Title 10, California Code of Regulations

Re-adopt Section 6432:

SECTION 6432: 2016 STANDARD BENEFIT PLAN DESIGNS

(a) For plan year and calendar year 2016, The California Health Benefit Exchange adopts the Standard Benefit Plan Designs identified as the 2016 Standard Benefit Plan Designs dated January 29, 2015 April 17, 2015 which are incorporated by reference.

Authority: Government Code Section 100504

Reference: Government Code Sections 100503 and 100504(c); Health and Safety Code Section 1366.6(e) and Insurance Code Section 10112.3(e)

2016 Standard Benefit Plan Designs

January 29, 2015 April 17, 2015

2016 Standard Benefit Plan Designs 10.0 EHB

Date: April 46<u>17</u>, 2015





| | hare amounts describe the En | rollee's out of pocket costs. | Platinu Coinsurand 88.5% | e Plan | Platinum Copay Plan 89.5% | |
|-------------------------------------|---|------------------------------------|--------------------------------|-----------------------|---------------------------------|-----------------------|
| | e - AV Calculator | | 88.5% No | U | 89.5% No | , |
| | Individual deductible | | \$0 | | \$0 | |
| | Family deductible | | \$0 | | \$0 | |
| | deductible, NOT integrated: uctible, NOT integrated: Me | Medical / Pharmacy / Dental | \$0 / \$0 / \$0 / \$0 / | | \$0 / \$0 / \$0 / \$0 / | |
| | -of-pocket maximum | aicai / Filaililacy / Delitai | \$4,00 | | \$4,000 | |
| amily Out-of- | pocket maximum | | \$8,00 | | \$8,000 | |
| | only coverage deductible n: Individual deductible | | N/A N/A | | N/A N/A | |
| ion iailily pla | II. IIIdividual deductible | | 1674 | | 1674 | |
| Common ledical Event | Se | rvice Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
| | Primary care visit to treat an | | \$20 | | \$20 | |
| ealth care rovider's ffice or | Other practitioner office visit | | \$20 | | \$20 | |
| linic visit | Specialist visit | | \$40 | | \$40 | |
| | Preventive care/ screening/ in | nmunization | No charge | | No charge | |
| | Laboratory Tests | | \$20 | | \$20 | |
| ests | X-rays and Diagnostic Imagir | | \$40 | | \$40 | |
| | Imaging (CT/PET scans, MR | 8) | 10% | | \$150 | |
| | Tier 1 | | \$5 | | \$5 | |
| rugs to treat | Tier 2 | | \$15 | | \$15 | |
| Iness or ondition | Tier 3 | | \$25 | | \$25 | |
| | Tier 4 | | 10% up to \$300 per script | | 10% up to \$300 per script | |
| | Surgery facility fee (e.g., ASC | :) | 10% | | \$250 | |
| Outpatient | Physician/surgeon fees | , | 10% | | \$40 | |
| ervices | Outpatient visit | | 10% | | 10% | |
| | Emergency room facility fee (| waived if admitted) | \$150 | | \$150 | |
| | | | | | | |
| eed nmediate | Emergency room physician for Emergency medical transport | 10% \$150 | | No charge \$150 | | |
| ttention | Urgent care | | \$40 | | \$40 | |
| | Facility fee (e.g. hospital roor | n) | 10% | | \$250 per day up | |
| ospital stay | Physician/surgeon fee | | 10% | | to 5 days \$40 | |
| | Mental/Behavioral health outpatient office visits | | \$20 | | \$20 | |
| | Mental/Behavioral health other outpatient items and services | | \$20 | | \$20 | |
| | Mental/Behavioral health inpatient facility fee (e.g.hospital room) | | | | | |
| | | | 10% | | \$250 per day up to 5 days | |
| lental health, ehavioral | Mental/Behavioral health inpatient physician/surgeon fee | | 10% | | \$40 | |
| ealth, or ubstance buse needs | Substance Use disorder outpatient office visits | | \$20 | | \$20 | |
| | Substance Use disorder other outpatient items and services | | \$20 | | \$20 | |
| | Substance Use inpatient facil | ity fee (e.g. hospital room) | 10% | | \$250 per day up to 5 days | |
| | Substance use disorder inpat | ient physician/surgeon fee | 10% | | \$40 | |
| | Prenatal care and preconcept | ion visits | No charge | | No charge | |
| regnancy | Delivery and all inpatient | Hospital | 10% | | \$250 per day up | |
| | services | Professional | 10% | | to 5 days \$40 | |
| | Home health care | • | 10% | | \$20 | |
| elp | Outpatient Rehabilitation service | | \$20 | | \$20 | |
| ecovering or | Outpatient Habilitation service | ds | \$20 | | \$20 \$150 per day up | |
| ther special ealth needs | Skilled nursing care | | 10% | | to 5 days | |
| necus | Durable medical equipment | | 10% | | 10% | |
| | Hospice service Eye exam | | No charge No charge | | No charge No charge | |
| hild eye | | contact lenses in lieu of glasses) | | | | |
| are | | contact tenses in fleu of glasses) | No charge | | No charge | |
| hild Dental | Oral Exam Preventive - Cleaning | | 1 | | | |
| hild Dental iagnostic | Preventive - Cleaning Preventive - X-ray | | No. stee | | No -t- | |
| nd reventive | Sealants per Tooth Topical Fluoride Application | | No charge | | No charge | |
| hild Dental | Space Maintainers - Fixed Amalgam Fill - 1 Surface | | 20% | | \$25 | |
| Services | Root Canal- Molar | | | | | |
| Child Dental | Root Canal- Molar Gingivectomy per Quad | | 1 | | \$300 \$150 | |
| Major | Extraction- Single Tooth Expo | osed Root or Erupted | 50% | | \$65 | |
| Services | Extraction- Complete Bony | | | | \$160 | |
| | Porcelain with Metal Crown | | | | \$300 | |
| Child | Medically necessary orthodor | ntics | 50% | | \$1,000 | |

| Primary care valid to treat an injury, illness, or condition \$35 \$ | Gold Gold Coinsurance Plan Copay Plan | | ollee's out of pocket costs. | nare amounts describe the Enr | Member Cost Si |
|---|--|-------------|---|-----------------------------------|-----------------------|
| Integrated Family deductable | 80.2% 81.0% | 80.29 | | - AV Calculator | Actuarial Value |
| Integrated Family deductible S0 S0 S0 S0 S0 S0 S0 S | | | | | |
| | | | | | |
| Manufact March Manufact M | \$0 / \$0 / \$0 \$0 / \$0 / \$0 | \$0 / \$0 / | | leductible, NOT integrated: N | Individual o |
| S12.400 S12.400 S12.400 S12.400 NA | | | ical / Pharmacy / Dental | | |
| Six plants selectionly coverage deductable | | | | | |
| Primary care visit to treat an injury, illness, or condition \$35 \$ | N/A N/A | N/A | | only coverage deductible | HSA plan: Self- |
| Permany care visit to treat an injury, illness, or condition Sast Sast Sast Sast Sast Sast Sast Sast | N/A N/A | N/A | | n: Individual deductible | HSA family pla |
| Primary care visit to treat an injury, lifness, or condition Sa5 Sa5 Sa5 Sa5 Sa5 Sa5 Prevented care is consening immunization Primary care of Congress of | | | | | |
| Chebr practition of other practition of office visit Chiffice visit Chebr practition of office visit Specialist visit Specialist visit Preventive card something immunization Preventive card something immunization No charge Preventive card something immunization No charge No charge No charge No charge No charge SSS SSS SSS SSS SSS SSS SSS | | | | | Medical Event |
| Second S | \$35 \$35 | \$35 | njury, illness, or condition | Primary care visit to treat an in | |
| Processive carrel cereaning/immunication No. charge SSS X-rays and Diagnostic Imaging First Sarray and Diagnostic Imaging Ter 1 Ter 2 Ter 3 Ter 3 Ter 3 Ter 3 Ter 3 Ter 3 SSS Supery facility fee (cg., ASC) Physician/surgeon fees Couplainter Emergency room facility lee (waived if admitted) Emergency room physician fee (waived if admitted) Emerg | | | | office or | |
| Laboratory Tests | | | | | |
| A | | | munization | | |
| Imaging (CTPET scans, INFILIS) 20% \$250 | | | q | | ests |
| Time | | | | | |
| Tier 3 | \$15 \$15 | \$15 | | Tier 1 | |
| Interest of condition | \$50 \$50 | \$50 | | Tier 2 | Orugs to treat |
| Tier 4 20% up to \$500. Per settlet Surgery facility fee (e.g., ASC) Physician/surgeon fees 20% 20% 20% 20% 20% 20% 20% 20% 20% 20% 20% 20% 20% 20% | \$70 \$70 | \$70 | | Tier 3 | liness or |
| Surgery facility fee (e.g., ASC) Projections Surgery facility fee (e.g., ASC) Outpatient visit Emergency room facility fee (waived if admitted) Emergency room facility fee (waived if admitted) Emergency room facility fee (waived if admitted) Emergency medical transportation Emergency medical transportation Urgent care Seo Seo Seo Seo Seo Seo Seo S | | | | Tier 4 | |
| Physician/surgeon fees exercices Ungent care Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted) Emergency room physician fee (waived if admitted) Emergency room physician fee (waived if admitted) Emergency medical transportation Urgent care S60 S60 S60 S60 S60 S60 S60 S6 | | | | | |
| Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted) Emergency room physician fee (waived if admitted) Emergency medical transportation Emergency medical transportation Urgent care Seo Seo Seo Seo Seo Seo Seo Seo Seo S | | | | | Dutpatient |
| Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted) Emergency room physician fee (waived if admitted) Emergency room physician fee (waived if admitted) Emergency medical transportation Urgent care \$60 \$60 \$60 \$60 \$60 \$60 \$60 \$60 \$ | | | | | ervices |
| Emergency room physician fee (waived if admitted) 20% No charge Emergency medical transportation S280 S250 S250 S250 S250 S250 S250 S250 S25 | | | vaived if admitted) | | |
| Emergency medical transportation \$250 \$250 \$250 | | | · · · · · · · · · · · · · · · · · · · | | |
| Urgent care Urgent care Urgent care Seo Seo Seo Seo Seo Seo Seo S | · · | | | Need | |
| Second per day up to 5 days | \$250 | Ψ230 | | | |
| Physician/surgeon fee 20% \$55 | \$60 \$60 | \$60 | | Urgent care | |
| Mental/Behavioral health 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 facility fee (e.g. hospital room) Mental/Behavioral health inpatient physician/surgeon fee Mental/Behavioral health inpatient physician/surgeon fee 20% S55 Mental/Behavioral health inpatient physician/surgeon fee 20% S55 Substance Use disorder outpatient office visits Substance Use disorder outpatient items and services Substance Use disorder outpatient physician/surgeon fee Substance Use inpatient facility fee (e.g. hospital room) Substance Use disorder inpatient physician/surgeon fee Prenatal care and preconception visits No charge Prenatal care and preconception visits No charge Prenatal care and preconception visits No charge Delivery and all inpatient physician/surgeon fee Delivery and all inpatient physician/surgeon fee Professional Hospital Delivery and all inpatient physician/surgeon fee Outpatient Rehabilitation services S35 S35 When health care Outpatient Rehabilitation services S35 S35 S35 S36 When health care Outpatient Rehabilitation services S35 S35 S35 S36 No charge Professional Durable medical equipment Hospice service No charge No charg | | 20% | 1) | Facility fee (e.g. hospital room | Hospital stay |
| Mental/Behavioral health other outpatient litems and services Mental/Behavioral health inpatient facility fee (e.g.hospital room) Mental/Behavioral health inpatient facility fee (e.g.hospital room) Mental/Behavioral health inpatient physician/surgeon fee 20% \$55 Mental/Behavioral health inpatient physician/surgeon fee 20% \$55 Substance Use disorder outpatient office visits \$35 \$35 \$35 Substance Use disorder other outpatient items and services \$35 \$35 \$36 Substance Use disorder other outpatient physician/surgeon fee 20% \$500 per day up to 5 days Substance use disorder inpatient physician/surgeon fee 20% \$500 per day up to 5 days Substance use disorder inpatient physician/surgeon fee 20% \$500 per day up to 5 days Prenatal care and preconception visits No charge No charge Professional Professional 20% \$500 per day up to 5 days Solved per day up to 5 days Professional 20% \$500 per day up to 5 days Solved per day up to 5 days Duptatient habilitation services \$35 \$35 \$35 \$36 Duptatient Habilitation services \$35 \$35 \$35 \$36 Duptatient Habilitation services \$35 \$35 \$36 Duptatient Habilitation services \$35 \$36 No charge No char | | 20% | | Physician/surgeon fee | loopital olay |
| Mental/Behavioral health inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient physician/surgeon fee 20% \$55 Mental/Behavioral health inpatient physician/surgeon fee 20% \$55 Substance Use disorder outpatient office visits \$35 \$35 \$35 \$35 \$35 \$35 \$35 \$3 | \$35 \$35 | \$35 | Mental/Behavioral health outpatient office visits | | |
| Mental health, behavioral health inpatient physician/surgeon fee 20% \$55 Mental Behavioral health inpatient physician/surgeon fee 20% \$55 Substance Use disorder outpatient office visits \$35 \$35 Substance Use disorder other outpatient items and services \$35 \$35 Substance Use inpatient facility fee (e.g. hospital room) 20% \$600 per day up to 5 days \$55 Substance use disorder inpatient physician/surgeon fee 20% \$55 Prenatal care and preconception visits No charge No charge 500 per day up to 5 days \$55 Prenatal care and preconception visits No charge 100 per day up to 5 days 100 per day | \$35 \$35 | \$35 | Mental/Behavioral health other outpatient items and services | | |
| Mental/Behavioral health inpatient physician/surgeon fee 20% \$55 whental/Behavioral health inpatient physician/surgeon fee 20% \$35 Substance Use disorder outpatient office visits \$35 \$35 \$35 Substance Use disorder other outpatient items and services \$35 \$35 \$35 \$36 Substance Use disorder inpatient physician/surgeon fee 20% \$40 \$500 per day up to 5 days \$55 Prenatal care and preconception visits No charge Pregnancy Pregnancy Delivery and all inpatient services Home health care Outpatient Rehabilitation services \$35 \$35 \$35 \$35 \$36 \$36 \$36 \$37 \$36 Professional 20% \$35 \$35 \$35 \$35 \$35 \$35 \$35 \$3 | | 20% | Mental/Behavioral health inpatient facility fee (e.g.hospital room) | | |
| Substance Use disorder outpatient office visits Substance Use disorder other outpatient items and services Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Pregnancy Pregnancy Delivery and all inpatient services Home health care Outpatient Rehabilitation services Outpatient Rehabilitation services Salided nursing care Durable medical equipment Hospice service Hospice service Professional 20% Salided nursing care Durable medical equipment Hospice service No charge Preventive - Cleaning Preven | | 20% | | | |
| Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Pregnancy Pregnancy Pregnancy Delivery and all inpatient services Home health care Outpatient Rehabilitation services Sisting Coupatient Habilitation services Sisting | \$35 \$35 | \$35 | Substance Use disorder outpatient office visits | | substance |
| Substance use disorder inpatient hability fee (e.g. inspite norm) 20% 555 Prenatal care and preconception visits No charge No charge S600 per day up to 5 days 555 Home health care 20% 555 Home health care 20% 530 0utpatient Rehabilitation services 535 535 535 535 535 535 535 535 535 53 | \$35 \$35 | \$35 | Substance Use disorder other outpatient items and services | | |
| Substance use disorder inpatient physician/surgeon fee 20% \$55 Prenatal care and preconception visits No charge No charge Services Professional 20% \$600 per day up to 5 days professional 20% \$355 Home health care 20% \$35 \$35 \$35 \$35 \$35 \$35 \$35 \$35 \$35 \$35 | | 20% | ty fee (e.g. hospital room) | Substance Use inpatient facili | |
| Delivery and all inpatient services Delivery and all inpatient services Professional Delivery and all inpatient services Professional Delivery and all inpatient services Drofessional Delivery and all inpatient services Drofessional Delivery and all inpatient services S35 Drofessional | | 20% | ent physician/surgeon fee | Substance use disorder inpati | |
| Delivery and all inpatient services Delivery and all inpatient services Professional Delivery and all inpatient services Professional Delivery and all inpatient services Drofessional Dupatient Rehabilitation services S35 S35 S35 S35 S35 S35 S36 S36 | | No charge | on visits | Prenatal care and preconcepti | |
| services Professional 20% \$555 Home health care 20% \$330 Outpatient Rehabilitation services \$35 Coupatient Habilitation services \$35 Salid Dental Agriculture Preventive - Cleaning Preventive | | 20% | Hospital | Delivery and all inpatient | Pregnancy |
| Home health care 20% \$30 Outpatient Rehabilitation services \$35 Outpatient Habilitation services \$35 Side outpatient Rehabilitation services \$35 Skilled nursing care 20% \$300 per day up to 5 days to 5 days to 5 days earth respectate earth needs Durable medical equipment 20% 20% 20% 100 charge No charge No charge Eye exam No charge No charge No charge I pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Oral Exam Preventive - Cleaning Preventi | to 5 days | | | | |
| Outpatient Habilitation services \$35 \$35 \$35 \$30 per day up to 5 days Skilled nursing care 20% \$300 per day up to 5 days Durable medical equipment 20% 20% 20% 20% 20% 20% 20% 20% No charge No charge No charge No charge No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge No charge Oral Exam Preventive - Cleaning No charge N | 20% \$30 | | | | |
| covering or obtained and services \$3.5 \$3.5 \$3.5 \$3.5 \$3.5 \$3.5 \$3.5 \$3.5 | | | | | lelp |
| Ito 5 days Ito 5 days Durable medical equipment Preventive Child Dental Diagnostic Preventive Child Dental Diagnostic Preventive Child Dental Diagnostic Preventive Child Dental Diagnostic Rocal Diagnosti | \$300 per day up | | 5 | | ecovering or |
| Durable médical equipment Hospice service Hospice service No charge Preventive - X-ray No charge Preventive - X-ray No charge Preventive - X-ray No charge | to 5 days | | | | ealth needs |
| Child eye are 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - Cleaning No charge Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed No charge Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed No charge Services Root Canal- Molar Sasic Services Root Canal- Molar Significant Space Molar | | | | | |
| 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Sasion Broot Canal- Molar Services Root Canal- Molar Gingivectomy per Quad Sisso Extraction - Single Tooth Exposed Root or Erupted Services Portel in Molar Sisso Sis | | | | | |
| Oral Exam Preventive - Cleaning Diagnostic Ind Sealarits per Tooth Preventive - Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Root Canal- Molar Gingivectomy per Quad Gingivectomy per Quad Services Services Extraction- Single Tooth Exposed Root or Erupted Services Extraction- Complete Bony Porcelain with Metal Crown Oral Exam Preventive - Cleaning No charge No charge No charge No charge No charge No charge Space Maintainers - Fixed Space Mainta | | | ontact lenses in lieu of glasses) | | Jillia eye |
| Preventive - X-ray No charge No charge | | | | Oral Exam | |
| Amalgam Fill - 1 Surface Child Dental Basic Services Child Dental Gingivectomy per Quad Sizo Services Child Dental Services Child Dental Gingivectomy per Quad Sizo Services Child Dental Sizo Sizo Sizo Sizo Sizo Sizo Sizo Sizo | | ı | | | |
| Topical Fluoride Application Space Maintainers - Fixed Child Dental State Space Maintainers - Fixed Space Maintainers - Fixed | No charge No charge | No charge | | | |
| Amalgam Fill - 1 Surface 20% \$25 | | | | Topical Fluoride Application | Preventive |
| Root Canal- Molar \$300 | 20% \$25 | 20% | | | Child Dental Basic |
| Child Dental Major Gingivectomy per Quad Major \$150 Services Extraction-Single Tooth Exposed Root or Erupted 50% \$85 Extraction-Complete Bony Porcelain with Metal Crown \$160 \$300 | \$300 | | | | |
| Services Extraction- Complete Bony \$160 Porcelain with Metal Crown \$300 | \$150 | | and David on E | Gingivectomy per Quad | Child Dental |
| Porcelain with Metal Crown \$300 | | 50% | sea Root or Erupted | | |
| Phila | | | | | |
| Child Medically necessary orthodontics 50% \$1,000 | 50% \$1,000 | 50% | tics | Medically necessary orthodon | Child |

