Date: June 16, 2016 January 26, 2017





| • | hare amounts describe the Enrollee's out of pocket costs. | Platinu | m | Platinu | m |
|---|---|--|-----------------------|--------------------------------------|-----------------------|
| | e - AV Calculator | Coinsurance 89.7%91 | | Copay P 90.3%88 | |
| | cludes a deductible? | No | .270 | No | . 170 |
| Integrated Inc | dividual deductible mily deductible | \$0 \$0 | | \$0 \$0 | |
| Individual de | ductible, NOT integrated: Medical / Pharmacy / Dental | \$0 / \$0 / | | \$0 / \$0 / | |
| Individual Out- | ctible, NOT integrated: Medical / Pharmacy / Dental | \$0 / \$0 / \$4,000 <u>\$3</u> | <u>,350</u> | \$0 / \$0 / \$4,000 <u>\$3</u> | <u>,350</u> |
| | pocket maximum -only coverage deductible | \$8,000 <u>\$6</u> N/A | <u>,700</u> | \$8,000 <u>\$6</u> N/A | ,700 |
| | n: Individual deductible | N/A | | N/A | |
| Common Medical Event | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
| | Primary care visit to treat an injury, illness, or condition | \$15 | | \$15 | |
| Health care provider's office or clinic | Other practitioner office visit | \$15 | | \$15 | |
| visit | Specialist visit | \$40 <u>\$30</u> | | \$40 <u>\$30</u> | |
| | Preventive care/ screening/ immunization | No charge | | No charge | |
| Tests | Laboratory Tests X-rays and Diagnostic Imaging | \$20 <u>\$15</u> \$40 <u>\$30</u> | | \$20 <u>\$15</u> \$40 <u>\$30</u> | |
| | Imaging (CT/PET scans, MRIs) | 10% | | \$150 <u>\$75</u> | |
| | 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 services | Surgery facility fee (e.g., ASC) Physician/surgeon fees | 10% 10% | | \$250\$100 \$40\$25 | |
| sei vices | Outpatient visit | 10% | | 10% | |
| | Emergency room facility fee (waived if admitted) | \$150 | | \$150 | |
| Need | Emergency room physician fee (waived if admitted) | No charge | | No charge | |
| immediate attention | Emergency medical transportation | \$150 | | \$150 | |
| attention | Urgent care | \$15 | | \$15 | |
| He suited stars | Facility fee (e.g. hospital room) | 10% | | \$250 per day up | |
| Hospital stay | Physician/surgeon fee | 10% | | to 5 days \$40No charge | |
| | Mental/Behavioral health outpatient office visits | \$15 | | \$15 | |
| | Mental/Behavioral health other outpatient items and services | \$15 | | \$15 | |
| | Mental/Behavioral health inpatient facility fee (e.g.hospital room) | 10% | | \$250 per day up to 5 days | |
| Mental health, behavioral | Mental/Behavioral health inpatient physician fee | 10% | | \$40No charge | |
| health, or substance abuse needs | Substance Use disorder outpatient office visits | \$15 | | \$15 | |
| | Substance Use disorder other outpatient items and services | \$15 | | \$15 | |
| | Substance Lies innetical facility for (2 or heavital access) | 4007 | | \$250 per day up | |
| | Substance Use inpatient facility fee (e.g. hospital room) | 10% | | to 5 days | |
| | Substance use disorder inpatient physician fee | 10% | | \$40No charge | |
| Pregnancy | Prenatal care and preconception visits Delivery and all inpatient Hospital | No charge 10% | | No charge \$250 per day up | |
| rognancy | services Professional | 10% | | to 5 days \$40No charge | |
| | Home health care (cost share per visit) Outpatient Rehabilitation services | 10% \$15 | | \$20 | |
| Help recovering or | Outpatient Habilitation services | \$15 \$15 | | \$15 \$15 | |
| other special health needs | Skilled nursing care | 10% | | \$150 per day up to 5 days | |
| nealth needs | Durable medical equipment Hospice service | 10% No charge | | 10% No charge | |
| Child ave save | 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 Preventive - Cleaning | | | | |
| Diagnostic and Preventive | Preventive - X-ray Sealants per Tooth Topical Fluoride Application | No charge | | No charge | |
| Child Dental | Space Maintainers - Fixed | | | | |
| Basic | Restorative Procedures | 20% | | See 2017 Dental Copay Schedule | |
| Services | Periodontal Maintenance Services Crowns and Casts | | | | |
| Child Dental | Endodontics | | | See 2017 Dental | |
| Major Services | Periodontics (other than maintenance) | 50% | | Copay Schedule | |
| | Prosthodontics Oral Surgery | | | | |
| Child Orthodontics | Medically necessary orthodontics | 50% | | \$1,000 | |
| | | | | | |

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Summary of Benefits and Coverage

| Member Cost S | Benefits and Coverage hare amounts describe the En - AV Calculator | rollee's out of pocket costs. | Gold Coinsurand 80.9%81 | ce Plan | Gold Copay P 81.2%78 | Plan |
|---|--|--|---|-----------------------|--|-----------------------|
| Plan design in | cludes a deductible? | | No | | No | |
| | dividual deductible mily deductible | | \$0 \$0 | | \$0 \$0 | |
| Individual de | ductible, NOT integrated: Mo | | \$0 / \$0 / | | \$0 / \$0 / | |
| | ctible, NOT integrated: Medic -of-pocket maximum | cal / Pharmacy / Dental | \$0 / \$0 / \$6,75 0 <u>\$6</u> | | \$0 / \$0 / \$6,750 \$6 | |
| Family Out-of- | pocket maximum | | \$13,500 <u>\$1</u> | 2,000 | \$13,500 <u>\$1</u> N/A | |
| | only coverage deductible n: Individual deductible | | N/A N/A | | N/A N/A | |
| Common Medical Event | Se | rvice Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
| | Primary care visit to treat an i | njury, illness, or condition | \$30 <u>\$25</u> | | \$30 <u>\$25</u> | |
| Health care provider's office or clinic | Other practitioner office visit | | \$30 <u>\$25</u> | | \$30 <u>\$25</u> | |
| visit | Specialist visit | | \$55 | | \$55 | |
