Date: May 21, 2015 January 21, 2016





Member Cost Share amounts describe the Enrollee's out of pocket costs.		Platinum Coinsurance Plan		Platinum Copay Plan		
	e - AV Calculator		88.5 <u>89.7</u>	2%	89.5 <u>90.4</u>	16%
	cludes a deductible?		No \$0		No \$0	
Integrated Individual deductible Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$0		\$0		
		\$0 / \$0 / \$0 / \$0 /		\$0 / \$0 / \$0 / \$0 /		
Individual Out-	-of-pocket maximum	car / Harmacy / Dentai	\$4,00)	\$4,00)
Family Out-of-	pocket maximum -only coverage deductible		\$8,000 N/A	0	\$8,00 N/A)
HSA family pla	n: Individual deductible		N/A		N/A	
Common			Member Cost	Deductible	Member Cost	Deductib
Medical Event	Ser	vice Type	Share	Applies	Share	Applies
	Primary care visit to treat an inj	\$20 <u>\$15</u>		\$20 <u>\$15</u>		
Health care provider's office or clinic visit	Other practitioner office visit		\$20 <u>\$15</u>		\$20 <u>\$15</u>	
clinic visit	Specialist visit		\$40		\$40	
	Preventive care/ screening/ imr	nunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging		\$20 \$40		\$20 \$40	
16515	Imaging (CT/PET scans, MRIs)		10%		\$40	
	Tier 1		\$5		\$5	
	Tier 2		\$15		\$15	
Drugs to treat illness or condition	Tier 3					
			\$25 10% up to \$250		\$25 10% up to \$250	
	Tier 4		per script		per script	
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees		10% 10%		\$250 \$40	
services	Outpatient visit	sility and physician fee (waived if	10%		10%	
	admitted)	and physician ree (waived in	\$150		\$150	
Need	Emergency room physician fee	(waived if admitted)	10%		No charge	
immediate	Emergency medical transporta	tion	\$150		\$150	
attention	Urgent care		\$49 <u>\$15</u>		\$40 <u>\$15</u>	
Hospital stay	Facility fee (e.g. hospital room))	10%		\$250 per day up to 5 days	
	Physician/surgeon fee		10%		\$40	
	Mental/Behavioral health outpa	\$20 <u>\$15</u>		\$20 <u>\$15</u>		
	Mental/Behavioral health other	\$20 <u>\$15</u>		\$20 <u>\$15</u>		
	Mental/Behavioral health inpati	ient facility fee (e.g.hospital room)	10%		\$250 per day up to 5 days	
Mental health, behavioral	Mental/Behavioral health inpati	ient physician/surgeon fee	10%		\$40	
health, or substance abuse needs	Substance Use disorder outpa	\$20 <u>\$15</u>		\$20 <u>\$15</u>		
	Substance Use disorder other	outpatient items and services	\$ 20 <u>\$15</u>		\$ 20 <u>\$15</u>	
	Substance Use inpatient facility	y fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Substance use disorder inpatie	ent physician/surgeon fee	10%		\$40	
	Prenatal care and preconception		No charge		No charge	
Pregnancy		Hospital	10%		\$250 per day up	
	eenicee	Professional	10%		to 5 days \$40	
	Home health care		10%		\$20	
Help	Outpatient Rehabilitation services Outpatient Habilitation services		\$20 \$15		\$20 \$15	
recovering or other special	Outpatient Habilitation services Skilled nursing care	•	\$20 \$15 10%		\$20 \$15 \$150 per day up	
otner special health needs	Durable medical equipment		10%		to 5 days	
	Hospice service		No charge		10% No charge	
Child	Eye exam		No charge		No charge	
Child eye care	1 pair of glasses per year (or co	ontact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Oral Exam					
Diagnostic	Preventive - Cleaning Preventive - X-ray		Net O		NI-4 C	
and	Sealants per Tooth		Not Covered		Not Covered	
Preventive	Topical Fluoride Application Space Maintainers - Fixed		1			
Child Dental Basic	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Services	Root Canal- Molar				Not Covered	
Child Dental	Gingivectomy per Quad Extraction- Single Tooth Expos	ed Poot or Frunted	Not Covered		Not Covered	
Major Services	Extraction- Complete Bony	ed Nooi or Erupted	NOT COVERED		Not Covered Not Covered	
	Porcelain with Metal Crown				Not Covered	
Child	Medically necessary orthodont		Not Covered		Not Covered	