| Member Cost S | Benefits and Coverage hare amounts describe the En | | Indiv Silver | Plan |
|----------------------------------|--|---|-------------------------------|------------------------|
| | e - AV Calculator | | 70.4 | 4% |
| | cludes a deductible? | | Yes, Medica | |
| | Individual deductible Family deductible | | N/ | |
| Individual o | leductible, NOT integrated: I | | \$2,250 / \$ | |
| | uctible, NOT integrated: Med | dical / Pharmacy / Dental | \$4,500 / \$ \$6,2 | |
| | -of-pocket maximum pocket maximum | | \$12, | |
| HSA plan: Self | only coverage deductible | | N/ | |
| HSA family pla | n: Individual deductible | | N/ | Ά |
| Common Medical Event | Sei | rvice Type | Member Cost Share | Deductible Applies |
| | Primary care visit to treat an i | njury, illness, or condition | \$45 | |
| Health care provider's office or | Other practitioner office visit | | \$45 | |
| clinic visit | Specialist visit | | \$70 | |
| | Preventive care/ screening/ im | nmunization | No charge | |
| Tests | Laboratory Tests X-rays and Diagnostic Imagin | 9 | \$35 \$65 | |
| 16212 | Imaging (CT/PET scans, MRI: | | \$250 | |
| | Tier 1 | , | \$15 | |
| Drugs to treat | Tier 2 | | \$50 | Pharmacy deductible |
| liness or condition | Tier 3 | | \$70 | Pharmacy deductible |
| | Tier 4 | | 20% up to \$500 per script | Pharmacy deductible |
| Outpatient | Surgery facility fee (e.g., ASC |) | 20% | |
| Outpatient services | Physician/surgeon fees | | 20% | |
| | Outpatient visit | | 20% | |
| | Emergency room facility fee (| waived if admitted) | \$250 | Х |
| | Emergency room physician fe | e (waived if admitted) | \$50 | Х |
| Veed | Emergency medical transport | · · · · · · · · · · · · · · · · · · · | \$250 | Х |
| attention | Urgent care | | \$90 | |
| | - | | | |
| Hospital stay | Facility fee (e.g. hospital room | 1) | 20% | Х |
| | Physician/surgeon fee Mental/Behavioral health outpatient office visits | | 20% \$45 | Х |
| | Mental/Behavioral health other outpatient items and services | | | |
| | | | \$45 | |
| Mental health, | Mental/Behavioral health inpa | tient facility fee (e.g.hospital room) | 20% | Х |
| behavioral health, or | Mental/Behavioral health inpa | tient physician/surgeon fee | 20% | Х |
| substance abuse needs | Substance Use disorder outpa | atient office visits | \$45 | |
| | Substance Use disorder other | outpatient items and services | \$45 | |
| | Substance Use inpatient facili | ty fee (e.g. hospital room) | 20% | Х |
| | Substance use disorder inpati | ent physician/surgeon fee | 20% | X |
| | Prenatal care and preconcepti | * | No charge | |
| Pregnancy | | | | Х |
| Pregnancy | Delivery and all inpatient services | Hospital | 20% | |
| | Home health care | Professional | 20% \$45 | X |
| John | Outpatient Rehabilitation serv | | \$45 | |
| lelp ecovering or | Outpatient Habilitation service | es | \$45 | |
| other special | Skilled nursing care | | 20% | Х |
| nealth needs | Durable medical equipment | | 20% | |
| | Hospice service | | No charge | |
| Child eye | Eye exam | | No charge | |
| are | 1 pair of glasses per year (or o | contact lenses in lieu of glasses) | No charge | |
| Child Dental | Oral Exam | | | |
| Child Dental Diagnostic | Preventive - Cleaning Preventive - X-ray | | | |
| and | Sealants per Tooth | | No charge | |
| Preventive | Topical Fluoride Application Space Maintainers - Fixed | | | |
| Child Dental | Amalgam Fill - 1 Surface | | 20% | |
| Services | Root Canal- Molar | | | |
| Child Dental | Gingivectomy per Quad | | | |
| Major Services | Extraction- Single Tooth Expo Extraction- Complete Bony | sed Root or Erupted | 50% | |
| | Porcelain with Metal Crown | | | |
| Child | Medically necessary orthodon | | 50% | |

| Summary of | f Banafits and Coverage | | en. | OB | eur | ND. |
|--|--|--|--|------------------------|--|------------------------|
| | f Benefits and Coverage | | SH | | SHO | |
| | Share amounts describe the Enri | ollee's out of pocket costs. | Coinsura | nce Plan | Copay | Plan |
| | e - AV Calculator | | 71.1 | | 71.4 | |
| | cludes a deductible? Individual deductible | | Yes, Medica N/ | | Yes, Medical | |
| | Family deductible deductible, NOT integrated: N | Indical / Pharmany / Dantal | N/ \$1,500 / \$ | | N/A \$1,500 / \$8 | |
| Family ded | luctible, NOT integrated: Med | | \$3,000 / \$ | 1,000 / \$0 | \$3,000 / \$1 | ,000 / \$0 |
| | -of-pocket maximum -pocket maximum | | \$6,5 \$13, | | \$6,50 \$13,0 | |
| HSA plan: Self | f-only coverage deductible | | N/ | 'A | N/A | ١ |
| HSA family pla | an: Individual deductible | | N/ | Α | N/A | \ |
| Common Medical Event | Ser | vice Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
| Health care | Primary care visit to treat an in | jury, illness, or condition | \$45 | | \$45 | |
| provider's office or clinic visit | Other practitioner office visit | \$45 | | \$45 | | |
| cimic visit | Specialist visit | \$70 | | \$70 | | |
| | Preventive care/ screening/ im | munization | No charge | | No charge | |
| Tests | Laboratory Tests X-rays and Diagnostic Imaging | 1 | \$35 \$65 | | \$35 \$65 | |
| | Imaging (CT/PET scans, MRIs | 20% | X | \$250 | | |
| | Tier 1 | | \$15 | | \$15 | |
| Drugs to treat | Tier 2 | | \$55 | Pharmacy deductible | \$55 | Pharmacy deductible |
| illness or condition | Tier 3 | | \$75 | Pharmacy deductible | \$75 | Pharmacy deductible |
| | Tier 4 | | 20% up to \$500 per script | Pharmacy deductible | 20% up to \$500 per script | Pharmacy deductible |
| Outpatient | Surgery facility fee (e.g., ASC) Physician/surgeon fees | | 20% | | 20% | |
| services | Outpatient visit | | 20% | | 20% | |
| | Emergency room facility fee (w | vaived if admitted) | \$250 | Х | \$250 | Х |
| Nood | Emergency room physician fee | (waived if admitted) | \$50 | Х | \$50 | X |
| Need immediate | Emergency medical transporta | \$250 | Х | \$250 | Х | |
| attention | Urgent care | | \$90 | | \$90 | |
| Hospital stay | Facility fee (e.g. hospital room |) | 20% | Х | 20% | Х |
| | Physician/surgeon fee | | 20% | Х | 20% | Х |
| | Mental/Behavioral health outpatient office visits | | \$45 | | \$45 | |
| | Mental/Behavioral health other | \$45 | | \$45 | | |
| | Mental/Behavioral health inpat | ient facility fee (e.g.hospital room) | 20% | Х | 20% | Х |
| Mental health, behavioral | Mental/Behavioral health inpat | ient physician/surgeon fee | 20% | Х | 20% | Х |
| health, or substance abuse needs | Substance Use disorder outpatient office visits | | \$45 | | \$45 | |
| | Substance Use disorder other | | | | | |
| | | outpution to the drive of vices | \$45 | | \$45 | |
| | Substance Use inpatient facility | · | \$45 | X | \$45 | х |
| | Substance Use inpatient facility Substance use disorder inpatie | y fee (e.g. hospital room) | 20% | | 20% | |
| | Substance use disorder inpatie | y fee (e.g. hospital room) ent physician/surgeon fee | 20% | x x | 20% | x x |
| Pregnancy | Substance use disorder inpatie | y fee (e.g. hospital room) ent physician/surgeon fee | 20% | | 20% | |
| Pregnancy | Substance use disorder inpatie Prenatal care and preconception Delivery and all inpatient | y fee (e.g. hospital room) ent physician/surgeon fee on visits Hospital | 20% 20% No charge | Х | 20% 20% No charge | х |
| Pregnancy | Substance use disorder inpatie Prenatal care and preconceptic Delivery and all inpatient services Home health care | y fee (e.g. hospital room) ent physician/surgeon fee on visits Hospital Professional | 20% 20% No charge 20% 20% 20% | x | 20% 20% No charge 20% 20% \$45 | x x |
| Help | Substance use disorder inpatie Prenatal care and preconceptio Delivery and all inpatient services | y fee (e.g. hospital room) ent physician/surgeon fee on visits Hospital Professional | 20% 20% No charge 20% 20% | x | 20% 20% No charge 20% 20% | x x |
| | Substance use disorder inpatie Prenatal care and preconceptic Delivery and all inpatient services Home health care Outpatient Rehabilitation servic | y fee (e.g. hospital room) ent physician/surgeon fee on visits Hospital Professional | 20% No charge 20% 20% 20% 40% 20% \$45 | x | 20% 20% No charge 20% 20% \$45 \$45 | x x |
| Help recovering or | Substance use disorder inpatie Prenatal care and preconceptic Delivery and all inpatient services Home health care Outpatient Rehabilitation services Outpatient Habilitation services | y fee (e.g. hospital room) ent physician/surgeon fee on visits Hospital Professional | 20% 20% No charge 20% 20% 20% \$45 \$45 | X X X | 20% 20% No charge 20% 20% \$45 \$45 \$45 \$45 | x x x |
| Help recovering or other special health needs | Substance use disorder inpatile Prenatal care and preconception Delivery and all inpatient services Home health care Outpatient Rehabilitation services Skilled nursing care Durable medical equipment Hospice service | y fee (e.g. hospital room) ent physician/surgeon fee on visits Hospital Professional | 20% 20% No charge 20% 20% \$45 \$45 \$20% 20% No charge | X X X | 20% 20% No charge 20% \$45 \$45 \$45 \$45 20% No charge | x x x |
| Help recovering or other special health needs Child eye | Substance use disorder inpatie Prenatal care and preconceptic Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam | y fee (e.g. hospital room) ent physician/surgeon fee on visits Hospital Professional ces s | 20% 20% No charge 20% 20% \$45 \$45 20% 20% No charge No charge | X X X | 20% 20% No charge 20% \$45 \$45 \$45 \$45 20% No charge No charge | x x x |
| Help recovering or other special health needs | Substance use disorder inpatile Prenatal care and preconception Delivery and all inpatient services Home health care Outpatient Rehabilitation services Skilled nursing care Durable medical equipment Hospice service | y fee (e.g. hospital room) ent physician/surgeon fee on visits Hospital Professional ces s | 20% 20% No charge 20% 20% \$45 \$45 \$20% 20% No charge | X X X | 20% 20% No charge 20% \$45 \$45 \$45 \$45 20% No charge | x x x |
| Help recovering or other special health needs Child eye care Child Dental | Substance use disorder inpatie Prenatal care and preconceptic Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or co Oral Exam Preventive - Cleaning | y fee (e.g. hospital room) ent physician/surgeon fee on visits Hospital Professional ces s | 20% 20% No charge 20% 20% \$45 \$45 20% 20% No charge No charge | X X X | 20% 20% No charge 20% \$45 \$45 \$45 \$45 20% No charge No charge | x x x |
| Help recovering or other special health needs Child eye care Child Dental Diagnostic and | Substance use disorder inpatie Prenatal care and preconceptic Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or cr Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth | y fee (e.g. hospital room) ent physician/surgeon fee on visits Hospital Professional ces s | 20% 20% No charge 20% 20% \$45 \$45 20% 20% No charge No charge | X X X | 20% 20% No charge 20% \$45 \$45 \$45 \$45 20% No charge No charge | x x x |
| Help recovering or other special health needs Child eye care Child Dental Diagnostic | Substance use disorder inpatie Prenatal care and preconceptic Delivery and all inpatient services Home health care Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospico service Eye exam 1 pair of glasses per year (or co Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application | y fee (e.g. hospital room) ent physician/surgeon fee on visits Hospital Professional ces s | 20% 20% No charge 20% 20% \$45 \$45 20% No charge No charge No charge | X X X | 20% 20% No charge 20% \$45 \$45 \$45 \$45 20% No charge No charge No charge | x x x |
| Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic | Substance use disorder inpatie Prenatal care and preconceptic Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or cr Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth | y fee (e.g. hospital room) ent physician/surgeon fee on visits Hospital Professional ces s | 20% 20% No charge 20% 20% \$45 \$45 20% No charge No charge No charge | X X X | 20% 20% No charge 20% \$45 \$45 \$45 \$45 20% No charge No charge No charge | x x x |
| Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental | Substance use disorder inpatie Prenatal care and preconceptic Prenatal care and preconceptic Polivery and all inpatient services Home health care Outpatient Rehabilitation servic Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or coloral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface | y fee (e.g. hospital room) ent physician/surgeon fee on visits Hospital Professional ces s | 20% 20% No charge 20% 20% \$45 \$45 20% No charge No charge No charge | X X X | 20% 20% No charge 20% 20% \$45 \$45 \$45 \$45 20% No charge No charge No charge No charge | x x x |
| Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental | Substance use disorder inpatie Prenatal care and preconceptic Prenatal care and preconceptic Pelivery and all inpatient services Home health care Outpatient Habilitation servic Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or co 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 | y fee (e.g. hospital room) ent physician/surgeon fee on visits Hospital Professional ces s ontact lenses in lieu of glasses) | 20% 20% No charge 20% 20% \$45 \$45 20% No charge No charge No charge No charge | X X X | 20% 20% No charge 20% \$45 \$45 \$45 \$45 20% No charge No charge No charge No charge \$55 \$50 \$150 | x x x |
| Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services | Substance use disorder inpatie Prenatal care and preconceptic Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or co Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - Aray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar | y fee (e.g. hospital room) ent physician/surgeon fee on visits Hospital Professional ces s ontact lenses in lieu of glasses) | 20% 20% No charge 20% 20% \$45 \$45 20% No charge No charge No charge | X X X | 20% 20% No charge 20% \$45 \$45 \$45 20% No charge No charge No charge No charge \$25 \$300 | x x x |
| Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major | Substance use disorder inpatie Prenatal care and preconceptic Delivery and all inpatient services Home health care Outpatient Rehabilitation servic Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or co Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - Salants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad Extraction - Single Tooth Expos | y fee (e.g. hospital room) ent physician/surgeon fee on visits Hospital Professional ces s ontact lenses in lieu of glasses) | 20% 20% No charge 20% 20% \$45 \$45 20% No charge No charge No charge No charge | X X X | 20% 20% No charge 20% \$45 \$45 \$45 \$45 20% No charge No charge No charge No charge \$25 \$300 \$150 \$565 | x x x |