| | Preventive care/ screening/ in | nmunization | No charge | | No charge | |
| Tests | Laboratory Tests X-rays and Diagnostic Imagin | g | \$35 \$55 | | \$35 \$55 | |
| | Imaging (CT/PET scans, MRI | s) | 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 Physician/surgeon fees |) | 20% 20% | | \$600 <u>\$300</u> \$55 <u>\$40</u> | |
| services | Outpatient visit | | 20% | | 20% | |
| | Emergency room facility fee (| waived if admitted) | \$325 | | \$325 | |
| | Emergency room physician fe | e (waived if admitted) | No charge | | No charge | |
| Need immediate | Emergency medical transport | ation | \$250 | | \$250 | |
| attention | Urgent care | | \$30 | | \$30 | |
| | Facility for the second and asset | Δ | 000/ | | \$600 per day up | |
| Hospital stay | Facility fee (e.g. hospital roon | 1) | 20% | | to 5 days | |
| | Physician/surgeon fee | | 20% | | \$55No charge | |
| N | Mental/Behavioral health outp | patient office visits | \$30 <u>\$25</u> | | \$30 <u>\$25</u> | |
| | Mental/Behavioral health othe | er outpatient items and services | \$30 <u>\$25</u> | | \$30 <u>\$25</u> | |
| | Mental/Behavioral health inpa | tient facility fee (e.g.hospital room) | 20% | | \$600 per day up to 5 days | |
| Mental health, behavioral | Mental/Behavioral health inpa | tient physician fee | 20% | | \$55No charge | |
| health, or substance abuse needs | Substance Use disorder outp | atient office visits | \$30 <u>\$25</u> | | \$30 <u>\$25</u> | |
| | Substance Use disorder othe | r outpatient items and services | \$30 <u>\$25</u> | | \$30 <u>\$25</u> | |
| | | | | | \$600 man | |
| | Substance Use inpatient facil | ty fee (e.g. hospital room) | 20% | | \$600 per day up to 5 days | |
| | Substance use disorder inpat | ient physician fee | 20% | | \$55No charge | |
| | Prenatal care and preconcept | | No charge | | No charge \$600 per day up | |
| Pregnancy | Delivery and all inpatient services | Hospital | 20% | | to 5 days | |
| | Home health care (cost share | Professional per visit) | 20% | | \$55 <u>No charge</u> \$30 | |
| Help | Outpatient Rehabilitation serv | ices | \$30 <u>\$25</u> | | \$30 <u>\$25</u> | |
| recovering or | Outpatient Habilitation service | es e | \$30 <u>\$25</u> | | \$30 <u>\$25</u> \$300 per day up | |
| other special health needs | Skilled nursing care | | 20% | | to 5 days | |
| | Durable medical equipment Hospice service | | 20% No charge | | 20% No charge | |
| Child eye care | Eye exam | | No charge | | No charge | |
| Ja Syc Gare | 1 pair of glasses per year (or | contact lenses in lieu of glasses) | No charge | | No charge | |
| Child Dental | Oral Exam Preventive - Cleaning | | | | | |
| Diagnostic | Preventive - X-ray | | No charge | | No charge | |
| and Preventive | Sealants per Tooth Topical Fluoride Application | | | | _ | |
| Child Dantal | Space Maintainers - Fixed | | | | | |
| Child Dental Basic | Restorative Procedures | | 20% | | See 2017 Dental | |
| Services | Periodontal Maintenance Ser | vices | | | Copay Schedule | |
| Child Daniel | Crowns and Casts Endodontics | | | | | |
| Child Dental | | tenance) | 50% | | See 2017 Dental | |
| Major | Endodontics Periodontics (other than maintenance) | | | | Copay Schedule | |
| Major Services | Prosthodontics Oral Surgery | | | | | |
| | Prosthodontics Oral Surgery Medically necessary orthodor | | 50% | | \$1,000 | |

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| • | Benefits and Coverage hare amounts describe the En | rollee's out of nocket costs | Individua Silver Plar | |
|--|--|---|---|------------------------|
| | nare amounts describe the En | ronee a out of pocket COSIS. | 71.5%71.9 | |
| | | | | _ |
| Integrated Inc | cludes a deductible? dividual deductible | | Yes, Medical/Pha N/A | armacy |
| | mily deductible ductible, NOT integrated: Me | edical / Pharmacy / Dental | N/A \$2,500/ \$250 <u>\$10</u> | 00 / \$0 |
| Family deduc | ctible, NOT integrated: Medic | | \$5,000/ \$500 <u>\$20</u> | <u>00</u> / \$0 |
| | -of-pocket maximum pocket maximum | | \$6800 <u>\$7,00</u> \$13,600 <u>\$</u> 14,0 | |
| | only coverage deductible n: Individual deductible | | N/A N/A | |
| TOA Turning plu | II. IIIaiviaaai acaaciisic | | 14/7 | |
| Common Medical Event | Se | rvice Type | Member Cost Share | Deductible Applies |
| | Primary care visit to treat an i | njury, illness, or condition | \$35 | |
| Health care provider's office or clinic | Other practitioner office visit | | \$35 | |
| visit | Specialist visit | | \$70 | |
| | Preventive care/ screening/ ir | nmunization | No charge | |
| Гests | Laboratory Tests X-rays and Diagnostic Imagin | | \$35 \$70 | |
| lesis | Imaging (CT/PET scans, MRI | | \$300 | |
| | Tier 1 | | \$15 | Pharmacy deductible |
| Drugs to treat | Tier 2 | | \$55 | Pharmac |
| liness or condition | Tier 3 | | \$80 | Pharmac |
| | Tier 4 | 20% up to \$250 per script after pharmacy | deductible | |
| | Surgery facility fee (e.g., ASC | 1 | deductible 20% | deductible |
| Outpatient services | Physician/surgeon fees | I | 20% | |
| SCI VICCS | Outpatient visit | | 20% | |
| | Emergency room facility fee (| waived if admitted) | \$350 | |
| Need | Emergency room physician fee (waived if admitted) | | No charge | |
| mmediate attention | Emergency medical transportation | | \$250 | Х |
| | Urgent care | | \$35 | |
| Hospital stay | Facility fee (e.g. hospital room | n) | 20% | Х |
| iospitai stay | Physician/surgeon fee | | 20% | X |
| | Mental/Behavioral health outp | patient office visits | \$35 | |