Summary	οf	Renefits	and	Coverage

	Member Cost Share amounts describe the Enrollee's out of pocket costs.		i ce Plan	Gold Copay Plan		
	e - AV Calculator	80.2 <u>80.</u>	86%	81.0 <u>81.5</u>	9%	
	cludes a deductible? Individual deductible	No \$0		No \$0		
Integrated	Family deductible	\$0		\$0		
Individual (Family ded	deductible, NOT integrated: Medical / Pharmacy / Dental luctible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0 / \$0 /		\$0 / \$0 / \$0 / \$0 /		
ndividual Out-	-of-pocket maximum	\$ 6,200 <u>6</u> \$ 12,400 1	,750	\$6,200 <u>6,</u> \$12,400 13	750	
HSA plan: Self	pocket maximum -only coverage deductible	N/A		N/A	3,500	
HSA family pla	n: Individual deductible	N/A		N/A		
Common		Member Cost	Deductible	Member Cost	Deducti	
Medical Event		Share	Applies	Share	Applie	
Health care	Primary care visit to treat an injury, illness, or condition	\$35 <u>\$30</u>		\$35 <u>\$30</u>		
orovider's office or clinic visit	Other practitioner office visit	\$35 <u>\$30</u>		\$35 <u>\$30</u>		
	Specialist visit	\$55		\$55		
	Preventive care/ screening/ immunization Laboratory Tests	No charge \$35		No charge \$35		
Гests	X-rays and Diagnostic Imaging	\$50 <u>\$55</u>		\$50 <u>\$55</u>		
	Imaging (CT/PET scans, MRIs)	20%		\$250 \$275		
	Tier 1	\$15		\$15		
illness or	Tier 2	\$50 <u>\$55</u>		\$50 <u>\$55</u>		
	Tier 3	\$70 <u>\$75</u>		\$70 <u>\$75</u>		
	Tier 4	20% up to \$250 per script		20% up to \$250 per script		
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees	20%		\$600 \$55		
services	Outpatient visit	20%		20%		
	Emergency room <u>combined</u> facility <u>and physician</u> fee (waived if admitted)	\$250 <u>\$325</u>		\$ 250 <u>\$325</u>		
	Emergency room physician fee (waived if admitted)	20%		No charge		
Need mmediate	Emergency medical transportation	\$250		\$250		
attention	Urgent care	\$ 60 <u>\$30</u>		\$ 60 <u>\$30</u>		
Hospital stay	Facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days		
	Physician/surgeon fee	20%		\$55		
	Mental/Behavioral health outpatient office visits	\$35 <u>\$30</u>		\$35 <u>\$30</u>		
	Mental/Behavioral health other outpatient items and services	\$35 <u>\$30</u>		\$35 <u>\$30</u>		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%		\$600 per day up		
Mental health,	Mental/Behavioral health inpatient physician/surgeon fee	20%		to 5 days		
behavioral health, or	wertanbenavioral nealth inpatient physician/surgeon ree	20%		\$55		
substance abuse needs	Substance Use disorder outpatient office visits	\$35 <u>\$30</u>		\$35 <u>\$30</u>		
	Substance Use disorder other outpatient items and services	\$35 <u>\$30</u>		\$35 <u>\$30</u>		
	Substance Use inpatient facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days		
	Substance use disorder inpatient physician/surgeon fee	20%		\$55		
	Prenatal care and preconception visits	No charge		No charge		
Pregnancy	Delivery and all inpatient Hospital	20%		\$600 per day up to 5 days		
	services Professional	20%		\$55		
	Home health care Outpatient Rehabilitation services	20% \$35 \$30		\$30 \$35 <u>\$30</u>		
lelp ecovering or	Outpatient Rehabilitation services Outpatient Habilitation services	\$35 \$30 \$35		\$35 <u>\$30</u>		
	Skilled nursing care	20%		\$300 per day up to 5 days		
ther special				20%		
other special	Durable medical equipment	20%				
other special	Hospice service	No charge		No charge No charge	_	
other special nealth needs				No charge No charge No charge		
other special nealth needs Child eye care	Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	No charge No charge		No charge		
other special nealth needs Child eye care Child Dental	Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning	No charge No charge No charge		No charge No charge		
other special health needs Child eye care Child Dental Diagnostic and	Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	No charge No charge		No charge		
other special nealth needs Child eye care Child Dental Diagnostic and	Hospite service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application	No charge No charge No charge		No charge No charge		
child eye care Child Dental Diagnostic and Preventive Child Dental	Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	No charge No charge No charge		No charge No charge		
child eye care Child Dental Diagnostic and Preventive Child Dental Basic	Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface	No charge No charge No charge No charge		No charge No charge Not Covered Not Covered		
other special nealth needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental	Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) 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	No charge No charge No charge Not Covered Not Covered		No charge No charge Not Covered		
other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major	Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad Extraction - Single Tooth Exposed Root or Erupted	No charge No charge No charge No charge		No charge No charge Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered		
other special nealth needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental	Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) 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	No charge No charge No charge Not Covered Not Covered		No charge No charge Not Covered Not Covered Not Covered Not Covered Not Covered		

