#### 2016 2017 Standard Benefit Plan Designs 10.0 EHB

Date: May 21, 2015 February 18, 2016





Member Cost S	hare amounts describe the Enr	ollee's out of pocket costs.	Platinu Coinsurance		Platinu Copay P	
Actuarial Value	e - AV Calculator		88.5 89.7		89.5 90.4	
	cludes a deductible?		No		No	
Integrated	Individual deductible		\$0		\$0	
	Family deductible	Indical / Pharmany / Dontal	\$0	ren	\$0	¢n.
	deductible, NOT integrated: N luctible, NOT integrated: Med		\$0 / \$0 / \$0 / \$0 /		\$0 / \$0 / \$0 / \$0 /	
Individual Out-	-of-pocket maximum		\$4,00	0	\$4,000	)
Family Out-of-	pocket maximum -only coverage deductible		\$8,00 N/A	0	\$8,000 N/A	)
	n: Individual deductible		N/A		N/A	
			Ì			
Common Medical Event		oles Tons	Member Cost Share	Deductible Applies	Member Cost	Deductib Applies
wedical Event	Ser	vice Type	Snare	Applies	Share	Applies
	Primary care visit to treat an in	jury, illness, or condition	\$20 <u>\$15</u>		\$20 <u>\$15</u>	
Health care						
provider's	Other practitioner office visit		\$20 \$15		\$20 \$15	
office or						
clinic visit	Specialist visit		\$40		\$40	
	Opecialist visit		\$40		\$40	
	Preventive care/ screening/ im	munization	No charge		No charge	
Tests	Laboratory Tests  X-rays and Diagnostic Imaging	1	\$20 \$40		\$20 \$40	
	Imaging (CT/PET scans, MRIs		10%		\$150	
	Tier 1		\$5		\$5	
	IIOI I		φο		φΟ	
	Tier 2		\$15		\$15	
Drugs to treat illness or			φιJ		φισ	
condition	Tier 3		\$25		\$25	
			<b>\$</b> ∠5		φ∠o	
	Tier 4		10% up to \$250		10% up to \$250	
			per script		per script	
Outpatient	Surgery facility fee (e.g., ASC)		10%		\$250	
services	Physician/surgeon fees Outpatient visit		10%		\$40 10%	
	· '	inited if admitted)				
	Emergency room facility fee (v	raived ii admitted)	\$150		\$150	
Need	Emergency room physician fe	(waived if admitted)	10% No charge		No charge	
immediate	Emergency medical transporta	tion	\$150		\$150	
attention						
	Urgent care		\$40 <u>\$15</u>		\$40 <u>\$15</u>	
Hospital stay	Facility fee (e.g. hospital room	)	10%		\$250 per day up to 5 days	
noopha oay	Physician/surgeon fee		10%		\$40	
	Mental/Behavioral health outpatient office visits		\$ <del>20</del> \$15		\$ <del>20</del> \$15	
	Mental/Behavioral health other outpatient items and services		<del>\$20</del> \$15		\$20 \$15	
	mentar/behavioral health other outpatient items and services					
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		10%		\$250 per day up to 5 days	
Mental health,	Mental/Behavioral health inpat	ient physician/surgeon fee	10%		\$40	
behavioral health, or	mortal Bortavioral ricalar inpai	ion priyololariyodi goori 100	1078		\$40	
substance	Substance Use disorder outpatient office visits		800 84E		600 64E	
abuse needs	Substance use disorder outpa	tient office visits	<del>\$20</del> <u>\$15</u>		<del>\$20</del> <u>\$15</u>	
	Substance Use disorder other	outpatient items and services	<del>\$20</del> <u>\$15</u>		\$20 \$15	
	Substance Use inpatient facilit	y fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Substance use disorder inpati	ent nhysician/surgeon fee	10%		\$40	
	·		1474			
	Prenatal care and preconcepti		No charge		No charge \$250 per day up	
Pregnancy	Delivery and all inpatient services	Hospital	10%		to 5 days	
		Professional	10%		\$40	
	Home health care Outpatient Rehabilitation servi	ces	10% \$20 \$15		\$20 \$20 \$15	
Help recovering or	Outpatient Habilitation service		\$20 \$15		\$ <del>20</del> \$15	
other special	Skilled nursing care		10%		\$150 per day up to 5 days	
health needs	Durable medical equipment		10%		10%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam  1 pair of glasses per year (or c	ontact laneae in liquid disease)	No charge		No charge	
	Oral Exam	oritact renses in ilea of glasses)	No charge		No charge	_
Child Dental	Preventive - Cleaning					
Diagnostic and	Preventive - X-ray		No charge		No charge	
and Preventive	Sealants per Tooth Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental	Ameleon Fill 10 1		0		05-	
Basic Services	Amalgam Fill - 1 Surface		20%		\$25	
	Root Canal- Molar				\$300	
Child Dental	Gingivectomy per Quad	and Done on Experient	500/		\$150	
Major Services	Extraction- Single Tooth Expo Extraction- Complete Bony	sea Koot or Erupted	50%		\$65 \$160	
	Porcelain with Metal Crown		1		\$300	
Child	Medically necessary orthodon		50%		\$1,000	

