needs	Substance Use disorder outp	patient office visits	0%	non-preventi
	Substance Use disorder other	er outpatient items and services	0%	After-1st three non-preventi visitsX
	Substance Use inpatient faci	lity fee (e.g. hospital room)	0%	х
	Substance use disorder inpa	tient physician fee	0%	х
	Prenatal care and preconcep	otion visits	No charge	
Pregnancy	Delivery and all inpatient	Hospital	0%	х
	Services	Professional	0%	X
(e)e	Home health care (cost share Outpatient Rehabilitation ser		0% 0%	X
lelp ecovering or	Outpatient Habilitation service	es	0%	Х
other special nealth needs	Skilled nursing care		0%	Х
	Durable medical equipment Hospice service		0% 0%	X
Child eye	Eye exam		No charge	
are	1 pair of glasses per year (or Oral Exam	contact lenses in lieu of glasses)	0%	Х
Child Dental	Preventive - Cleaning			
Diagnostic and	Preventive - X-ray Sealants per Tooth		Not Covered	
Preventive	Topical Fluoride Application Space Maintainers - Fixed			-
Child Dental	Restorative Procedures			
Basic Bervices		nvices	Not Covered	
	Periodontal Maintenance Sei Crowns and Casts	vices		
Child Dental	Endodontics		Net Com	
Major	Periodontics (other than main	ntenance)	Not Covered	
Services	Prosthodontics			