Member Cost S	hare amounts describe the En	rollee's out of pocket costs.	Silver Plan	1
Actuarial Value	- AV Calculator		70.4 71.53°	%
	cludes a deductible?		Yes, Medical/Pha	armacy
Integrated	Individual deductible		N/A	arridoy
Integrated Individual	Family deductible deductible, NOT integrated: I	Medical / Pharmacy / Dental	N/A \$ 2,250 2,500/ \$2	50 / \$0
Family ded	uctible, NOT integrated: Med	ical / Pharmacy / Dental	\$ 4,500 5,000/ \$5	00 / \$0
	of-pocket maximum		\$6250 6,80 \$12,500 13,6	
	only coverage deductible		N/A N/A	
пом таппту рта	n: Individual deductible		N/A	
Common				Deductible
Medical Event	Se	rvice Type	Member Cost Share	Applies
	Primary care visit to treat an ir	njury, illness, or condition	\$45 \$35	
Health care provider's office or	Other practitioner office visit		\$45 <u>\$35</u>	
clinic visit	Specialist visit		\$70	
	Preventive care/ screening/ in	munization	No charge	
	Laboratory Tests		\$35	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs		\$65 <u>\$70</u> \$250 <u>\$300</u>	
	Tier 1		\$15	
	Tier 2		\$50 \$5 <u>5</u>	Pharmacy
Drugs to treat illness or condition				deductible
	Tier 3		\$70 \$80 20% up to \$250 per	deductible
	Tier 4 Surgery facility fee (e.g., ASC)	script after pharmacy deductible 20%	Pharmacy deductible
Outpatient services	Physician/surgeon fees		20%	
	Outpatient visit Emergency room combined fa	acility and physician fee (waived if	20%	
	admitted)		\$ 250 <u>\$350</u>	×
Need	Emergency room physician fe	\$50	×	
immediate attention	Emergency medical transportation		\$250	×
attention	Urgent care		\$ 90 <u>\$35</u>	
	Facility fee (e.g. hospital roon	n)	20%	х
Hospital stay	Physician/surgeon fee		20%	Х
	Mental/Behavioral health outp	\$45 <u>\$35</u>		
	Mental/Behavioral health othe	\$45 <u>\$35</u>		
	Mental/Rehavioral health inna	tient facility fee (e.g.hospital room)	20%	X
Mental health,				- "
behavioral health, or	Mental/Behavioral health inpa	tient physician/surgeon fee	20%	Х
substance abuse needs	Substance Use disorder outpo	\$45 <u>\$35</u>		
	Substance Use disorder other	outpatient items and services	\$45 <u>\$35</u>	
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%	х
	Substance use disorder inpat		20%	X
	Prenatal care and preconcept	* * * *	No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	×
-gy	services	Professional	20%	X
	Home health care		\$45	- ^
Help	Outpatient Rehabilitation services Outpatient Habilitation services		\$45 <u>\$35</u> \$45 <u>\$35</u>	
recovering or other special	Skilled nursing care		20%	х
health needs	Durable medical equipment		20%	
	Hospice service Eye exam		No charge	
Child eye care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge No charge	
	Oral Exam		9-	
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray			
and	Sealants per Tooth		Not Covered	
Preventive	Topical Fluoride Application Space Maintainers - Fixed			
Child Dental Basic	Amalgam Fill - 1 Surface		Not Covered	
Services	Root Canal- Molar			
Child Dental	Gingivectomy per Quad	10 1 5 1		
Major Services	Extraction- Single Tooth Expo Extraction- Complete Bony	sea Root or Erupted	Not Covered	
	Porcelain with Metal Crown			
Child		tics	Not Covered	