Member Cost Si	hare amounts describe the Er	rollee's out of pocket costs.	Gold Coinsurand		Gold Copay P	
Actuarial Value	- AV Calculator		80.2 80.8		81.0 <u>81.5</u>	
	cludes a deductible?		No		No	
	Individual deductible Family deductible		\$0 \$0		\$0 \$0	
Individual of	deductible, NOT integrated:	Medical / Pharmacy / Dental	\$0 / \$0 /		\$0 / \$0 /	
	uctible, NOT integrated: Me -of-pocket maximum	dical / Pharmacy / Dental	\$0 / \$0 / \$ <del>6,200</del> 6		\$0 / \$0 / \$ <del>6,200</del> 6.	
Family Out-of-	oocket maximum		\$ <del>12,400</del> 1		\$ <del>12,400</del> <u>1</u> :	
	only coverage deductible n: Individual deductible		N/A N/A		N/A N/A	
,,,						
Common Medical Event	So	ervice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies
	Primary care visit to treat an	injury, illness, or condition	\$35 <u>\$30</u>		\$35 <u>\$30</u>	
Health care provider's office or	Other practitioner office visit		<del>\$35</del> <u>\$30</u>		\$35 <u>\$30</u>	
clinic visit	Specialist visit		\$55		\$55	
	Preventive care/ screening/ in	mmunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagir	na	\$35 \$ <del>50</del> <u>\$55</u>		\$35 \$60 <u>\$55</u>	
	Imaging (CT/PET scans, MR		20%		\$250 \$275	
	Tier 1		\$15		\$15	
Drugs to treat	Tier 2		\$ <del>50</del> \$ <u>55</u>		\$50 <u>\$55</u>	
illness or condition	Tier 3		<del>\$70</del> <u>\$75</u>		<del>\$70</del> <u>\$75</u>	
	Tier 4		20% up to \$250 per script		20% up to \$250 per script	
	Surgery facility fee (e.g., ASC	C)	20%		\$600	
Outpatient services	Physician/surgeon fees	,	20%		\$55	
361 11663	Outpatient visit		20%		20%	
	Emergency room facility fee	(waived if admitted)	\$250 <u>\$325</u>		\$ <del>250</del> <u>\$325</u>	
	Emergency room physician f	ee (waived if admitted)	20% No charge		No charge	
Need mmediate	Emergency medical transpor	tation	\$250		\$250	
attention	Urgent care		\$ <del>60</del> <u>\$30</u>		\$60 <u>\$30</u>	
	Facility fee (e.g. hospital room	n)	20%		\$600 per day up	
Hospital stay	Physician/surgeon fee	",	20%		to 5 days \$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>	
	Montal/Robaviaral health inn	atient facility fee (e.g.hospital room)	000/		\$600 per day up	
Mental health,			20%		to 5 days	
behavioral	Mental/Behavioral health inp	atient physician/surgeon fee	20%		\$55	
health, or substance abuse needs	Substance Use disorder outp	eatient office visits	\$35 <u>\$30</u>		\$35 <u>\$30</u>	
	Substance Use disorder other outpatient items and services		\$35 <u>\$30</u>		\$ <del>35</del> <u>\$30</u>	
	Substance Use inpatient faci	lity fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Substance use disorder inpa	tient physician/surgeon fee	20%		\$55	
	Prenatal care and preconcep	· · ·	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%		\$600 per day up	
3	services	Professional	20%		to 5 days \$55	
	Home health care		20%		\$30	
Help	Outpatient Rehabilitation service Outpatient Habilitation service		\$35 <u>\$30</u> \$35 <u>\$30</u>		\$35 \$30 \$35 \$30	
recovering or other special	Skilled nursing care		20%		\$300 per day up	
health needs	Durable medical equipment		20%		to 5 days 20%	
	Hospice service		No charge		No charge	
Child eye care	Eye exam		No charge		No charge	
a eye care		contact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Oral Exam Preventive - Cleaning					
Diagnostic	Preventive - X-ray		No charge		No charge	
and Preventive	Sealants per Tooth Topical Fluoride Application		onarge		s on ange	
Child Dental	Space Maintainers - Fixed					
Basic Services	Amalgam Fill - 1 Surface		20%		\$25	
	Root Canal- Molar Gingivectomy per Quad				\$300 \$150	
Child Dental			500/			
Major	Extraction- Single Tooth Exp	osed Root or Erupted	50%		\$65	
Child Dental Major Services	Extraction- Single Tooth Exp Extraction- Complete Bony Porcelain with Metal Crown	osed Root or Erupted	50%		\$160 \$300	

