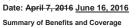
2017 Standard Benefit Plan Designs

April 7, 2016 June 16, 2016 Final Board-approved Revised for Board Review and Action

2017 Standard Benefit Plan Designs 10.0 EHB





Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.			Platinum Coinsurance Plan		Platinum Copay Plan	
Actuarial Value	e - AV Calculator		89.7%		90.3%	
	cludes a deductible?		No \$0		No	
Integrated Fa	Integrated Individual deductible Integrated Family deductible				\$0 \$0	
Individual de Family deduc	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental			\$0	\$0 / \$0 / \$0 / \$0 /	
Individual Out-	-of-pocket maximum pocket maximum	carrinamacy / Demai	\$0 / \$0 / \$4,00	0	\$4,00	C
Family Out-of- HSA plan: Self	pocket maximum -only coverage deductible		\$8,00 N/A	0	\$8,000 N/A)
	n: Individual deductible		N/A		N/A	
Common Medical Event	St	ervice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an	njury, illness, or condition	\$15		\$15	
Health care provider's office or clinic	Other practitioner office visit	\$15		\$15		
visit	Specialist visit	\$40		\$40		
	Preventive care/ screening/ i Laboratory Tests	mmunization	No charge \$20		No charge \$20	
Tests	X-rays and Diagnostic Imagir		\$40		\$40	
	Imaging (CT/PET scans, MR	10%		\$150		
	Tier 1		\$5		\$5	
Drugs to treat illness or	Tier 2		\$15		\$15	
condition	Tier 3		\$25		\$25	
	Tier 4		10% up to \$250 per script		10% up to \$250 per script	
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	•)	10% 10%		\$250 \$40	
services	Outpatient visit		10%		10%	
	Emergency room facility fee (waived if admitted)	\$150		\$150	
Need immediate	Emergency room physician fe Emergency medical transport	No charge \$150		No charge \$150		
attention	Urgent care		\$15		\$15	
Hospital stay	Facility fee (e.g. hospital roor	n)	10%		\$250 per day up to 5 days	
Hospital Stay	Physician/surgeon fee		10%		\$40	
	Mental/Behavioral health out	\$15		\$15		
	Mental/Behavioral health oth	\$15		\$15		
	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	10%		\$250 per day up to 5 days	
Mental health, behavioral	Mental/Behavioral health inpa	atient physician fee	10%		\$40	
health, or substance abuse needs	Substance Use disorder outp	atient office visits	\$15		\$15	
	Substance Use disorder othe	r outpatient items and services	\$15		\$15	
	Substance Use inpatient facil	ity fee (e.g. hospital room)	10%		\$250 per day up	
	Substance use disorder inpat		10%		to 5 days \$40	
	Prenatal care and preconcep		No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	10%		\$250 per day up	
	services	Professional	10%		to 5 days \$40	
	Home health care Outpatient Rehabilitation service	vices	10% \$15		\$20 \$15	
Help recovering or	Outpatient Habilitation servic		\$15		\$15	
other special	Skilled nursing care		10%		\$150 per day up to 5 days	
health needs	Durable medical equipment		10%		10%	
	Hospice service Eye exam		No charge No charge		No charge No charge	
Child eye care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge		No charge	
Child Pantal	Oral Exam					
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray		No charge		No charge	
and Preventive	Sealants per Tooth Topical Fluoride Application		No charge		No charge	
Child Dental	Space Maintainers - Fixed Restorative Procedures				See 2017 Dental	
Basic Services	Periodontal Maintenance Ser	vices	20%		Copay Schedule	
	Crowns and Casts Endodontics					
Child Dental Major	Periodontics (other than mair	itenance)	50%		See 2017 Dental	
Services	Prosthodontics Oral Surgery				Copay Schedule	
Child Orthodontics	Medically necessary orthodo	ntics	50%		\$1,000	

10.0 EHB	dard Benefit Plan Designs -7, 2016 June 16, 2016				
Summary of	Benefits and Coverage				
Member Cost S	hare amounts describe the Enrollee's out of pocket costs.	Gold		Gold	
	e - AV Calculator	Coinsurant 80.9%		Copay F 81.2%	
	cludes a deductible?	No	0		0
	dividual deductible	\$0		No \$0	
Integrated Fa	amily deductible	\$0	100	\$0	
	ductible, NOT integrated: Medical / Pharmacy / Dental ctible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 \$0 / \$0		\$0 / \$0 / \$0 / \$0 /	
Individual Out-	-of-pocket maximum	\$6,75	0	\$6,75	0
	pocket maximum -only coverage deductible	\$13,50 N/A		\$13,50 N/A)0
	in: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Dedu Apj
	Primary care visit to treat an injury, illness, or condition	\$30		\$30	
Health care provider's office or clinic visit	Other practitioner office visit	\$30		\$30	
	Specialist visit	\$55		\$55	
	Preventive care/ screening/ immunization Laboratory Tests	No charge \$35		No charge \$35	
Tests	X-rays and Diagnostic Imaging	\$55		\$55	
	Imaging (CT/PET scans, MRIs)	20%		\$275	
	Tier 1	\$15		\$15	
Drugs to treat illness or	Tier 2	\$55		\$55	
condition	Tier 3	\$75		\$75	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
Outpatient	Surgery facility fee (e.g., ASC)	20% 20%		\$600 \$55	
services	Physician/surgeon fees Outpatient visit	20%		\$55 20%	
	Emergency room facility fee (waived if admitted)	\$325		\$325	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
Need immediate	Emergency medical transportation	\$250		\$250	
attention	Urgent care	\$30		\$30	
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	\$30		\$30	

	Imaging (CT/PET scans, MRIs)	20%		\$275	
	Tier 1		\$15		\$15	
ugs to treat	Tier 2		\$55		\$55	
ness or ondition	Tier 3		\$75		\$75	
	Tier 4		20% up to \$250 per script		20% up to \$250 per script	
utpatient	Surgery facility fee (e.g., ASC)		20%		\$600	[
ervices	Physician/surgeon fees		20%		\$55	ŀ
	Outpatient visit		20%		20%	Ļ
	Emergency room facility fee (v		\$325		\$325	
ed	Emergency room physician fe	e (waived if admitted)	No charge		No charge	
mediate	Emergency medical transporta	ition	\$250		\$250	
tention	Urgent care		\$30		\$30	
ospital stay	Facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Physician/surgeon fee		20%		\$55	Ļ
	Mental/Behavioral health outp	atient office visits	\$30		\$30	
	Mental/Behavioral health othe	\$30		\$30		
	Mental/Behavioral health inpat	20%		\$600 per day up to 5 days		
ental health, ehavioral ealth, or	Mental/Behavioral health inpat	ient physician fee	20%		\$55	L
bstance use needs	Substance Use disorder outpa	tient office visits	\$30		\$30	
	Substance Use disorder other	outpatient items and services	\$30		\$30	
	Substance Use inpatient facilit	y fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Substance use disorder inpati	ent physician fee	20%		\$55	
	Prenatal care and preconcepti	on visits	No charge		No charge	[
egnancy	Delivery and all inpatient services	Hospital	20%		\$600 per day up to 5 days	L
		Professional	20%		\$55	Ļ
	Home health care Outpatient Rehabilitation servi	CPS	20% \$30		\$30 \$30	ŀ
elp	Outpatient Habilitation service		\$30		\$30	
covering or her special			20%		\$300 per day up	ľ
alth needs	Skilled nursing care				to 5 days	
	Durable medical equipment		20%		20%	ŀ
	Hospice service		No charge No charge		No charge No charge	ŀ
nild eye care	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
	Oral Exam	· ·				ŀ
nild Dental	Preventive - Cleaning					ľ
agnostic	Preventive - X-ray		No charge		No charge	l
nd	Sealants per Tooth		10 010190		. to ondigo	
eventive	Topical Fluoride Application Space Maintainers - Fixed			_		ŀ
nild Dental	opuso maintainers - rixeu					ł

See 2017 Dental Copay Schedule

See 2017 Dental Copay Schedule

\$1,000

20%

50%

50%

Child Den Basic Services

Child Den Major Services

Child Orthoo

Restorative Procedures

Prosthodontics Oral Surgery

Periodontal Maintenance Services Crowns and Casts Endodontics

Medically necessary orthodontics

Periodontics (other than maintenance)

	7, 2016 June 16, 2016		
Summary of	Benefits and Coverage	Individual	1
Member Cost S	hare amounts describe the Enrollee's out of pocket costs.	Silver Plan	ı
	e - AV Calculator	71.5%	
	cludes a deductible? dividual deductible	Yes, Medical/Pha N/A	armacy
Integrated Fa	ımily deductible ductible, NOT integrated: Medical / Pharmacy / Dental	N/A \$2,500/ \$250	/ \$0
Family deduc	tible, NOT integrated: Medical / Pharmacy / Dental -of-pocket maximum	\$5,000/ \$500 \$6,800	
Family Out-of-	pocket maximum	\$13,600	
HSA family pla	-only coverage deductible n: Individual deductible	N/A N/A	
Common			Deductibl
Medical Event	Service Type	Member Cost Share	Applies
	Primary care visit to treat an injury, illness, or condition	\$35	
Health care			
provider's	Other practitioner office visit	\$35	
office or clinic visit			
	Specialist visit	\$70	
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$35 \$70	
	Imaging (CT/PET scans, MRIs)	\$300	
	Tier 1	\$15	
	Tex 2	055	Pharma
Drugs to treat illness or	Tier 2	\$55	deductib
condition	Tier 3	\$80	Pharmad deductib
		20% up to \$250 per	
	Tier 4	script after pharmacy deductible	Pharmac deductibl
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees	20%	
services	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$350	
	Emergency room physician fee (waived if admitted)	No charge	
Need immediate	Emergency medical transportation	\$250	Х
attention			
	Urgent care	\$35	
Hospital stay	Facility fee (e.g. hospital room) Physician/surgeon fee	20%	x x
	Mental/Behavioral health outpatient office visits	\$35	
	Mental/Behavioral health other outpatient items and services	\$35	
Mental health,	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	Х
behavioral health, or	Mental/Behavioral health inpatient physician fee	20%	х
substance abuse needs	Substance Use disorder outpatient office visits	\$35	
	Substance Use disorder other outpatient items and services	\$35	
	Substance Lise innatient facility for (o.g. bessitel year)	20%	x
	Substance Use inpatient facility fee (e.g. hospital room)		_
	Substance use disorder inpatient physician fee Prenatal care and preconception visits	20%	×
Pregnancy	Delivery and all inpatient Hospital	No charge 20%	x
	services Professional	20%	X
	Home health care Outpatient Rehabilitation services	\$45 \$35	
Help recovering or	Outpatient Habilitation services	\$35	
other special health needs	Skilled nursing care	20%	х
	Durable medical equipment Hospice service	20% No charge	
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	No charge	
Child Dental	Preventive - Cleaning		
Diagnostic and	Preventive - X-ray Sealants per Tooth	No charge	
	Topical Fluoride Application Space Maintainers - Fixed		
Preventive			
Child Dental		20%	
Child Dental Basic	Restorative Procedures Periodontal Maintenance Services	2070	
Preventive Child Dental Basic Services	Periodontal Maintenance Services Crowns and Casts		
Child Dental Basic Services Child Dental	Periodontal Maintenance Services Crowns and Casts Endodontics		
Child Dental Basic Services	Periodontal Maintenance Services Crowns and Casts	50%	