| | Mental/Behavioral health other | er outpatient items and services | \$35 | |
| | Mental/Behavioral health inpa | tient facility fee (e.g.hospital room) | 20% | Х |
| Mental health, | Mental/Behavioral health inpa | | 20% | Х |
| pehavioral nealth, or | Wernal Benavioral Health inpa | morte priyololari 100 | 2070 | Λ |
| substance abuse needs | Substance Use disorder outpo | \$35 | | |
| | Substance Use disorder other | \$35 | | |
| | Substance Use inpatient facili | ty fee (e.g. hospital room) | 20% | Х |
| | Substance use disorder inpat | | 20% | Х |
| | Prenatal care and preconcept | | No charge | ^ |
| Pregnancy | Delivery and all inpatient | Hospital | 20% | Х |
| | services | Professional | 20% | X |
| | Home health care (cost share Outpatient Rehabilitation serv | | \$45 \$35 | |
| Help recovering or | Outpatient Rehabilitation service | | \$35 \$35 | |
| other special | Skilled nursing care | | 20% | Х |
| | Durable medical equipment | | 20% | |
| | Hann's s | | - No oboveo | |
| | Hospice service Eye exam | | No charge No charge | |
| nealth needs | | contact lenses in lieu of glasses) | | |
| nealth needs | Eye exam 1 pair of glasses per year (or of Oral Exam | contact lenses in lieu of glasses) | No charge | |
| Child eye care | Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning | contact lenses in lieu of glasses) | No charge No charge | |
| Child eye care Child Dental Diagnostic | Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth | contact lenses in lieu of glasses) | No charge | |
| Child eye care Child Dental Diagnostic | Eye exam 1 pair of glasses per year (or of or o | contact lenses in lieu of glasses) | No charge No charge | |
| Child eye care Child Dental Diagnostic and Preventive Child Dental Basic | Eye exam 1 pair of glasses per year (or of or o | | No charge No charge | |
| Child eye care Child Dental Diagnostic and Preventive Child Dental Basic | Eye exam 1 pair of glasses per year (or of or o | | No charge No charge No charge | |
| Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental | Eye exam 1 pair of glasses per year (or of or o | | No charge No charge No charge | |
| Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major | Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Sent | vices | No charge No charge No charge | |
| Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental | Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Sen | vices | No charge No charge No charge 20% | |

| Member Cost S | Benefits and Coverage Share amounts describe the En | rollee's out of pocket costs. | CCSB Silver Coinsurance 71.6%71.8 | | CCSB Silver Copay Pla | |
|---|---|--|---|------------------------|---|------------------------|
| Plan design in | cludes a deductible? | | Yes, Medical/Ph | _ | Yes, Medical/Pha | _ |
| Integrated Fa | dividual deductible amily deductible | | N/A N/A | | N/A N/A | |
| | eductible, NOT integrated: Me ctible, NOT integrated: Medic | | \$2,000/ \$250 <u>\$1</u> \$4,000 / \$500 <u>\$2</u> | | \$2,000/ \$250 <u>\$10</u> \$4,000 / \$500 <u>\$20</u> | |
| | of-pocket maximum | | \$6,800 \$13,600 | | \$6,800 \$13,600 | |
| HSA plan: Self | i-only coverage deductible | | N/A N/A | | N/A N/A | |
| Tion running pla | - | | 14// | | 14/74 | |
| Common Medical Event | Se | rvice Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
| Haalih aana | Primary care visit to treat an i | njury, illness, or condition | \$45 | | \$45 | |
| Health care provider's office or clinic visit | Other practitioner office visit | | \$45 | | \$45 | |
| | Specialist visit | | \$75 | | \$75 | |
| | Preventive care/ screening/ in Laboratory Tests | nmunization | No charge \$40 | | No charge \$40 | |
| Tests | X-rays and Diagnostic Imagin Imaging (CT/PET scans, MRI | <u> </u> | \$70 20% | | \$70 \$300 | |
| | Tier 1 | - | \$15 | Pharmacy | \$15 | Pharmacy |
| | | | | deductible Pharmacy | | deductible Pharmacy |
| Drugs to treat illness or condition | Tier 2 | | \$55 | deductible | \$55 | deductible |
| Janaraon | Tier 3 | | \$85 20% up to \$250 per | Pharmacy deductible | \$85 20% up to \$250 per | Pharmacy |
| | Tier 4 Surgery facility fee (e.g., ASC |) | script after pharmacy deductible 20% | Pharmacy deductible | script after pharmacy deductible 20% | Pharmacy deductible |
| Outpatient services | Physician/surgeon fees | | 20% | | 20% | |
| | Outpatient visit Emergency room facility fee (| vaived if admitted) | 20% \$350 | | \$350 | |
| | Emergency room physician fe | · · | No charge | | No charge | |
| Need immediate | Emergency medical transport | <u> </u> | \$250 | X | \$250 | X |
| attention | Urgent care | | \$45 | | \$45 | |
| Hospital stay | Facility fee (e.g. hospital room | n) | 20% | Х | 20% | Х |
| | Physician/surgeon fee | | 20% | Х | 20% | Х |
| | Mental/Behavioral health outp | patient office visits | \$45 | | \$45 | |
| | Mental/Behavioral health othe | er outpatient items and services | \$45 | | \$45 | |
| | Mental/Behavioral health inpa | tient facility fee (e.g.hospital room) | 20% | Х | 20% | Х |
| Mental health, behavioral | Mental/Behavioral health inpa | tient physician fee | 20% | Х | 20% | Х |
| health, or substance abuse needs | Substance Use disorder outp | atient office visits | \$45 | | \$45 | |
| | Substance Use disorder othe | r outpatient items and services | \$45 | | \$45 | |
| | Substance Use inpatient facili | ty fee (e.g. hospital room) | 20% | Х | 20% | Х |
| | Substance use disorder inpat | ent physician fee | 20% | Х | 20% | X |