=	Benefits and Coverage hare amounts describe the En		Individua Silver Plar	
	- AV Calculator	rollee's out of pocket costs.	70.4 71.539	
	cludes a deductible?		Yes, Medical/Pha	_
Integrated I	ndividual deductible		N/A N/A	imacy
Individual of	Family deductible deductible, NOT integrated: I	Medical / Pharmacy / Dental	\$ <del>2,250</del> 2,500/ \$2	
	uctible, NOT integrated: Med- of-pocket maximum	lical / Pharmacy / Dental	\$4,500 <u>5,000</u> / \$5 \$6250 6,80	00 / \$0
Family Out-of-p	oocket maximum only coverage deductible		\$ <del>12,500</del> 13.6 N/A	00
	n: Individual deductible		N/A	
Camman				
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an ir	njury, illness, or condition	<del>\$45</del> \$35	
Health care provider's office or	Other practitioner office visit		\$45 <u>\$35</u>	
clinic visit	Specialist visit		\$70	
	Preventive care/ screening/ in	nmunization	No charge	
Tests	Laboratory Tests		\$35	
rests	X-rays and Diagnostic Imagin Imaging (CT/PET scans, MRI		\$65 <u>\$70</u> \$250 <u>\$300</u>	
	Tier 1		\$15	
Drugs to treat	Tier 2		\$ <del>50</del> \$ <u>55</u>	Pharmacy
illness or condition	Tier 3	\$70 \$80	Pharmacy	
	Tier 4	20% up to \$250 per script after pharmacy	deductible	
	Surgery facility fee (e.g., ASC	3	deductible	deductible
Outpatient services	Physician/surgeon fees	1	20%	
	Outpatient visit  Emergency room facility fee (	vaived if admitted)	20% \$250 \$350	×
	Emergency room physician fe			
Need immediate	Emergency medical transport	\$50 No charge \$250	×	
attention	Urgent care		\$90 <u>\$35</u>	
Hospital stay	Facility fee (e.g. hospital room	1)	20%	х
,	Physician/surgeon fee		20%	Х
	Mental/Behavioral health outpatient office visits		\$45 <u>\$35</u>	
	Mental/Behavioral health other	er outpatient items and services	\$45 <u>\$35</u>	
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	Х
Mental health, behavioral	Mental/Behavioral health inpa	tient physician/surgeon fee	20%	х
health, or substance abuse needs	Substance Use disorder outpa	atient office visits	<del>\$45</del> <u>\$35</u>	
	Substance Use disorder other	r outpatient items and services	\$45 <u>\$35</u>	
	Substance Use inpatient facili	ity 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%	х
	services Home health care	Professional	20%	Х
	Outpatient Rehabilitation serv	ices	\$45 \$45 <u>\$35</u>	
Help recovering or	Outpatient Habilitation service		<del>\$45</del> <u>\$35</u>	
other special health needs	Skilled nursing care		20%	Х
ammieeus	Durable medical equipment Hospice service		20% No charge	
	Eye exam		No charge No charge	
Child eye care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge	
Child Dental	Oral Exam Preventive - Cleaning			
Diagnostic	Preventive - X-ray		No charge	
and Preventive	Sealants per Tooth Topical Fluoride Application		5 Grounge	
Child Dental	Space Maintainers - Fixed			
Basic Services	Amalgam Fill - 1 Surface		20%	
Child Dental	Root Canal- Molar Gingivectomy per Quad			
Major	Extraction- Single Tooth Expo Extraction- Complete Bony	sed Root or Erupted	50%	
Services				
Services Child	Porcelain with Metal Crown			