2017 Standard Benefit Plan Designs 10.0 EHB Date: April 7, 2016 <u>June 16, 2016</u>

Date. April	7, 2016 June 16, 20	10					
Summary of	Benefits and Coverage		CCSB		CCSB		
	hare amounts describe the Er		Silver	Dian	Silver		
	e - AV Calculator		Coinsurance 71.6%	Plan	Copay Plan 71.3%		
	cludes a deductible? dividual deductible		Yes, Medical/Ph N/A	armacy	Yes, Medical/Pha N/A	armacy	
Integrated Fa	amily deductible		N/A \$2,000/ \$250	1.00	N/A	180	
Family deduc	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental			/\$0	\$2,000/ \$250 \$4,000 / \$500		
Individual Out-	-of-pocket maximum	····	\$6,800		\$6,800		
Family Out-of-	pocket maximum -only coverage deductible		\$13,600 N/A		\$13,600 N/A		
HSA family pla	in: Individual deductible		N/A		N/A		
Common				Deductible		Deductible	
Medical Event	S	ervice Type	Member Cost Share	Applies	Member Cost Share	Applies	
	Primary care visit to treat an	njury, illness, or condition	\$45		\$45		
Health care provider's office or clinic	Other practitioner office visit		\$45		\$45		
visit	Specialist visit		\$75		\$75		
	Preventive care/ screening/ in	nmunization	No charge		No charge		
Teste	Laboratory Tests	-	\$40		\$40		
Tests	X-rays and Diagnostic Imagin Imaging (CT/PET scans, MR	9 s)	\$70		\$70 \$300		
		-7					
	Tier 1		\$15		\$15		
Drugs to treat illness or	Tier 2		\$55	Pharmacy deductible	\$55	Pharmacy deductible	
condition	Tier 3		\$85 20% up to \$250 per	Pharmacy deductible	\$85	Pharmacy deductible	
	Tier 4		script after pharmacy deductible	Pharmacy deductible	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	•)	20%		20%		
services	Outpatient visit		20%		20%		
	Emergency room facility fee (waived if admitted)	\$350		\$350		
	Emorgonov room physician fr	No charge		No chargo			
Need	Emergency room physician fee (waived if admitted) Emergency medical transportation		\$250	X	No charge \$250	X	
immediate attention	Emergency medical transport	allon	\$250	~	\$250	~	
	Urgent care		\$45		\$45		
Hospital stay	Facility fee (e.g. hospital roor	n)	20%	x	20%	x	
	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 inpa	atient facility fee (e.g.hospital room)	20%	х	20%	х	
Mental health,	Mental/Behavioral health inpa		20%	х	20%	x	
behavioral health, or	Menta/Benavioral nealth inpa	allent physician lee	2076	^	2076	^	
substance abuse needs	Substance Use disorder outp	\$45		\$45			
	Substance Use disorder othe	r outpatient items and services	\$45		\$45		
	Substance Use inpatient facil	ity fee (e.g. hospital room)	20%	х	20%	х	
	Substance use disorder inpat	ient physician fee	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%	X	20%	X	
	Home health care		20%		\$45		
Help	Outpatient Rehabilitation service Outpatient Habilitation service		\$45 \$45		\$45 \$45		
recovering or other special	Skilled nursing care		20%	x	20%	х	
health needs	Durable medical equipment		20%	^	20%	~	
	Hospice service		20% No charge		20% No charge		
Child	Eye exam		No charge		No charge		
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge		
Child Dental	Oral Exam						
Diagnostic	Preventive - Cleaning Preventive - X-ray Sealants per Tooth		No. chao		No. of an		
and			No charge		No charge		
Preventive	Topical Fluoride Application Space Maintainers - Fixed			_			
Child Dental Basic	Restorative Procedures		20%		See 2017 Dental Copay Schedule		
Services	Periodontal Maintenance Ser	vices			Generale		
	Crowns and Casts Endodontics						
Child Dental Major	Periodontics (other than main	tenance)	- 50%		See 2017 Dental Copay		
Major Services		(C)			Schedule		
	Prosthodontics Oral Surgery		1				
Child		stice	500/		61 005		
Orthodontics	Medically necessary orthodor	nics	50%		\$1,000		

2017 Standard Benefit Plan Designs 10.0 EHB Date: April 7, 2016 June 16, 2016

Summary of	Benefits and Coverage		CCSB	
Member Cost S	hare amounts describe the En	rollee's out of pocket costs.	Silver	
	e - AV Calculator		HDHP PI 71.3%	
	cludes a deductible?		Yes, integr	
Integrated In	dividual deductible		\$2,000 integ	
Integrated Fa	mily deductible ductible, NOT integrated: Me	dical / Pharmacy / Dental	\$4,000 integ N/A	grated
Family deduc	ctible, NOT integrated: Medic	al / Pharmacy / Dental	N/A N/A	
Individual Out-	-of-pocket maximum		\$6,650 <u>\$6</u>	
HSA plan: Self	pocket maximum -only coverage deductible		\$13,300 \$11 \$2,000	
HSA family pla	n: Individual deductible		\$2,600	
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Appl
	Primary care visit to treat an in		20%	х
Health care provider's office or clinic	Other practitioner office visit		20%	x
visit	Specialist visit		20%	х
	Preventive care/ screening/ in	nmunization	No charge	
	Laboratory Tests		20%	Х
Tests	X-rays and Diagnostic Imaging		20%	X X
	Imaging (CT/PET scans, MRIs	5)		
	Tier 1		20% up to \$250 per script	x
Drugs to treat illness or	Tier 2		20% up to \$250 per script	x
condition	Tier 3		20% up to \$250 per script	х
	Tier 4		20% up to \$250 per script	х
Outpatient	Surgery facility fee (e.g., ASC)	20%	X
services	Physician/surgeon fees Outpatient visit		20%	X
	Emergency room facility fee (v	waived if admitted)	20%	x
Need	Emergency room physician fee (waived if admitted) Emergency medical transportation		0%	X
immediate attention	Emergency medical transportation		20%	X
attendon	Urgent care		20%	х
Hospital stay	Facility fee (e.g. hospital room)	20%	X X
	Physician/surgeon fee		∠0%	X
	Mental/Behavioral health outpatient office visits		20%	x
	Mental/Behavioral health other outpatient items and services		20%	х
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	х
Mental health,	Mental/Behavioral health inpatient physician fee		20%	x
behavioral health, or substance abuse needs	Substance Use disorder outpa		20%	x
	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 inpati	ent physician fee	20%	x
	Prenatal care and preconcept	ion visits	No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	х
	services	Professional	20%	X
	Home health care Outpatient Rehabilitation serv	ices	20%	X
Help recovering or	Outpatient Habilitation service		20%	X
other special	Skilled nursing care		20%	х
health needs	Durable medical equipment		20%	Х
	Hospice service Eye exam		0% No charge	X
	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge	
Child eye care	Oral Exam		Ť	
	Preventive - Cleaning		1	
Child Dental	Preventive - Cleaning			
Child Dental Diagnostic and	Preventive - Cleaning Preventive - X-ray Sealants per Tooth		No charge	
Child Dental Diagnostic and	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application		No charge	
Child Dental Diagnostic and Preventive	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed		No charge	
Child eye care Child Dental Diagnostic and Preventive Child Dental Basic	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures		No charge	
Child Dental Diagnostic and Preventive Child Dental Basic	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Sen	rices		
Child Dental Diagnostic and Preventive Child Dental Basic Services	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures	vices		
Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Sen Crowns and Casts			
Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Sen Crowns and Casts Endodontics		20%	