Summary of	. D		_		_	
	f Benefits and Coverage	SHOP CCS Silver	<u>iB</u>	SHOP CCS Silver	<u>iB</u>	
Member Cost Share amounts describe the Enrollee's out of pocket costs.		Coinsurance	Plan	Copay Plan		
Actuarial Value	e - AV Calculator	71.6 71.56°	%	71.3 71.25°	%	
Plan design in	cludes a deductible?	Yes, Medical/Pha	armacy	Yes, Medical/Pha	armacy	
	Individual deductible Family deductible	N/A N/A		N/A N/A		
	deductible, NOT integrated: Medical / Pharmacy / Dental	\$ 1,500 <u>2,000</u> / \$2		\$ 1,500 <u>2,000</u> / \$2	50 / \$0	
	ductible, NOT integrated: Medical / Pharmacy / Dental	\$3,000 4,000 / \$5		\$3,000 4,000 / \$5		
	-of-pocket maximum pocket maximum	\$ 6,500 <u>6,80</u> \$ 13,000 <u>13,6</u>		\$6,500 <u>6,80</u> \$13,000 <u>13,6</u>		
HSA plan: Self	-only coverage deductible	N/A		N/A	_	
HSA family pla	n: Individual deductible	N/A		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductibl Applies	
	Primary care visit to treat an injury, illness, or condition	\$45		\$45		
Health care provider's office or	Other practitioner office visit	\$45		\$45		
clinic visit	Specialist visit	\$70 <u>\$75</u>		\$70 <u>\$75</u>		
	Preventive care/ screening/ immunization	No charge		No charge		
	Laboratory Tests	\$35 <u>\$40</u>		\$35 <u>\$40</u>		
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	\$65 \$70 20%	×	\$65 <u>\$70</u> \$250 <u>\$300</u>		
	Tier 1	\$15		\$15		
Drugs to treat illness or	Tier 2	\$55	Pharmacy deductible	\$55	Pharmac deductibl	
condition	Tier 3	\$ 75 <u>\$85</u>	Pharmacy deductible	\$76 <u>\$85</u>	Pharmac deductibl	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20% up to \$250 per script after pharmacy deductible	Pharmac deductibl	
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees	20% 20%		20% 20%		
services	Outpatient visit	20%		20%		
	Emergency room combined facility and physician fee (waived if admitted)	\$250 \$350	×	\$250 \$350	×	
	Emergency room physician fee (waived if admitted)	\$50	×	\$50	×	
Need	Emergency medical transportation	\$250	×	\$250	×	
attention	Urgent care	\$90 <u>\$45</u>		\$90 <u>\$45</u>		
	<u> </u>					
Hospital stay	Facility fee (e.g. hospital room)	20%	Х	20%	Х	
	Physician/surgeon fee	20%	X	20%	X	
	Mental/Behavioral health outpatient office visits	\$45		\$45		
	Mental/Behavioral health other outpatient items and services	\$45		\$45		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	х	20%	х	
Mental health, behavioral	Mental/Behavioral health inpatient physician/surgeon fee	20%	Х	20%	х	
health, or substance abuse needs	Substance Use disorder outpatient office visits	\$45				
abuse needs				\$45		
	Substance Use disorder other outpatient items and services	\$45		\$45 \$45		
	Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room)	\$45 20%	x		X	
	cascance declaration canal capación name ana connece		x x	\$45	x x	
	Substance Use inpatient facility fee (e.g. hospital room)	20%		\$45 20%		
Pregnancy	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee	20% 20%		\$45 20% 20%		
Pregnancy	Substance Use inpatient facility fee (e.g., hospital room) Substance use disorder inpatient physician/surgeon fee Prenatal care and preconception visits Delivery and all inpatient services Professional	20% 20% No charge	х	\$45 20% 20% No charge	х	
Pregnancy	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Prenatal care and preconception visits Delivery and all inpatient services Professional Home health care	20% 20% No charge 20% 20% 20%	x	\$45 20% 20% No charge 20% \$45	x	
Help	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Prenatal care and preconception visits Delivery and all inpatient services Hospital Professional Home health care Outpatient Rehabilitation services	20% 20% No charge 20% 20% 20% \$45	x	\$45 20% 20% No charge 20% 20% \$45	x	
Help recovering or	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Prenatal care and preconception visits Delivery and all inpatient services Hospital Professional Home health care Outpatient Rehabilitation services Outpatient Rehabilitation services	20% 20% No charge 20% 20% 20% 4545 \$45	X X X	\$45 20% 20% No charge 20% 20% \$45 \$45 \$45	X X X	
Help recovering or other special	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Prenatal care and preconception visits Delivery and all inpatient services Hospital Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care	20% 20% No charge 20% 20% 20% \$45 \$45 \$45	x	\$45 20% 20% No charge 20% \$45 \$45 \$45 \$45	x	
Help recovering or other special	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Prenatal care and preconception visits Delivery and all inpatient services Hospital Professional Home health care Outpatient Rehabilitation services Outpatient Rehabilitation services Skilled nursing care Durable medical equipment Hospice service	20% 20% No charge 20% 20% 20% 4545 \$45	X X X	\$45 20% 20% No charge 20% 20% \$45 \$45 \$45	X X X	
Help recovering or other special health needs	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Prenatal care and preconception visits Delivery and all inpatient services Hospital Professional Home health care Outpatient Rehabilitation services Outpatient Rehabilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam	20% 20% No charge 20% 20% 20% 545 \$45 20% No charge No charge	X X X	\$45 20% 20% No charge 20% \$45 \$45 \$45 \$45 No charge No charge No charge	X X X	
Help recovering or other special health needs	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Prenatal care and preconception visits Delivery and all inpatient Hospital Hospital Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	20% 20% No charge 20% 20% 20% \$45 \$45 20% 20% No charge	X X X	\$45 20% 20% No charge 20% \$45 \$45 \$45 \$20% No charge	X X X	
Help recovering or other special health needs Child eye care	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Prenatal care and preconception visits Delivery and all inpatient Hospital services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	20% 20% No charge 20% 20% 20% 545 \$45 20% No charge No charge	X X X	\$45 20% 20% No charge 20% \$45 \$45 \$45 \$45 No charge No charge No charge	X X X	
Help recovering or other special realth needs Child eye care Child Dental Diagnostic	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Prenatal care and preconception visits Delivery and all inpatient Hospital Hospital Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	20% 20% No charge 20% 20% 20% \$45 \$45 20% No charge No charge No charge	X X X	\$45 20% 20% No charge 20% \$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	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Prenatal care and preconception visits Delivery and all inpatient Hospital services Delivery and all inpatient Hospital Professional Home health care Outpatient Rehabilitation services Outpatient Rehabilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	20% 20% No charge 20% 20% 20% 545 \$45 20% No charge No charge	X X X	\$45 20% 20% No charge 20% \$45 \$45 \$45 \$45 No charge No charge No charge	X X X	
Help recovering or other special health needs Child eye care Child Dental Diagnostic and	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Prenatal care and preconception visits Delivery and all inpatient services Hospital Professional Home health care Outpatient Rehabilitation services Outpatient Rehabilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application	20% 20% No charge 20% 20% 20% \$45 \$45 20% No charge No charge No charge	X X X	\$45 20% 20% No charge 20% \$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 inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Prenatal care and preconception visits Delivery and all inpatient Hospital services Delivery and all inpatient Hospital Professional Home health care Outpatient Rehabilitation services Outpatient Rehabilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	20% 20% No charge 20% 20% 20% \$45 \$45 20% No charge No charge No charge	X X X	\$45 20% 20% No charge 20% \$45 \$45 \$45 20% No charge No charge No charge	X X X	
Pregnancy Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Prenatal care and preconception visits Delivery and all inpatient services Delivery and all inpatient Hospital Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - Salants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface	20% 20% No charge 20% 20% 20% \$45 20% \$45 20% No charge No charge No charge No charge	X X X	\$45 20% 20% No charge 20% \$45 \$45 \$45 \$0% No charge 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 inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Prenatal care and preconception visits Delivery and all inpatient services Delivery and all inpatient Hospital Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Ginglivectomy per Quad	20% 20% No charge 20% 20% 20% \$45 \$45 \$45 20% No charge No charge No charge Not Covered	X X X	\$45 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 Major	Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Prenatal care and preconception visits Delivery and all inpatient services Hospital services Hospital services Outpatient Habilitation services Outpatient Habilitation services Outpatient Habilitation services Ustalied nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - Sray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted	20% 20% No charge 20% 20% 20% \$45 20% \$45 20% No charge No charge No charge No charge	X X X	\$45 20% 20% No charge 20% \$45 \$45 \$45 \$45 \$0% 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 inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician/surgeon fee Prenatal care and preconception visits Delivery and all inpatient services Delivery and all inpatient Hospital Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Ginglivectomy per Quad	20% 20% No charge 20% 20% 20% \$45 \$45 \$45 20% No charge No charge No charge Not Covered	X X X	\$45 20% 20% No charge 20% \$45 \$45 \$45 20% No charge No charge No charge No charge Not Covered	X X X	