| | Prenatal care and preconcept | ion visits | No charge | | No charge | |
| Pregnancy | Delivery and all inpatient services | Hospital Professional | 20% | X | 20% | X |
| | Home health care (cost share | per visit) | 20% | X | 20% \$45 | X |
| Help | Outpatient Rehabilitation services Outpatient Habilitation services | | \$45 \$45 | | \$45 \$45 | |
| recovering or other special | Skilled nursing care | | 20% | Х | 20% | Х |
| health needs | Durable medical equipment | | 20% | | 20% | |
| | Hospice service Eye exam | | No charge No charge | | No charge No charge | |
| Child eye care | i pair of glasses per year (or o | contact lenses in lieu of glasses) | No charge | | No charge | |
| Child Dental | Oral Exam Preventive - Cleaning | | | | | |
| Diagnostic and | Preventive - X-ray Sealants per Tooth | | No charge | | No charge | |
| Preventive | Topical Fluoride Application | | | | | |
| Child Dental | Space Maintainers - Fixed Restorative Procedures | | | | See 2017 Dontal Con- | |
| Basic Services | | vicas | 20% | | See 2017 Dental Copay Schedule | |
| | Periodontal Maintenance Service Crowns and Casts | vices | | | | |
| Child Dental Major | Endodontics Periodontics (other than main | tenance) | 50% | | See 2017 Dental Copay | |
| Services | Prosthodontics | ышы с) | 3 0 % | | Schedule | |
| Child | Oral Surgery | | | | | |
| Child Orthodontics | Medically necessary orthodor | ntics | 50% | | \$1,000 | |

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| Date: June | : 16, 2016 January 26, | <u> 2017</u> | | |
|---|---|--|--------------------------------|--------------------|
| Summary of | Benefits and Coverage | | CCSB | |
| Member Cost S | hare amounts describe the En | rollee's out of pocket costs. | Silver HDHP PI | |
| Actuarial Value | e - AV Calculator | | 71.3% <u>71.</u> | <u>7%</u> |
| | cludes a deductible? | | Yes, integr | |
| | dividual deductible imily deductible | | \$2,000 integ \$4,000 integ | |
| | ductible, NOT integrated: Me ctible, NOT integrated: Medic | | N/A N/A | |
| Individual Out- | -of-pocket maximum | ai / Pharmacy / Dentai | \$6,550 |) |
| | pocket maximum -only coverage deductible | | \$13,100 \$2,000 | |
| | n: Individual deductible | | \$2,600 | |
| | | | | |
| Common Medical Event | Se | rvice Type | Member Cost Share | Deductible Applies |
| | | | | |
| | Primary care visit to treat an i | njury, illness, or condition | 20% | X |
| 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 | |
| Tests | Laboratory Tests X-rays and Diagnostic Imagin | n | 20% 20% | X |
| 16313 | Imaging (CT/PET scans, MRI | | 20% | X |
| | Tier 1 | | 20% up to \$250 per | |
| | Tier i | | script | X |
| Drugs to treat illness or | Tier 2 | | 20% up to \$250 per script | Х |
| condition | Tier 3 | | 20% up to \$250 per script | X |
| 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% 20% | X |
| | Emergency room facility fee (| waived if admitted) | 20% | ^ X |
| | | · | | |
| Need | Emergency room physician fe | <u> </u> | 0% | Х |
| immediate | Emergency medical transport | ation | 20% | X |
| attention | Urgent care | | 20% | Х |
| | Facility fee (e.g. hospital room | 1) | 20% | Х |
| Hospital stay | Physician/surgeon fee | • | 20% | X |
| | Mental/Behavioral health outp | atient office visits | 20% | Х |
| | 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, | · · | | | |
| behavioral health, or | Mental/Behavioral health inpa | tient physician fee | 20% | X |
| substance abuse needs | Substance Use disorder outpo | atient office visits | 20% | Х |
| | Substance Use disorder other | outpatient items and services | 20% | Х |
| | Substance Use inpatient facili | ty fee (e.g. hospital room) | 20% | Х |
| | Substance use disorder inpat | ent physician fee | 20% | X |
| | Prenatal care and preconcept | | | ^ |
| Prognancy | Delivery and all inpatient | | No charge 20% | X |
| Pregnancy | services | Hospital Professional | 20% | X |
| | Home health care (cost share | per visit) | 20% | X |
| Help | Outpatient Rehabilitation serv Outpatient Habilitation service | | 20% 20% | X |
| recovering or other special | Skilled nursing care | | 20% | X |
| health needs | Durable medical equipment | | 20% | X |
| | Hospice service | | 0% | X |
| Child eye care | Eye exam | | No charge | |
| | 1 pair of glasses per year (or or Oral Exam | contact lenses in lieu of glasses) | No charge | |
| Child Dental | Preventive - Cleaning | | | |
| Diagnostic and | Preventive - X-ray Sealants per Tooth | | No charge | |
| Preventive | Topical Fluoride Application Space Maintainers - Fixed | | | |
| Child Dental | | | | |
| Basic | Restorative Procedures | | 20% | |
| Services | Periodontal Maintenance Service Crowns and Casts | vices | | |
| Child Dental | Endodontics | | | |
| Major | Periodontics (other than main | tenance) | 50% | |
| Services | Prosthodontics Oral Surgery | | | |
| Child Orthodontics | Medically necessary orthodor | tics | 50% | |
| | | | | |

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| Member Cost SI | Benefits and Coverage hare amounts describe the End a - AV Calculator | rollee's out of pocket costs. | Silver F 100%-150 94.1%93 | % FPL | Silver Plan 150%-200% F 87.5%87.9% | PL |
|--|---|--|--|-----------------------|---|------------------------|
| Plan design ind | cludes a deductible? | | Yes, Medical/ | Pharmacy | Yes, Medical/Pha | |
| | dividual deductible mily deductible | | N/A N/A | | N/A N/A | |
| Individual ded | ductible, NOT integrated: Me | | \$75 / \$0 | /\$0 | \$650 / \$50 / \$ | |