2017 Standard Benefit Plan Designs 10.0 EHB Date: April 7, 2016 June 16, 2016

Number location Data Applies Member location Applies Amage of the set in hybry. liness, or condition \$3 \$10 \$10 \$10 Benerics or cline, visit. \$5 \$10 \$10 \$10 \$10 Benerics or cline, visit. \$5 \$10		summary or Benefits and Coverage lember Cost Share amounts describe the Enrollee's out of pocket costs.		Plan % FPL	Silver Plan 150%-200% FPL	
Image NA NA NA Series of Contracts of Contracts Marian (Marian (Plannage / Densit) Sin (Plannage / Densi) Sin (Plannage / Densi)	Actuarial Value	e - AV Calculator	94.19	%		
Image and particulation of the sector of the se	Plan design in	cludes a deductible?		Pharmacy		
Painal of control (Control (Contro) (Contro) (Control (Control (Contro) (Contro) (Contro) (Contr	Integrated Fa	mily deductible				
<form> Image <</form>						
Bits pice NA NA NA NA NA NA Converse NA NA NA Converse NA NA NA Converse Name Sector Sect						\$0
High feety with between in the sector of types DAT DAT Common Ansatz Perspective sector is provided by the sector of the sector of the sector or officient sector of the sector of the se	Family Out-of-	pocket maximum		0		
Control Benefact State Panelos Manther Cost State Manther Cost State Additional Cost State Addition Cost State <th< td=""><td>HSA plan: Self HSA family pla</td><td>n: Individual deductible</td><td></td><td></td><td></td><td></td></th<>	HSA plan: Self HSA family pla	n: Individual deductible				
Model of Event Banes Applies Member (cost Share) Applies Nome Cost Share Si						
Image Image <th< th=""><th></th><th>Service Type</th><th></th><th></th><th>Member Cost Share</th><th>Deductible Applies</th></th<>		Service Type			Member Cost Share	Deductible Applies
provide of all system of all system of all system is a system of all sys		Primary care visit to treat an injury, illness, or condition	\$5		\$10	
Speciality with erroring control control perturbation transNot charge to the charge 	provider's office or clinic	Other practitioner office visit	\$5		\$10	
Luboratory Tests S8 C S15 S15 S15 Imaging CF PEF transm, Mells S3 S3 S3 S50 S100 S100 Tor 1 Tor 1 S3 S10 S100 S100 </td <td>vian</td> <td>Specialist visit</td> <td>\$8</td> <td></td> <td>\$25</td> <td></td>	vian	Specialist visit	\$8		\$25	
Tests Xange and Dappets imaging transmer in the second sec						
imaging (CTPET scares, MRIs) 550 5100 Ter 1 S33 S5 Parrow Ter 1 S10 S50 S50 Parrow cendition Ter 2 S10 S10 S50 Parrow cenditions or cenditions or cenditions or cenditions or cenditions or cenditions or comparison for (second or comparis	Tests					_
Drugs to a condition condition conditions or conditions of the second condition product for (p. ASC) Note that the second condition for (p. ASC) Note the second condition for (p. ASC) Note that the second condition for (p. ASC) Note the second condition f		Imaging (CT/PET scans, MRIs)				
Drings for condition Image for part solution Image for part solution Same for part solution Pharm solution Outpatient view for (a, ASC) Image for part solution Image for pa		Tier 1	\$3		\$5	
Sendition Relation Service Ser		Tier 2	\$10		\$20	Pharmacy deductible
The 410% bb 16 3 PU per carptcomp atter putper back to the decirable addicable addicable addicable addicable addicable addicable addicable addicable addicable addicable addicable addicable addicable addicable addicable addicable addicable behavioral number of the state o		Tier 3	\$15			Pharmacy deductible
Displants Physical stream 10%			per script		script after pharmacy deductible	Pharmacy deductible
services Disk Disk Disk Disk Disk Image: properties 10% No charge No charge <td< td=""><td></td><td></td><td></td><td></td><td>15%</td><td></td></td<>					15%	
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Mental Pehavioral health orber outpatient items and services \$5		Physician/surgeon fee	10%	X	15%	Х
Nental health Mental/Behavioral health inpatient facility fee (e.g. hospital room) 10% X 15% X Mental/Behavioral health inpatient physician fee 10% X 15% X Neath, or substance Use disorder outpatient office visits \$\$5 \$\$10<		Mental/Behavioral health outpatient office visits	\$5		\$10	
Mental health, behavioral health or substance abuse needs Mental/Behavioral health inpatient physician fee 10% X 15% X Substance abuse needs Substance Use disorder outpatient office visits \$\$5 \$\$10 <td></td> <td>Mental/Behavioral health other outpatient items and services</td> <td>\$5</td> <td></td> <td>\$10</td> <td></td>		Mental/Behavioral health other outpatient items and services	\$5		\$10	
Mental health, behavioral health, or substance abuse needs Mental/Behavioral health inpatient physician fee 10% X 15% X Substance abuse needs Substance Use disorder outpatient office visits \$\$ \$\$ \$\$10 \$\$ Substance Use disorder other outpatient literns and services \$\$ \$\$ \$\$10 \$\$ Substance Use disorder other outpatient facility fee (e.g. hospital room) 10% X 15% X Pregnancy Prental care and preconception visits No charge		Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%	x	15%	x
health, or substance abuse needs Substance Use disorder outpatient office visits \$5 \$10 Substance Use disorder other outpatient items and services \$5 \$10 Substance Use inpatient facility fee (e.g. hospital room) 10% X 15% X Substance Use inpatient facility fee (e.g. hospital room) 10% X 15% X Prenatal care and preconception visits No charge No charge No charge No charge Pregnancy Perivery and all inpatient ervices Hospital 10% X 15% X Hole tother special 10% X 15% X X X X Hole tother special 10% X 15% X						
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Substance Use inpatient facility fee (e.g. hospital room) 10% X 15% X Substance use disorder inpatient physician fee 10% X 15% X Pregnancy Prenatal care and preconception visits No charge No charge No charge Pregnancy Delivery and all inpatient services Hospital 10% X 15% X Home heatth care \$3 \$15 State \$15% X Outpatient Rehabilitation services \$55 \$10 Outpatient Habilitation services \$55 \$10 Outpatient Habilitation services \$55 \$10 Stilled nursing care No charge No charge Child evel care 10% X 15% X 15% X Child bentat Preventive - X-ray No charge No charge No charge No charge No charge Child bentat Preventive - Cleaning No No charge Sillef nuray Sillef nuray N		Substance Use disorder outpatient office visits	\$5		\$10	
Substance use disorder inpatient physician fee 10% X 15% X Pregnancy Prenatal care and preconception visits No charge No charge No charge No charge Prematal care and preconception visits No charge No charge No charge Prematal care and preconception visits No charge		Substance Use disorder other outpatient items and services	\$5		\$10	
Prenatal care and preconception visits No charge No charge Pregnancy Delivery and all inpatient services Hospital 10% X 15% X Home health care \$3 \$15 \$15 X 15% X Help recovering or Outpatient Rehabilitation services \$5 \$10 \$15 \$15 Outpatient Rehabilitation services \$5 \$10 \$15 \$15 Outpatient Habilitation services \$5 \$10 \$15 \$15 Outpatient Habilitation services \$5 \$10 \$15% \$15 Durable medical equipment 10% X 15% \$X Durable medical equipment 10% X 15% \$X Ital of glasses per year (or contact lenses in lieu of glasses) No charge No charge No charge Child bental per Tooth Freventive - X-ray No charge No charge No charge Child bental Basic Restorative Procedures 20% 20% 20% 20% 20% 20% 20% 20%		Substance Use inpatient facility fee (e.g. hospital room)	10%	х	15%	х
Pregnancy services Delivery and all inpatient services Hospital 10% X 15% X Help outpatient Rehabilitation services 53 \$15				х		х
services professional 10% X 15% X Home heath care \$3 \$15 \$10 Outpatient Rebabilitation services \$5 \$10 \$10 Durable medical equipment 10% X 15% X hospice service No charge No charge No charge Child everative Yair of glasses per year (or contact lenses in lieu of glasses) No charge No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge No charge Child Dental Briverive - X-ray Treventive - Cleaning No charge No charge No charge Preventive - Z-ray Saelants per Tooth No charge 20% 20% 20% Child Dental Basic Restorative Procedures 20% 20% 20% 20% Services Periodontis Maintenaros Fixed 50% 50% 50% 50%						
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nup recovering of bits recovering of basiled nursing care Outpatient Habilitation services \$55 \$10 Stilled nursing care 10% X 15% X Durable medical equipment 10% X 15% X Hospice service No charge No charge No charge No charge Child eye care Oral Exam No charge No charge No charge No charge Child Dental Diagnostic Preventive - Cleaning No charge No charge No charge No charge Child Dental Basic Preventive - X-ray Space Maintainers - Fixed No charge No charge No charge No charge Child Dental Basic Restorative Procedures 20%	Help	Outpatient Rehabilitation services	\$5		\$10	
other special health needial bank medical equipment 10% X 15% X Durable medical equipment 10% 0 15% 0 Hospice service No charge No charge No charge 0 Child everation Yet evantion No charge No charge 0 Child Dental 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge 0 Child Dental and Sealants per Yoentive - Cleaning Image: Space Maintainers - Fixed I			\$5		\$10	
Outside medical equipment 10% 15% Hospice service No charge No charge No charge Child eye car Ye exam No charge No charge No charge Child bental Diagnostic and Services Preventive - Cleaning Image: Cleaning <td>other special</td> <td>Skilled nursing care</td> <td>10%</td> <td>х</td> <td>15%</td> <td>х</td>	other special	Skilled nursing care	10%	х	15%	х
Eye exam No charge No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Child Dental Diagnostic Preventive - Cleaning	neann needs	Durable medical equipment				
Child eye car of al Exam On o charge No charge No charge Oral Exam Gal Exam Image: Child Dental Mainters - Freed						
Oral Exam Oral Exam Child Dental Diagnostic Preventive - Cleaning Image: Cleaning	Child eye care				-	
Diagnostic and Preventive - X-ray and Preventive Space Maintainers - Fixed No charge Image Maintainers - Fixed Child Dental Basic Child Dental Basic Crowns and Casis Endodnitics (other than maintenance) 20% 20% 20% Child Dental Finddonitics (other than maintenance) 50% 50% 50%		Oral Exam	· · ·			
and Preventive Space Maintainers - Fixed No Charge No Charge Child Dental Basic Restorative Procedures 20% 20% Crowns and Casts 20% 20% Child Dental Basic Periodontics (other than maintenance) 50% 50% Services Prododntics (other than maintenance) 50% 1						
Child Dental Basic Restorative Procedures 20%	and	Sealants per Tooth Topical Fluoride Application	No charge		No charge	
Basic Restorative Procedures 20% <td>Child Dental</td> <td></td> <td></td> <td></td> <td></td> <td></td>	Child Dental					
Crowns and Casts	Basic		20%		20%	
Endodontics Image: Child Dentity Major Periodontics (other than maintenance) 50% Services Prosthodontics	Services					
Major Periodontics (other than maintenance) 50% 50% Services Prosthodontics	Child Dental					
Services Prosthodontics		Periodontics (other than maintenance)	50%		50%	
Oral Surgery						
Child Orthodontics 50% 50%			50%		50%	

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Member Cost S	nare amounts describe the Enr	ollee's out of pocket costs.	Silver Plan 200%-250% FP	L
Actuarial Value	- AV Calculator		73.7%	
	ludes a deductible?		Yes, Medical/Pharr	nacy
Integrated Inc Integrated Fa	lividual deductible mily deductible		N/A N/A	
Individual de	ductible, NOT integrated: Me tible, NOT integrated: Medic	dical / Pharmacy / Dental	\$2,200 / \$250 / \$ \$4,400 / \$500 / \$	
	of-pocket maximum	al / Pharmacy / Dental	\$4,4007\$50075 \$5,700	ÞU
	oocket maximum only coverage deductible		\$11,400 N/A	
HSA family pla	n: Individual deductible		N/A N/A	
Common				Deductibl
Medical Event	Se	rvice Type	Member Cost Share	Applies
	Primary care visit to treat an ir	njury, illness, or condition	\$30	
Health care provider's office or clinic	Other practitioner office visit		\$30	
visit	Specialist visit		\$55	
	Preventive care/ screening/ in	munization	No charge	
Fests	Laboratory Tests X-rays and Diagnostic Imaging	3	\$35 \$65	
	Imaging (CT/PET scans, MRIs		\$300	
	Tier 1		\$15	
orugs to treat	Tier 2		\$50	Pharmac deductibl
Ilness or condition	Tier 3		\$75	Pharmac deductibl
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmac deductibl
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees		20% 20%	
services	Outpatient visit		20%	
	Emergency room facility fee (v	\$350		
	Emergency room physician fe	No charge		
Need mmediate	Emergency medical transporta	\$250	Х	
attention	Urgent care	\$30		
Hospital stay	Facility fee (e.g. hospital room)	20%	х
nospital stay	Physician/surgeon fee	20%	Х	
	Mental/Behavioral health outp	\$30		
	Mental/Behavioral health othe	\$30		
	Mental/Behavioral health inpat	tient facility fee (e.g.hospital room)	20%	х
Mental health,	Mental/Behavioral health inpat		20%	х
pehavioral nealth, or	inental Denavioral freatur inpa		2070	~
substance abuse needs	Substance Use disorder outpa	atient office visits	\$30	
	Substance Use disorder other	outpatient items and services	\$30	
	Substance Use inpatient facilit	y fee (e.g. hospital room)	20%	х
	Substance use disorder inpati	ent physician fee	20%	х
	Prenatal care and preconcepti	on visits	No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	х
	services	Professional	20%	Х
lala.	Home health care Outpatient Rehabilitation servi	ces	\$40 \$30	
Help recovering or	Outpatient Habilitation service		\$30	
other special nealth needs	Skilled nursing care		20%	х
icatin neeus	Durable medical equipment		20%	
	Hospice service Eye exam		No charge No charge	
Child eye care	1 pair of glasses per year (or c	ontact lenses in lieu of glasses)	No charge	
Oral Exam				
Child Dental Diagnostic	Preventive - X-ray Sealants per Tooth		No charge	
and Preventive			No charge	
	Space Maintainers - Fixed			
hild Dental asic Restorative Procedures		20%		
Services	asic			
	Crowns and Casts Endodontics			
Child Dental Major	Periodontics (other than maint	enance)	50%	
Services	Prosthodontics	•		
	Oral Curaanu			
Child	Oral Surgery			