2016 Standard Benefit Plan Designs 10.0 EHB

Date: April 46<u>17</u>, 2015

| Member Cost S | F Benefits and Coverage share amounts describe the En e - AV Calculator | | SHOF Silver HSA Pla 70.5% | an |
|---|---|--|------------------------------------|--------------------|
| | cludes a deductible? | | Yes, integr | |
| Integrated | Individual deductible | | \$2,000 integ | grated |
| | Family deductible deductible, NOT integrated: I | Medical / Pharmacy / Dental | \$4,000 integ | grated |
| | uctible, NOT integrated: Med | lical / Pharmacy / Dental | N/A | |
| Family Out-of- | -of-pocket maximum pocket maximum | | \$6,250 \$12,50 | |
| | only coverage deductible n: Individual deductible | | \$2,000 See endr | |
| noA faililly pla | iii. Iliulviuual ueuuctible | | See end | lote |
| Common Medical Event | Se | rvice Type | Member Cost Share | Deductible Applies |
| Health care | Primary care visit to treat an i | njury, illness, or condition | 20% | х |
| provider's office or clinic visit | Other practitioner office visit | | 20% | х |
| | Specialist visit | | 20% | Х |
| | Preventive care/ screening/ in Laboratory Tests | nmunization | No charge 20% | X |
| Tests | X-rays and Diagnostic Imagin | | 20% | Х |
| | Imaging (CT/PET scans, MRI | s) | 20% | X |
| | Tier 1 | | 20% | Х |
| Drugs to treat | Tier 2 | | 20% | Х |
| condition | Tier 3 | | 20% | Х |
| | Tier 4 | | 20% | x |
| Outpatient | Surgery facility fee (e.g., ASC Physician/surgeon fees |) | 20% | X |
| services | Outpatient visit | | 20% | X |
| | Emergency room facility fee (| waived if admitted) | 20% | Х |
| Need | Emergency room physician fe | e (waived if admitted) | 20% | х |
| immediate | Emergency medical transport | ation | 20% | Х |
| attention | Urgent care | | 20% | х |
| Hospital stay | Facility fee (e.g. hospital roon | n) | 20% | х |
| | Physician/surgeon fee | | 20% | X |
| | Mental/Behavioral health outpatient office visits | | 20% | × |
| | Mental/Behavioral health other outpatient items and services | | 20% | х |
| Mental health, | Mental/Behavioral health inpa | tient facility fee (e.g.hospital room) | 20% | Х |
| behavioral | Mental/Behavioral health inpa | tient physician/surgeon fee | 20% | х |
| health, or substance abuse needs | Substance Use disorder outpa | atient office visits | 20% | х |
| | Substance Use disorder other | outpatient items and services | 20% | х |
| | Substance Use inpatient facili | ty fee (e.g. hospital room) | 20% | Х |
| | Substance use disorder inpati | ent physician/surgeon fee | 20% | х |
| | Prenatal care and preconcept | - · · · | No charge | |
| Pregnancy | Delivery and all inpatient | Hospital | 20% | Х |
| | services | Professional | 20% | Х |
| | Home health care | | 20% | X |
| Help | Outpatient Rehabilitation service Outpatient Habilitation service | | 20% 20% | X |
| recovering or other special | Skilled nursing care | | 20% | Х |
| health needs | Durable medical equipment | | 20% | Х |
| | Hospice service Eye exam | | 0% No charge | X |
| Child eye care | 1 pair of glasses per year (or | contact lenses in lieu of classes) | No charge No charge | |
| | Oral Exam | | . to draige | |
| Child Dental | Preventive - Cleaning | | | |
| Diagnostic and | Preventive - X-ray Sealants per Tooth | | No charge | |
| Preventive | Topical Fluoride Application Space Maintainers - Fixed | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | 20% | |
| | Root Canal- Molar | | | |
| Child Dental Major | Gingivectomy per Quad Extraction- Single Tooth Expo | sed Root or Erupted | 50% | |
| Services | Extraction- Complete Bony Porcelain with Metal Crown | | | |
| Child | Medically necessary orthodon | tics | 50% | |
| Orthodontics | | | | |

| Summary | of R | enefite | and | Coverage |
|---------|------|---------|-----|----------|

| Summary of | Benefits and Coverage | | | | | |
|--|---|---|---------------------------|-----------------------|------------------------------|------------------------|
| | hare amounts describe the Enr | ollee's out of pocket costs. | Silver F 100%-150 | | Silver F 150%-200 | % FPL |
| | e - AV Calculator | | 93.89 | | 86.89 | |
| | cludes a deductible? Individual deductible | | Yes, Medical/I N/A | | Yes, Medical/I N/A | |
| Integrated | Family deductible | | N/A | | N/A | |
| Individual of Family ded | deductible, NOT integrated: Muctible, NOT integrated: Med | ledical / Pharmacy / Dental ical / Pharmacy / Dental | \$75 / \$0 \$150 / \$0 | | \$550 / \$5 \$1,100 / \$1 | |
| Individual Out- | of-pocket maximum | | \$2,25 \$4,50 | 0 | \$2,25 | 0 |
| HSA plan: Self | pocket maximum -only coverage deductible | | \$4,50 N/A | | \$4,50 N/A | U |
| HSA family pla | n: Individual deductible | | N/A | | N/A | |
| Common Medical Event | Ser | vice Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
| | Primary care visit to treat an in | njury, illness, or condition | \$5 | | \$15 | |
| Health care provider's office or | Other practitioner office visit | | \$5 | | \$15 | |
| clinic visit | Specialist visit | | \$8 | | \$25 | |
| | Preventive care/ screening/ im | munization | No charge | | No charge | |
| Tests | Laboratory Tests X-rays and Diagnostic Imaging | , | \$8 \$8 | | \$15 \$25 | |
| 10313 | Imaging (CT/PET scans, MRIs) | | \$50 | | \$100 | |
| | Tier 1 | | \$3 | | \$5 | |
| | Tier 2 | | \$10 | | \$20 | Pharmacy |
| Drugs to treat illness or | Tier 3 | | \$15 | | \$35 | deductible Pharmacy |
| condition | | | 10% up to \$200 | | 15% <u>up to \$200</u> | deductible |
| | Tier 4 | | per script | | per script | deductible |
| Outpatient | Surgery facility fee (e.g., ASC) | | 10% | | 15% | |
| services | Physician/surgeon fees Outpatient visit | | 10% 10% | | 15% 15% | |
| | Emergency room facility fee (v | vaived if admitted) | \$30 | Х | \$75 | Х |
| | Emergency room physician fe | \$25 | х | \$40 | х | |
| Need immediate | Emergency medical transporta | ation | \$30 | Х | \$75 | Х |
| attention | Urgent care | | \$6 | | \$30 | |
| Hospital stay | Facility fee (e.g. hospital room |) | 10% | Х | 15% | Х |
| поѕрна ѕыу | Physician/surgeon fee | | 10% | Х | 15% | Х |
| | Mental/Behavioral health outpatient office visits | | \$5 | | \$15 | |
| | Mental/Behavioral health other | \$5 | | \$15 | | |
| | Mental/Behavioral health inpat | ient facility fee (e.g.hospital room) | 10% | х | 15% | х |
| Mental health, behavioral | Mental/Behavioral health inpat | ient physician/surgeon fee | 10% | х | 15% | х |
| health, or substance abuse needs | Substance Use disorder outpa | \$5 | | \$15 | | |
| | Substance Use disorder other | \$5 | | \$15 | | |
| | Substance Use inpatient facilit | y fee (e.g. hospital room) | 10% | Х | 15% | х |
| | Substance use disorder inpatie | 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 |
| | Home health care Outpatient Rehabilitation servi | ces | \$3 \$5 | | \$15 \$15 | |
| Help recovering or | Outpatient Habilitation service | | \$5 \$5 | | \$15 | |
| other special | Skilled nursing care | | 10% | Х | 15% | Х |
| health needs | Durable medical equipment | | 10% | | 15% | |
| OLUL . | 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 Preventive | Sealants per Tooth Topical Fluoride Application | | No charge | | No charge | |
| | Space Maintainers - Fixed | | | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | 20% | | 20% | |
| Child Dental | Root Canal- Molar Gingivectomy per Quad | | | | | |
| Major Services | Extraction- Single Tooth Expos Extraction- Complete Bony Porcelain with Metal Crown | sed Root or Erupted | 50% | | 50% | |
| Child Orthodontics | Medically necessary orthodon | ics | 50% | | 50% | |