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	21, 2015 January 21	<u></u>	SHOP CO	ep
	Benefits and Coverage		SHOP CO Silver	<u>-98</u>
	hare amounts describe the En	rollee's out of pocket costs.	HSA HDHP	
	- AV Calculator		70.5 <u>71.1</u>	
Plan design in	cludes a deductible?		Yes, integr \$2,000 integ	
Integrated I	Family deductible		\$4,000 integ	rated
	deductible, NOT integrated: I uctible, NOT integrated: Med		N/A N/A	
Individual Out-	-of-pocket maximum	nour r numusy r Domai	\$ 6,250 <u>6,6</u>	
	oocket maximum only coverage deductible		\$ 12,500 <u>13</u> \$2,000	
HSA family pla	n: Individual deductible		\$2,600	
Common Medical Event	e _o	rvice Type	Member Cost Share	Deductible Applie
Medical Event	36	TVICE Type	Member Cost Share	Deddedale Applie
	Primary care visit to treat an in	njury, illness, or condition	20%	×
Health care provider's office or	Other practitioner office visit		20%	х
clinic visit	Specialist visit		20%	х
	Preventive care/ screening/ in	munization	No charge	
	Laboratory Tests		20%	Х
Tests	X-rays and Diagnostic Imagin Imaging (CT/PET scans, MRIs		20% 20%	X
		2)	20% 20% up to \$250 per	
	Tier 1		<u>script</u>	х
Drugs to treat	Tier 2		20% up to \$250 per script	х
condition	Tier 3		20% <u>up to \$250 per</u> script	х
	Tier 4		20% up to \$250 per	х
			script	
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees)	20% 20%	X
services	Outpatient visit		20%	X
	Emergency room combined fa admitted)	acility and physician fee (waived if	20%	Х
	Emergency room physician fo	e (waived if admitted)	20%	×
Need	Emergency medical transportation		20%	×
immediate attention	Urgent care		20%	x
Hospital stay	Facility fee (e.g. hospital roon	1)	20%	х
	Physician/surgeon fee Mental/Behavioral health outpatient office visits		20%	X
	wentai/benavioral nearth out	attent office visits	20%	X
	Mental/Behavioral health other	r outpatient items and services	20%	Х
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	х
Mental health, behavioral health, or	Mental/Behavioral health inpa	tient physician/surgeon fee	20%	x
substance abuse needs	Substance Use disorder outpo	atient office visits	20%	х
	Substance Use disorder other	outpatient items and services	20%	x
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%	х
	Substance use disorder inpat	ient physician/surgeon fee	20%	х
	Prenatal care and preconcept	. ,	No charge	^
Pregnancy	Delivery and all inpatient	Hospital	20%	x
Jgloy	services	Professional	20%	X
	Home health care		20%	Х
Help	Outpatient Rehabilitation services Outpatient Habilitation services		20%	X
recovering or other special	Skilled nursing care		20%	X
health needs	Durable medical equipment		20%	X
	Hospice service		0%	X
Child eye care	Eye exam 1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge No charge	
Child Day	Oral Exam			
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray		Net Commit	
and	Sealants per Tooth		Not Covered	
Preventive	Topical Fluoride Application Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered	
Child Dental Major Services	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Expo Extraction- Complete Bony	sed Root or Erupted	Not Covered	
Child	Porcelain with Metal Crown Medically necessary orthodor		Not Covered	

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Summary of Benefits and Coverage

Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.		Silver Plan		Silver Plan		
Actuarial Value - AV Calculator		100%-150% FPL 93.8 94.12%		150%-200% FPL 86-8 87-48%		
	cludes a deductible?	Yes, Medical/F	Pharmacy	Yes, Medical/Pha	rmacy	
	Individual deductible Family deductible	N/A N/A		N/A N/A		
Individual	deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0		\$ 550 <u>650</u> / \$50		
	luctible, NOT integrated: Medical / Pharmacy / Dental -of-pocket maximum	\$150 / \$0 \$ 2,250 2		\$ 1,100 <u>1,300</u> / \$10 \$ 2,250 2,350		
Family Out-of-	pocket maximum	\$4,500 4		\$4,500 4,700		
HSA plan: Self	f-only coverage deductible an: Individual deductible	N/A N/A		N/A N/A		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	I					
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
	Primary care visit to treat an injury, illness, or condition	\$5		\$15 <u>\$10</u>		
Health care provider's office or clinic visit	Other practitioner office visit	\$5		\$15 <u>\$10</u>		
Cimic Visit	Specialist visit	\$8		\$25		
	Preventive care/ screening/ immunization	No charge		No charge		
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$8 \$8		\$15 \$25		
	Imaging (CT/PET scans, MRIs)	\$50		\$100		
	Tier 1	\$3		\$5		
Drugs to treat	Tier 2	\$10		\$20	Pharmacy deductible	
condition	Tier 3	\$15		\$35	Pharmacy deductible	
	Tier 4	10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharmacy deductible	
Outpatient	Surgery facility fee (e.g., ASC)	10%		15%		
services	Physician/surgeon fees Outpatient visit	10% 10%		15% 15%		
	Emergency room combined facility and physician fee (waived if		v		~	
	admitted)	\$30 <u>\$50</u>	×	\$75 <u>\$100</u>	×	
Need	Emergency room physician fee (waived if admitted)	\$ 25	×	\$40	×	
immediate	Emergency medical transportation	\$30	×	\$75	×	
attention	Urgent care	\$6 <u>\$5</u>		\$30 <u>\$10</u>		
	Facility fee (e.g. hospital room)	10%	х	15%	X	
Hospital stay	Physician/surgeon fee	10%	X	15%	X	
	Mental/Behavioral health outpatient office visits	\$5	^	\$15 \$10	^	
	Mental/Behavioral health other outpatient items and services	\$5		\$15 \$10		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%	х	15%	x	
Mental health, behavioral	Mental/Behavioral health inpatient physician/surgeon fee	10%	×	15%	x	
health, or substance abuse needs	Substance Use disorder outpatient office visits	\$5	~	\$15 <u>\$10</u>		
	Substance Use disorder other outpatient items and services	\$5		\$15 <u>\$10</u>		
	Substance Use inpatient facility fee (e.g. hospital room)	10%	х	15%	Х	
	Substance use disorder inpatient physician/surgeon fee	10%	х	15%	х	
	Prenatal care and preconception visits	No charge		No charge		
Pregnancy	Delivery and all inpatient Hospital	10%	х	15%	х	
	services Professional	10%	Х	15%	Х	
	Home health care Outpatient Rehabilitation services	\$3 \$5		\$15 \$15 <u>\$10</u>		
Help recovering or	Outpatient Habilitation services	\$5		\$15 \$10		
other special	Skilled nursing care	10%	х	15%	х	
health needs	Durable medical equipment	10%		15%		
	Hospice service Eye exam	No charge No charge		No charge No charge		
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray					
and	Sealants per Tooth	Not Covered		Not Covered		
Preventive	Topical Fluoride Application Space Maintainers - Fixed					
Child Dental Basic	Amalgam Fill - 1 Surface	Not Covered		Not Covered		
Services	Root Canal- Molar					
Child Dental Major Services	Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony	Not Covered		Not Covered		
Child Orthodontics	Porcelain with Metal Crown Medically necessary orthodontics	Not Covered		Not Covered		
Critiodonities						