2017 Standard Benefit Plan Designs 10.0 EHB Date: April 7, 2016 June 16, 2016

Member Cost Share amounts describe the Enrollee's out of pocket costs. Bronze Plan HDHP Plan Actuarial Value - AV Calculator 61.9% 62.0% Plan design includes a deductible? Yes, Medical/Pharmacy Yes, integrated Integrated Individual deductible? N/A \$4,566 \$4,800 Integrated Family deductible N/A \$6,000 / \$0.00	Summary of	Benefits and Coverage						
<form>Kancard Wave, Ar GlavabarKancard Wave, and Sale a</form>	Member Cost S	hare amounts describe the En	rollee's out of pocket costs.	Bronze Pla	n	Bronze HDHP Plan		
<form>Interpart benchmarked letter basesInterpart of the sector basesInterpart</form>	Actuarial Value	e - AV Calculator		61.9%				
Image and a constrained Image a local display						Yes, integrated		
Tendy denotes lossed Status (F) Notes (F) <td>Integrated Fa</td> <td>mily deductible</td> <td></td> <td>N/A</td> <td></td> <td colspan="2">\$4,500 \$4,800 integrated \$9,000 \$9,600 integrated</td>	Integrated Fa	mily deductible		N/A		\$4,500 \$4,800 integrated \$9,000 \$9,600 integrated		
Intercase Image: set of the set of								
Bit party all involution Initial decision Initial decision <thinitial< td=""><td>Individual Out-</td><td>-of-pocket maximum</td><td>ar / marmacy / Demar</td><td>\$6,800</td><td>, 40</td><td>\$6,650 <u>\$6</u></td><td></td></thinitial<>	Individual Out-	-of-pocket maximum	ar / marmacy / Demar	\$6,800	, 40	\$6,650 <u>\$6</u>		
High near yeak which which which any set of the se	Family Out-of- HSA plan: Self	pocket maximum -only coverage deductible						
Matcher (Context) Service Type Memory Cost Single Advance Barray Approximation Reserved on a linger, lines, or consider S75 American and the tensor and singer, lines, or consider S75 American and tensor and singer and tensor and singer and tensor and	HSA family pla	n: Individual deductible		N/A		\$4,500 <u>\$</u> 4	,800	
Restance Address are larger and source of any of a set of a se		Se	rvice Type	Member Cost Share		Member Cost Share		
provember properties of the same set					non-preventive	40%		
<form> Special vial Special vial Spit Spit Spit Spit Spit Spit Spit Spit</form>	Health care provider's office or clinic	Other practitioner office visit		\$75	non-preventive	40%	х	
Backetory Tests Generation Generation Generation Automation Automation Automation Automation Inf an absence it maxima 100% AU AU% AU% AU% Inf an absence it maxima 100% 100% Rest AU% AU% Inf a absence it maxima 100% 100% Rest Inf a low public biol Inf a low pu	visit	Specialist visit		\$105	non-preventive	40%	х	
Xirtys and Dagsold imaging 100% X 40% X Teri 100% 100% No 40% X Teri 100% 100% 100% 00% 0% </td <td></td> <td></td> <td>nmunization</td> <td></td> <td></td> <td></td> <td></td>			nmunization					
Image (CTVPT F norm, MPR) ID ID ID ID	Tests		1		X			
Image base of point of the parametry obtained by th					Х	40%	X	
Drags to reg ref 2 after plannarg descabible Descabible per serigit ^^ Ter 3 10% is to \$500 per society per serigit 3% 4% is possible 2% Ter 4 10% is to \$500 per society per serigit 4% is possible 2% Surgery facility fee (e.g., SC) 100% X 40% X Objacistic 100% X 40% X Advantament 100% X 40% X Objacistic 100% X 40% X Advantament 100% X 40% X Mendigen vom facisitie file (waved if admited) 100% X 40% X Mendigen vom facisitie file (waved if admited) 100% X 40% X Ugent care 100% X 40% X X Projectic vom dicat transportation 100% X 40% X X Advantament Advantament Advantament Advantament Advantament Advantament X X Mental Behavioral headh inepatier facility file (e.g. hospital room) <td></td> <td>Tier 1</td> <td></td> <td></td> <td></td> <td></td> <td>х</td>		Tier 1					х	
sendition Tra - 3 100% is ploShop exception Peamong 4% exception Tra - 4 100% is ploShop exception Peamong 6% exception 2% Curpant Programme 100% is ploShop exception Peamong 6% exception 2% Curpant Peamong 100% is ploShop exception Peamong 6% exception 2% Curpanter 100% is ploShop exception 100% is ploShop exception 8% 3% Curpanter 100% is ploShop exception 4% is ploShop exception 4% is ploShop exception Rengency model transportation 100% is ploShop exception 100% is ploShop exception 4% is ploShop exception Rengency model transportation 100% is ploShop exception 100% is ploShop exception 100% is ploShop exception 100% is ploShop exception Rengency model transportation is ploShop exception 100% is ploShop exception 100% is ploShop exception 100% is ploShop exception Rengency model transportation is ploShop exception 100% is ploShop exception 100% is ploShop exception 100% is ploShop exception Rengency model transportation is ploShop exception 100% is ploShop exception 100% is ploShop exception 100% is ploShop exception Rengency model transportation is ploShop exception 100% is ploShop exception		Tier 2					х	
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Unsplant Physican functionImage is a set of the				after pharmacy deductible	Deductible	per script		
Netd Qupatent visit Image of the second of)					
Amend innovation innovateri innovateri innovation innovation innovation innovation inn	services							
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Urgent care S75 Angle Failure visits 40% X Hospital To Visits Physican Xurgeon fe 100% X 40% X Physican Xurgeon fe 0.00% S75 After fait three visits 40% X Mental/Behavioral health outputient toffice visits S75 After fait three visits 40% X Mental/Behavioral health outputient tacility fee (e.g. hospital room) 100% X 40% X Mental/Behavioral health inpatient physician fee 100% X 40% X Mental/Behavioral health inpatient physician fee 100% X 40% X Substance Use disorder outputient lems and services S75 After fait three on-preventive visits 40% X Substance Use disorder outputient lems and services S75 After fait three on preventive visits 40% X Mental/Behavioral health inpatient physician fee 100% X 40% X Substance Use disorder outputient lems and services S75 After fait three on the preventive / A(X) X Mopital Table Table Table Table Table Table Table Tab		Emergency medical transport	ation	100%	Х	40%	Х	
Heaping and provide control from the part of the set	attention	Urgent care		\$75	non-preventive	40%	х	
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Mental/Behavioral health inpatient facility fee (e.g.hospital room) 100% X 40% X Mental/Behavioral health, or behavioral health, or abuse needs Mental/Behavioral health inpatient physician fee 100% X 40% X Substance Use disorder outpatient office visits \$75 After 1st three non-preventive visits 40% X Substance Use disorder outpatient items and services \$75 After 1st three non-preventive visits 40% X Substance Use disorder inpatient physician fee 100% X 40% X Substance Use disorder inpatient physician fee 100% X 40% X Pregnanzy Prenatal care and preconception visits No charge No charge No charge Home health care 100% X 40% X Outpatient Habilitation services \$75 40% X Outpatient Rehabilitation services \$75 40% X Outpatient Rehabilitation services \$75 40% X Outpatient Rehabilitation services \$75 40% X Durabit medicid		Mental/Behavioral health other outpatient items and services		\$75	non-preventive	40%	x	
Mental behavioral behavioral beakayioral basistenced substance substance substance basistenced substance sub substance sub substance substance substance substance substance		Mental/Rehavioral health inna	tient facility fee (e a hospital room)	100%		40%	×	
health, or substance abuse needs After 1st three non-preventive visits After 1st three non-preventive visits 40% X Substance Use disorder outpatient letms and services \$75 Årfer 1st three non-preventive visits 40% X Substance Use disorder other outpatient items and services \$75 Årfer 1st three non-preventive visits 40% X Substance Use inpatient facility (e.e., hospital room) 100% X 40% X Pregnancy Prenatal care and preconception visits No charge No charge No charge Pregnancy Delivery and all inpatient services Hospital 100% X 40% X Heigh recovering of outpatient Habilitation services \$75 40% X X X Outpatient Habilitation services \$75 40% X X X X Durable medical equipment health need 100% X 40% X X Durable medical equipment health need 100% X 40% X X Durable medical equipment health need 100% X 40% X X Durable medical equipment health need								
substance abuse needs abuse needs Substance Use disorder outpatient ifer visits S75 After 1st three visits 40% X Substance Use disorder outpatient items and services \$375 After 1st three visits 40% X Substance Use inpatient facility fee (e.g. hospital room) 100% X 40% X Prenetal care and preconception visits No charge No charge No charge No charge Prenetal care and preconception visits No charge 40% X X Alter stating Prenetal care and preconception visits No charge No charge X Precevering Outpatient Habilitation services 975 40% X X Alter stating Professional 100% X 40% X Alter stating Professional 100% X		Mental/Behavioral health inpa	tient physician fee	100%		40%	X	
Substance Use disorder other outpatient items and services \$75 non-preventive visits 40% X Substance Use inpatient facility register 0.00% X 40% X Substance Use inpatient facility register 0.00% X 40% X Substance Use inpatient facility register 0.00% X 40% X Prestal Care and preconceptionation No charge No charge No charge No Pregnancy Delivery and inpatient inpatient Hospital 100% X 40% X No charge Incompressional 100% X 40% X No prevention More health care 100% X 40% X Outpatient Habilitation services \$75 40% X X Outpatient Habilitation services \$75 40% X X Durable medical equipment 100% X 40% X Durable medical equipment No charge No charge No charge No charge Child bental Apertos <	substance	Substance Use disorder outpa	atient office visits	\$75	non-preventive	40%	х	
Substance use disorder inpatient physician fee 100% X 40% X Pregnancy Prenatal care and preconception visits No charge No charge No charge Image: Comparison of the comparison of		Substance Use disorder other outpatient items and services		\$75	non-preventive	40%	х	
Prenatal care and preconception visits No charge No charge Pregnancy Delivery and all inpatient services Hospital 100% X 40% X Home health care 000% X 40% X		Substance Use inpatient facili	ty fee (e.g. hospital room)	100%	х	40%	х	
Prenatal care and preconception visits No charge No charge Pregnancy Delivery and all inpatient services Hospital 100% X 40% X Home health care 100% X 40% X		Substance use disorder inpati	ent physician fee	100%	×	40%	х	
Pregnancy services Delivery and all inpatient services Hospital 100% X 40% X Home health care Outpatient Rehabilitation services 100% X 40% X Outpatient Rehabilitation services \$75 40% X Skilled nursing care 100% X 40% X Durable medical equipment No charge 0% X 40% X Hospice service No charge 0% X 40% X Child eve care No charge No charge No charge No charge No charge Oral Exam Terventive - Cleaning No charge No charge No charge Image: Cleaning Image: Cleaning<			1.7					
services Professional 100% X 40% X Home health care 100% X 40% X Home health care 100% X 40% X Outpainter Habilitation services \$75 40% X Outpainter Habilitation services \$75 40% X Durable medical equipment 100% X 40% X Home health needs Quipainter Habilitation services No charge 0% X Durable medical equipment 100% X 40% X Hospice service No charge 0% X X Thid eye care 100% X 40% X Additation service No charge No charge No charge No charge Child eye care 1 pair of glasses per year (contact lenses in lieu of glasses) No charge	Pregnancy	Delivery and all inpatient			х		х	
Heip recovering of outpatient Habilitation services \$75 40% X outpatient Habilitation services \$75 40% X outpatient Habilitation services \$75 40% X outpatient Habilitation services \$75 40% X beath needs Skilled nursing care 100% X 40% X Durable metical equipment 100% X 40% X Hospice service 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 No charge Image: Child bental Preventive - Cleaning Image: Child bental Sealants per Tooth No charge Image: Child bental Sealants per Tooth Image: Child bental Sealants Image: Child bental Sealants Image: Child bental Sealants Image: Chi								
Andposition Outpatient Habilitation services \$75 40% X other special health needs burble medical equipment 100% X 40% X Durable medical equipment 00% ocharge 0% X Thild begics service No charge No charge No charge No charge Child bental Diagnostic Preventive - Cleaning No charge No charge No charge Image: Cleaning Image: Cleaning <td></td> <td></td> <td>ces</td> <td></td> <td>X</td> <td></td> <td></td>			ces		X			
other special health need: Skilled nursing care 100% X 40% X Durable medical equipment 100% X 40% X Durable medical equipment 100% X 40% X Durable medical equipment No charge 0% X Disprice service No charge No charge No charge Tail cong lasses per year (or contact lenses in lieu of glasses) No charge No charge No charge Child per call Preventive - Cleaning								
Duration medical equipment 100% X 40% X Hospice service No charge 0% X Child beyacits Yesentive No charge 0% X 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge No charge Child bental Preventive - Cleaning No charge No charge No charge Image: Cleaning Diagnostic Preventive - Cleaning No charge No charge Image: Cleaning Image: Cleaning Diagnostic Sealants per Tooth No charge Image: Cleaning Image: Cleaning Image: Cleaning Sealants per Tooth Sealants per Tooth Image: Cleaning Image: Cleaning Image: Cleaning Image: Cleaning Space Maintainers - Fxeed Image: Cleaning Image: Cleaning Image: Cleaning Image: Cleaning Image: Cleaning Services Periodontal Maintenance Services Image: Cleaning Image: Cleaning Image: Cleaning Image: Cleaning Services Prosthodontics Image: Cleaning Image: Cleaning Image: Cleaning Image: Cleaning Services Prosthodontics Image: Cleaning Image: Cleaning Image: Cleaning Image: Cleaning Image: Cleaning Services Pr	other special							
Eye exam 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 Image: Cleaning Image: Cleaning Diagnostic Preventive - Cleaning Image: Cleaning Image: Cleaning Preventive - Cleaning Image: Cleaning Image: Cleaning Image: Cleaning Preventive - X-ray Image: Cleaning Image: Cleaning Image: Cleaning Preventive - Scalanis per Tooth Preventive - Cleaning Image: Cleaning Image: Cleaning Space Maintainers - Fixed Image: Cleaning Image: Cleaning Image: Cleaning Image: Cleaning Starvices Periodontal Maintenance Services 20% 20% Image: Cleaning Image: Cleaning Child Dental Basic Endodontics Image: Cleaning	nearth needs				Х			
Train of gasses per yeal (or ontact reliess in neu or gasses) No thange No charge Child Dental Preventive - Cleaning Seatants per Tooth Topical Fluoride Application Space Maintainers - Fixed No charge Image: Cleaning Preventive - Cleaning Image: Cleaning Preventive - Cleaning Child Dental Basic Restorative Procedures 20% Image: Cleaning Preventive - Cleaning Image: Cleaning Child Dental Basic Restorative Procedures 20% Image: Cleaning Image: Cleaning Child Dental Major Periodontics (other than maintenance) 50% Image: Cleaning Image: Cleaning Services Prosthodontics 50% Image: Cleaning Image: Cleaning Child Dental Major Medically necessary onthodontics 50% Image: Cleaning Child Medically necessary onthodontics 50% Image: Cleaning	01.11.6							
Child Dental and Sealarts per Toolth Topical Fluoride Application Space Maintainers - Exed No charge No charge Child Dental Basic Restorative - X-ray No charge No charge Child Dental Basic Restorative Procedures 20% 20% Child Dental Basic Periodontal Maintenance Services 20% 20% Crowns and Casts 20% 20% Crowns and Casts 50% 1 Brodoontics 50% 1 Services Prostodontics (other than maintenance) 50% Prostodontics (other than maintenance) 50% 1 Child Medically necessary orthodontics 50% 1	Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge		
Diagnostic and Sestints per Tooth Topical Fluoride Application Space Maintainers - Fixed No charge Image: Chiral per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Basic Restorative Procedures 20% 20% Services Periodontal Maintenance Services 20% Child Dental Endodontics Endodontics 1 Periodontics (other than maintenance) 50% 50% Services Prosthodontics (other than maintenance) 50% Oral Surgery 50% 1 Child Medically necessary orthodontics 50%	Child Dental	Preventive - Cleaning Preventive - X-ray						
and Sealants per 100h Preventive Topical Fluxida Application Space Maintainers - Fixed	Diagnostic			No charge		No charge		
Child Dental Basic Restorative Procedures 20% 20% Services Periodontial Maintenance Services 20% Child Dental Major Crowns and Casts 20% Periodontics 50% 50% Services Prosthodontics 50% Prosthodontics 50% 50% Child Medically necessary onthodontics 50% 50%		Sealants per Tooth Topical Fluoride Application						
Crowns and Casts Endodontics Major Periodontics (other than maintenance) 50% Prosthodontics (other than maintenance) 50% Child Medically necessary orthodontics				20%		20%		
Child Dental Endodontics Major Periodontics (other than maintenance) 50% 50% Prosthodontics (other than maintenance) 50% 60% Oral Surgery 50% 60% Child Medically necessary orthodontics 50% 50%			rices					
Major Services Periodontics (other than maintenance) 50% 50% Prosthodontics (other than maintenance) 50%	Child Dental							
Child Medically necessary orthodontics E0% E0%	Major		enance)	50%		50%		
Child Medically necessary orthodontics 50% 50%	Services							
			tics	50%		50%		