| Primary care visit to treat an injury, illness, or condition \$40 | | hare amounts describe the Enr | ollee's out of pocket costs. | Silver P 200%-250 | % FPL |
|--|---|---|---|--|---------------------|
| Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Individual deductible, NOT integrated: Medical / Pharmacy / Dental S100 S20 / 50 / 50 / 50 / 50 / 50 / 50 / 50 / | | | | 72.8% | 6 |
| Initingizated Family deductible introllegated: Medical / Pharmacy / Dental 3,300 (\$5 | | | | | Pharmacy |
| Individual deducible, NOT integrated: Medical / Pharmacy / Dental \$3,00 / \$5 | | | | | |
| Individual Out-of-pecket maximum | | | Medical / Pharmacy / Dental | | 50 / \$0 |
| Semily Out-of-pooker maximum Si 10,900 NA NA NA NA NA NA NA | | | lical / Pharmacy / Dental | | |
| HSA plains Self-only coverage deductible NA NA NA NA NA NA NA NA NA N | | | | | |
| Member Goal Declaration Member Goal Declaration | HSA plan: Self | only coverage deductible | | N/A | |
| Primary care visit to treat an injury, illness, or condition Primary care visit to treat an injury, illness, or condition Primary care visit to treat an injury, illness, or condition Other practitioner office visit Specialist visit Preventive care' screening' immunization No charge Tests Ary and Disprostic Imaging Test Frest Specialist visit Preventive care' screening' immunization No charge Test Sist Test Sist Preventive care' screening' immunization No charge Test Sist Preventive care' screening' immunization No charge Test Sist Promy and Disprostic Imaging Scool Imaging (CVTPE's care, MRIs) Surgery facility lee (e.g., ASC) Pharma Surgery facility lee (e.g., ASC) Pharma Surgery facility lee (e.g., ASC) Power of the services Outpatient visit Emergency cond physician fee (walved if admitted) Surgery facility lee (walved if admitted) Emergency mon physician fee (walved if admitted) Surgery facility lee (walved if a | HSA family pla | n: Individual deductible | | N/A | |
| Promotive or control of the practitions of fice visit S40 S4 | | Ser | vice Type | | Deductib Applies |
| Other practitioner office visit Specialist visit Specialist visit Specialist visit Preventive care screening immunization Lobotantory Tests X-rays and Diagnostic Imaging Tier 1 Tier 1 Strip Tier 1 Tier 2 Strip Tier 3 Strip Tier 3 Tier 3 Strip Strip Strip Tier 4 20% up 15 \$500 Pharma deductit Tier 4 20% up 15 \$500 Pharma deductit Tier 4 Strip Strip Strip Strip Strip Strip Tier 4 Strip | Haalib aasa | Primary care visit to treat an in | njury, illness, or condition | \$40 | |
| Specialist visit Preventive care' screening/ immunization S55 No. charge Laboratory Tests S35 X-rays and Diagnostic Imaging S50 | provider's office or | Other practitioner office visit | | \$40 | |
| Laboratory Tests X-rays and Diagnostic Imaging Imaging (CTPET scans, MRIs) Ter 1 Ter 2 Ter 2 Ter 3 Surgery Incility fee (e.g., ASC) Physician/surgeon fees Outpatient services Cutpatient Services Cutpatient Services Physician/surgeon fees Outpatient visit Emergency room facility fee (waived if admitted) Emergency room facility fee (waived if admitted) Emergency room facility fee (waived if admitted) Urgert care Facility (e.g., hospital room) Urgert care Mental/Behavioral health outpatient office visits Mental/Behavioral health outpatient office visits Mental/Behavioral health outpatient office visits Mental/Behavioral health inpatient facility fee (e.g., hospital room) Substance Use disorder outpatient office visits No charge Pregnancy Presental acrea and preconception visits No charge The preventive Substance Use disorder outpatient office visits No charge The preventive Substance | Clinic visit | | | | |
| Tests | | | munization | | |
| Tier 1 St55 Tier 2 St56 Tier 2 St56 Tier 3 St70 Pharma deductit deductit condition Tier 4 St70 Pharma deductit condition Tier 4 St70 Tier 4 St70 Pharma deductit condition Tier 4 St70 Physician/surgeon fees 20% Outpatient visit 20% Emergency room facility fee (waived if admitted) \$20% Emergency room physician fee (waived if admitted) \$50 | Tests | | n | | |
| Tier 2 | | | | | |
| Drugs to treat liters Section | | Tier 1 | | \$15 | |
| Tier 3 S70 Pharma decondition Tier 4 20% up to \$500 Pharma decondition Tier 4 20% up to \$500 Per script Physician/surgeon fees 20% 2 | Drugs to treat | | | | Pharma |
| Tier 4 20% up to \$500 per script deductit | illness or | Tier 3 | | \$70 | Pharma |
| Physician/surgeon fees 20% | | Tier 4 | | | Pharma |
| Services Cupatient visit 20% 2 | Outpations | | | 20% | |
| Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted) Emergency room physician fee (waived if admitted) Emergency room physician fee (waived if admitted) Emergency medical transportation Urgent care S80 Hospital stay Facility fee (e.g. hospital room) Physician/surgeon fee Mental/Behavioral health outpatient office visits Mental/Behavioral health outpatient office visits Mental/Behavioral health outpatient items and services Mental/Behavioral health other outpatient items and services Mental/Behavioral health nor substance Mental/Behavioral health inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient physician/surgeon fee Substance Use disorder outpatient office visits Substance Use disorder outpatient office visits Substance Use disorder outpatient items and services Substance Use disorder outpatient items and services Substance Use disorder inpatient physician/surgeon fee Substance Use disorder inpatient physician/surgeon fee Pregnancy Pregnancy Prenatal care and preconception visits No charge Pregnancy Prenatal care and preconception visits No charge Pregnancy Prenatal care and preconception visits No charge Preventive Substance Use disorder inpatient physician/surgeon fee Substance Use disorder inpatient physician/surgeon fee 20% X Delivery and all inpatient Hospital 20% X Professional 20% X Delivery and all inpatient 4 Hospital 20% X Delivery and all inpatient 4 Hospital 20% No charge Skilled nursing care 20% No charge The reventive - Cleaning Preventive - Cleaning Root Canal- Molar Root Canal- | | | | | |
| Emergency room physician fee (waived if admitted) \$50 | | | | | |
| Emergency medical transportation Urgent care Facility fee (e.g. hospital room) Physician/surgeon fee Mental/Behavioral health outpatient office visits Mental/Behavioral health outpatient items and services Mental/Behavioral health inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient physician/surgeon fee 20% X Mental/Behavioral health inpatient physician/surgeon fee 20% X Substance Substance Use disorder outpatient office visits \$40 Substance Use disorder outpatient items and services \$40 Substance Use inpatient facility fee (e.g. hospital room) 20% X Substance Use inpatient facility fee (e.g. hospital room) 20% X Prenatal care and preconception visits No charge Pregnancy Delivery and all inpatient physician/surgeon fee 20% X Professional Hop coupatient Rehabilitation services \$40 Home health care Outpatient Rehabilitation services \$40 Uurpatient Rehabilitation services \$40 Uurpatient Rehabilitation services \$40 Durable medical equipment Hospice service No charge Eye exam Child Dental Diagnostic Amalgam Fill - 1 Surface Root Canal-Molar Ginglevectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Single Tooth Exposed Root or Erupted Extraction- Services Services Profesional Extraction- Single Tooth Exposed Root or Erupted Extraction- Complex Bony Extraction- Complex Bony Exposed M | | Emergency room facility fee (v | vaived if admitted) | \$250 | Х |
| Emergency medical transportation \$250 X Hospital stay Facility fee (e.g. hospital room) 20% X Physician/surgeon fee 20% X Mental/Behavioral health outpatient office visits \$40 Mental/Behavioral health outpatient facility fee (e.g. hospital room) 20% X Mental/Behavioral health inpatient facility fee (e.g. hospital room) 20% X Mental/Behavioral health inpatient facility fee (e.g. hospital room) 20% X Mental/Behavioral health inpatient physician/surgeon fee 20% X Mental/Behavioral health inpatient physician/surgeon fee 20% X Substance Use disorder outpatient office visits \$40 Substance Use disorder outpatient items and services \$40 Substance Use disorder outpatient items and services \$40 Substance use disorder inpatient physician/surgeon fee 20% X Prenatal care and preconception visits No charge Pregnancy Delivery and all inpatient physician/surgeon fee 20% X Prenatal care and preconception visits No charge Home health care \$40 Outpatient Habilitation services \$40 Uutpatient Habilitation services \$40 Uutpatient Habilitation services \$40 Child Dental Diagnostic and Preventive - Cleaning P | | Emergency room physician fe | e (waived if admitted) | \$50 | х |
| Hospital stay Facility fee (e.g. hospital room) Physician/surgeon fee Mental/Behavioral health outpatient office visits Mental/Behavioral health outpatient items and services Mental/Behavioral health inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient physician/surgeon fee 20% X Mental/Behavioral health inpatient physician/surgeon fee 20% X Substance Use disorder outpatient office visits Substance Use disorder outpatient office visits Substance Use disorder outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance Use inpatient physician/surgeon fee 20% X Prenatal care and preconception visits No charge Delivery and all inpatient physician/surgeon fee 20% X Home health care Outpatient Rehabilitation services S40 Unable in Rehabilitation services S40 Outpatient Rehabilitation services S40 Outpatient Rehabilitation services Skilled nursing care Durable medical equipment Hospice service Sidled pursip medical equipment Hospice service Preventive - Cleaning Preventive - Creaning Preventive - Varay Saciants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Root Canal-Molar Gingle toomy per Quad Extraction- Complete Bony Porcelain with Metal Crown | | Emergency medical transporta | ation | \$250 | Х |
| Mental/Behavioral health outpatient office visits Mental/Behavioral health outpatient items and services Mental/Behavioral health inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient physician/surgeon fee 20% X Mental/Behavioral health inpatient physician/surgeon fee 20% X Mental/Behavioral health inpatient physician/surgeon fee 20% X Substance Substance Use disorder outpatient office visits \$40 Substance Use disorder outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) 20% X Substance use disorder inpatient physician/surgeon fee 20% X Prenatal care and preconception visits No charge Pregnancy Preventive and all inpatient physician/surgeon fee 20% X Professional Professional 20% X Substance Use inpatient physician/surgeon fee 20% X X A Preventive and all inpatient physician/surgeon fee 20% X Substance use disorder inpatient physician/surgeon fee 20% X A Preventive and all inpatient physician/surgeon fee 20% X Substance use disorder inpatient physician/surgeon fee 20% X A Preventive and all inpatient physician/surgeon fee 20% X Substance use disorder inpatient physician/surgeon fee 20% X Substance use disorder inpatient physician/surgeon fee 20% X Substance use disorder inpatient physician/surgeon fee 20% X A Preventive and preconception visits No charge Child petal health needs Diagnostic And preventive - Cleaning Preve | | Urgent care | | \$80 | |
| Mental/Behavioral health 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 facility fee (e.g.hospital room) Mental/Behavioral health inpatient physician/surgeon fee 20% X Mental/Behavioral health inpatient physician/surgeon fee 20% X Substance Substance Use disorder outpatient office visits Substance Use disorder outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) 20% X Substance use disorder inpatient physician/surgeon fee 20% X Prenatal care and preconception visits No charge Pregnancy Preventives Home health care Outpatient Rehabilitation services Substance use disorder inpatient physician/surgeon fee 20% X X Prenatal care and preconception visits No charge Help recovering or outpatient the physician/surgeon fee Substance use disorder inpatient physician/surgeon fee Substance use disorder inpatient physician/surgeon fee 20% X A Preventives Substance use disorder inpatient physician/surgeon fee 20% X A Substance use disorder inpatient physician/surgeon fee 20% X V Prenatal care and preconception visits No charge Substance use disorder inpatient physician/surgeon fee 20% X X Substance use disorder inpatient physician/surgeon fee 20% X Substance use disorder inpatient physician/surgeon fee 20% X Substance use disorder inpatient physician/surgeon fee 20% X X Preventive Skilled nursing care No charge Sealant need call equipment Hospice service No charge No charge No charge No charge Preventive - Cleaning Preve | Hospital stay | |) | | |
| Mental/Behavioral health inpatient facility fee (e.g.hospital room) Mental/Behavioral health inpatient physician/surgeon fee 20% X Substance Use disorder outpatient office visits Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance Use inpatient facility fee (e.g. hospital room) Substance Use inpatient facility fee (e.g. hospital room) Substance Use inpatient physician/surgeon fee 20% X Prenatal care and preconception visits No charge Pregnancy Pregnancy Hospital Professional Home health care Outpatient Rehabilitation services Skilled nursing care Durabie medical equipment Hospice service Child Dental Diagnostic Amalgam Fill - 1 Surface Services Root Canal-Molar Gingivectomy per Quad Extraction- Complete Bony Procelain with Metal Crown | | | | | |
| Mental health, behavioral health inpatient physician/surgeon fee 20% X | | Mental/Behavioral health other | r outpatient items and services | \$40 | |
| Mental health, behavioral health inpatient physician/surgeon fee 20% X | | Mental/Behavioral health inpat | tient facility fee (e.g.hospital room) | 20% | Х |
| health, or substance abuse needs Substance Use disorder outpatient office visits Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Prenatal care and preconception visits No charge Prenatal care and preconception visits No charge Prenatal care and preconception visits No charge Home health care Outpatient Rehabilitation services Substance use disorder inpatient physician/surgeon fee 20% X Prenatal care and preconception visits No charge Home health care Outpatient Rehabilitation services Substance Use disorder inpatient physician/surgeon fee Substance Use disorder inpatient physician/surgeon fee 20% X Substance Use inpatient physician/surgeon fee Substance Use disorder inpatient physician/surgeon fee 20% X Substance Use | Mental health, | · | | | |
| Substance Use disorder outpatient office visits Substance Use disorder other outpatient items and services Substance Use disorder other outpatient items and services Substance Use disorder other outpatient items and services Substance Use disorder inpatient physician/surgeon fee Pregnancy Prenatal care and preconception visits No charge Pregnancy Delivery and all inpatient Hospital 20% X Professional 20% X Professional 20% X Home health care 340 Outpatient Rehabilitation services 340 Outpatient Rehabilitation services 340 Outpatient Rehabilitation services 340 Skilled nursing care 20% X Burable medical equipment 20% X Hospice service No charge No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) Preventive - Cleaning Preventive - Varay Sealants per Tooth Preventive - Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Root Canal- Molar Gingivectomy per Quad Extraction - Single Tooth Exposed Root or Erupted Extraction - Single Tooth Exposed Root or Erupted Extraction - Single Tooth Exposed Root or Erupted Extraction - Complete Bony Porcelain with Metal Crown | | Mental/Behavioral health inpat | tient physician/surgeon fee | 20% | Х |
| Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Pregnancy Pregnancy Pregnancy Delivery and all inpatient services Professional Delivery and all inpatient services Delivery and all inpatient services Substance Uses in services No charge Uses Uses Uses Uses Uses Uses Uses In services Uses Uses Uses Uses Uses Uses Uses U | substance | Substance Use disorder outpa | tient office visits | \$40 | |
| Substance use disorder inpatient physician/surgeon fee 20% X Pregnancy | | Substance Use disorder other | outpatient items and services | \$40 | |
| Pregnancy Pregnancy Delivery and all inpatient services Professional Profession | | Substance Use inpatient facilit | ry fee (e.g. hospital room) | 20% | Х |
| Pregnancy Services Delivery and all inpatient services Horp health care Outpatient Rehabilitation services Outpatient Rehabilitation services S40 Outpatient Rehabilitation services S40 Outpatient Habilitation services S40 VX No charge Eye exam No charge Oral Exam Child Dental Diagnostic and Preventive - Cleaning Preventive - Cleaning Preventive - Cleaning Preventive - Cleaning Preventive - Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Root Canal- Molar Gingivectomy per Quad Extraction - Single Tooth Exposed Root or Erupted Extraction - Complete Bony Porcelain with Metal Crown | | Substance use disorder inpatie | ent physician/surgeon fee | 20% | Х |
| Pregnancy Services Delivery and all inpatient services Horp health care Outpatient Rehabilitation services Outpatient Rehabilitation services S40 Outpatient Rehabilitation services S40 Outpatient Habilitation services S40 VX No charge Eye exam No charge Oral Exam Child Dental Diagnostic and Preventive - Cleaning Preventive - Cleaning Preventive - Cleaning Preventive - Cleaning Preventive - Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Root Canal- Molar Gingivectomy per Quad Extraction - Single Tooth Exposed Root or Erupted Extraction - Complete Bony Porcelain with Metal Crown | | | on visite | No charge | |
| Services | | Prenatal care and preconcepti | OII VISILS | | |
| Home health care | Pregnancy | | | 20% | Х |
| Child Dental Basic Services Child Dental Basic Services Root Canal- Molar Child Dental Major Services Root Canal- Molar Child Dental Major Services Root Canal- Molar Complete Bony Porcelain with Metal Crown Complete Bony Porcelain Wild Instructions Complete Bony Porcelain Wi | Pregnancy | Delivery and all inpatient | Hospital | | |
| recovering or outputent habitination services 340 other special Skilled nursing care 20% X Durable medical equipment 20% Hospice service No charge Child eye Eye exam No charge Child Dental Diagnostic Preventive - Cleaning Preventive - Cleaning Preventive - Seaning Preventive - Seaning Preventive - Services Amalgam Fill - 1 Surface 20% Child Dental Diagnostic Application Space Maintainers - Fixed Child Dental Basic Services Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted 50% Extraction- Complete Bony Porcelain with Metal Crown | Pregnancy | Delivery and all inpatient services Home health care | Hospital Professional | 20% \$40 | |
| health needs Hospice service Child eye Care Oral Exam Child Dental Diagnostic Diagnostic Diagnostic Diagnostic Diagnostic Diagnostic Child Dental Diagnostic Diagn | | Delivery and all inpatient services Home health care Outpatient Rehabilitation servi | Hospital Professional ces | 20% \$40 \$40 | |
| Durable medical equipment Hospice service No charge No c | Help recovering or | Delivery and all inpatient services Home health care Outpatient Rehabilitation service Outpatient Habilitation service | Hospital Professional ces | 20% \$40 \$40 \$40 | X |
| Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge Child Dental Diagnostic Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony Porcelain with Metal Crown | Help recovering or other special | Delivery and all inpatient services Home health care Outpatient Rehabilitation service Outpatient Habilitation service Skilled nursing care | Hospital Professional ces | 20% \$40 \$40 \$40 \$20% | X |
| Child Dental Diagnostic Driventive - Cleaning Preventive - Cleanin | Help recovering or other special | Delivery and all inpatient services Home health care Outpatient Rehabilitation service Outpatient Habilitation service Skilled nursing care Durable medical equipment | Hospital Professional ces | 20% \$40 \$40 \$40 20% | X |
| Oral Exam Oral Exam Preventive - Cleaning Preventive - Vary and Sealants per Tooth Preventive - Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Root Canal- Molar Gingivectomy per Quad Major Extraction- Single Tooth Exposed Root or Erupted Services Extraction- Complete Bony Porcelain with Metal Crown | Help recovering or other special health needs | Delivery and all inpatient services Home health care Outpatient Rehabilitation service Outpatient Habilitation service Skilled nursing care Durable medical equipment Hospice service | Hospital Professional ces | 20% \$40 \$40 \$40 20% 20% No charge | X |
| Child Dental Diagnostic Preventive - Cleaning Preventive - X-ray No charge Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Amalgam Fill - 1 Surface 20% Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted 50% Extraction- Single Tooth Exposed Root or Erupted 50% Services Extraction- Complete Bony Porcelain with Metal Crown | Help recovering or other special health needs Child eye | Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam | Hospital Professional ces s | 20% \$40 \$40 \$40 20% 20% No charge No charge | X |
| Diagnostic and Preventive - X-ray and Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Services Rot Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted 50% Services Porcelain with Metal Crown | Help recovering or other special health needs Child eye | Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of | Hospital Professional ces s | 20% \$40 \$40 \$40 20% 20% No charge No charge | X |
| Preventive Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Amalgam Fill - 1 Surface 20% Services Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted 50% Services Extraction- Complete Bony Porcelain with Metal Crown | Help recovering or other special health needs Child eye care | Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or c) Oral Exam Preventive - Cleaning | Hospital Professional ces s | 20% \$40 \$40 \$40 20% 20% No charge No charge | X |
| Space Maintainers - Fixed Child Dental Basic Services Root Canal- Molar Gingivectomy per Quad Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Services Extraction- Complete Bony Porcelain with Metal Crown | Help recovering or other special health needs Child eye care Child Dental Diagnostic | Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or c Oral Exam Preventive - Cleaning Preventive - X-ray | Hospital Professional ces s | 20% \$40 \$40 \$40 20% 20% No charge No charge | X |
| Basic Amalgam Fill - 1 Surface 20% Services Root Canal- Molar Child Dental Major Extraction- Single Tooth Exposed Root or Erupted 50% Services Extraction- Complete Bony Porcelain with Metal Crown | Help recovering or other special health needs Child eye care Child Dental Diagnostic and | Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or c Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth | Hospital Professional ces s | 20% \$40 \$40 \$40 20% 20% No charge No charge | X |
| Child Dental Major Extraction- Single Tooth Exposed Root or Erupted 50% Services Extraction- Complete Bony Porcelain with Metal Crown | Help recovering or other special health needs Child eye care Child Dental Diagnostic and | Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or or Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application | Hospital Professional ces s | 20% \$40 \$40 \$40 20% 20% No charge No charge | X |
| Major Extraction- Single Tooth Exposed Root or Erupted 50% Services Extraction- Complete Bony Porcelain with Metal Crown | Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic | Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or c) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed | Hospital Professional ces s | 20% \$40 \$40 \$40 20% No charge No charge No charge | X |
| | Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services | Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or of Carl Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar | Hospital Professional ces s | 20% \$40 \$40 \$40 20% No charge No charge No charge | X |
| | Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services | Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or or Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Expo | Hospital Professional ces s ontact lenses in lieu of glasses) | 20% \$40 \$40 \$40 20% 20% No charge No charge No charge | X |

| | hare amounts describe the En | rollee's out of pocket costs. | Br | onze Plan | Bronze HSA Plan | | |
|---|---|------------------------------------|------------------------|--|--------------------------|------------|--|
| | e - AV Calculator | | | 61.2% | 61.1 | | |
| | cludes a deductible? Individual deductible | | | s, integrated 00 integrated | Yes, inte \$4,500 int | | |
| Integrated | Family deductible | | | 000 integrated | \$9,000 int | egrated | |
| | deductible, NOT integrated: uctible, NOT integrated: Med | | | N/A N/A | N/A N/A | | |
| ndividual Out- | -of-pocket maximum | acai / i naimacy / Demai | | \$6,500 | \$6,50 | 00 | |
| | pocket maximum -only coverage deductible | | | \$13,000 N/A | \$13,0 \$4,50 | | |
| | n: Individual deductible | | | N/A | \$4,50 | | |
| Common | | | Member Cost | | Member Cost | Deductible | |
| Medical Event | Se | rvice Type | Share | Deductible Applies | Share | Applies | |
| Health care | Primary care visit to treat an | njury, illness, or condition | \$70 | After 1st three non- preventive visits | 40% | Х | |
| orovider's office or clinic visit | Other practitioner office visit | | \$70 | After 1st three non- preventive visits | 40% | Х | |
| | Specialist visit | | \$90 | After 1st three non- preventive visits | 40% | Х | |
| | Preventive care/ screening/ in Laboratory Tests | nmunization | No charge \$40 | | No charge 40% | X | |
| ests | X-rays and Diagnostic Imagir | g | 0% | Х | 40% | X | |
| | Imaging (CT/PET scans, MRI | | 0% | X | 40% | Х | |
| | Tier 1 | | 0% | Deductible up to \$500 | 40% | х | |
| Orugs to treat | Tier 2 | | 0% | Deductible up to \$500 maximum per script | 40% | Х | |
| Iness or condition | Tier 3 | | 0% | Deductible up to \$500 maximum per script | 40% | х | |
| | Tier 4 | | 0% | Deductible up to \$500 | 40% | х | |
| | Surgery facility fee (e.g., ASC |) | | maximum per script | | | |
| Outpatient | Physician/surgeon fees | 7 | 0% | X | 40% 40% | X | |
| services | Outpatient visit | | 0% | X | 40% | X | |
| | Emergency room facility fee (| waived if admitted) | 0% | Х | 40% | Х | |
| | Emergency room physician fe | e (waived if admitted) | 0% | х | 40% | х | |
| Need mmediate | Emergency medical transport | 0% | X | 40% | X | | |
| attention | Urgent care | | \$120 | After 1st three non- preventive visits | 40% | х | |
| | Facility fee (e.g. hospital room | n) | 0% | X | 40% | X | |
| lospital stay | Physician/surgeon fee | | 0% | X | 40% | Х | |
| | Mental/Behavioral health outpatient office visits | | \$70 | After 1st three non- preventive visits | 40% | х | |
| | Mental/Behavioral health other outpatient items and services | | \$70 | After 1st three non- preventive visits | 40% | х | |
| | Mental/Behavioral health inpatient facility fee (e.g.hospital room) | | 0% | Х | 40% | х | |
| Mental health, behavioral | Mental/Behavioral health inpatient physician/surgeon fee | | 0% | Х | 40% | х | |
| nealth, or substance abuse needs | Substance Use disorder outpatient office visits | | \$70 | After 1st three non- preventive visits | 40% | х | |
| | Substance Use disorder other outpatient items and services | | \$70 | After 1st three non- preventive visits | 40% | × | |
| | Substance Use inpatient facil | ity fee (e.g. hospital room) | 0% | х | 40% | Х | |
| | Substance use disorder inpat | ient physician/surgeon fee | 0% | х | 40% | х | |
| | Prenatal care and preconcept | ion visits | No charge | | No charge | | |
| Pregnancy | Delivery and all inpatient | Hospital | 0% | x | 40% | х | |
| | services | Professional | 0% | Х | 40% | Х | |
| | Home health care | | 0% | X | 40% | Х | |
| lelp | Outpatient Rehabilitation service | | \$70 | | 40% | X | |
| ecovering or | Outpatient Habilitation service | \$ | \$70 | | 40% | Х | |
| other special nealth needs | Skilled nursing care | | 0% | Х | 40% | Х | |
| | Durable medical equipment | | 0% | X | 40% 0% | X | |
| Child ove | Hospice service Eye exam | | No charge No charge | | 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 | Preventive - Cleaning | | | |] | | |
| Diagnostic and | Preventive - X-ray | | No charge | | No charge | | |
| reventive | Sealants per Tooth Topical Fluoride Application | | | | | | |
| Child Dental Basic | Space Maintainers - Fixed Amalgam Fill - 1 Surface | | 20% | | 20% | | |
| Services | Root Canal- Molar | | | | | | |
| Child Dental | Gingivectomy per Quad | 10 . 5 . | l I | | | | |
| Major Services | Extraction- Single Tooth Expo Extraction- Complete Bony | sed Root or Erupted | 50% | | 50% | | |
| | Porcelain with Metal Crown | | | | | | |
| Child | Medically necessary orthodor | at | 50% | | 50% | | |