| | ctible, NOT integrated: Medic -of-pocket maximum | ai / Pharmacy / Dentai | \$150 / \$0 \$ 2,350 \$1 | | \$1,300 / \$100 / \$ 2,35 0 <u>\$2,45</u> | |
| | pocket maximum -only coverage deductible | | \$4,700 <u>\$2</u> N/A | | \$4,700 <u>\$4,90</u> N/A | <u>0</u> |
| | n: Individual deductible | | N/A | | N/A | |
| Common Medical Event | Se | rvice Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductible Applies |
| | Primary care visit to treat an ir | | \$5 | | \$10 | |
| office or clinic | Other practitioner office visit | | \$5 | | \$10 | |
| visit | Specialist visit | | \$8 | | \$25 | |
| | Preventive care/ screening/ in | nmunization | No charge | | No charge | |
| Tests | Laboratory Tests X-rays and Diagnostic Imaging | ם | \$8 \$8 | | \$15 \$25 | |
| | Imaging (CT/PET scans, MRIs | | \$50 | | \$100 | |
| | Tier 1 | | \$3 | | \$5 | |
| Drugs to treat | Tier 2 | | \$10 | | \$20 | Pharmacy deductible |
| illness or condition | Tier 3 | | \$15 | | \$35 | Pharmacy deductible |
| | Tier 4 | | 10% up to \$150 per script | | 15% up to \$150 per script after pharmacy | Pharmacy deductible |
| | Surgery facility fee (e.g., ASC) | | 10% | | deductible 15% | |
| Outpatient services | Physician/surgeon fees | | 10% | | 15% | |
| | Outpatient visit | | 10% | | 15% | |
| | Emergency room facility fee (v | vaived if admitted) | \$50 | | \$100 | |
| Need | Emergency room physician fe | e (waived if admitted) | No charge | | No charge | |
| immediate | Emergency medical transporta | ation | \$30 | X | \$75 | X |
| attention | Urgent care | | \$5 | | \$10 | |
| Hospital stay | Facility fee (e.g. hospital room |) | 10% | Х | 15% | Х |
| | Physician/surgeon fee | | 10% | X | 15% | X |
| | Mental/Behavioral health outpatient office visits | | \$5 | | \$10 | |
| | Mental/Behavioral health othe | \$5 | | \$10 | | |
| | Mental/Behavioral health inpa | tient facility fee (e.g.hospital room) | 10% | Х | 15% | Х |
| Mental health, behavioral | Mental/Behavioral health inpa | tient physician fee | 10% | Х | 15% | Х |
| health, or substance abuse needs | Substance Use disorder outpa | atient office visits | \$5 | | \$10 | |
| | Substance Use disorder other | outpatient items and services | \$5 | | \$10 | |
| | Substance Use inpatient facili | ty fee (e.g. hospital room) | 10% | X | 15% | X |
| | Substance use disorder inpati | | 10% | X | 15% | X |
| | Prenatal care and preconcept | | | ^ | | ^ |
| Pregnancy | Delivery and all inpatient | Hospital | No charge | Х | No charge 15% | Х |
| | services | Professional | 10% | X | 15% | X |
| | Home health care (cost share | per visit) | \$3 | | \$15 | |
| Help | Outpatient Rehabilitation serv Outpatient Habilitation service | | \$5 \$5 | | \$10 \$10 | |
| recovering or other special | Skilled nursing care | | ან 10% | Х | 15% | Х |
| health needs | Durable medical equipment | | 10% | ^ | 15% | ^ |
| | Hospice service | | No charge | | No charge | |
| Child eye care | Eye exam | | No charge | | No charge | |
| | 1 pair of glasses per year (or of Oral Exam | contact ienses in lieu of glasses) | No charge | | No charge | |
| Child Dental | Preventive - Cleaning | | | | | |
| Diagnostic and Preventive | Preventive - X-ray Sealants per Tooth Topical Fluoride Application | | No charge | | No charge | |
| Child Dental | Space Maintainers - Fixed | | | | | |
| Basic | Restorative Procedures | | 20% | | 20% | |
| Services | Periodontal Maintenance Service Crowns and Casts | rices | | | | |
| Child Dental Major Services | Endodontics Periodontics (other than maint | enance) | 50% | | 50% | |
| | Prosthodontics Oral Surgery | | | | | |
| Child | Medically necessary orthodon | | 50% | | 50% | |

| Summary of | Benefits and Coverage | | |
|---|--|--|------------------------|
| • | hare amounts describe the Enrollee's out of pocket costs. | Silver Plan 200%-250% Fl | PL |
| Actuarial Value | - AV Calculator | 73.7% 73.9% | |
| Plan design inc | cludes a deductible? | Yes, Medical/Phar | macv |
| | dividual deductible | N/A | mady |
| | mily deductible | N/A | |
| | ductible, NOT integrated: Medical / Pharmacy / Dental | \$2,200 / \$250 \$10 | <u>0</u> / \$0 |
| Family deduc | tible, NOT integrated: Medical / Pharmacy / Dental | \$4,400 / \$500 <u>\$20</u> | 0 / \$0 |
| ndividual Out- | -of-pocket maximum | \$5,700 <u>\$5,85</u> (| <u>)</u> |
| Family Out-of- | pocket maximum | \$11,400 <u>\$11,7</u> 0 | <u>)0</u> |
| | only coverage deductible | N/A | |
| HSA family pla | n: Individual deductible | N/A | |
| Common Medical Event | Service Type | Member Cost Share | Deductible Applies |
| | Primary care visit to treat an injury, illness, or condition | \$30 | |
| Health care provider's office or clinic | Other practitioner office visit | \$30 | |
| visit | Specialist visit | \$ 55 <u>\$65</u> | |
| | Preventive care/ screening/ immunization | No charge | |
| | Laboratory Tests | \$35 | |
| Tests | X-rays and Diagnostic Imaging | \$65 <u>\$70</u> | |
| | Imaging (CT/PET scans, MRIs) | \$300 | |
| | Tier 1 | \$15 | Pharmacy deductible |
| Drugs to treat | Tier 2 | \$50 | Pharmacy deductible |
| | | | |

| Summary of | Benefits and Coverage | | | | |
|--|--|---|---|-------------------------------|---------------------|
| Member Cost SI | nare amounts describe the Enrollee's out of pocket costs. | Bronze Pla | n | Bronze HDHP Pl | |
| Actuarial Value | - AV Calculator | 61.9% 60.8% | <u>6</u> | 62.0%61. | |
| | cludes a deductible? | Yes, Medical/Pha | armacv | Yes, integr | rated |