2017 Standard Benefit Plan Designs 10.0 EHB

Date: April 7, 2016 June 16, 2016

	hare amounts describe the En	rollee's out of pocket costs.	Catastro	phic Plan
	- AV Calculator			
	cludes a deductible?			tegrated ntegrated
Integrated Fa	mily deductible			integrated
Individual de	ductible, NOT integrated: M			/A
	tible, NOT integrated: Medi of-pocket maximum	cai / Pharmacy / Dentai		/A 150
Family Out-of-	oocket maximum		\$14	,300
HSA plan: Self- HSA family pla	only coverage deductible n: Individual deductible			/A /A
Common			Member Cost	Deductible
Medical Event		ervice Type	Share	Applies After 1st thre
Health care	Primary care visit to treat an i	njury, illness, or condition	0%	non-preventiv visits
provider's office or clinic visit	Other practitioner office visit		0%	non-preventiv visits
	Specialist visit		0%	х
	Preventive care/ screening/ in Laboratory Tests	mmunization	No charge 0%	x
Tests	X-rays and Diagnostic Imagin	a	0%	X
	Imaging (CT/PET scans, MRI		0%	Х
	Tier 1		0%	х
Drugs to treat	Tier 2		0%	х
Ilness or condition	Tier 3		0%	x
	Tier 4			
			0%	x
Outpatient	Surgery facility fee (e.g., ASC	3)	0%	X
services	Physician/surgeon fees Outpatient visit		0%	X
	Emergency room facility fee (waived if admitted)	0%	×
	Emergency room raciity ree (waived if admitted)	0 /8	^
Veed	Emergency room physician fee (waived if admitted)		No charge	
mmediate	Emergency medical transportation		0%	Х
attention				After 1st thre
	Urgent care		0%	non-preventiv visits
Hospital stay	Facility fee (e.g. hospital room	n)	0%	х
	Physician/surgeon fee		0%	Х
	Mental/Behavioral health outpatient office visits		0%	After 1st thre non-prevention visits
	Mental/Behavioral health other outpatient items and services		0%	After 1st three non-preventiv visits
	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	0%	х
Mental health,				
	Mental/Behavioral health inpa	atient physician fee	0%	Х
health, or substance abuse needs	Substance Use disorder outp	atient office visits	0%	After 1st thre non-preventi visits
	Substance Use disorder othe	r outpatient items and services	0%	After 1st thre
				visits
	Substance Use inpatient facil	ity fee (e.g. hospital room)	0%	х
	Substance use disorder inpat	ient physician 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		0%	X
lelp	Outpatient Rehabilitation service Outpatient Habilitation service		0%	X
ecovering or other special	Skilled nursing care		0%	X
health needs	Durable medical equipment		0%	X
	Hospice service		0%	X
Child eye care	Eye exam		No charge	
sind bye cale	1 pair of glasses per year (or	contact lenses in lieu of glasses)	0%	Х
Child Dental	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application			
Diagnostic			No charge	
and Preventive			No charge	
Teventive	Space Maintainers - Fixed			
Child Dental	Restorative Procedures		00/	х
Basic Services		vices	0%	
	Periodontal Maintenance Ser Crowns and Casts	AIPE2		X
Child Dental	Endodontics		1	X
Major	Periodontics (other than main	itenance)	0%	х
Services	Prosthodontics		1	Х
	Oral Surgery			Х
Child				