| | hare amounts describe the Er | nrollee's out of pocket costs. | Catastro | phic Plan |
|---|--|---|---------------------------------------|---------------------------------------|
| | - AV Calculator | | Voc. int | ograted |
| | ndividual deductible | | | egrated ntegrated |
| | amily deductible | Madical (Dhamasa (Danta) | | ntegrated |
| Family ded | leductible, NOT integrated: uctible, NOT integrated: Me | Medical / Pharmacy / Dental dical / Pharmacy / Dental | N. | /A /A |
| Individual Out- | of-pocket maximum | | \$6, | 850 |
| Family Out-of- HSA plan: Self- | oocket maximum only coverage deductible | | \$13. N | ,700 /A |
| HSA family pla | n: Individual deductible | | N | |
| Common | | | Member Cost | Deductible |
| Medical Event | Se | ervice Type | Share | Applies After 1st three |
| Health care | Primary care visit to treat an injury, illness, or con | | 0% | non-preventive visits |
| provider's office or clinic visit | Other practitioner office visit | | 0% | non-preventive |
| | Specialist visit | | 0% | Х |
| | Preventive care/ screening/ in | mmunization | No charge | |
| Tests | Laboratory Tests X-rays and Diagnostic Imagi | ng | 0% 0% | X |
| | Imaging (CT/PET scans, MR | | 0% | Х |
| | Tier 1 | | 0% | Х |
| Drumo to troot | Tier 2 | | 0% | х |
| Drugs to treat | Tier 3 | | 0% | Х |
| condition | | | 00/ | |
| | Tier 4 Surgery facility fee (e.g., ASC | 7 | 0% | X |
| Outpatient | Physician/surgeon fees | ~1 | 0% | X |
| services | Outpatient visit | | 0% | X |
| | Emergency room facility fee | (waived if admitted) | 0% | Х |
| | Emergency room physician f | ee (waived if admitted) | 0% | х |
| Need immediate | Emergency medical transpor | , , | 0% | X |
| attention | Emergency medical transportation | | | After 1st three |
| | Urgent care | | 0% | non-preventive visits |
| Hospital stay | Facility fee (e.g. hospital roo | m) | 0% | х |
| | Physician/surgeon fee | | 0% | Х |
| | Mental/Behavioral health outpatient office visits | | 0% | After 1st three non-preventive visits |
| | Mental/Behavioral health other outpatient items and services | | 0% | After 1st three non-preventive visits |
| | Mental/Behavioral health inpo | atient facility fee (e.g.hospital room) | 0% | х |
| Mental health, behavioral | Mental/Behavioral health inp | atient physician/surgeon fee | 0% | х |
| health, or substance abuse needs | Substance Use disorder outp | 0% | After 1st three non-preventive visits | |
| | Substance Use disorder other | 0% | After 1st three non-preventive visits | |
| | Substance Use inpatient faci | lity fee (e.g. hospital room) | 0% | х |
| | Substance use disorder inpa | tient physician/surgeon fee | 0% | х |
| | Prenatal care and preconcep | tion visits | No charge | |
| Pregnancy | Delivery and all inpatient | Hospital | 0% | х |
| | services | Professional | 0% | Х |
| | Home health care Outpatient Rehabilitation ser | vices | 0% 0% | X |
| Help | Outpatient Habilitation service | | 0% | X |
| recovering or other special | Skilled nursing care | | 0% | Х |
| health needs | Durable medical equipment | | 0% | Х |
| | Hospice service | | 0% | X |
| Child eye | Eye exam | | No charge | |
| care | | contact lenses in lieu of glasses) | 0% | Х |
| Child Dental | Oral Exam Preventive - Cleaning | | | |
| Diagnostic | Preventive - X-ray | | No charge | |
| and Preventive | Sealants per Tooth Topical Fluoride Application | | | |
| | Space Maintainers - Fixed | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | 0% | х |
| Child Day to | Root Canal- Molar | | | X |
| Child Dental Major | Gingivectomy per Quad Extraction- Single Tooth Exp | osed Root or Erupted | 0% | X |
| Services | Extraction- Complete Bony | · · | | X |
| | Porcelain with Metal Crown | | | X |
| Child | | | | |

2016 Standard Benefit Plan Designs 9.5 EHB

Date: April 46<u>17</u>, 2015





| | Benefits and Coverage hare amounts describe the En | | Platinu | | Platinu | |
|--|--|--|-------------------------------|-----------------------|-------------------------------|-----------------------|
| | e - AV Calculator | ones a out or pouret costs. | Coinsurance 88.5% | | Copay P 89.5% | |
| | cludes a deductible? | | No | , | No | |
| | Individual deductible Family deductible | | \$0 \$0 | | \$0 \$0 | |
| Individual of | deductible, NOT integrated: I | | \$0 / \$0 / | | \$0 / \$0 / | |
| | uctible, NOT integrated: Med -of-pocket maximum | lical / Pharmacy / Dental | \$0 / \$0 / \$4,000 | | \$0 / \$0 / \$4,000 | |
| | pocket maximum -only coverage deductible | | \$8,000 N/A |) | \$8,000 N/A |) |
| | n: Individual deductible | | N/A | | N/A | |
| Common Medical Event | Se | rvice Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
| | Primary care visit to treat an i | niun, illnoss, or condition | \$20 | | 620 | |
| Health care provider's office or | Other practitioner office visit | ijury, iliness, or condition | \$20 \$20 | | \$20 \$20 | |
| clinic visit | Specialist visit | | \$40 | | \$40 | |
| | Preventive care/ screening/ in | nmunization | No charge | | No charge | |
| | Laboratory Tests | | \$20 | | \$20 | |
| Tests | X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRI | | \$40 10% | | \$40 \$150 | |
| | Tier 1 | | \$5 | | \$5 | |
| | Tier 2 | | \$15 | | \$15 | |
| illness or | Tier 3 | | | | | |
| condition | | | \$25 | | \$25 | |
| | Tier 4 | | 10% up to \$300 per script | | 10% up to \$300 per script | |
| Outpatient | Surgery facility fee (e.g., ASC | gery facility fee (e.g., ASC) sician/surgeon fees | | | \$250 | |
| services | Physician/surgeon fees Outpatient visit | | 10% 10% | | \$40 10% | |
| | Emergency room facility fee (| waived if admitted) | \$150 | | \$150 | |
| | Emergency room physician fe | e (waived if admitted) | 10% | | No charge | |
| Need immediate | Emergency medical transport | | \$150 | | \$150 | |
| attention | Urgent care | \$40 | | \$40 | | |
| | Facility for the absorbed asset | A | | | \$250 per day up | |
| Hospital stay | Facility fee (e.g. hospital roon | 1) | 10% | | to 5 days | |
| | Physician/surgeon fee | | 10% | | \$40 | |
| | Mental/Behavioral health outpatient office visits | | \$20 | | \$20 | |
| | Mental/Behavioral health othe | \$20 | | \$20 | | |
| | Mental/Behavioral health inpa | tient facility fee (e.g.hospital room) | 10% | | \$250 per day up to 5 days | |
| Mental health, behavioral | Mental/Behavioral health inpa | tient physician/surgeon fee | 10% | | \$40 | |
| health, or substance abuse needs | Substance Use disorder outpa | atient office visits | \$20 | | \$20 | |
| | Substance Use disorder other outpatient items and services | | \$20 | | \$20 | |
| | Substance Use inpatient facili | ty fee (e.g. hospital room) | 10% | | \$250 per day up to 5 days | |
| | Substance use disorder inpati | | 10% | | \$40 | |
| | Prenatal care and preconcept | | No charge | | No charge \$250 per day up | |
| Pregnancy | Delivery and all inpatient services | Hospital Professional | 10% | | to 5 days \$40 | \vdash |
| | Home health care | | 10% | | \$20 | |
| Help | Outpatient Rehabilitation service Outpatient Habilitation service | | \$20 \$20 | | \$20 \$20 | |
| recovering or other special | Skilled nursing care | | 10% | | \$150 per day up | |
| health needs | Durable medical equipment | | 10% | | to 5 days 10% | |
| Object | 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 | • | Ť | | Ť | |
| Child Dental Diagnostic | Preventive - Cleaning Preventive - X-ray | | Not Comment | | Not Comme | |
| and Preventive | Sealants per Tooth Topical Fluoride Application | | Not Covered | | Not Covered | |
| | Space Maintainers - Fixed | | | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | Not Covered | | Not Covered | |
| Child Dental | Root Canal- Molar Gingivectomy per Quad | | | | Not Covered | |
| Major | Gingivectomy per Quad Extraction- Single Tooth Expo | sed Root or Erupted | Not Covered | | Not Covered Not Covered | |
| Services | Extraction- Complete Bony Porcelain with Metal Crown | | | | Not Covered Not Covered | |
| Child Orthodontics | Medically necessary orthodon | tics | Not Covered | | Not Covered | |
| | | | | | | |

2016 Standard Benefit Plan Designs 9.5 EHB

Date: April 4617, 2015

| | hare amounts describe the En | rollee's out of pocket costs. | Gold Coinsurand | | Gold Copay P | lan |
|--|---|---------------------------------------|-------------------------------|-----------------------|-------------------------------|---------------------|
| Actuarial Value | e - AV Calculator | | 80.29 | 6 | 81.0% | |
| | cludes a deductible? | | No | | No | |
| | Individual deductible | | \$0 | | \$0 | |
| | Family deductible deductible, NOT integrated: I | Aedical / Pharmacy / Dental | \$0 \$0 / \$0 | / \$ 0 | \$0 \$0 / \$0 / | \$0 |
| Family ded | uctible, NOT integrated: Med | lical / Pharmacy / Dental | \$0 / \$0 / | | \$0 / \$0 / | |
| | -of-pocket maximum | | \$6,20 | | \$6,20 | |
| amily Out-of- | pocket maximum | | \$12,40 | 00 | \$12,40 | 0 |
| | only coverage deductible in: Individual deductible | | N/A N/A | | N/A N/A | |
| TOA Tallilly pla | in. marviduai deddetible | | N/A | | Tex | |
| Common Medical Event | Ser | vice Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductib Applies |
| | Primary care visit to treat an i | njury, illness, or condition | \$35 | | \$35 | |
| Health care provider's office or | Other practitioner office visit | | \$35 | | \$35 | |
| clinic visit | Specialist visit | | \$55 | | \$55 | |
| | Preventive care/ screening/ im | munization | No charge | | No charge | |
| | Laboratory Tests | | \$35 | | \$35 | |
| Tests | X-rays and Diagnostic Imagin | 9 | \$50 | | \$50 | |
| | Imaging (CT/PET scans, MRI | s) | 20% | | \$250 | |
| | Tier 1 | | \$15 | | \$15 | |
| Orugs to treat | Tier 2 | | \$50 | | \$50 | |
| Ilness or condition | Tier 3 | | \$70 | | \$70 | |
| | Tier 4 | | 20% up to \$500 per script | | 20% up to \$500 per script | |
| Duta et la uni | Surgery facility fee (e.g., ASC | | 20% | | \$600 | |
| Outpatient services | Physician/surgeon fees | | 20% | | \$55 | |
| TIUU3 | Outpatient visit | | 20% | | 20% | |
| | Emergency room facility fee (| vaived if admitted) | \$250 | | \$250 | |
| | Emergency room physician fe | e (waived if admitted) | 20% | | No charge | |
| Need | Emergency medical transport | \$250 | | \$250 | | |
| mmediate attention | Linergency medical transport | 20011 | \$250 | | \$250 | |
| | Urgent care | | \$60 | | \$60 | |
| Hospital stay | Facility fee (e.g. hospital room | 1) | 20% | | \$600 per day up to 5 days | |
| | Physician/surgeon fee | | 20% | | \$55 | |
| | Mental/Behavioral health outp | \$35 | | \$35 | | |
| | Mental/Behavioral health other outpatient items and services | | \$35 | | \$35 | |
| Mental health, | Mental/Behavioral health inpatient facility fee (e.g.hospital room) | | 20% | | \$600 per day up to 5 days | |
| nentai neatti, pehavioral | Mental/Behavioral health inpa | tient physician/surgeon fee | 20% | | \$55 | |
| health, or substance abuse needs | Substance Use disorder outpa | itient office visits | \$35 | | \$35 | |
| | Substance Use disorder other | outpatient items and services | \$35 | | \$35 | |
| | Substance Use inpatient facili | ty fee (e.g. hospital room) | 20% | | \$600 per day up | |
| | Substance use disorder inpati | | 20% | | to 5 days | |
| | · | ., | | | \$55 | |
| | Prenatal care and preconcept | on visits | No charge | | No charge | |
| Pregnancy | Delivery and all inpatient | Hospital | 20% | | \$600 per day up to 5 days | |
| | services | Professional | 20% | | \$55 | |
| | Home health care | | 20% | | \$30 | |
| łelp | Outpatient Rehabilitation services | | \$35 | | \$35 | |
| ecovering or | Outpatient Habilitation service | .s | \$35 | | \$35 \$300 per day up | |
| other special nealth needs | Skilled nursing care | | 20% | | to 5 days | |
| | Durable medical equipment | | 20% | | 20% | |
| | Hospice service Eye exam | | No charge No charge | | No charge | |
| Child eye are | 1 pair of glasses per year (or o | contact language in liqui of classes) | | | No charge | |
| ui C | | ornaci renses in neu di glasses) | No charge | | No charge | |
| Child Dental | Oral Exam Preventive - Cleaning | | 1 | | | |
| Diagnostic | Preventive - X-ray | | No. 6 | | Nac : | |
| ınd | Sealants per Tooth | | Not Covered | | Not Covered | |
| Preventive | Topical Fluoride Application Space Maintainers - Fixed | | 1 | | | |
| Child Dental | Amalgam Fill - 1 Surface | | Not Covered | | Not Covered | |
| Services | Root Canal- Molar | | | | Not Covered | |
| Child Dental | Gingivectomy per Quad | | 1 | | Not Covered Not Covered | |
| Major | Extraction- Single Tooth Expo | sed Root or Erupted | Not Covered | | Not Covered | |
| Services | Extraction- Complete Bony Porcelain with Metal Crown | | 4 | | Not Covered | |
| | · Grociani with Metal Crown | | | | Not Covered | |
| Child | | | | | | |