| Integrated Inc | lividual deductible | N/A | | \$4,800 integ | grated |
| | mily deductible ductible, NOT integrated: Medical / Pharmacy / Dental | N/A \$6,300 / \$500 | / \$ 0 | \$9,600 integ N/A | grated |
| | tible, NOT integrated: Medical / Pharmacy / Dental | \$12,600 / \$1,00 | | N/A | |
| | of-pocket maximum | \$6,800 <u>\$7,00</u> | | \$6,550 | |
| | oocket maximum only coverage deductible | \$13,600 <u>\$14,0</u> N/A | <u>100</u> | \$13,10 \$4,800 | |
| | n: Individual deductible | N/A | | \$4,800 | |
| Common Medical Event | Service Type | Member Cost Share | Deductible Applies | Member Cost Share | Deductib Applies |
| Wedlour Everit | Gervice Type | Member Cost Chare | After 1st three | Onare | Дриос |
| | Primary care visit to treat an injury, illness, or condition | \$75 | non-preventive visits | 40% | Х |
| office or clinic visit | Other practitioner office visit | \$75 | After 1st three non-preventive visits | 40% | Х |
| | Specialist visit | \$105 | After 1st three non-preventive visits | 40% | X |
| | Preventive care/ screening/ immunization | No charge | | No charge | |
| | Laboratory Tests X-rays and Diagnostic Imaging | \$40 100% | X | 40% 40% | X |
| | Imaging (CT/PET scans, MRIs) | 100% | X | 40% | X |
| | Tier 1 | 100% up to \$500 per script after pharmacy deductible | Pharmacy Deductible | 40% up to \$500 per script | Х |
| Drugs to treat | Tier 2 | 100% up to \$500 per script after pharmacy deductible | Pharmacy Deductible | 40% up to \$500 per script | Х |
| liness or | Tier 3 | 100% up to \$500 per script after pharmacy deductible | Pharmacy Deductible | 40% up to \$500 per script | Х |
| | Tier 4 | 100% up to \$500 per script after pharmacy deductible | Pharmacy Deductible | 40% up to \$500 per script | Х |
| Outpatient | Surgery facility fee (e.g., ASC) | 100% | X | 40% | X |
| services | Physician/surgeon fees Outpatient visit | 100% 100% | X | 40% 40% | X |
| | Emergency room facility fee (waived if admitted) | 100% | X | 40% | X |
| | Emergency room physician fee (waived if admitted) | No charge | | 0% | Х |
| Need | Emergency medical transportation | 100% | X | 40% | X |
| mmediate attention | Urgent care | \$75 | After 1st three non-preventive visits | 40% | х |
| Hospital stay | Facility fee (e.g. hospital room) | 100% | X | 40% | Х |
| | Physician/surgeon fee | 100% | X | 40% | Х |
| | 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 X | 40% | Х |
| | Mental/Behavioral health inpatient facility fee (e.g.hospital room) | 100% | Х | 40% | Х |
| Jona Viorai | Mental/Behavioral health inpatient physician fee | 100% | Х | 40% | Х |
| nealth, or substance abuse needs | Substance Use disorder outpatient office visits | \$75 | After 1st three non-preventive visits | 40% | Х |
| | | | VISILO | | |

| | Specialist visit | | \$105 | non-preventive visits | 40% | Х |
|---|--|---------------------------------------|---|---|-------------------------------|---|
| | Preventive care/ screening/ im | munization | No charge | | No charge | |
| | Laboratory Tests | | \$40 | | 40% | Х |
| Tests | X-rays and Diagnostic Imaging | | 100% | X | 40% | X |
| | Imaging (CT/PET scans, MRIs |) | 100% | X | 40% | X |
| | Tier 1 | | 100% up to \$500 per script after pharmacy deductible | Pharmacy Deductible | 40% up to \$500 per script | Х |
| Drugs to treat 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) | | 100% | X | 40% | X |
| services | Physician/surgeon fees | | 100% | X | 40% | X |
| | Outpatient visit | | 100% | X | 40% | X |
| | Emergency room facility fee (w | • | 100% | X | 40% | Х |
| Need | Emergency room physician fee | e (waived if admitted) | No charge | | 0% | Х |
| immediate | Emergency medical transporta | tion | 100% | X | 40% | X |
| attention | Urgent care | | \$75 | After 1st three non-preventive visits | 40% | х |
| Hospital stay | Facility fee (e.g. hospital room) | | 100% | Х | 40% | Х |
| , | Physician/surgeon fee | | 100% | X | 40% | X |
| | Mental/Behavioral health outpa | atient 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 visitsX | 40% | Х |
| | Mental/Behavioral health inpat | ient facility fee (e.g.hospital room) | 100% | X | 40% | Х |
| Mental health, behavioral | Mental/Behavioral health inpat | ient physician fee | 100% | Х | 40% | Х |
| health, or substance abuse needs | Substance Use disorder outpa | tient office visits | \$75 | After 1st three non-preventive visits | 40% | х |
| | Substance Use disorder other | outpatient items and services | \$75 | After 1st three- non-preventive- visits X | 40% | х |
| | Substance Use inpatient facility | y fee (e.g. hospital room) | 100% | Х | 40% | Х |
| | Substance use disorder inpatie | ent physician fee | 100% | Х | 40% | Х |
| | Prenatal care and preconception | on visits | No charge | | No charge | |
| Pregnancy | Delivery and all inpatient | Hospital | 100% | Х | 40% | Х |
| | services | Professional | 100% | Х | 40% | X |
| | Home health care (cost share | | 100% | X | 40% | X |
| Holm | Outpatient Rehabilitation servi | | \$75 | | 40% | X |
| Help recovering or | Outpatient Habilitation services | 5 | \$75 | | 40% | X |
| other special | Skilled nursing care | | 100% | X | 40% | Х |
| health needs | Durable medical equipment | | 100% | X | 40% | X |
| | Hospice service | | No charge | A | 0% | X |
| | Eye exam | | No charge | | No charge | |
| Child eye care | i pair of glasses per year (or co | ontact lenses in lieu of glasses) | No charge | | No charge | |