2017 Standard Benefit Plan Designs 9.5 EHB Date: April 7, 2016 June 16, 2016





	7, 2016 June 16, 20		V ai	тм		
-	Benefits and Coverage		Platinu	ım	Platinu	m
	hare amounts describe the E	nrollee's out of pocket costs.	Coinsurand	e Plan	Copay P	lan
	- AV Calculator		89.7%	6	90.3%	,
Integrated Inc	cludes a deductible?		No \$0		No \$0	
	mily deductible ductible, NOT integrated: M	ledical / Pharmacy / Dental	\$0 \$0 / \$0 /	\$0	\$0 \$0 / \$0 /	\$0
Family deduc	tible, NOT integrated: Medi	ical / Pharmacy / Dental	\$0 / \$0 /	\$0	\$0 / \$0 /	\$0
Individual Out- Family Out-of-	-of–pocket maximum pocket maximum		\$4,00 \$8,00		\$4,000	
HSA plan: Self-	only coverage deductible		N/A		N/A	
HSA family pla	n: Individual deductible		N/A		N/A	
Common Medical Event	s	ervice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an	injury, illness, or condition	\$15		\$15	
Health care provider's office or clinic	Other practitioner office visit		\$15		\$15	
visit	Specialist visit		\$40		\$40	
	Preventive care/ screening/ i	mmunization	No charge \$20		No charge \$20	
Tests	Laboratory Tests X-rays and Diagnostic Imagin	ng	\$40		\$40	
	Imaging (CT/PET scans, MR	ls)	10%		\$150	
	Tier 1		\$5		\$5	
illness or	Tier 2		\$15		\$15	
condition	Tier 3		\$25		\$25	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script		
Outpatient	Surgery facility fee (e.g., AS	C)	10%		\$250	
services	Physician/surgeon fees Outpatient visit		10% 10%		\$40 10%	
	Emergency room facility fee	(waived if admitted)	\$150		\$150	
	Emergency room physician f	, ,	No charge	_	No charge	
Need	Emergency medical transpor	\$150		\$150		
immediate attention						
	Urgent care		\$15		\$15	
Hospital stay	Facility fee (e.g. hospital room	m)	10%		\$250 per day up to 5 days	
nospital stay	Physician/surgeon fee		10%		\$40	
	Mental/Behavioral health out	\$15		\$15		
	Mental/Behavioral health oth	\$15		\$15		
	Mental/Behavioral health inp	atient facility fee (e.g.hospital room)	10%		\$250 per day up	
Mental health, behavioral	Mental/Behavioral health inp	atient physician fee	10%		to 5 days \$40	
health, or	mentar benavioral nealth inp	ation physician ice	1070		ψτο	
substance abuse needs	Substance Use disorder outp	patient office visits	\$15		\$15	
	Substance Use disorder othe	er outpatient items and services	\$15		\$15	
	Substance Use inpatient faci	lity fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Substance use disorder inpa	tient physician fee	10%		\$40	
	Prenatal care and preconcep		No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	10%		\$250 per day up to 5 days	
	services	Professional	10%		\$40	
	Home health care Outpatient Rehabilitation ser	vices	10% \$15		\$20 \$15	
Help recovering or	Outpatient Habilitation service		\$15		\$15	
other special	Skilled nursing care		10%		\$150 per day up to 5 days	
health needs	Durable medical equipment Hospice service		10%		10% No charge	
	Eye exam		No charge No charge		No charge	
Child eye care		contact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Oral Exam Preventive - Cleaning					
Diagnostic	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application		Not Covered		Not Covered	
and Preventive						
Child Dantal	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures		Not Covered		Not Covered	
Services	Periodontal Maintenance Se	rvices			Not Courses	
Child Dental	Crowns and Casts Endodontics				Not Covered Not Covered	
Major	Periodontics (other than main	ntenance)	Not Covered		Not Covered	
Services	Prosthodontics				Not Covered	
	Oral Surgery				Not Covered	
Child	Medically necessary orthodo		Not Covered		Not Covered	

2017 Standard Benefit Plan Designs

9.5 EHB Date: April 7, 2016 June 16, 2016 Summary of Benefits and Coverage Gold Copay Plan Gold Member Cost Share amounts describe the Enrollee's out of pocket costs. Coinsurance Plan - AV (No No tegrated Individu al de Integrated Intrividual deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum amily Out-of-pocket maximum 45A plan: Self-only coverage deductible 45A family nai: Individual deductible \$0 \$0 / \$0 / \$0 \$0 \$0 / \$0 / \$0 \$0/\$0/\$0 \$6,750 \$0 / \$0 / \$0 \$6,750 \$0,750 \$13,500 N/A N/A \$0,730 \$13,500 N/A N/A Common ledical Event Member Cost r Cost Primary care visit to treat an injury, illness, or condition \$30 \$30 alth care ovider's Other practitioner office visit \$30 \$30 fice or clin isit Specialist visit \$55 \$55 Preventive care/ screening/ immunization No charge \$35 No charge \$35 Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) **Fests** \$55 20% \$55 \$275 Tier 1 \$15 \$15 Drugs to treat illness or condition Tier 2 \$55 \$55 Tier 3 \$75 \$75 20% up to \$250 20% up to \$250 Tier 4 per script per script Surgery facility fee (e.g., ASC) Physician/surgeon fees \$600 20% Outpatient services 20% \$55 Outpatient visit 20% 20% \$325 \$325 Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted) No charge No charge \$250 \$250 Emergency medical transportation nediate ention Urgent care \$30 \$30 lospital stay Facility fee (e.g. hospital room) \$600 per day up to 5 days 20% Physician/surgeon fee 20% \$55 Mental/Behavioral health outpatient office visits \$30 \$30 Mental/Behavioral health other outpatient items and services \$30 \$30 \$600 per day up to 5 days Mental/Behavioral health inpatient facility fee (e.g.hospital room) 20% ntal health Mental/Behavioral health inpatient physician fee havioral alth, or 20% \$55 ostance Substance Use disorder outpatient office visits \$30 \$30 use needs Substance Use disorder other outpatient items and services \$30 \$30 \$600 per day up Substance Use inpatient facility fee (e.g. hospital room) 20% to 5 days Substance use disorder inpatient physician fee 20% \$55 No charge Prenatal care and preconception visits No charge \$600 per day up to 5 days Delivery and all inpatient Hospital 20% regnancy services Professional 20% Home health care Outpatient Rehabilitation services Outpatient Habilitation services \$30 \$30 \$30 \$30 elp ering or \$300 per day up to 5 days 20% Skilled nursing care 20% . alth needs Durable medical equipment 20% No charge No charge Hospice service Eye exam No charge No charge Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Oral Exam Child Denta Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Diagn and Not Covered Not Covered

Not Covered

Not Covered

Not Covered

Not Covered

Not Covered

Not Covered

Not Covered

Not Covered

Not Covered

Not Covered

Child Denta

Child Dental Major Services

ervice

hild

Restorative Procedures

ns and Casts Endodontics

Prosthodontics

Oral Surgery

Periodontal Maintenance Services

Periodontics (other than maintenance)

Medically necessary orthodontics

2017 Standard Benefit Plan Designs 9.5 EHB Date: April 7, 2016 June 16, 2016 Summary of Benefits and Coverage Individual Member Cost Share amounts describe the Enrollee's out of pocket costs. Silver Plan 71.5% - AV C Yes, Medical/Pharmacy N/A N/A \$2,500/ \$250 / \$0 egrated Individ al deductible Integrated Intrividual deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum amily Out-of-pocket maximum 45A pian: Self-only coverage deductible 45A family nai: Individual deductible \$5,000/ \$500 / \$0 \$6.800 \$13,600 N/A N/A Common ledical Even Primary care visit to treat an injury, illness, or condition \$35 Health care provider's office or clin visit Other practitioner office visit \$35 Specialist visit \$70 Preventive care/ screening/ immunization No charge \$35 Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) **Fests** \$70 \$300 Tier 1 \$15 Drugs to treat Ilness or condition Tier 2 \$55 Tier 3 \$80 20% up to \$250 per script after pharmacy Tier 4 deductible Surgery facility fee (e.g., ASC) Physician/surgeon fees Outpatient services 20% Outpatient visit 20% \$350 Emergency room facility fee (waived if admitted) Emergency room physician fee (waived if admitted) No charge Emergency medical transportation \$250 nmediate ttention Urgent care \$35 Facility fee (e.g. hospital room) 20% Physician/surgeon fee 20% Mental/Behavioral health outpatient office visits \$35 Mental/Behavioral health other outpatient items and services \$35 Mental/Behavioral health inpatient facility fee (e.g.hospital room) 20% lental health. Mental/Behavioral health inpatient physician fee ehavioral ealth, or 20% Substance Use disorder outpatient office visits \$35 buse needs Substance Use disorder other outpatient items and services \$35 Substance Use inpatient facility fee (e.g. hospital room) 20% Substance use disorder inpatient physician fee 20% Prenatal care and preconception visits No charge Delivery and all inpatient Hospital 20% regnancy services Professional 209 \$45 Home health care Outpatient Rehabilitation services Outpatient Habilitation services \$35 \$35 lelp vering or Skilled nursing care ther special ealth needs 20% Durable medical equipment 20% Hospice service No charge Eye exam No charge Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge Oral Exam Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Dental Diagnostic and Preventive Not Covered Child Dental Restorative Procedures Not Covered

Pharmacv

deductible Pharmacy deductible

Pharmacy deductible

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Not Covered

Not Covered

ervices

Child

Child Dental Major Services

Periodontal Maintenance Services Crowns and Casts Endodontics

Medically necessary orthodontics

Prosthodontics Oral Surgery

Periodontics (other than maintenance)