	Benefits and Coverage		SHOP CCS Silver		SHOP CCS Silver	_	
Member Cost S	hare amounts describe the Er	rollee's out of pocket costs.	Coinsurance		Copay Plan		
Actuarial Value	e - AV Calculator		<del>71.6</del> 71.56	%	<del>71.3</del> <u>71.25</u>	%	
Plan design in	cludes a deductible?		Yes, Medical/Ph	armacy	Yes, Medical/Ph	armacy	
	Individual deductible Family deductible		N/A N/A		N/A N/A		
		Medical / Pharmacy / Dental	\$ <del>1,500</del> 2,000/ \$2	250 / \$0	\$ <del>1,500</del> 2,000/ \$2	250 / \$0	
Family ded	luctible, NOT integrated: Me		\$ <del>3,000</del> 4 <u>,000</u> / \$	500 / \$0	\$ <del>3,000</del> 4,000 / \$5	500 / \$0	
	of-pocket maximum		\$ <del>6,500</del> <u>6,8</u> 0 \$ <del>13,000</del> <u>13,</u> 0		\$6,500 <u>6,80</u> \$13,000 <u>13,6</u>		
HSA plan: Self	-only coverage deductible		N/A	<u> </u>	N/A	<del>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</del>	
HSA family pla	n: Individual deductible		N/A		N/A		
Common Medical Event		min Time	Member Cost Share	Deductible Applies	Member Cost Share	Deductib Applies	
Wedical Evelit	30	ervice Type	Welliber Cost Share	Applies	Member Cost Share	Applies	
	Primary care visit to treat an i	njury, illness, or condition	\$45		\$45		
Health care provider's	Other practitioner office visit		\$45		\$45		
office or	Other practitioner office visit		\$40		\$45		
clinic visit							
	Specialist visit		<del>\$70</del> <u>\$75</u>		<del>\$70</del> <u>\$75</u>		
	Preventive care/ screening/ ir	nmunization	No charge		No charge		
	Laboratory Tests		\$35 <u>\$40</u>		\$35 <u>\$40</u>		
Tests	X-rays and Diagnostic Imagir		\$65 <u>\$70</u>		\$65 <u>\$70</u>		
	Imaging (CT/PET scans, MR	s)	20%	×	\$250 <u>\$300</u>		
	Tier 1		\$15		\$15		
Druge to t	Tier 2		\$55	Pharmacy	\$55	Pharmac	
Drugs to treat illness or				deductible		deductib	
condition	Tier 3		<del>\$75</del> \$85	Pharmacy	<del>\$75</del> <u>\$85</u>	Pharmac	
			фт <del>о</del> <u>900</u>	deductible	<del>φτο</del> <u>φυο</u>	deductib	
	Tier 4		20% up to \$250 per	Pharmacy	20% up to \$250 per	Pharmac	
	nor 4		script after pharmacy deductible	deductible	script after pharmacy deductible	deductib	
Outpatient	Surgery facility fee (e.g., ASC	0)	20%		20%		
services	Physician/surgeon fees		20%		20%		
	Outpatient visit		20%		20%		
	Emergency room facility fee	waived if admitted)	\$250 <u>\$350</u>	×	\$ <del>250</del> \$350	×	
	Emergency room physician for	ee (waived if admitted)	\$50 No charge	×	\$50 No charge	×	
Need immediate	Emergency medical transpor	tation	\$250	Х	\$250	Х	
attention							
	Urgent care		\$90 <u>\$45</u>		\$90 <u>\$45</u>		
	Encility for (o.g. bospital roos	m)	20%	Х	20%	х	
Hospital stay	Facility fee (e.g. hospital roor	11)					
	Physician/surgeon fee		20%	X	20%	X	
	Mental/Behavioral health out	patient office visits	\$45		\$45		
	Mental/Behavioral health oth	er outpatient items and services	\$45		\$45		
	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	20%	Х	20%	Х	
Mental health, behavioral	Mental/Behavioral health inpa	atient physician/surgeon fee	20%	Х	20%	х	
health, or							
substance	Substance Use disorder outp	atient office visits	\$45		\$45		
abuse needs			<b>V</b> 10		<b>V</b> .0		
	Substance Use disorder other	r outpatient items and services	\$45		\$45		
	Substance Use inpatient faci	lity fee (e.g. hospital room)	20%	х	20%	х	
	Substance use disorder inpa	* * * *	20%	Х	20%	Х	
	Prenatal care and preconcep	tion visits	No charge		No charge		
Pregnancy	Delivery and all inpatient	Hospital	20%	х	20%	х	
	services	Professional	20%	Х	20%	Х	
	Home health care		20%		\$45		
Help	Outpatient Rehabilitation ser Outpatient Habilitation service		\$45 \$45		\$45 \$45		
recovering or other special	Skilled nursing care		20%	х	20%	х	
health needs	Durable medical equipment			^		^	
	Hospice service		20% No charge		20% No charge		
Child a	Eye exam		No charge		No charge		
Child eye care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge		No charge		
01.11.1	Oral Exam						
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray						
and	Sealants per Tooth		No charge		No charge		
Preventive	Topical Fluoride Application						
Child David	Space Maintainers - Fixed						
Child Dental Basic	Amalgam Fill - 1 Surface		20%		\$25		
Services							
Child Deetel	Root Canal- Molar				\$300		
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Exp	osed Root or Erupted	50%		\$150 \$65		
Services	Extraction- Complete Bony	•			\$160		
	Porcelain with Metal Crown				\$300		
Child							