Date: May 21, 2015 January 21, 2016

Summary of Benefits and Coverage

	hare amounts describe the En		200%-250% FP 72.8 73.67%	L
	cludes a deductible?		Yes, Medical/Phari	macv
Integrated	Individual deductible		N/A	ildoy
Integrated	Family deductible deductible, NOT integrated: I	Medical / Pharmacy / Dental	N/A \$ 1,900 2,200 / \$25	n / \$n
Family ded	luctible, NOT integrated: Med	lical / Pharmacy / Dental	\$3,800 <u>4,400</u> / \$500	
ndividual Out	of-pocket maximum		\$5,450 <u>5,700</u>	
amily Out-of- ISA plan: Self	pocket maximum -only coverage deductible		\$ 10,900 <u>11,40</u> N/A	<u>)</u>
ISA family pla	n: Individual deductible		N/A	
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an in	njury, illness, or condition	\$4 0 \$30	
Health care provider's office or	Other practitioner office visit		\$40 <u>\$30</u>	
clinic visit	Specialist visit		\$55	
	Preventive care/ screening/ in	nmunization	No charge	
	Laboratory Tests		\$35	
ests	X-rays and Diagnostic Imagin		\$50 <u>\$65</u>	
	Imaging (CT/PET scans, MRI	B)	\$250 \$300	
	Tier 1		\$15	
Orugs to treat	Tier 2		\$45 <u>\$50</u>	Pharmacy deductible
Ilness or condition	Tier 3		\$ 70 \$ <u>75</u>	Pharmacy deductible
	Tier 4		20% up to \$250 per script after pharmacy	Pharmacy
	Surgery facility fee (e.g., ASC)	deductible 20%	
Outpatient	Physician/surgeon fees	,	20%	
services	Outpatient visit	79	20%	
	Emergency room combined fa admitted)	acility and physician fee (waived if	\$250 \$350	×
	Emergency room physician fe	e (waived if admitted)	\$ 50	×
leed				* *
mmediate ittention	Emergency medical transport	ation	\$250	×
ittention	Urgent care		\$ 80 <u>\$30</u>	
	Facility fee (e.g. hospital roon	1)	20%	х
Hospital stay	Physician/surgeon fee	<u>'</u>	20%	×
	Mental/Behavioral health outp	patient office visits	\$40 <u>\$30</u>	
	Mental/Behavioral health other	\$40 <u>\$30</u>		
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	X
Mental health,	Mental/Behavioral health inpa		20%	х
ehavioral nealth, or	Wentan benavioral realth inpa	ment priyacian/aurgeon rec	20%	^
substance abuse needs	Substance Use disorder outpo	atient office visits	\$ 40 <u>\$30</u>	
	Substance Use disorder other	\$40 <u>\$30</u>		
	Substance Use inpatient facil	ity fee (e.g. hospital room)	20%	х
	Substance use disorder inpat	. ,	20%	х
	Prenatal care and preconcept	ion visits	No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	х
	services	Professional	20%	Х
	Home health care	inae	\$40 \$40 \$30	
-lelp	Outpatient Rehabilitation service Outpatient Habilitation service		\$40 \$30 \$40 \$30	
ecovering or other special	Skilled nursing care		20%	х
nealth needs	Durable medical equipment		20%	^
	Hospice service		No charge	
No. 11 d	Eye exam		No charge	
Child eye care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge	
	Oral Exam			
Child Dental Diagnostic	Preventive - Cleaning			
ind	Preventive - X-ray Sealants per Tooth		Not Covered	
Preventive	Topical Fluoride Application			
Child Dental Basic	Space Maintainers - Fixed Amalgam Fill - 1 Surface		Not Covered	
Services	Root Canal- Molar			
Child Dental	Gingivectomy per Quad	and Dont or Francis d	No. Commit	
Major Services	Extraction- Single Tooth Expo Extraction- Complete Bony Porcelain with Metal Crown	sed Root or Erupted	Not Covered	

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Cummon		Donofito	and	Coverage
Summarv	ot (Benetits	and	Coverage

	Member Cost Share amounts describe the Enrollee's out of pocket costs. Actuarial Value - AV Calculator		Bronze Pla	n	Bronze HSA HDHP Plan		
Actuarial Value	e - AV Calculator		61.9%		61.06 <u>61.</u>	<u>13</u> %	
	cludes a deductible?		Yes, Medical/Pha	armacy	Yes, integ		
	Individual deductible Family deductible		N/A N/A		\$4,500 integ \$9,000 integ		
Individual	deductible, NOT integrated: I	Medical / Pharmacy / Dental	\$ 6,000 <u>6,300</u> / \$5		N/A	gratou	
	luctible, NOT integrated: Med	lical / Pharmacy / Dental	\$ 12,000 <u>12,600</u> / \$1		N/A	eeo.	
	of-pocket maximum		\$ 6,500 <u>6,80</u> \$ 13,000 <u>13,6</u>		\$6,500 <u>6,</u> \$13,000 <u>11</u>		
HSA plan: Self	only coverage deductible		N/A		\$4,500)	
HSA family pla	ın: Individual deductible		N/A		\$4,500)	
Common Medical Event		nica Tuna	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
medical Event	Primary care visit to treat an in	rvice Type		After 1st three	40%		
Health care	<u> </u>	ijury, iiiriess, or contaition	\$70 <u>\$75</u>	non-preventive visits After 1st three		Х	
provider's office or clinic visit	Other practitioner office visit		\$70 <u>\$75</u>	non-preventive visits After 1st three	40%	Х	
	Specialist visit Preventive care/ screening/ in	omunization	\$90 \$105	non-preventive visits	40%	Х	
	Laboratory Tests	imunization	No charge \$40		No charge 40%	X	
Tests	X-rays and Diagnostic Imagin	g	100%	Х	40%	X	
	Imaging (CT/PET scans, MRI	s)	100%	X	40%	Х	
	Tier 1		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	х	
Drugs to treat	Tier 2		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	х	
illness or condition	Tier 3		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	х	
	Tier 4		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	х	
Outpatient	Surgery facility fee (e.g., ASC)	100%	Х	40%	Х	
services	Physician/surgeon fees Outpatient visit		100%	X	40% 40%	X	
		acility and physician fee (waived if	100%	X	40%	X	
	admitted)						
Need	Emergency room physician fo		100%	×	40%	×	
immediate	Emergency medical transport	ation	100%	Х	40%	Х	
attention	Urgent care		\$ 120 <u>\$75</u>	After 1st three non-preventive visits	40%	х	
Hospital stay	Facility fee (e.g. hospital roon	1)	100%	x	40%	х	
riospitai stay	Physician/surgeon fee		100%	х	40%	Х	
	Mental/Behavioral health outp	atient office visits	\$70 <u>\$75</u>	After 1st three non-preventive visits	40%	х	
	Mental/Behavioral health other	er outpatient items and services	\$70 <u>\$75</u>	After 1st three non-preventive visits	40%	х	
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	100%	Х	40%	х	
Mental health,	Mental/Behavioral health inpa	tient physician/surgeon fee	100%	х	40%	×	
behavioral health, or substance abuse needs	Substance Use disorder outp		\$70 <u>\$75</u>	After 1st three non-preventive visits	40%	×	
	Substance Use disorder other outpatient items and services		\$70 \$75	After 1st three non-preventive	40%	х	
	Substance Use inpatient facil	itv fee (e.g. hospital room)	100%	visits	40%	Х	
	Substance use disorder inpat		100%	Х	40%	Х	
Prognancy	Prenatal care and preconcept Delivery and all inpatient		No charge	_	No charge	V	
Pregnancy	services	Hospital	100%	X	40%	X	
	Home health care	Professional	100%	X	40%	X	
Holp	Outpatient Rehabilitation serv	ices	\$70 \$75	^	40%	X	
Help recovering or	Outpatient Habilitation service		\$70 <u>\$75</u>		40%	Х	
other special	Skilled nursing care		100%	х	40%	х	
health needs	Durable medical equipment		100%	Х	40%	Х	
	Hospice service Eye exam		No charge		0%	X	
Child eye care	1 pair of glasses per year (or	contact lenses in lieu of classes)	No charge No charge		No charge No charge		
	Oral Exam		140 onarge		140 Glaige		
Child Dental	Preventive - Cleaning]				
Diagnostic and	Preventive - X-ray		Not Covered		Not Covered		
and Preventive	Sealants per Tooth Topical Fluoride Application						
	Space Maintainers - Fixed						
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered		
	Root Canal- Molar						
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Expo	sed Root or Erupted	Not Covered		Not Covered		
Services	Extraction- Complete Bony	,					
Child	Porcelain with Metal Crown Medically necessary orthodor	tics	Not Covered		Not Covered		
Orthodontics	,		THE COVERED		1101 0040100		