2017 Standard Benefit Plan Designs 9.5 EHB Date: April 7, 2016 <u>June 16, 2016</u>

Date: April	7, 2016 June 16, 201	6				
Summary of	Benefits and Coverage		CCSB		CCSB	
Member Cost S	hare amounts describe the En	rollee's out of pocket costs.	Silver Coinsurance Plan		Silver Copay Plan	
Actuarial Value	e - AV Calculator		71.6%		71.3%	
Plan design in	cludes a deductible?		Yes, Medical/Ph	armacy	Yes, Medical/Ph	armacy
	dividual deductible		N/A N/A		N/A N/A	
Individual de	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental			/ \$0	\$2,000/ \$250	/ \$0
	ctible, NOT integrated: Medic	cal / Pharmacy / Dental	\$4,000 / \$500 \$6,800	/ \$0	\$4,000 / \$500 \$6,800	/\$0
Family Out-of-	ndividual Out–of–pocket maximum amily Out-of-pocket maximum				\$13,600	
HSA plan: Self	-only coverage deductible n: Individual deductible		N/A N/A		N/A N/A	
					1075	
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an i	njury, illness, or condition	\$45		\$45	
Health care provider's office or clinic	Other practitioner office visit	\$45		\$45		
visit	Specialist visit	\$75		\$75		
	Preventive care/ screening/ in	nmunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagin	a	\$40 \$70		\$40 \$70	
	Imaging (CT/PET scans, MRI		20%		\$300	
	Tier 1		\$15		\$15	
Drugs to treat illness or	Tier 2		\$55	Pharmacy deductible	\$55	Pharmacy deductible
condition	Tier 3		\$85	Pharmacy deductible	\$85	Pharmacy deductible
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees)	20%		20%	
services	Outpatient visit		20%		20%	
	Emergency room facility fee (\$350		\$350		
	Emergency room physician fe	No charge		No charge		
Need immediate	Emergency medical transportation		\$250	X	\$250	X
attention						
	Urgent care		\$45		\$45	
Hospital stay	Facility fee (e.g. hospital roon Physician/surgeon fee	1)	20% 20%	X X	20% 20%	x 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%	x
Mental health,			20%	x	20%	X
behavioral health, or	Mental/Behavioral health inpa	20%	^	20%	^	
substance abuse needs	Substance Use disorder outpatient office visits		\$45		\$45	
	Substance Use disorder othe	r outpatient items and services	\$45		\$45	
	Substance Use inpatient facil	ty fee (e.g. hospital room)	20%	х	20%	х
	Substance use disorder inpat	ient physician fee	20%	х	20%	х
	Prenatal care and preconcept	ion visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	х	20%	х
	services	Professional	20%	X	20%	Х
	Home health care Outpatient Rehabilitation serve	ices	20% \$45		\$45 \$45	
Help recovering or	Outpatient Habilitation service		\$45		\$45	
other special	Skilled nursing care		20%	х	20%	х
health needs	Durable medical equipment		20%		20%	
	Hospice service Eye exam		No charge No charge		No charge No charge	
Child eye care		contact lenses in lieu of glasses)	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam		. to onarge			
Child Dental	Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures		1			
Diagnostic and			Not Covered		Not Covered	
Preventive						
Child Dental						
Basic			Not Covered		Not Covered	
Services	Periodontal Maintenance Ser Crowns and Casts	vices			Not Covered	
Child Dental	Endodontics		1		Not Covered	
Major	Periodontics (other than main	tenance)	Not Covered		Not Covered	
Services	Prosthodontics				Not Covered	
	Oral Surgery				Not Covered	
Child Orthodontics	Medically necessary orthodor	tics	Not Covered		Not Covered	

2017 Standard Benefit Plan Designs

9.5 EHB Date: April 7, 2016, June 16, 2016

Date: April 7, 2016 June 16, 2016 Summary of Benefits and Coverage CCSB Silver HDHP Plan Member Cost Share amounts describe the Enrollee's out of pocket costs. - AV C 71.3% Yes, integrated egrated Individu al deductible \$2,000 integrated \$4,000 integrated Integrated minividual deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum HSA plan: Self-only.coverage deductible HSA family Hartis- Individual deductible N/A N/A \$6,650 <u>\$6,550</u> \$13,300 <u>\$13,100</u> \$2,000 \$2,600 Common edical Even Primary care visit to treat an injury, illness, or condition 20% Х ealth care rovider's Other practitioner office visit 20% х fice or clini sit Specialist visit 20% х Preventive care/ screening/ immunization Laboratory Tests No charge 20% X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) ests 20% 20% ¥ 20% up to \$250 per script Tier 1 х 20% up to \$250 per Drugs to trea illness or condition Tier 2 Х script 20% up to \$250 per script Tier 3 Х 20% up to \$250 per Tier 4 х script Surgery facility fee (e.g., ASC) Physician/surgeon fees 20% Outpatient services 20% Х Outpatient visit 20% Х х Emergency room facility fee (waived if admitted) 20% 0% Х Emergency room physician fee (waived if admitted) Emergency medical transportation 20% Х tention Urgent care 20% Х Facility fee (e.g. hospital room) 20% х Physician/surgeon fee 20% Mental/Behavioral health outpatient office visits х 20% Mental/Behavioral health other outpatient items and services Х 20% Mental/Behavioral health inpatient facility fee (e.g.hospital room) 20% х ntal health Mental/Behavioral health inpatient physician fee 20% Х navioral alth, or Substance Use disorder outpatient office visits 20% х use needs 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 fee 20% х Prenatal care and preconception visits No charge Delivery and all inpatient Hospital 20% Х regnancy services Professional 20% Home health care Outpatient Rehabilitation services Outpatient Habilitation services 20% 20% elp X ering or Skilled nursing care 20% Х ther sp . alth needs Durable medical equipment 20% х Hospice service 0% Eye exam No charge Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge Oral Exam Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Child Den Diagnostic and Not Covered ventive Child Denta Restorative Procedures Not Covered Periodontal Maintenance Services rowns and Casts Endodontics Child Dental Major Services Periodontics (other than maintenance) Not Covered Prosthodontics Oral Surgery Child Medically necessary orthodontics Not Covered

2017 Standard Benefit Plan Designs 9.5 EHB Date: April 7, 2016 June 16, 2016

Integrated Indi Integrated Fam Individual ded	ludes a deductible?	100%-150 94.19		87.5%	FL.	
Integrated Indi Integrated Fam Individual ded				150%-200% FPL 87.5%		
Integrated Fam Individual ded		Yes, Medical/	Pharmacy	Yes, Medical/Pha	rmacy	
Individual ded	ividual deductible	N/A N/A		N/A N/A		
Family deduct	luctible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0		\$650 / \$50 / \$		
Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum		\$150 / \$0 / \$0 \$2,350		\$1,300 / \$100 / \$0 \$2,350		
Family Out-of-po HSA plan: Self-o	ocket maximum only coverage deductible	\$4,70 N/A	0	\$4,700 N/A		
HSA family plan	n: Individual deductible	N/A		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
F	Primary care visit to treat an injury, illness, or condition	\$5		\$10		
office or clinic	Other practitioner office visit	\$5		\$10		
visit S	Specialist visit	\$8		\$25		
	Preventive care/ screening/ immunization	No charge \$8		No charge		
Tests X	Laboratory Tests X-rays and Diagnostic Imaging	\$8		\$15 \$25		
<u>li</u>	Imaging (CT/PET scans, MRIs)	\$50		\$100		
T	Tier 1	\$3		\$5		
illness or	Tier 2	\$10		\$20	Pharmacy deductible	
condition T	Tier 3	\$15		\$35 15% up to \$150 per	Pharmacy deductible	
	Tier 4	10% up to \$150 per script		script after pharmacy deductible	Pharmacy deductible	
Outpatient	Surgery facility fee (e.g., ASC)	10% 10%		15%		
	Physician/surgeon fees Outpatient visit	10%		15%		
_	Emergency room facility fee (waived if admitted)	\$50		\$100		
E Contra da	Emergency room physician fee (waived if admitted)	No charge		No charge		
Need	Emergency medical transportation	\$30	X	\$75	X	
attention	Urgent care	\$5		\$10		
F	Facility fee (e.g. hospital room)	10%	x	15%	x	
Hospital stay	Physician/surgeon fee	10%	X	15%	Х	
N	Mental/Behavioral health outpatient office visits	\$5		\$10		
N	Mental/Behavioral health other outpatient items and services	\$5		\$10		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%	х	15%	х	
Mental health, behavioral	Mental/Behavioral health inpatient physician fee	10%	х	15%	х	
health, or substance	Substance Use disorder outpatient office visits	\$5		\$10		
s	Substance Use disorder other outpatient items and services	\$5		\$10		
5	Substance Use inpatient facility fee (e.g. hospital room)	10%	х	15%	х	
	Substance use disorder inpatient physician fee Prenatal care and preconception visits	10% No charge	x	15% No charge	x	
	Delivery and all inpatient Hospital	10%	x	15%	х	
	services Professional	10%	X	15%	X	
C	Home health care Outpatient Rehabilitation services	\$3		\$15		
	Outpatient Rehabilitation services	\$5 \$5		\$10 \$10		
other special	Skilled nursing care	10%	х	15%	х	
health needs	Durable medical equipment	10%		15%		
E	Hospice service Eye exam	No charge No charge		No charge No charge		
Child ovo coro	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
Diagnostic F	Preventive - Cleaning Preventive - X-ray	Not Covered		Not Covered		
Preventive T	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed					
Child Dental	Restorative Procedures			-		
Dasic	Restorative Procedures Periodontal Maintenance Services	Not Covered		Not Covered		
	Crowns and Casts					
Child Dental	Endodontics	Net Original		No. Course 1		
Services F	Periodontics (other than maintenance) Prosthodontics Oral Surgery	Not Covered		Not Covered		
Child	Medically necessary orthodontics	Not Covered		Not Covered		

2017 Standard Benefit Plan Designs 9.5 EHB

Date: April 7, 2016 June 16, 2016

Member Cost S	hare amounts describe the Enr	ollee's out of pocket costs.	Silver Plan 200%-250% FP	L
Actuarial Value	- AV Calculator		73.7%	-
	cludes a deductible?		Yes, Medical/Pharr	nacy
	dividual deductible mily deductible		N/A N/A	
Individual de	ductible, NOT integrated: Me tible, NOT integrated: Medic	dical / Pharmacy / Dental	\$2,200 / \$250 / \$ \$4,400 / \$500 / \$	
ndividual Out-	-of-pocket maximum	ai / Pharmacy / Dentai	\$5,700	þΟ
	oocket maximum only coverage deductible		\$11,400 N/A	
	n: Individual deductible		N/A	
Common				Deductibl
Medical Event	Se	rvice Type	Member Cost Share	Applies
	Primary care visit to treat an injury, illness, or condition		\$30	
Health care provider's office or clinic	Other practitioner office visit		\$30	
<i>r</i> isit	Specialist visit		\$55	
	Preventive care/ screening/ immunization		No charge	
Fests	Laboratory Tests X-rays and Diagnostic Imaging		\$35 \$65	
	Imaging (CT/PET scans, MRIs	3)	\$300	
	Tier 1		\$15	
Drugs to treat liness or	Tier 2		\$50	Pharmac deductibl
condition	Tier 3		\$75	Pharmac deductibl
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmac deductibl
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees	·	20% 20%	
services	Outpatient visit		20%	
	Emergency room facility fee (waived if admitted)		\$350	
Need	Emergency room physician fe		No charge	
mmediate	Emergency medical transportation		\$250	Х
attention	Urgent care		\$30	
Hospital stay	Facility fee (e.g. hospital room)	20%	х
	Physician/surgeon fee Mental/Behavioral health outpatient office visits		20% \$30	X
	Mental/Behavioral health othe	\$30		
	Mental/Behavioral health inpat	tient facility fee (e.g.hospital room)	20%	х
Mental health,		, , , , ,	20%	X
behavioral nealth, or substance abuse needs	Mental/Behavioral health inpatient physician fee Substance Use disorder outpatient office visits		\$30	~
	Substance Use disorder other	\$30		
	Substance Use inpatient facilit	y fee (e.g. hospital room)	20%	Х
	Substance use disorder inpati		20%	х
	Prenatal care and preconcepti	ion visits	No charge	
Pregnancy	Delivery and all inpatient services	Hospital	20%	х
	Home health care	Professional	20% \$40	Х
Help	Outpatient Rehabilitation servi		\$30	
ecovering or other special	Outpatient Habilitation services Skilled nursing care		\$30 20%	х
health needs	Durable medical equipment		20%	^
	Hospice service		No charge	
Child eye care	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge No charge	
	Oral Exam		i to silai go	
Child Dental	Preventive - Cleaning			
Diagnostic and	Preventive - X-ray Sealants per Tooth		Not Covered	
Preventive	Topical Fluoride Application Space Maintainers - Fixed			
Child Dental Basic	Space Maintainers - Fixed Restorative Procedures		Not Covered	
Services	Periodontal Maintenance Serv	ices		
	Crowns and Casts Endodontics			
Child Dental Major	Periodontics (other than maint	enance)	Not Covered	
Services	Prosthodontics	···		
Child	Oral Surgery			