#### 2016 2017 Standard Benefit Plan Designs 10.0 EHB

Child Dental Basic Services

Child Dental Major Services

Amalgam Fill - 1 Surface

Medically necessary orthodontics

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

Summary of	Benefits and Coverage	)	SHOP CO	CSB	
	hare amounts describe the En		Silver		
		nones a out of pocket coats.	HSA HDHP	71.16%	
	- AV Calculator				
	cludes a deductible?		Yes, integ \$2,000 integ		
Integrated I	Family deductible		\$4,000 integ	grated	
	deductible, NOT integrated: uctible, NOT integrated: Med	Medical / Pharmacy / Dental	N/A N/A		
Individual Out-	-of-pocket maximum	alcai / Filarmacy / Demai	\$6,250 6,		
Family Out-of-	oocket maximum		\$12,500 <u>13</u>		
HSA family pla	only coverage deductible n: Individual deductible		\$2,000 \$2,600		
Common Medical Event	Se	ervice Type	Member Cost Share	Deductible Appl	
	Primary care visit to treat an i	injury, illness, or condition	20%	х	
Health care provider's office or	Other practitioner office visit		20%	х	
clinic visit	Specialist visit		20%	х	
	Preventive care/ screening/ in	nmunization	No charge		
Focto	Laboratory Tests		20%	X	
Гests	X-rays and Diagnostic Imagin Imaging (CT/PET scans, MRI		20%	X	
		,	20% up to \$250 per		
	Tier 1		script	Х	
Orugs to treat	Tier 2		20% up to \$250 per script	х	
condition	Tier 3		20% <u>up to \$250 per</u> <u>script</u>	х	
	Tier 4		20% up to \$250 per script	х	
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	C)	20%	X	
envices	Outpatient visit		20% 20%	X	
	Emergency room facility fee (	(waiwad if admitted)	20%	X	
			20%	^	
Need	Emergency room physician fee (waived if admitted)		<del>20%</del> <u>0%</u>	Х	
mmediate	Emergency medical transportation		20%	Х	
attention	Urgent care		20%	х	
Hospital stay	Facility fee (e.g. hospital roor	n)	20%	Х	
	Physician/surgeon fee		20%	X	
	Mental/Behavioral health outpatient office visits		20%	x	
	Mental/Behavioral health other outpatient items and services		20%	х	
Mental health,	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	20%	х	
behavioral	Mental/Behavioral health inpa	atient physician/surgeon fee	20%	х	
health, or substance abuse needs	Substance Use disorder outp	vatient office visits	20%	х	
	Substance Use disorder other outpatient items and services		20%	×	
	Substance Use inpatient facil	lity fee (e.g. hospital room)	20%	х	
	Substance use disorder inpat	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		20%	Х	
lelp	Outpatient Rehabilitation service Outpatient Habilitation service		20%	X	
recovering or other special	Skilled nursing care		20%	X	
health needs	-		20%	X	
	Durable medical equipment Hospice service		20%	X	
Obild are a	Eye exam		No charge		
Child eye care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge		
01.11.15	Oral Exam				
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray				
and	Sealants per Tooth		No charge		
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				