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Summary	of B	enefits	and	Coverage

	hare amounts describe the En	ronoces out or pocket costs.	Catastro	phic Plan
	cludes a deductible?		Yes, int	egrated
	Individual deductible			egrated 0 integrated
Integrated	Family deductible			00 integrated
Individual	deductible, NOT integrated: N	Medical / Pharmacy / Dental	N	
ramily ded Individual Out	uctible, NOT integrated: Med -of-pocket maximum	iicai / Pnarmacy / Dental		/A 7,150
	pocket maximum			14,300
HSA plan: Self	only coverage deductible			/A
HSA family pla	n: Individual deductible		N	/A
Common Medical Event	Ser	rvice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition		0%	After 1st three non-preventiv visits
Health care provider's office or clinic visit	Other practitioner office visit		0%	After 1st three non-preventive visits
CHITIC VISIT	Specialist visit		0%	х
	Preventive care/ screening/ im	nmunization	No charge	
	Laboratory Tests		0%	Х
Tests	X-rays and Diagnostic Imaging		0%	Х
	Imaging (CT/PET scans, MRIs	s)	0%	X
	Tier 1		0%	х
Drugs to treat	Tier 2		0%	х
illness or condition	Tier 3		0%	х
	Tier 4		0%	х
	Surgery facility fee (e.g., ASC)	0%	X
Outpatient	Physician/surgeon fees	,	0%	X
services	Outpatient visit		0%	X
		acility and physician fee (waived if	0%	Х
	admitted)			^
Need	Emergency room physician fee (waived if admitted)		0%	×
immediate	Emergency medical transportation		0%	Х
attention	Urgent care		0%	After 1st thre non-preventiv visits
Hospital stay	Facility fee (e.g. hospital room	1)	0%	Х
	Physician/surgeon fee		0%	Х
	Mental/Behavioral health outp	atient office visits	0%	After 1st thre non-preventiv visits
	Mental/Behavioral health other outpatient items and services		0%	After 1st three non-preventiv visits
Mental health,	Mental/Behavioral health inpa	0%	х	
behavioral	Mental/Behavioral health inpa	0%	х	
health, or substance abuse needs	Substance Use disorder outpa	0%	After 1st thre non-preventiv visits	
	Substance Use disorder other	0%	After 1st thre	
				visits
	Substance Use inpatient facili Substance use disorder inpati		0%	x
	·	. ,		^
	Prenatal care and preconcept		No charge	
Pregnancy	Delivery and all inpatient	Hospital	0%	х
	services	Professional	0%	Х
	Home health care		0%	Х
Help	Outpatient Rehabilitation service Outpatient Habilitation service		0%	X
recovering or	· ·			
other special health needs	Skilled nursing care		0%	Х
	Durable medical equipment		0%	X
	Hospice service Eye exam		0% No charge	X
Child eye care		contact langue in liqu of classes)		v
	1 pair of glasses per year (or o	contact tenses in lieu of glasses)	0%	Х
Child Dental	Oral Exam Preventive - Cleaning			
Diagnostic	Preventive - X-ray		Not Course	
and	Sealants per Tooth		Not Covered	
Preventive	Topical Fluoride Application			
Child Dental Basic	Space Maintainers - Fixed Amalgam Fill - 1 Surface		Not Covered	
Services				
Child Dental	Root Canal- Molar			
Child Dental Major Services	Gingivectomy per Quad Extraction- Single Tooth Expo Extraction- Complete Bony Perceloin with Metal Crown	sed Root or Erupted	Not Covered	
	Porcelain with Metal Crown			
Child Orthodontics	Medically necessary orthodon	tics	Not Covered	