| Member Cost S | Benefits and Coverage hare amounts describe the Er | | Indiv | Plan |
|---|---|---|-------------------------------|------------------------|
| Actuarial Value | e - AV Calculator | | 70. | 4% |
| | cludes a deductible? | | Yes, Medica | |
| | Individual deductible Family deductible | | N. | |
| | | Medical / Pharmacy / Dental | \$2,250 / | |
| | uctible, NOT integrated: Me -of-pocket maximum | dical / Pharmacy / Dental | \$4,500 / : \$6,: | |
| Family Out-of- | pocket maximum | | \$12 | 500 |
| | only coverage deductible n: Individual deductible | | N. | |
| nort running plu | III III III III III III III III III II | | | ** |
| Common Medical Event | Se | rvice Type | Member Cost Share | Deductible Applies |
| Health care | Primary care visit to treat an | injury, illness, or condition | \$45 | |
| provider's office or clinic visit | Other practitioner office visit | | \$45 | |
| Cillic Visit | Specialist visit | | \$70 | |
| | Preventive care/ screening/ in Laboratory Tests | nmunization | No charge \$35 | |
| Tests | X-rays and Diagnostic Imagir | | \$65 | |
| | Imaging (CT/PET scans, MR | ls) | \$250 | |
| | Tier 1 | | \$15 | |
| Drugs to treat | Tier 2 | | \$50 | Pharmacy deductible |
| illness or condition | Tier 3 | | \$70 | Pharmacy deductible |
| | Tier 4 | | 20% up to \$500 per script | Pharmacy deductible |
| Outpatient | Surgery facility fee (e.g., ASC | 0) | 20% | |
| services | Physician/surgeon fees Outpatient visit | | 20% | |
| | Emergency room facility fee | (waived if admitted) | \$250 | Х |
| | | , | | |
| Need | Emergency room physician for | | \$50 | Х |
| immediate | Emergency medical transportation | | \$250 | X |
| attention | Urgent care | | \$90 | |
| Hospital stay | Facility fee (e.g. hospital roor | n) | 20% | Х |
| | Physician/surgeon fee | /surgeon fee | | Х |
| | Mental/Behavioral health outpatient office visits | | \$45 | |
| | Mental/Behavioral health other outpatient items and services | | \$45 | |
| | Mental/Behavioral health inpa | atient facility fee (e.g.hospital room) | 20% | Х |
| Mental health, behavioral | Mental/Behavioral health inpatient physician/surgeon fee | | 20% | х |
| health, or substance abuse needs | Substance Use disorder outpatient office visits | | \$45 | |
| | Substance Use disorder other outpatient items and services | | \$45 | |
| | Substance Use inpatient facil | ity fee (e.g. hospital room) | 20% | х |
| | Substance use disorder inpat | | 20% | х |
| | Prenatal care and preconcep | | No charge | |
| Pregnancy | Delivery and all inpatient | Hospital | 20% | × |
| | services | Professional | 20% | X |
| | Home health care | | \$45 | ., |
| Help | Outpatient Rehabilitation service Outpatient Habilitation service | | \$45 \$45 | |
| recovering or other special | Skilled nursing care | | 20% | X |
| health needs | | | 20% | ^ |
| | Durable medical equipment Hospice service | | No charge | |
| Child eye | Eye exam | | No charge | |
| care | | contact lenses in lieu of glasses) | No charge | |
| Child Dantal | Oral Exam Preventive - Cleaning | | | |
| Child Dental Diagnostic | Preventive - Cleaning Preventive - X-ray | | Nac : | |
| and | Sealants per Tooth | | Not Covered | |
| Preventive | Topical Fluoride Application Space Maintainers - Fixed | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | Not Covered | |
| OCI VICES | Root Canal- Molar | | | |
| Child Dental | Gingivectomy per Quad | and Death of France 1 | Nu O | |
| Major Services | Extraction- Single Tooth Exp Extraction- Complete Bony Porcelain with Metal Crown | osea Koot or Erupted | Not Covered | |
| Child | Medically necessary orthodor | | Not Covered | |

| Member Cost SI | Benefits and Coverage hare amounts describe the Enrollee's out of pocket costs. | Silv Coinsura | nce Plan | SHC Silve Copay | er Plan |
|--|---|-------------------------------|------------------------------------|-------------------------------|------------------------------------|
| | e - AV Calculator | 71. | 7% | 71.4 | % |
| | cludes a deductible? | Yes, Medica | | Yes, Medical | |
| | Individual deductible Family deductible | N/ | | N/A N/A | |
| | deductible, NOT integrated: Medical / Pharmacy / Dental | \$1,500 / \$ | | \$1,500 / \$ | |
| Family ded | uctible, NOT integrated: Medical / Pharmacy / Dental | \$3,000/\$ | 1,000 / \$0 | \$3,000 / \$1 | ,000 / \$0 |
| | -of-pocket maximum pocket maximum | \$6,8 \$13, | | \$6,50 \$13,0 | |
| ISA plan: Self- | -only coverage deductible | N/ | | N/A | |
| | n: Individual deductible | N/ | /A | N/A | ١ |
| 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 | \$45 | | \$45 | |
| lealth care provider's office or | Other practitioner office visit | \$45 | | \$45 | |
| clinic visit | Specialist visit | \$70 | | \$70 | |
| | Preventive care/ screening/ immunization | No charge | | No charge | |
| | Laboratory Tests | \$35 | | \$35 | |
| ests | X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) | \$65 20% | Х | \$65 \$250 | |
| | Tier 1 | \$15 | | \$15 | |
| | 11611 | 915 | D) | \$15 | - |
| liness or | Tier 2 | \$55 | Pharmacy deductible Pharmacy | \$55 | Pharmacy deductible Pharmacy |
| ondition | Tier 3 | \$75 | deductible | \$75 | deductible |
| | Tier 4 | 20% up to \$500 per script | Pharmacy deductible | 20% up to \$500 per script | Pharmacy deductible |
| Outpatient | Surgery facility fee (e.g., ASC) | 20% | | 20% | |
| ervices | Physician/surgeon fees Outpatient visit | 20% 20% | | 20% | |
| | Emergency room facility fee (waived if admitted) | \$250 | X | \$250 | Х |
| | | \$250 | ^ | \$250 | ^ |
| Need | Emergency room physician fee (waived if admitted) | \$50 | Х | \$50 | Х |
| mmediate | Emergency medical transportation | \$250 | Х | \$250 | Х |
| attention | Urgent care | \$90 | | \$90 | |
| lospital stay | Facility fee (e.g. hospital room) | 20% | Х | 20% | Х |
| | Physician/surgeon fee | 20% | Х | 20% | Х |
| | 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% | Х | 20% | Х |
| Mental health, behavioral | Mental/Behavioral health inpatient physician/surgeon fee | 20% | х | 20% | Х |
| nealth, 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/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 | |
| łelp | Outpatient Rehabilitation services | \$45 | | \$45 | |
| ecovering or | Outpatient Habilitation services | \$45 | | \$45 | |
| other special nealth needs | Skilled nursing care | 20% | Х | 20% | Х |
| | Durable medical equipment Hospice service | 20% | | 20% | |
| | Eye exam | No charge No charge | | No charge No charge | |
| Child eye are | 1 pair of glasses per year (or contact lenses in lieu of glasses) | No charge | | No charge | |
| | Oral Exam | 3- | | | |
| Child Dental | Preventive - Cleaning |] | |] | |
| Diagnostic and | Preventive - X-ray Sealants per Tooth | Not Covered | | Not Covered | |
| nd Preventive | Sealants per Tooth Topical Fluoride Application | | | 1 | |
| | Space Maintainers - Fixed | | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | Not Covered | | Not Covered | |
| | Root Canal- Molar | | | Not Covered | |
| Child Dental | Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted | Neco | | Not Covered | |
| Uniid Dental Major | | Not Covered | | Not Covered | |
| Major | | | | Not Covered | |
| | Extraction- Complete Bony Porcelain with Metal Crown | | | Not Covered Not Covered | |

| | f Benefits and Coverage Share amounts describe the Enrollee's out of pocket costs. | SHOF Silver HSA Pla | |
|--|--|---------------------------|--------------------|
| Actuarial Valu | e - AV Calculator | 70.5% | |
| | cludes a deductible? | Yes, integr | ated |
| | Individual deductible Family deductible | \$2,000 integ | |
| Individual | deductible, NOT integrated: Medical / Pharmacy / Dental | \$4,000 integ N/A | grated |
| Family dec | ductible, NOT integrated: Medical / Pharmacy / Dental | N/A | |
| | e-of-pocket maximum -pocket maximum | \$6,250 \$12,50 | |
| HSA plan: Self | f-only coverage deductible | \$2,000 |) |
| HSA family pla | an: Individual deductible | See endn | ote |
| | | | |
| Common Medical Event | Service Type | Member Cost Share | Deductible Applies |
| | | | |
| | Primary care visit to treat an injury, illness, or condition | 20% | Х |
| Health care | | | |
| provider's office or | Other practitioner office visit | 20% | х |
| clinic visit | <u> </u> | | |
| | Specialist visit | 20% | х |
| | Preventive care/ screening/ immunization | No charge | |
| | Laboratory Tests | 20% | Х |
| Tests | X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) | 20% | X |
| | Tier 1 | 20% | X |
| | Her 1 | 20% | Х |
| Drugs to treat | Tier 2 | 20% | Х |
| illness or | Tier 3 | 20% | х |
| condition | | 20 /0 | ^ |
| | Tier 4 | 20% | х |
| | Surgery facility fee (e.g., ASC) | 20% | X |
| Outpatient | Physician/surgeon fees | 20% | X |
| services | Outpatient visit | 20% | Х |
| | Emergency room facility fee (waived if admitted) | 20% | Х |
| | Emergency soon physician for (welved if admitted) | | |
| Need | Emergency room physician fee (waived if admitted) | 20% | X |
| immediate attention | Emergency medical transportation | 20% | Х |
| attention | University of the Control of the Con | | ., |
| | Urgent care | 20% | Х |
| | | | |
| Hospital stay | Facility fee (e.g. hospital room) | 20% | х |
| | Physician/surgeon fee | 20% | Х |
| | | | |
| | Mental/Behavioral health outpatient office visits | 20% | Х |
| | | | |
| | Mental/Behavioral health other outpatient items and services | 20% | × |
| | world// Denavioral realth office outpatient reins and services | 2076 | ^ |
| | Mental/Behavioral health inpatient facility fee (e.g.hospital room) | 20% | Х |
| Mental health. | | 2076 | ^ |
| behavioral | Mental/Behavioral health inpatient physician/surgeon fee | 20% | Х |
| health, or substance | | | |
| abuse needs | Substance Use disorder outpatient office visits | 20% | Х |
| | | | |
| | Substance Hee diseases other outset in the second and | | |
| | Substance Use disorder other outpatient items and services | 20% | Х |
| | | | |
| | Substance Use inpatient facility fee (e.g. hospital room) | 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 |
| og. ianoy | services | 20% | X |
| | Professional Home health care | 20% | X |
| Help | Outpatient Rehabilitation services | 20% | Х |
| recovering or | Outpatient Habilitation services | 20% | Х |
| other special | Skilled nursing care | 20% | х |
| health needs | Durable medical equipment | 20% | Х |
| | Hospice service Eye exam | 0% No charge | X |
| Child eye care | 1 pair of glasses per year (or contact lenses in lieu of glasses) | No charge | |
| | Oral Exam | 140 Glarge | |
| Child Dental | Preventive - Cleaning | | |
| | Preventive - X-ray | Not Covered | |
| | Sealants per Tooth Topical Fluoride Application | | |
| and | | 1 | |
| and | Space Maintainers - Fixed | | |
| and Preventive Child Dental Basic | | Not Covered | |
| and Preventive Child Dental Basic | Space Maintainers - Fixed Amalgam Fill - 1 Surface | Not Covered | |
| and Preventive Child Dental Basic Services | Space Maintainers - Fixed | Not Covered | |
| Diagnostic and Preventive Child Dental Basic Services Child Dental Major | Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted | Not Covered Not Covered | |
| and Preventive Child Dental Basic Services Child Dental | Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Ginglivectomy per Quad | | |
| and Preventive Child Dental Basic Services Child Dental Major | Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony | | |

| Months Cots Para amount decretche le Finders out of posite costs Months Cots Para Months Para Para Months Para | Summary of | Benefits and Coverage | | 011 | N | 0.11 | N |
|---|----------------------|--|--|--------------|-----------------|---------------|------------|
| Ministry and brothings of relative and relative tables No. | | | rollee's out of pocket costs. | 100%-150 | % FPL | 150%-200 | % FPL |
| Intergrated Invidual disclaration Invitation Invita | | | | | | | |
| Individuals deductible, NOT integrated: Bridge and Paramage / Dental \$75.56 / 16 / 20 / 20 / 20 / 20 / 20 / 20 / 20 / 2 | | | | | Pharmacy | | Pharmacy |
| Part | | | Modical / Pharmacy / Dontal | | . / \$ 0 | | |
| March Marc | Family ded | uctible, NOT integrated: Med | | \$150 / \$0 |) / \$0 | \$1,100 / \$1 | 00/\$0 |
| March Marc | | | | | | | |
| Member Cost Share Member Cost Share Member Cost Share Sh | HSA plan: Self | only coverage deductible | | N/A | | N/A | |
| Primary core visit to breat an injury, illness, or condition \$5 \$1 | HSA family pla | n: Individual deductible | | N/A | | N/A | |
| Control | | Se | rvice Type | | | | |
| Separation Sep | | Primary care visit to treat an i | njury, illness, or condition | \$5 | | \$15 | |
| Specialist visit | provider's office or | Other practitioner office visit | | \$5 | | \$15 | |
| Care | Cimic Visit | | | | | | |
| Tests Marging Sample S | | | nmunization | | | | |
| Time 1 | Tests | X-rays and Diagnostic Imagin | | \$8 | | \$25 | |
| Drugs to trees S10 | | | S) | | | | |
| Drugs to treat | | 114. 1 | | \$3 | | \$5 | Dhama |
| Tier 3 Singery facility fee (e.g., ASC) Physicanosusyens fees Outpatients services Surgery facility fee (e.g., ASC) Physicanosusyens fees Outpatient services Emergency room facility fee (waived if admitted) Singery facility fee (e.g., ASC) Physicanosusyens fees Outpatient services Emergency room facility fee (waived if admitted) Singery facility fee (e.g., fees) Emergency room facility fee (waived if admitted) Emergency room facility fee (waived if admitted) Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitt | | Tier 2 | | \$10 | | \$20 | deductible |
| Outpatient sortices Outpatient sortices Outpatient sortices Outpatient sortices Physicians/support facility fee (e.g. ASC) Physicians/support fees 10% Physicians/support fees 10% 11% 11% 11% 11% 11% 11% 11% 11% 11% | | Tier 3 | | | | \$35 | |
| Services Opposited Physician/surgeon fees | | | | per script | | per script | |
| Comparison Com | | | | | | | |
| Emergency room physician fee (waived if admitted) \$25 | services | Physician/surgeon rees | | | | | |
| Immediate attention Covered Child Dental Covered Covered Covered Child Dental Child Dental Covered Child Dental Covered Child Dental Covered Child Dental Child D | | Emergency room facility fee (| waived if admitted) | \$30 | Х | \$75 | Х |
| Immediate attention Covered Child Dental Covered Covered Covered Child Dental Child Dental Covered Child Dental Covered Child Dental Covered Child Dental Child D | | Emergency room physician fe | e (waived if admitted) | \$25 | X | \$40 | x |
| Hospital stay Physician/surgeon fee | | | | | | | |
| Hospital stay Practicular Surgeon fee Mental/Behavioral health outpatient office visits Mental/Behavioral health outpatient office visits Mental/Behavioral health outpatient items and services Mental/Behavioral health inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient physician/surgeon fee 10% Mental/Behavioral health inpatient physician/surgeon fee 10% X 15% X 15% X 15% X 15% X 15% Substance Use disorder outpatient items and services Substance Use disorder outpatient items and services Substance Use disorder outpatient items and services Substance Use disorder inpatient physician/surgeon fee 10% X 15% X | | | | Ç | | ψ.σ | ~ |
| Mental/Behavioral health outpatient office visits Mental/Behavioral health 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 facility fee (e.g. hospital room) Mental/Behavioral health inpatient physician/surgeon fee 10% X 15% X Mental/Behavioral health inpatient physician/surgeon fee 10% X 15% X Substance Substance Use disorder outpatient office visits Substance Use disorder outpatient office visits Substance Use disorder other outpatient items and services Substance Use disorder inpatient facility fee (e.g. hospital room) Substance use disorder inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee 10% X 15% X 15% X Prenatal care and preconception visits No charge Pregnancy Delivery and all inpatient services Pregnancy Delivery and all inpatient services Professional Hospital Home health care Outpatient Rehabilitation services Substance Use disorder inpatient physician/surgeon fee 10% X 15% X 1 | | Urgent care | | \$6 | | \$30 | |
| Mental/Behavioral health 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 outpatient office visits Substance Use disorder outpatient items and services Substance Use disorder inpatient facility fee (e.g. hospital room) Substance Use disorder inpatient physician/surgeon fee Pregnancy Pregnancy Delivery and all inpatient services Pregnancy Delivery and all inpatient services Mental/Behavioral health inpatient physician/surgeon fee Holp recovering or outpatient Rehabilitation services Substance Use disorder inpatient physician/surgeon fee Hospital 10% X 15% X 15% X Pregnancy Delivery and all inpatient services Mental/Behavioral health inpatient physician/surgeon fee Hospital physician/surgeon fee Hospital physician/surgeon fee Mocharge No charge N | Hospital stay | | n) | | | | |
| 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 10% X 15% X 15% X 15% X 15% X 15% X Substance Use disorder outpatient office visits Substance Use disorder outpatient office visits Substance Use disorder outpatient office visits Substance Use disorder orther outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) 10% X 15% X Substance Use inpatient facility fee (e.g. hospital room) 10% X 15% X 15% X Pregnancy Pregnancy Pregnancy Delivery and all inpatient Hospital Services Home health care and preconception visits No charge Professional 10% X 15% X 1 | | Physician/surgeon fee | | 10% | X | 15% | X |
| Mental/Behavioral health inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient physician/surgeon fee abuse needs Substance Use disorder outpatient office visits Substance Use disorder outpatient items and services Substance Use disorder outpatient items and services Substance Use disorder outpatient items and services Substance Use disorder inpatient physician/surgeon fee 10% X 15% X Substance Use disorder inpatient physician/surgeon fee 10% X 15% X Substance use disorder inpatient physician/surgeon fee 10% X 15% X Pregnancy Pregnancy Pregnatic care and preconception visits No charge No charge Pregnancy Pregna | | Mental/Behavioral health outp | atient office visits | \$5 | | \$15 | |
| Mental health, behavioral health inpatient physician/surgeon fee 10% X 15% X 15% X 15% Stance hause needs Substance Use disorder outpatient office visits S5 S15 S15 Substance Use disorder other outpatient items and services S5 S15 Substance Use disorder other outpatient items and services S5 S15 Substance Use disorder other outpatient items and services S5 S15 Substance Use disorder inpatient physician/surgeon fee 10% X 15% X X Substance use disorder inpatient physician/surgeon fee 10% X 15% X X Substance use disorder inpatient physician/surgeon fee 10% X 15% X X Substance use disorder inpatient physician/surgeon fee 10% X 15% X X Substance use disorder inpatient physician/surgeon fee 10% X 15% X X X X X X X X X | | Mental/Behavioral health othe | r outpatient items and services | \$5 | | \$15 | |
| Mental/Behavioral health inpatient physician/surgeon fee hoalth, or substance abuse needs Substance Use disorder outpatient office visits S5 S15 S15 Substance Use disorder outpatient items and services S5 S15 S15 Substance Use disorder outpatient items and services S5 S15 S15 Substance Use inpatient facility fee (e.g. hospital room) 10% X 15% X X Substance use disorder inpatient physician/surgeon fee 10% X 15% X X X X X X X X X | | Mental/Behavioral health inpa | tient facility fee (e.g.hospital room) | 10% | х | 15% | Х |
| Substance Use disorder outpatient office visits Substance Use disorder other outpatient items and services Substance Use disorder inpatient physician/surgeon fee Pregnancy Pregnancy Pregnancy Pregnancy Delivery and all inpatient Hospital 10% X 15% X Delivery and all inpatient Hospital 10% X 15% X Professional 10% X 15% X Home health care Outpatient Rehabilitation services \$5 \$15 Outpatient Rehabilitation services \$5 \$15 Substance use disorder inpatient Hospital 10% X 15% X A 15% | | Mental/Behavioral health inpa | tient physician/surgeon fee | 10% | х | 15% | х |
| Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Pregnancy Pregnancy Delivery and all inpatient services Delivery and all inpatient Hospital Delivery and all inpatient All 15% Delivery and all inpatient Hospital Delivery and all inpatient Most All 15% Delivery and and inpatient Hospital Delivery and and inpatient Hospital Delivery and and inpatient Hospital | substance | Substance Use disorder outpa | atient office visits | \$5 | | \$15 | |
| Substance use disorder inpatient physician/surgeon fee 10% X 15% X Pregnancy Pregnancy Delivery and all inpatient services Professional 10% X 15% X 15% X 15% X 15% X 15% X Unpatient Habilitation services SS \$15 Outpatient Rehabilitation services SS \$15 Skilled nursing care Outpatient Rehabilitation services SS \$15 Skilled nursing care Durable medical equipment Hospice service No charge Oral Exam Preventive Cleaning Preventive Cleaning Preventive Cleaning Preventive Cleaning Preventive Cleaning Preventive Cleaning Preventive Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Services Root Canal-Molar Gingivectomy per Quad Extraction-Single Tooth Exposed Root or Erupted Services Services Services Not Covered Services Services Not Covered | | Substance Use disorder other | outpatient items and services | \$5 | | \$15 | |
| Pregnancy Pregnancy Delivery and all inpatient services Professional Delivery and all inpatient services Delivery and and services Delivery and all inpatient services Delivery and and se | | Substance Use inpatient facili | ty fee (e.g. hospital room) | 10% | Х | 15% | х |
| Pregnancy Pregnancy Delivery and all inpatient services Professional Delivery and all inpatient services Delivery and and services Delivery and all inpatient services Delivery and and se | | Substance use disorder inpati | ent physician/surgeon fee | 10% | х | 15% | х |
| Pregnancy Delivery and all inpatient services Hospital 10% X 15% X | | | | No charge | | No charge | |
| Help Help Outpatient Rehabilitation services Help Tecovering or other special Skilled nursing care Hother special Relations of the special Relations of the special Relations of the special Realth needs White Relations of the special Relations of | Pregnancy | | Hospital | 10% | х | 15% | х |
| Help recovering or outpatient Rehabilitation services \$5 \$15 \$15 Outpatient Habilitation services \$5 \$15 \$15 S15 S15 S15 S15 S15 S15 S15 S15 S15 S | | | Professional | | Х | | Х |
| Outpatient Habilitation services cher special health needs Skilled nursing care Durable medical equipment Hospice service Child eye care Child Dental Diagnostic and Preventive - Cleaning Not cleaning Not Covered | | | ices | | | | |
| other special health needs health needs Durable medical equipment Hospice service Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) Child Dental Preventive - Cleaning Diagnostic and Sealants per Tooth Preventive Child Dental Basic Amalgam Fill - 1 Surface Rot Canal- Molar Child Dental Basic Services Rot Coored Not Covered | | | | | | | |
| Durable medical equipment Hospice service No charge No c | other special | - | | 10% | Х | 15% | Х |
| Child eye care | nearth needs | | | | | | |
| Child Dental Dental Preventive - Cleaning Diagnostic Preventive - Cleaning Diagnostic Di | Child eve | | | | | | |
| Child Dental Preventive - Cleaning Preventive - Cleaning Preventive - X-ray Sealants per Tooth Space Maintainers - Fixed Space Maintainers - Fixed Not Covered Services Child Dental Space Services Servic | | 1 pair of glasses per year (or | contact lenses in lieu of glasses) | | | | |
| Diagnostic and Preventive - X-ray Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed Services Root Canal - Molar Covered Not Covered Not Covered Not Covered Not Covered Services Root Canal - Molar Covered Not Covered Not Covered Services Patraction - Complete Bony Procelain with Metal Crown Child Medically seems any orthodoxies Not Covered Not Covered Not Covered Services Proceeding with Metal Crown Not Covered N | Ohilla E | | | | | | |
| and Sealants per Tooth Not Covered Not Covered Not Covered Space Maintainers - Fixed Not Covered Not Covered Services Root Canal- Molar Child Dental Major Extraction- Single Tooth Exposed Root or Erupted Not Covered Services Extraction- Complete Bony Porcelain with Metal Crown Child Medically species are visible of the Covered Not Covered Not Covered Services Porcelain with Metal Crown Not Covered N | | | | No. Occurred | | Net O | |
| Child Dental Basic Amalgam Fill - 1 Surface Not Covered Not Covered Not Covered Not Covered Services Child Dental Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Not Covered Services Extraction- Complete Bony Porcelain with Metal Crown Child Medically seeess as a strong or surfaced on the covered Service Services Servi | and | Sealants per Tooth Topical Fluoride Application | | INUL Covered | | Not Covered | |
| Root Canal- Molar Child Dental Gingivectomy per Quad Major Extraction- Single Tooth Exposed Root or Erupted Not Covered Services Extraction- Complete Bony Porcelain with Metal Crown Child Medically seeess as orthodoxtics | | | | Not Covered | | Not Covered | |
| Child Dental Gingivectomy per Quad Major Extraction- Single Tooth Exposed Root or Erupted Not Covered Not Covered Services Extraction- Complete Bony Porcelain with Metal Crown Child Medically necessary orthodoxtics Not Covered N | Services | Root Canal- Molar | | | | | |
| Services Extraction- Complete Bony Porcelain with Metal Crown Child Medically necessary orthodontics Not Counted Not Counted | | Gingivectomy per Quad | | | | | |
| Porcelain with Metal Crown Child Medically peressary orthodontics Not Counted Not Counted | | | sed Root or Erupted | Not Covered | | Not Covered | |
| | | Porcelain with Metal Crown | | | | | |
| | | Medically necessary orthodon | tics | Not Covered | | Not Covered | |

| Member Cost S | hare amounts describe the Er | nrollee's out of pocket costs. | Silver F 200%-250 | |
|---|---|---|-------------------------------|----------------------|
| Actuarial Value | e - AV Calculator | | 72.89 | |
| Plan design in | cludes a deductible? | | Yes, Medical/I | Pharmacy |
| | Individual deductible | | N/A | |
| | Family deductible deductible. NOT integrated: | Medical / Pharmacy / Dental | N/A \$1,900 / \$2 | 50 / \$0 |
| Family ded | uctible, NOT integrated: Me | | \$3,800 / \$5 | 00 / \$0 |
| Individual Out- Family Out-of- | -of-pocket maximum pocket maximum | | \$5,45 \$10,90 | |
| HSA plan: Self | -only coverage deductible | | N/A | |
| HSA family pla | n: Individual deductible | | N/A | |
| Common Medical Event | Se | ervice Type | Member Cost Share | Deductibl Applies |
| Health care | Primary care visit to treat an | injury, illness, or condition | \$40 | |
| provider's office or clinic visit | Other practitioner office visit | | \$40 | |
| Cillic Visit | Specialist visit | | \$55 | |
| | Preventive care/ screening/ in | mmunization | No charge | |
| Tests | Laboratory Tests X-rays and Diagnostic Imagin | ng | \$35 \$50 | |
| | Imaging (CT/PET scans, MR | | \$250 | |
| | Tier 1 | | \$15 | |
| Drugs to treat | Tier 2 | | \$45 | Pharmac deductibl |
| illness or condition | Tier 3 | | \$70 | Pharmac deductibl |
| | Tier 4 | | 20% up to \$500 per script | Pharmac deductibl |
| Outpatient | Surgery facility fee (e.g., ASC Physician/surgeon fees | C) | 20% 20% | |
| services | Outpatient visit | | 20% | |
| | Emergency room facility fee | (waived if admitted) | \$250 | Х |
| | Emergency room physician f | ee (waived if admitted) | \$50 | Х |
| Need immediate | Emergency medical transpor | <u> </u> | \$250 | X |
| attention | Urgent care | | \$80 | |
| Hospital stay | Facility fee (e.g. hospital room | m) | 20% | Х |
| | Physician/surgeon fee | | 20% | X |
| | Mental/Behavioral health out | patient office visits | \$40 | |
| | Mental/Behavioral health oth | \$40 | | |
| | Mental/Behavioral health inpa | atient facility fee (e.g.hospital room) | 20% | х |
| Mental health, | Mental/Behavioral health inpa | atient physician/surgeon fee | 20% | Х |
| behavioral health, or substance | Substance Use disorder outp | \$40 | ^ | |
| abuse needs | | | \$10 | |
| | Substance Use disorder other | er outpatient items and services | \$40 | |
| | Substance Use inpatient faci | lity fee (e.g. hospital room) | 20% | Х |
| | Substance use disorder inpar | tient physician/surgeon fee | 20% | Х |
| | Prenatal care and preconcep | tion visits | No charge | |
| Pregnancy | Delivery and all inpatient | Hospital | 20% | Х |
| | services | Professional | 20% | Х |
| | Home health care Outpatient Rehabilitation ser | vinge | \$40 \$40 | |
| Help recovering or | Outpatient Habilitation service | | \$40 | |
| other special | Skilled nursing care | | 20% | х |
| health needs | Durable medical equipment | | 20% | |
| | Hospice service Eye exam | | No charge | |
| Child eye care | | contact lenses in lieu of glasses) | No charge | |
| Care | Oral Exam | contact lenses in fied or glasses) | No charge | |
| Child Dental | Preventive - Cleaning | | | |
| Diagnostic | Preventive - X-ray | | Not Covered | |
| and Preventive | Sealants per Tooth Topical Fluoride Application | | | |
| | Space Maintainers - Fixed | | | |
| Child Dental Basic Services | Amalgam Fill - 1 Surface | | Not Covered | |
| | Root Canal- Molar | | | |
| Child Dental Major | Gingivectomy per Quad Extraction- Single Tooth Exp | osed Root or Frunted | Not Covered | |
| Services | Extraction- Complete Bony | | 2070100 | |
| | Porcelain with Metal Crown | | | |
| Child Orthodontics | Medically necessary orthodo | ntics | Not Covered | |
| | | | | |

| Summary | of Ranafit | s and Cove | rana |
|---------|------------|------------|------|

| | Benefits and Coverage | | D | ranna Dian | Bron | ze |
|---|--|--|--|--|--|------------|
| | hare amounts describe the En | rollee's out of pocket costs. | В | 61.2% | HSA P | |
| | cludes a deductible? | | Yes | s, integrated | Yes, integ | |
| Integrated | Individual deductible Family deductible | | \$6,500 integrated \$13,000 integrated | | \$4,500 integrated \$9,000 integrated | |
| Individual o | deductible, NOT integrated: | Medical / Pharmacy / Dental | N/A | | N/A | |
| | uctible, NOT integrated: Med | dical / Pharmacy / Dental | | N/A \$6,500 | N/A \$6,50 | |
| Family Out-of- | pocket maximum -only coverage deductible | | | \$13,000 N/A | \$13,0 \$4,50 | 00 |
| HSA family pla | n: Individual deductible | | | N/A | \$4,50 | |
| Common | | | Member Cost | | Member Cost | Deductible |
| Medical Event | | rvice Type | Share | Deductible Applies After 1st three non- | Share | Applies |
| Health care | Primary care visit to treat an | njury, illness, or condition | \$70 | preventive visits | 40% | Х |
| provider's office or clinic visit | Other practitioner office visit | | \$70 | After 1st three non- preventive visits | 40% | Х |
| | Specialist visit | | \$90 | After 1st three non- preventive visits | 40% | Х |
| | Preventive care/ screening/ in Laboratory Tests | nmunization | No charge \$40 | | No charge 40% | X |
| Tests | X-rays and Diagnostic Imagir | 9 | 0% | Х | 40% | X |
| | Imaging (CT/PET scans, MRI | s) | 0% | X Dadweiblaue to \$500 | 40% | X |
| | Tier 1 | | 0% | Deductible up to \$500 maximum per script | 40% | Х |
| Drugs to treat illness or | Tier 2 | 0% | Deductible up to \$500 maximum per script | 40% | Х | |
| condition | Tier 3 | | 0% | Deductible up to \$500 maximum per script | 40% | Х |
| | Tier 4 | | 0% | Deductible up to \$500 maximum per script | 40% | х |
| Outpatient | Surgery facility fee (e.g., ASC |) | 0% 0% | X | 40% 40% | X |
| services | Physician/surgeon fees Outpatient visit | | 0% | X | 40% | X |
| | Emergency room facility fee (| waived if admitted) | 0% | х | 40% | Х |
| | Emergency room physician fe | ee (waived if admitted) | 0% | х | 40% | х |
| Need | Emergency medical transport | | 0% | X | 40% | X |
| immediate attention | Urgent care | | \$120 | After 1st three non- preventive visits | 40% | x |
| | Facility fee (e.g. hospital room | n) | 0% | X | 40% | Х |
| Hospital stay | Physician/surgeon fee | | 0% | X | 40% | Х |
| | Mental/Behavioral health outp | vatient office visits | \$70 | After 1st three non- preventive visits | 40% | х |
| | Mental/Behavioral health other | er outpatient items and services | \$70 | After 1st three non- preventive visits | 40% | х |
| Mental health, | Mental/Behavioral health inpa | tient facility fee (e.g.hospital room) | 0% | х | 40% | Х |
| behavioral | Mental/Behavioral health inpa | tient physician/surgeon fee | 0% | Х | 40% | Х |
| health, or substance abuse needs | Substance Use disorder outpatient office visits | | \$70 | After 1st three non- preventive visits | 40% | х |
| | Substance Use disorder other | e Use disorder other outpatient items and services | | After 1st three non- preventive visits | 40% | х |
| | Substance Use inpatient facil | ty fee (e.g. hospital room) | 0% | х | 40% | Х |
| | Substance use disorder inpat | | 0% | х | 40% | х |
| | Prenatal care and preconcept | | No charge | | No charge | |
| Pregnancy | Delivery and all inpatient | Hospital | 0% | х | 40% | х |
| | services | Professional | 0% | X | 40% | Х |
| | Home health care | | 0% | X | 40% | Х |
| Help | Outpatient Rehabilitation service Outpatient Habilitation service | | \$70 \$70 | | 40% 40% | X |
| recovering or other special | Skilled nursing care | | 0% | х | 40% | X |
| health needs | Durable medical equipment | | 0% | X | 40% | X |
| | Hospice service | | No charge | | 0% | X |
| Child eye | Eye exam | | No charge | | No charge | |
| care | 1 pair of glasses per year (or | cornact ienses in lieu of glasses) | No charge | | No charge | |
| Child Dental | Oral Exam Preventive - Cleaning | | | | 1 | |
| Diagnostic | Preventive - X-ray | | Not Covered | | Not Covered | |
| and Preventive | Sealants per Tooth Topical Fluoride Application | | | | | |
| Child Dental Basic | Space Maintainers - Fixed Amalgam Fill - 1 Surface | | Not Covered | | Not Covered | |
| Services | Root Canal- Molar | | | | | |
| Child Dental | Gingivectomy per Quad | | 1 | | 1 | |
| Major Services | Extraction- Single Tooth Expo Extraction- Complete Bony Porcelain with Metal Crown | sed Root or Erupted | Not Covered | | Not Covered | |
| Child | | | | | | |