20%

50%

50%

Date: May 21, 2015 February 18, 2016

Summary of Benefits and Coverage

Summary of	Benefits and Coverage					
Member Cost S	hare amounts describe the En	ollee's out of pocket costs.	Silver P 100%1509		Silver Plan 150%-200% Fi	
<b>Actuarial Value</b>	e - AV Calculator		93.8 94.	12%	86.8 <u>87.48</u> %	
	cludes a deductible?		Yes, Medical/I	Pharmacy	Yes, Medical/Pha	rmacy
	Individual deductible Family deductible		N/A N/A		N/A N/A	
Individual	deductible, NOT integrated: N	ledical / Pharmacy / Dental	\$75 / \$0		\$ <del>550</del> <u>650</u> / \$50	
Individual Out-	luctible, NOT integrated: Med -of-pocket maximum	ical / Pharmacy / Dental	\$150 / \$0 \$ <del>2,250</del> 2		\$ <del>1,100</del> <u>1,300</u> / \$10 \$ <del>2,250</del> <u>2,350</u>	
Family Out-of-	pocket maximum		\$4,500 <u>4</u>		\$4,500 4,700 N/A	
	only coverage deductible in: Individual deductible		N/A N/A		N/A	
Common Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an in	jury, illness, or condition	\$5		\$15 <u>\$10</u>	
Health care provider's office or clinic visit	Other practitioner office visit		\$5		<del>\$15</del> <u>\$10</u>	
	Specialist visit		\$8		\$25	
	Preventive care/ screening/ im	munization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	<u> </u>	\$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% 10%		15% 15%	
services	Physician/surgeon fees Outpatient visit		10%		15%	
	Emergency room facility fee (v	vaived if admitted)	\$30 <u>\$50</u>	×	\$75 <u>\$100</u>	×
	Emergency room physician fe	e (waived if admitted)	\$25 No charge	×	\$40 No charge	×
Need immediate	Emergency medical transporta		\$30	Х	\$75	Х
attention	Urgent care		\$6 <u>\$5</u>		\$30 <u>\$10</u>	
	For The Control of th	`				
Hospital stay	Facility fee (e.g. hospital room	)	10%	Х	15%	Х
	Physician/surgeon fee		10%	X	15%	X
	Mental/Behavioral health outp	atient office visits	\$5		\$15 <u>\$10</u>	
	Mental/Behavioral health othe	outpatient items and services	\$5		<del>\$15</del> <u>\$10</u>	
	Mental/Behavioral health inpar	ient facility fee (e.g.hospital room)	10%	х	15%	х
Mental health, behavioral	Mental/Behavioral health inpar	ient physician/surgeon fee	10%	Х	15%	Х
health, or substance abuse needs	Substance Use disorder outpa	tient office visits	\$5		\$ <del>15</del> \$ <u>10</u>	
					4.54.5	
	Substance Use disorder other	<u> </u>	\$5		<del>\$15</del> <u>\$10</u>	
	Substance Use inpatient facili		10%	X	15%	Х
	Substance use disorder inpati		10%	Х	15%	Х
	Prenatal care and preconcept		No charge		No charge	
Pregnancy	Delivery and all inpatient services	Hospital	10%	Х	15%	Х
	Home health care	Professional	10% \$3	X	15% \$15	X
Help	Outpatient Rehabilitation servi		\$5		\$15 <u>\$10</u>	
recovering or	Outpatient Habilitation service	3	\$5		\$15 \$10	
other special health needs	Skilled nursing care		10%	Х	15%	Х
	Durable medical equipment Hospice service		10% No charge		15% No charge	
Child our st	Eye exam		No charge		No charge	
Child eye care	1 pair of glasses per year (or o	ontact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Oral Exam Preventive - Cleaning					
Diagnostic	Preventive - X-ray		No charge		No charge	
and Preventive	Sealants per Tooth Topical Fluoride Application		140 charge		140 charge	
Child Dental Basic	Space Maintainers - Fixed  Amalgam Fill - 1 Surface		20%		20%	
Services	Root Canal- Molar					
Child Dental	Gingivectomy per Quad					
Major Services	Extraction- Single Tooth Expor Extraction- Complete Bony Porcelain with Metal Crown	sed Root or Erupted	50%		50%	
Child Orthodontics	Medically necessary orthodon	ics	50%		50%	

#### 2016 2017 Standard Benefit Plan Designs 10.0 EHB

Date: May 21, 2015 February 18, 2016

Summary of Benefits and Coverage

	hare amounts describe the En	rollee's out of pocket costs.	Silver Plan 200%-250% FP 72.8 73.67%	L
	e - AV Calculator cludes a deductible?			
	Individual deductible?		Yes, Medical/Phare N/A	macy
	Family deductible	Madical / Dharmany / Dantal	N/A \$ <del>1,900</del> <u>2,200</u> / \$25	0 / 60
	deductible, NOT integrated: luctible, NOT integrated: Med		\$3,800 <u>4,400</u> / \$50	
	of-pocket maximum		\$ <del>5,450</del> <u>5,700</u> \$ <del>10,900</del> 11,40	n
ISA plan: Self	only coverage deductible		N/A	<u>v</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 i	njury, illness, or condition	\$4 <del>0</del> \$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	
Γests	Laboratory Tests X-rays and Diagnostic Imagin	σ.	\$35 \$ <del>50</del> <u>\$65</u>	
16313	Imaging (CT/PET scans, MRI		\$250 \$300	
	Tier 1		\$15	
Drugs to treat	Tier 2		\$45 <u>\$50</u>	Pharmacy
illness or condition	Tier 3	\$ <del>70</del> <u>\$75</u>	Pharmacy deductible	
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
Outpatient	Surgery facility fee (e.g., ASC	:)	20%	
services	Physician/surgeon fees Outpatient visit		20% 20%	
	Emergency room facility fee (	waived if admitted)	\$250 \$350	×
	Emergency room physician fe			*
Need	Emergency medical transport	\$50 No charge \$250	X	
mmediate attention	Emergency medical transport	Manori	\$250	
	Urgent care		\$ <del>80</del> <u>\$30</u>	
Hospital stay	Facility fee (e.g. hospital roor	n)	20%	Х
iospitai stay	Physician/surgeon fee		20%	Х
	Mental/Behavioral health out	patient office visits	\$40 <u>\$30</u>	
	Mental/Behavioral health other	\$40 <u>\$30</u>		
	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	20%	х
Mental health, behavioral	Mental/Behavioral health inpa	atient physician/surgeon fee	20%	Х
nealth, or substance abuse needs	Substance Use disorder outp	atient office visits	\$ <del>40</del> <u>\$30</u>	
	Substance Use disorder othe	r outpatient items and services	\$40 <u>\$30</u>	
	Substance Use inpatient facil	ity fee (e.g. hospital room)	20%	Х
	Substance use disorder inpat		20%	×
	Prenatal care and preconcep	* * * * * * * * * * * * * * * * * * * *	No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	Х
	services	Professional	20%	X
	Home health care		\$40	
lelp .	Outpatient Rehabilitation service Outpatient Habilitation service		\$40 <u>\$30</u> \$40 <u>\$30</u>	
recovering or other special	Skilled nursing care		20%	х
nealth needs	Durable medical equipment		20%	
	Hospice service		No charge	
Child eye care	Eye exam 1 pair of glasses per year (or	contact lengue in liqu of alconos)	No charge No charge	
	Oral Exam	oornaar ini inaa Ul Yidaana)	ivo charge	
Child Dental	Preventive - Cleaning			
Diagnostic and	Preventive - X-ray Sealants per Tooth		No charge	
Preventive	Topical Fluoride Application			
Child Dental Basic	Space Maintainers - Fixed  Amalgam Fill - 1 Surface		20%	
Services				
Child Dental	Root Canal- Molar Gingivectomy per Quad			
Major Services	Extraction- Single Tooth Expo Extraction- Complete Bony	osed Root or Erupted	50%	
services	Porcelain with Metal Crown			