2017 Standard Benefit Plan Designs 9.5 EHB

Date: April 7, 2016 June 16, 2016

Summary of	Benefits and Coverage				Prop	0
Member Cost Share amounts describe the Enrollee's out of pocket costs.			Bronze Pla	Bronze HDHP Plan		
Actuarial Value - AV Calculator Plan design includes a deductible?		61.9% Yes, Medical/Pharmacy		62.0% Yes, integrated		
Integrated Individual deductible		N/A		\$4,500 \$4,800 integrated		
Individual de	Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A \$6,300 / \$500 /		\$9,000 \$9,600 integrated N/A	
Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum		\$12,600 / \$1,000 \$6,800) / \$0	N/A \$6,650 <u>\$6</u>	3.550	
Family Out-of-	pocket maximum		\$13,600		\$13,300 <u>\$1</u>	13,100
HSA plan: Self HSA family pla	-only coverage deductible n: Individual deductible		N/A N/A		\$4,500 <u>\$4,800</u> \$4,500 <u>\$4,800</u>	
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
				After 1st three		
Health care	Primary care visit to treat an ir	jury, illness, or condition	\$75	non-preventive visits After 1st three	40%	X
provider's office or clinic	Other practitioner office visit c		\$75 non-preventive visits		40%	х
visit	Specialist visit		\$105	After 1st three non-preventive visits	40%	х
	Preventive care/ screening/ in	munization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging]	\$40 100%	Х	40% 40%	X X
	Imaging (CT/PET scans, MRIs)	100%	Х	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 illness or	Tier 2		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	х
condition	Tier 3		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	х
	Tier 4		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	х
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees		100% 100%	X X	40% 40%	X
services	Outpatient visit		100%	X	40%	X
	Emergency room facility fee (v	vaived if admitted)	100%	Х	40%	х
	Emergency room physician fe	e (waived if admitted)	No charge		0%	х
Need immediate	Emergency medical transportation		100% X		40%	Х
attention	Urgent care		\$75	After 1st three non-preventive visits	40%	x
				VISIIS		
Hospital stay	Facility fee (e.g. hospital room)	100%	Х	40%	х
	Physician/surgeon fee		100%	X	40%	X
	Mental/Behavioral health outpatient office visits		\$75	After 1st three non-preventive visits	40%	х
	Mental/Behavioral health other outpatient items and services		\$75	After 1st three non-preventive visits	40%	х
	Mental/Behavioral health inpa	ient facility fee (e.g.hospital room)	100%	х	40%	х
Mental health, behavioral	Mental/Behavioral health inpa	ient physician fee	100%	х	40%	х
health, or substance abuse needs	Substance Use disorder outpatient office visits		\$75	After 1st three non-preventive	40%	x
	Substance Use disorder other outpatient items and services		ê75	visits After 1st three	40%	v
				\$75 non-preventive visits		×
	Substance Use inpatient facility fee (e.g. hospital room)		100%			X
	Substance use disorder inpati		100% X		40%	Х
	Prenatal care and preconcept		No charge		No charge	
Pregnancy	Delivery and all inpatient services	Hospital	100%	X X	40%	X
	Home health care	Professional	100%	X	40%	X
Help	Outpatient Rehabilitation servi Outpatient Habilitation service		\$75 \$75		40% 40%	X X
recovering or other special	Skilled nursing care		100%	х	40%	X
health needs	Durable medical equipment		100%	Х	40%	X
	Hospice service Eye exam		No charge No charge		0% No charge	<u> </u>
Child eye care	1 pair of glasses per year (or c	ontact lenses in lieu of glasses)	No charge		No charge	
01111	ral Exam					
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray		Not Coursed		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application		Not Covered		NUL COVERED	
Child Dental Basic	Space Maintainers - Fixed Restorative Procedures		Not Covered		Not Covered	·
Services	Periodontal Maintenance Serv	ices				
Child Dental	Crowns and Casts Endodontics					
Major	Periodontics (other than maint	enance)	Not Covered		Not Covered	
Services	Prosthodontics		(
Child	Oral Surgery					
Orthodontics	Medically necessary orthodon	tics	Not Covered		Not Covered	

2017 Standard Benefit Plan Designs 9.5 EHB

Date: April 7, 2016 June 16, 2016

	hare amounts describe the En	rollee's out of pocket costs.	Catastro	phic Plan
	- AV Calculator			
	ludes a deductible?		Yes, int \$7,150 ir	egrated
Integrated Fa	mily deductible			ntegrated
Individual de	ductible, NOT integrated: Me	edical / Pharmacy / Dental		/A
	tible, NOT integrated: Medic of-pocket maximum	al / Pharmacy / Dental	\$7,	/A 150
Family Out-of-	oocket maximum		\$14	,300
HSA plan: Self- HSA family pla	only coverage deductible		N	/A /A
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an in	njury, illness, or condition	0%	After 1st thre non-preventi visits
office or clinic	Other practitioner office visit		0%	After 1st thre non-preventi visits
visit	Specialist visit		0%	х
	Preventive care/ screening/ in	nmunization	No charge	
Taata	Laboratory Tests		0%	X
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs		0%	X
	Tier 1		0%	x
Drugs to treat	Tier 2		0%	x
illness or condition	Tier 3		0%	x
	Tier 4		0%	x
Outpatient	Surgery facility fee (e.g., ASC)	0%	X
services	Physician/surgeon fees Outpatient visit		0%	X
	Emergency room facility fee (v	vaived if admitted)	0%	X
	Emergency room raciity ree (^
Need	Emergency room physician fe	e (waived if admitted)	No charge	
mmediate	Emergency medical transport	ation	0%	Х
attention	Urgent care		0%	After 1st thre non-preventi visits
Hospital stay	Facility fee (e.g. hospital room)		0%	х
	Physician/surgeon fee		0%	Х
	Mental/Behavioral health outpatient office visits		0%	After 1st thre non-preventi visits
	Mental/Behavioral health othe	0%	After 1st thre non-preventivisits	
	Mental/Behavioral health inpa	0%	х	
Mental health,				v
behavioral	Mental/Behavioral health inpa	0%	Х	
nealth, or substance abuse needs	Substance Use disorder outpatient office visits		0%	After 1st thr non-prevent visits
	Substance Use disorder other	0%	After 1st thre non-preventi	
			09/	visits
	Substance Use inpatient facili		0%	X
	Substance use disorder inpati		0%	X
	Prenatal care and preconcept		No charge	-
Pregnancy	Delivery and all inpatient services	Hospital	0%	х
		Professional	0%	X
	Home health care Outpatient Rehabilitation serv	ices	0%	X
Help recovering or	Outpatient Habilitation service		0%	X
other special	Skilled nursing care		0%	х
	Durable medical equipment		0%	Х
	Hospice service Eye exam		0% No charge	X
Child ove eare		contact lenses in lieu of alaesee)	0%	x
	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam		0.0	^
Child Dental	Preventive - Cleaning			
Diagnostic and	Preventive - X-ray		Not Covered	
Preventive	Sealants per Tooth Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures		Not Covered	
	Periodontal Maintenance Serv	vices	Not Covered	_
Services	Crowns and Casts			
Child Dental	Endodontics			
	Periodontics (other than main	tenance)	Not Covered	
Child Dental Major Services		tenance)	Not Covered	

Endnotes to 2017 Standard Benefit Plan Designs

These endnotes and the Standard Benefit Plan Designs apply only to covered services.

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 issuer.
- 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-ofpocket 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 plans except HDHPs, 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 issuer pays all costs for covered services for all family members.
- 5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of the specified deductible amount for individual coverage or \$X,XXX2,600⁴ for Plan Year 2017. 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.
- 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 an up to 30-day prescription supply. Nothing in this note precludes an issuer from offering mail order prescriptions at a reduced cost-share.

⁴ The minimum deductible amount for high-deductible health plans will be the 2017 inflation-adjusted amount determined by the IRS pursuant to section 223(c)(2)(A) of the Internal Revenue Code for other than self-only coverage.

- 11) As applicable, for the child dental portion of the benefit design, an issuer may choose the child dental standard benefit copay or coinsurance design, regardless of whether the issuer selects the copay or the coinsurance design for the non-dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.
- 12) A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 2017 Dental Copay Schedule.
- 13) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
- 14) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Standard Benefit Plan Designs.
- 15) Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
- 16) 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.
- 17) Specialists are 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.
- 18) The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than specialist for a service provided by one of these practitioners.
- 19) 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.

- 20) The inpatient physician cost share may apply for any physician who bills separately from the facility (e.g. surgeon). A member's primary care physician or specialist may apply the office visit cost share when conducting a visit to the member in a hospital or skilled nursing facility.
- 21) Cost-sharing for services subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) may be different but not more than those listed in these standard benefit plan designs if necessary for compliance with MHPAEA.
- 22) Behavioral health treatment for autism and pervasive developmental disorder is covered under Mental/Behavioral health outpatient services.
- 23) Drug tiers are defined as follows:

Tier	Definition
1	1) Most generic drugs and low cost preferred brands.
2	1) Non-preferred generic drugs or;
	2) Preferred brand name drugs or;
	3) Recommended by the plan's pharmaceutical and
	therapeutics (P&T) committee based on drug safety, efficacy
	and cost.
3	1) Non-preferred brand name drugs or;
	2) Recommended by P&T committee based on drug safety,
	efficacy and cost or;
	3) Generally have a preferred and often less costly
	therapeutic alternative at a lower tier.
4	1) Food and Drug Administration (FDA) or drug
	manufacturer limits distribution to specialty pharmacies or;
	2) Self administration requires training, clinical monitoring or;
	3) Drug was manufactured using biotechnology or;
	4) Plan cost (net of rebates) is >\$600.

- 24) 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.
- 25) 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.
- 26) The health issuer may not impose a member cost share for Diabetes Self-Management which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member's physician. This includes but is not limited to instruction that will enable diabetic

patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.