| | hare amounts describe the En | rollee's out of pocket costs. | Catastro | ohic Plan |
|--|--|--|--------------------------|---------------------------------------|
| | e - AV Calculator | | | |
| | cludes a deductible? Individual deductible | | Yes, int | |
| | Family deductible | | \$6,850 ir \$13,700 i | |
| Individual o | leductible, NOT integrated: I | Medical / Pharmacy / Dental | N _i | 'A |
| Family ded | uctible, NOT integrated: Med | lical / Pharmacy / Dental | N. | |
| ndividual Out- | -of-pocket maximum pocket maximum | | \$6,8 \$13 | 700 |
| -amily Out-of- -IS∆ nlan: Self | ocket maximum only coverage deductible | | \$13. N | |
| HSA family pla | n: Individual deductible | | N. | |
| | | | | |
| Common Medical Event | Ser | vice Type | Member Cost Share | Deductible Applies |
| | Primary care visit to treat an i | njury, illness, or condition | 0% | After 1st three non-preventive visits |
| Health care provider's office or clinic visit | Other practitioner office visit | | 0% | After 1st three non-preventive visits |
| omine visit | Specialist visit | | 0% | х |
| | Preventive care/ screening/ im | munization | No charge | |
| Tanto | Laboratory Tests | ~ | 0% | X |
| Tests | X-rays and Diagnostic Imagin | | 0% | X |
| | Imaging (CT/PET scans, MRI: | 5) | 0% | |
| | Tier 1 | | 0% | Х |
| | Tier 2 | | 0% | Х |
| Drugs to treat illness or condition | Tier 3 | | 0% | X |
| onuidon | Tier 4 | | 0% | X |
| | | | | |
| Surgery facility fee (e.g., ASC) | | | 0% | X |
| services | Physician/surgeon fees | | 0% | X |
| | Outpatient visit | | 0% | X |
| | Emergency room facility fee (| | 0% | Х |
| Need immediate | Emergency room physician fe | 0% | Х | |
| | Emergency medical transportation | | 0% | Х |
| attention | Urgent care | | 0% | After 1st three non-preventive visits |
| Hospital stay | Facility fee (e.g. hospital room | n) | 0% | х |
| | Physician/surgeon fee | | 0% | X |
| | Mental/Behavioral health outpatient office visits | | 0% | After 1st three non-preventive visits |
| | Mental/Behavioral health other outpatient items and services | | 0% | After 1st three non-preventive visits |
| Mental health, | Mental/Behavioral health inpa | tient facility fee (e.g.hospital room) | 0% | х |
| behavioral | Mental/Behavioral health inpa | tient physician/surgeon fee | 0% | х |
| health, or substance abuse needs | 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 |
| | Substance Use inpatient facili | ty fee (e.g. hospital room) | 0% | х |
| | Substance use disorder inpati | ent physician/surgeon fee | 0% | х |
| | Prenatal care and preconcepti | on visits | No charge | |
| Pregnancy | Delivery and all inpatient | Hospital | 0% | Х |
| | services | | | |
| | Home health care | Professional | 0% | X |
| | Outpatient Rehabilitation serv | ices | 0% | X |
| Help recovering or | Outpatient Habilitation service | | 0% | X |
| ecovering or other special | Skilled nursing care | | 0% | х |
| nealth needs | - | | | |
| | Durable medical equipment Hospice service | | 0% | X |
| Shilled asset | Eye exam | | No charge | ^ |
| Child eye care | 1 pair of glasses per year (or o | contact lenses in lieu of alseese) | 0% | х |
| | | | 0,0 | |
| Child Dental | Oral Exam Preventive - Cleaning | | 1 | |
| Diagnostic | Preventive - X-ray | | Not C | |
| and | Sealants per Tooth | | Not Covered | |
| Preventive | Topical Fluoride Application | | | |
| Child Dental Basic | Space Maintainers - Fixed Amalgam Fill - 1 Surface | | Not Covered | |
| Services | | | | |
| Child Dental Major Services | Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Expo Extraction- Complete Bony | sed Root or Erupted | Not Covered | |
| Porcelain with Metal Crown | | | | |
| Child | Medically necessary orthodon | siaa | Not Covered | |

Endnotes to 2016 Standard Benefit Plan Designs

Notes:

- Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. Innetwork services include services provided by an out-of-network provider but are approved as in-network by the carrier.
- 2) For covered out of network services in a PPO plan, these Standard Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
- 3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
- 4) For <u>all</u> plans <u>except including</u> HDHPs linked to HSA plans, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the carrier pays all costs for covered services for all family members.
- 5) For HDHPs linked to HSAs, in other than self-only coverage, <u>an individual's payment toward a deductible</u>, if required, must be the higher of the specified <u>deductible amount for individual coverage or the each individual in the family</u> individual minimum deductible amount established by the Internal Revenue Service for the applicable Plan Year. <u>In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.</u>
- 6) Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the \$45 copayment, the lesser amount is the applicable cost-sharing amount.
- 7) For the Bronze and Catastrophic plans, the deductible is waived for the first three non-preventive visits, which may include urgent care visits or outpatient Mental Health/Substance Use Disorder visits.
- 8) Member cost-share for oral anti-cancer drugs shall not exceed \$200 per month per state law.
- 9) In the Platinum and Gold Copay Plans, inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of a continuous stay.
- 10) For drugs to treat an illness or condition_the copay or co-insurance applies to the prescription supply. For example, if the prescription is for a month's supply, one co-pay or co-insurance can be collected. If the prescription is written for a 90 day supply, a single cost-share amount applies. Nothing in this note precludes a carrier from offering mail order prescriptions at a reduced cost.

- 11) As applicable, for the child dental portion of the benefit design, a carrier may choose the copay or coinsurance child dental Standard Benefit Plan Design, regardless of whether the carrier selects the copay or the coinsurance design for the non-child dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.
- 12) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Standard Benefit Plan Designs.
- 13) Mental Health/Substance Use Disorder Outpatient Items and Services include post-discharge ancillary care services, such as counseling and other outpatient support services, which may be provided as part of the offsite recovery component of a residential treatment plan.
- 14) Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
- 15) Specialists include physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate (28 CCR § 1300.51(I)(1)).
- 16) The Other Practitioner category includes Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors and other practitioners included in 28 CCR § 1300.67(a)(1).
- 17) The Outpatient Visit line item within the Outpatient Services category includes but is not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.
- 18) Cost-sharing for services subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) may be less than those listed in these standard benefit plan designs if necessary for compliance with MHPAEA.
- 19) Drug tiers are defined as follows:

| Tier | Definition |
|------|---|
| 1 | 1) Most generic drugs and low cost preferred brands. |
| | 1) Non-preferred generic drugs or; |
| | 2) Preferred brand name drugs or; |
| 2 | 3) Recommended by the plan's pharmaceutical and |
| | therapeutics (P&T) committee based on drug safety, efficacy |
| | and cost. |

| | 1) Non-preferred brand name drugs or; |
|---|---|
| | 2) Recommended by P&T committee based on drug safety, |
| 3 | efficacy and cost or; |
| | 3) Generally have a preferred and often less costly |
| | therapeutic alternative at a lower tier. |
| | 1) Food and Drug Administration (FDA) or drug |
| | manufacturer limits distribution to specialty pharmacies or; |
| 4 | 2) Self administration requires training, clinical monitoring or; |
| | Drug was manufactured using biotechnology or; |
| | 4) Plan cost (net of rebates) is >\$600. |

- 20) If a drug would otherwise qualify for placement on tier 4 and at least 3 treatment options are available for that particular condition as determined by either a plan's pharmaceutical and therapeutics (P&T) committee or indicated by the Food and Drug Administration (FDA) or according to applicable treatment guidelines for that condition, one drug used to treat that condition must be placed on either tier 1, 2 or 3. Plan formularies must include at least one drug in Tiers 1 or 2 or 3 if all FDA-approved drugs in the same drug class would otherwise qualify for Tier 4 and at least 3 drugs in that class are available as FDA-approved drugs.
- 21) All drugs covered in tier 4 must be expressly listed in the plan's formulary. All drugs placed in tiers 1 through 3 to treat the following conditions must be expressly listed in the plan's formulary: HIV/AIDs, hepatitis C, rheumatoid arthritis, multiple sclerosis, systemic lupus erythematosus. Issuers must comply with 45 CFR Section 156.122(d) dated February 27, 2015 which requires the health plan to publish an up-to-date, accurate and complete list of all covered drugs on its formulary list including any tiering structure that is adopted.
- 22) A plan's formulary must include a statement that other drugs that are covered may not be listed on the formulary for tiers 1-3.
- 2322) A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary.
- 23) For 2016, a carrier may offer a plan with two in-network facility tiers if the lowest-cost tier network (Tier 1), complies with the cost-sharing requirements in the standard benefit plan design, meets state network adequacy and timeliness standards as applied by the applicable regulator and the carrier demonstrates that the two in-network facility tiers are in the best interest of the consumer as determined by Covered California on a case-by-case basis, based on premium stability, price, quality, choice and value. For non-Qualified Health Plans, the applicable regulator will review.

24) When a pharmacy deductible applies to a Tier 4 drug script, the maximum cost-sharing paid for that script shall not exceed the stated cap inclusive of the pharmacy deductible. For example, in the Silver plans where the pharmacy deductible is \$250 and the per script Tier 4 cap is up to \$500, application of the co-insurance cost-share cannot result in more than \$500 out of pocket cost for that script.



2016 Dental Standard Benefit Plan Designs

Date: April 1617, 2015

| Summary of Benefits | Standalone <u>C</u> Dental I | | Standalone Children's Dental Plan | | |
|--|--|--------------------------------------|-----------------------------------|--|-----------------------|
| Member Cost Share amounts describe the Enrollee's out of pocket costs. | | t Pediatric Dental EHB Copay Plan | | Pediatric Dental EHB Coinsurance Plan | |
| | | Up to Ag | je 19 | Up to Aç | je 19 |
| Actuarial Value | | 83.09 | % | 86.89 | 6 |
| Individual Deductible (waived for Diagnostic & Preventive) | | \$0 | | \$65 In Ne \$65 Out of I | |
| Family Deductible (Two of waived for Diagnostic & | Preventive) | \$0 | | \$130 In Ne \$130 Out of | |
| Individual Out of Pocket | | \$350 | | \$350 | |
| | ximum (Two or More Children) | \$700 \$0 |) | \$700 |) |
| | Office Copay | | | \$0 | |
| Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d) | | None | | None | |
| Annual Benefit Limit (the maximum amount the dental | plan will pay in the benefit year) | None | Э | None | Э |
| Procedure Category | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
| | Oral Exam | \$0 | | 0% | |
| | Preventive - Cleaning | \$0 | | 0% | |
| Diagnostic & Preventive | Preventive - X-ray | \$0 | | 0% | |
| | Sealants per Tooth | \$0 | | 0% | |
| | Topical Fluoride Application | \$0 | | 0% | |
| | Space Maintainers - Fixed | \$0 | | 0% | |
| Basic Services | Amalgam Fill - One Surface | \$25 | | 20% | X |
| Major Services - Crowns | Root Canal - Molar Gingivectomy per Quad | \$300 \$150 | | | |
| and Casts, Endodontics, Periodontics, Prosthodontics, Oral | Extraction- Single Tooth Exposed Root or Erupted | \$65 | | 50% | х |
| Surgery | Extraction - Complete Bony | \$160 | | | |
| | Crown - Porcelain with Metal | \$300 | | | |
| Orthodontia | Medically Necessary Orthodontia | \$350 | | 50% | Х |

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Standalone Dental Plan or Family Dental Plan)

- 1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.
- Cost sharing payments made by each individual child for innetwork services accrue to the child's out-of-pocket maximum.
 Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
 In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to
- made by each individual child for in-network services contribute the family deductible, if applicable, as well as the family out-of-pocket maximum.
- 4) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.

Adult Dental Benefit Notes (only applicable to the Family Dental Plan)

- 5) Each adult is responsible for an individual deductible.
- 6) Families eligible to purchase a Family Dental Plan must include at least one adult who has purchased a Qualified Health Plan through the Exchange.
- 7) If a child is enrolled in the Family Dental Plan, all children in the family under age 19 years must be enrolled in the same Family Dental Plan.
- 8) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.



2016 Dental Standard Benefit Plan Designs

Date: April 1617, 2015

| Summary of Benefits and Coverage | | Family Dental Plan | | | | |
|--|--|------------------------------------|-----------------------|----------------------------|-----------------------|--|
| Member Cost Share amounts describe the Enrollee's out of pocket costs. | | Pediatric Dental EHB Copay Plan | | Adult Dental Copay Plan | | |
| | | Up to Age 19 | | Age 19 and Older | | |
| Actuarial Value | | 83.0% | | Not Calculated | | |
| Individual Deductible (waived for Diagnostic & Preventive) | | \$0 | | \$0 | | |
| Family Deductible (Two or more children) (waived for Diagnostic & Preventive) | | \$0 | | \$0 | | |
| Individual Out of Pocket Maximum | | \$350 | | Not Applicable | | |
| Family Out of Pocket Maximum (Two or More Children) | | \$700 | | Not Applicable | | |
| Office Copay | | \$0 | | \$0 | | |
| Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d) | | None | | None | | |
| Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year) | | None | | None | | |
| Procedure Category | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies | |
| Diagnostic & Preventive | Oral Exam | \$0 | | \$0 | | |
| | Preventive - Cleaning | \$0 | | \$0 | | |
| | Preventive - X-ray | \$0 | | \$0 | | |
| | Sealants per Tooth | \$0 | | Not Covered | | |
| | Topical Fluoride Application | \$0 | | Not Covered | | |
| Dania Camaiana | Space Maintainers - Fixed | \$0 | | Not Covered | | |
| Basic Services | Amalgam Fill - One Surface Root Canal - Molar | \$25 | | \$25 | | |
| Major Services - Crowns | Gingivectomy per Quad | \$300 \$150 | | \$300 \$150 | | |
| and Casts, Endodontics, | Extraction- Single Tooth Exposed Root | | | | | |
| Periodontics, | or Erupted | \$65 | | \$65 | | |
| Prosthodontics, Oral Surgery | Extraction - Complete Bony | \$160 | | \$160 | | |
| | Crown - Porcelain with Metal | \$300 | | \$300 | | |
| Orthodontia | Medically Necessary Orthodontia | \$350 | | Not Covered | | |

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Standalone Dental Plan or Family Dental Plan)

- 1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.
- 2) Cost sharing payments made by each individual child for innetwork services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
- 3) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family deductible, if applicable, as well as the family out-of-pocket maximum.
- 4) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.

Adult Dental Benefit Notes (only applicable to the Family Dental Plan)

- 5) Each adult is responsible for an individual deductible.
- 6) Families eligible to purchase a Family Dental Plan must include at least one adult who has purchased a Qualified Health Plan through the Exchange.
- 7) If a child is enrolled in the Family Dental Plan, all children in the family under age 19 years must be enrolled in the same Family Dental Plan.
- 8) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.



2016 Dental Standard Benefit Plan Designs

Date: April 4617, 2015

| Summary of Benefits and Coverage | | Family Dental Plan | | | | |
|--|---|---|-----------------------|--|-----------------------|--|
| Member Cost Share amounts describe the Enrollee's out of pocket costs. | | Pediatric Dental EHB Coinsurance Plan | | Adult Dental Coinsurance Plan | | |
| | | Up to Age 19 | | Age 19 and Older | | |
| Actuarial Value | | 86.8% | | Not Calculated | | |
| Individual Deductible | | \$65 In Network/ | | \$50 In Network/ | | |
| (waived for Diagnostic & Preventive) | | \$65 Out of Network | | \$50 Out of Network | | |
| Family Deductible (Two or more children) (waived for Diagnostic & Preventive) | | \$130 In Network/ \$130 Out of Network | | Not Applicable | | |
| Individual Out of Pocket Maximum | | \$350 | | Not Applicable | | |
| Family Out of Pocket Maximum (Two or More Children) | | \$700 | | Not Applicable | | |
| Office Copay | | \$0 | | \$0 | | |
| Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d) | | None | | 6 months for Major Services, Waived with Proof of Prior Coverage | | |
| Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year) | | None | | \$1,500 | | |
| Procedure Category | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies | |
| Diagnostic & Preventive | Oral Exam | 0% | | 0% | | |
| | Preventive - Cleaning | 0% | | 0% | | |
| | Preventive - X-ray | 0% | | 0% | | |
| | Sealants per Tooth | 0% | | Not Covered | | |
| | Topical Fluoride Application | 0% | | Not Covered | | |
| | Space Maintainers - Fixed | 0% | | Not Covered | | |
| Basic Services | Amalgam Fill - One Surface | 20% | X | 20% | Х | |
| Major Services - Crowns and Casts, Endodontics, Periodontics, Prosthodontics, Oral Surgery | Root Canal - Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction - Complete Bony Crown - Porcelain with Metal | 50% | х | 50% | х | |
| Orthodontia | Medically Necessary Orthodontia | 50% | Х | Not Covered | | |

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Standalone Dental Plan or Family Dental Plan)

- 1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.
- 2) Cost sharing payments made by each individual child for innetwork services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
 3) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family deductible, if applicable, as well as the family out-of-
- 4) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.

Adult Dental Benefit Notes (only applicable to the Family Dental Plan)

5) Each adult is responsible for an individual deductible.

pocket maximum.

- 6) Families eligible to purchase a Family Dental Plan must include at least one adult who has purchased a Qualified Health Plan through the Exchange.
- 7) If a child is enrolled in the Family Dental Plan, all children in the family under age 19 years must be enrolled in the same Family Dental Plan.
- 8) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.