Summary of Benefits and Coverage

	hare amounts describe the E	nrollee's out of pocket costs.	Bronze Pla	n	Bronz	Plan
	- AV Calculator		61.9%		61.06 61.	
	cludes a deductible? Individual deductible		Yes, Medical/Pha N/A	armacy	Yes, integral \$4,500 integral	
Integrated F	Family deductible	Madical / Dharman / Dantal	N/A	00 / 60	\$9,000 integ	
Family ded	uctible, NOT integrated: Me	Medical / Pharmacy / Dental dical / Pharmacy / Dental	\$ <del>6,000</del> <u>6,300</u> / \$5 \$ <del>12,000</del> 12,600 / \$1		N/A N/A	
ndividual Out-	-of-pocket maximum		\$ <del>6,500</del> <u>6,80</u>	0	\$ <del>6,500</del> <u>6,</u>	
-amily Out-of-p ISA plan: Self-	oocket maximum only coverage deductible		\$ <del>13,000</del> <u>13,6</u> N/A	00	\$1 <del>3,000</del> <u>13</u> \$4,500	
HSA family plan	n: Individual deductible		N/A		\$4,500	)
Common Medical Event	S	ervice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductit Applies
	Primary care visit to treat an		\$ <del>70</del> <u>\$75</u>	After 1st three non-preventive visits	40%	х
Health care provider's perfect or	Other practitioner office visit		<del>\$70</del> <u>\$75</u>	After 1st three non-preventive visits	40%	х
clinic visit	Specialist visit		\$ <del>90</del> <u>\$105</u>	After 1st three non-preventive visits	40%	х
	Preventive care/ screening/ i	mmunization	No charge		No charge	
	Laboratory Tests X-rays and Diagnostic Imagii	na	\$40 100%	×	40% 40%	X
	Imaging (CT/PET scans, MR		100%	x	40%	X
	Tier 1		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	х
Drugs to treat	Tier 2		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	х
Ilness 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
	Surgery facility fee (e.g., AS	0)	100%	X	40%	X
ervices	Physician/surgeon fees Outpatient visit		100%	X	40% 40%	X
	Emergency room facility fee	(waived if admitted)	100%	X	40%	X
leed	Emergency room physician f		100% No charge	×	<del>40%</del> <u>0%</u>	Х
ouiuto	Emergency medical transpor	tation	100%	Х	40%	Х
attention L	Urgent care		\$120 <u>\$75</u>	After 1st three non-preventive visits	40%	х
Hospital stay	Facility fee (e.g. hospital roo	m)	100%	х	40%	х
	Physician/surgeon fee		100%	х	40%	Х
	Mental/Behavioral health out	patient office visits	<del>\$70</del> <u>\$75</u>	After 1st three non-preventive visits	40%	х
	Mental/Behavioral health oth	er outpatient items and services	<del>\$70</del> <u>\$75</u>	After 1st three non-preventive visits	40%	х
	Mental/Behavioral health inp	atient facility fee (e.g.hospital room)	100%	х	40%	Х
Mental health,	Mental/Behavioral health inp	atient physician/surgeon fee	100%	×	40%	X
nealth, or	Substance Use disorder out	.,,	\$70 <u>\$75</u>	After 1st three non-preventive visits	40%	x
	Substance Use disorder other	er outpatient items and services	<del>\$70</del> <u>\$75</u>	After 1st three non-preventive visits	40%	x
	Substance Use inpatient fac	lity fee (e.g. hospital room)	100%	x	40%	Х
	Substance use disorder inpa	tient physician/surgeon fee	100%	х	40%	х
	Prenatal care and preconcep		No charge		No charge	
	Delivery and all inpatient	Hospital	100%	х	40%	Х
	services	Professional	100%	X	40%	X
	Home health care		100%	X	40%	Х
1eip	Outpatient Rehabilitation service Outpatient Habilitation service		\$70 <u>\$75</u> \$70 <u>\$75</u>		40% 40%	X
ecovering or	Skilled nursing care		100%	х	40%	X
palth needs	Durable medical equipment		100%	X	40%	X
	Hospice service		No charge	^	40% 0%	X
hild eve care	Eye exam		No charge		No charge	
		contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam Preventive - Cleaning					
Diagnostic	Preventive - X-ray		No charge		No charge	
	Sealants per Tooth Topical Fluoride Application		No charge		140 Glaige	
	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%		20%	
	Root Canal- Molar					
	Gingivectomy per Quad					
Major Services	Extraction- Single Tooth Exp Extraction- Complete Bony Porcelain with Metal Crown	osed Root or Erupted	50%		50%	