| Child Dental Diagnostic and Preventive | Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed | | No charge | | No charge | |
| Child Dental Basic Services | Restorative Procedures | | 20% | | 20% | |
| Child Dental Major Services | Periodontal Maintenance Serv Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics Oral Surgery | | 50% | | 50% | |
| Child Orthodontics | Medically necessary orthodont | ics | 50% | | 50% | |

| Primary care visit to treat an injury, illness, or condition | _ | | | | |
|--|---|--|--|-------------------------------------|---|
| Plan design includes a deductible? | • | J | | | |
| Principated Individual addicable Yes, integrated Yes, integrated Integrated Individual addicable S7.15927_350 integrated S7.15927_350 i | | | ollee's out of pocket costs. | Catastro | phic Plan |
| Integrated Individual deductible S14,309\$1,700 integrated: Medical / Pharmacy / Dental S44,309\$1,700 integrated: Medical / Pharmacy / Dental N/A N/A N/A S7,1109\$7,350 integrated: Medical / Pharmacy / Dental N/A N/ | | | | V · | |
| Individual deductible, NOT integrated: Medical / Pharmacy / Dental N/A N | Integrated Inc | dividual deductible | | \$ 7.15 0 <u>\$7.3</u> 5 | 50 integrated |
| Maritable Mar | | | dical / Dharmany / Dantal | | |
| Standard | | | | | |
| Machibar Minimal Min | | | | | |
| | | | | | |
| Primary care visit to treat an injury, illness, or condition O% After 1st th non-prevent visits O% After 1st the non-prevent visits After 1st the non-p | | | | N | /A |
| Primary care visit to treat an injury, illness, or condition Primary care visit to treat an injury, illness, or condition Office or clinic visit Specialist visit Speciali | | | | | Deductible |
| Primary care visit to treat an injury. Illness, or condition Ohe primary care visit to treat an injury. Illness, or condition Oher practitioner office visit Oher practitioner office visit Specialist visit Specialist visit Oher practitioner office visits Oher practitioner office v | Medicai Event | Se | rvice Type | Share | After 1st thr |
| provider's office or clinic visit Specialist visit Specialist visit Specialist visit Specialist visit Specialist visit Specialist visit Specialist visit O% X | | Primary care visit to treat an in | njury, illness, or condition | 0% | non-prevent |
| Specialist visit 0% X Preventive care/ screening/ immunization No charge Laboratory Tests 0% X X-rays and Diagnostic Imaging 0% X Tier 1 0% X Tier 1 0% X Tier 2 0% X Tier 3 0% X Tier 3 0% X Surgery facility fee (e.g. ASC) 0% X Physician/surgeon fees 0% X Cutpatient visit 0% X Emergency room physician fee (waived if admitted) 0% X Emergency room physician fee (waived if admitted) No charge 0% X Emergency room physician fee (waived if admitted) No charge 0% X Hospital stay Physician/surgeon fees 0% X Hospital stay Physician/surgeon fee 0% X Mental/Behavioral health outpatient office visits 0% After 1st the non-prevent v | Health care provider's office or clinic | Other practitioner office visit | | 0% | After 1st thr non-prevent visits |
| Laboratory Tests | visit | Specialist visit | | 0% | X |
| Name | | | nmunization | | |
| Tier 1 Tier 2 Outpatient Surgery facility fee (e.g., ASC) Physician/surgeon fees Outpatient visit Emergency room facility fee (waived if admitted) Facility fee (e.g., ASC) Ow A Compatient visit Emergency room facility fee (waived if admitted) Facility fee (e.g., hospital room) Urgent care Mental/Behavioral health outpatient office visits Mental/Behavioral health outpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient physician fee Mental/Behaviora | | - | 1 | _ | - |
| Tier 2 0% X Tier 3 0% X Tier 4 0% X Tier 4 0% X Outpatient Services Outpatient Services Outpatient it services Outpatient of services Outpatient outpatient of services Outpatient outpatient of services Outpatient outpatien | | | | | |
| Tier 3 0% X Tier 4 0% X Tier 4 0% X Tier 4 0% X Tier 4 0% X Dutpatient services | | Tier 1 | | 0% | х |
| Tier 4 Tier 4 Ow x The physician/surgeon fees Ow x Outpatient visit Emergency room facility fee (waived if admitted) Ow x Emergency room physician fee (waived if admitted) Facility fee (e.g. hospital room) Urgent care Ow After 1st the non-preven visits Facility fee (e.g. hospital room) Physician/surgeon fee Ow X Mental/Behavioral health outpatient office visits Ow non-preven visits Mental/Behavioral health other outpatient items and services Ow After 1st the non-preven visits Mental/Behavioral health inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient physician fee Ow X Mental/Behavioral health inpatient physician fee Ow X Substance Use disorder outpatient items and services Ow After 1st the non-preven visits Substance Use disorder outpatient office visits Ow Non-preven visits Substance Use disorder outpatient items and services Ow After 1st the non-preven visits Substance Use disorder outpatient facility fee (e.g. hospital room) X Substance Use disorder outpatient items and services Ow After 1st the non-preven visits Substance Use disorder outpatient items and services Ow After 1st the non-preven visits Substance Use disorder outpatient items and services Ow After 1st the non-preven visits Substance Use disorder outpatient physician fee Pregnancy Pregnancy Pregnancy Ow X Pressional Home health care (cost share per visit) Ow X Home health care (cost share per visit) Ow X | Drugs to treat | Tier 2 | | 0% | × |