			-
Summary	of Benefits	and Cove	rage

	hare amounts describe the En		Catastrop	
	cludes a deductible?		Yes, into	egrated
Integrated	Individual deductible		\$ <del>6,850</del> <u>7,15</u> 6	integrated
	Family deductible deductible, NOT integrated: N	Medical / Pharmacy / Dental	\$ <del>13,700</del> <u>14,3</u> 0 N/	
Family ded	uctible, NOT integrated: Med	lical / Pharmacy / Dental	N/	Ά
ndividual Out-	-of-pocket maximum		\$6,850	
	pocket maximum -only coverage deductible		\$ <del>13,700</del> N	
ISA family pla	n: Individual deductible		N/	'A
Common Medical Event	Sei	rvice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an ir	njury, illness, or condition	0%	After 1st three non-preventing visits
Health care provider's office or	Other practitioner office visit		0%	After 1st three non-preventing visits
clinic visit	Specialist visit		0%	х
	Preventive care/ screening/ im	nmunization	No charge	
	Laboratory Tests		0%	Х
ests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs		0%	X
		2)		
	Tier 1		0%	Х
Orugs to treat	Tier 2	0%	Х	
condition	Tier 3		0%	х
	Tier 4		0%	х
Outpatient	Surgery facility fee (e.g., ASC	)	0%	X
ervices	Physician/surgeon fees Outpatient visit		0%	X
	Emergency room facility fee (v	waived if admitted)	0%	×
leed	Emergency room physician fee (waived if admitted)		9% No charge	×
nmediate ttention	Emergency medical transportation		0%	Х
ttention	Urgent care		0%	After 1st thr non-prevent visits
lospital stay	Facility fee (e.g. hospital room	n)	0%	Х
	Physician/surgeon fee		0%	X
	Mental/Behavioral health outpatient office visits		0%	After 1st thronon-prevention visits
	Mental/Behavioral health othe	or outpatient items and services	0%	After 1st three non-preventi visits
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	0%	х
Mental health, ehavioral	Mental/Behavioral health inpa	tient physician/surgeon fee	0%	х
ealth, or substance sbuse needs	Substance Use disorder outpa	atient office visits	0%	After 1st thr non-prevent visits
	Substance Use disorder other	r outpatient items and services	0%	After 1st thro
	Substance Hec innation ( = -iii	ty fee (e.g. boenital room)	621	visits
	Substance Use inpatient facili  Substance use disorder inpati		0%	X
	Prenatal care and preconcept	* * * *	No charge	
regnancy	Delivery and all inpatient	Hospital	0%	×
. Jg. arroy	services	Professional	0%	X
	Home health care	i rordooluriai	0%	X
elp	Outpatient Rehabilitation serv		0%	Х
ecovering or	Outpatient Habilitation service	rs .	0%	X
ther special ealth needs	Skilled nursing care		0%	Х
	Durable medical equipment Hospice service		0% 0%	X
	Eye exam		No charge	
hild eye care	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	0%	х
hild Deer 1	Oral Exam			
hild Dental iagnostic	Preventive - Cleaning Preventive - X-ray			
nd	Sealants per Tooth		No charge	
reventive	Topical Fluoride Application Space Maintainers - Fixed			
hild Dental	Amalgam Fill - 1 Surface		0%	х
ervices	Poet Congl. Mailer			
hild Dental	Root Canal- Molar Gingivectomy per Quad			X
Major	Extraction- Single Tooth Expo	sed Root or Erupted	0%	Х
Services	Extraction- Complete Bony Porcelain with Metal Crown			X
				^
Child	Medically necessary orthodon	et a constant and a c	0%	Х