| Surgery facility fee (e.g., ASC) Physician/surgeon fees Outpatient visit Emergency room facility fee (waived if admitted) No charge Emergency room physician fee (waived if admitted) Emergency room physician fee (waived if admitted) Emergency medical transportation Urgent care Ow After 1st the non-prevent visits Hospital stay Facility fee (e.g. hospital room) Physician/surgeon fee Ow X After 1st the non-prevent visits Mental/Behavioral health outpatient office visits Mental/Behavioral health other outpatient items and services Mental/Behavioral health inpatient physician fee Wental/Behavioral health inpatient physician fee Substance Substance Use disorder outpatient office visits Ow After 1st the non-prevent visits Mental/Behavioral health inpatient physician fee Substance Use disorder outpatient office visits Ow After 1st the non-prevent visits After 1st the non-prevent visits Mental/Behavioral health inpatient physician fee Substance Use disorder outpatient office visits Ow After 1st the non-prevent visits Substance Use disorder outpatient items and services Ow After 1st the non-prevent visits Substance Use disorder outpatient office visits Ow After 1st the non-prevent visits Substance Use disorder outpatient physician fee Ow X Prenatal care and prevent visits Prenatal care and preconception visits No charge Pregnancy Pregnancy Prepsional Home health care (cost share per visit) Ow X | condition | Tier 3 | | 0% | х |
| Physician/surgeon fees 0% X | | Tier 4 | | 0% | X |
| Coutpatient visit Cout | Outpatient | | | - | - |
| Emergency room facility fee (waived if admitted) | services | | | | |
| Emergency room physician fee (waived if admitted) No charge | | | vaived if admitted) | 0% | X |
| Emergency medical transportation 0% X | | | · | _ | |
| Hospital stay Facility fee (e.g. hospital room) 0% X | Need | • | <u> </u> | | Y |
| Urgent care Urgent care O'M Inter-1st tin non-preven visits Facility fee (e.g. hospital room) Physician/surgeon fee Mental/Behavioral health outpatient office visits Mental/Behavioral health other outpatient items and services Mental/Behavioral health inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient physician fee Substance Substance Use disorder outpatient office visits O'M After 1st the nen-preven visitsX Mental/Behavioral health inpatient physician fee Substance Use disorder outpatient office visits O'M After 1st the nen-preven visitsX After 1st the non-preven visitsX Substance Use disorder outpatient office visits O'M After 1st the non-preven visitsX Substance Use disorder outpatient items and services O'M After 1st the non-preven visitsX No charge Pregnancy Pregnancy Delivery and all inpatient services Professional Hospital O'M X After 1st the non-preven visitsX No charge Professional O'M X X After 1st the non-preven visitsX No charge Professional O'M X X | | Emergency medical transport | ation | 070 | |
| Physician/surgeon fee 0% X Mental/Behavioral health outpatient office visits 0% non-preven visits Mental/Behavioral health other outpatient items and services 0% non-preven visits \(\) Mental/Behavioral health inpatient facility fee (e.g. hospital room) 0% X Mental/Behavioral health inpatient physician fee 0% X Substance Use disorder outpatient office visits 0% non-preven visits \(\) Substance Use disorder outpatient office visits 0% non-preven visits \(\) Substance Use disorder outpatient items and services 0% After 1st the non-preven visits \(\) Substance Use disorder outpatient items and services 0% After 1st the non-preven visits \(\) Substance Use disorder other outpatient items and services 0% After 1st the non-preven visits \(\) Substance use disorder inpatient physician fee 0% X Prenatal care and preconception visits No charge Pregnancy Delivery and all inpatient Hospital 0% X Professional 0% X Home health care (cost share per visit) 0% X | attention | Urgent care | | 0% | non-preven |
| Physician/surgeon fee 0% X Mental/Behavioral health outpatient office visits 0% non-prevent visits Mental/Behavioral health other outpatient items and services 0% non-prevent visits X Mental/Behavioral health inpatient facility fee (e.g. hospital room) 0% X Mental/Behavioral health inpatient physician fee 0% X Mental/Behavioral health inpatient physician fee 0% X Mental/Behavioral health inpatient physician fee 0% X Substance Use disorder outpatient office visits 0% non-prevent visits Substance Use disorder outpatient items and services 0% After 1st the non-prevent visits X Substance Use inpatient facility fee (e.g. hospital room) 0% X Substance use disorder inpatient physician fee 0% X Prenatal care and preconception visits No charge Pregnancy Delivery and all inpatient services Professional 0% X Home health care (cost share per visit) 0% X | Hospital stav | Facility fee (e.g. hospital room |) | 0% | Х |
| Mental/Behavioral health outpatient office visits Mental/Behavioral health other outpatient items and services Mental/Behavioral health inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient physician fee Mental/Behavioral health inpatient physician fee Substance abuse needs Substance Use disorder outpatient office visits Substance Use disorder outpatient items and services Substance Use disorder outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient physician fee Mental/Behavioral health other outpatient physician fee Mental/Behavioral health inpatient physician fee Mental/Behavioral health other outpatient physician fee Mental/Behavioral health inpatient physician fe | noophar stay | Physician/surgeon fee | | 0% | Х |
| Mental/Behavioral health other outpatient items and services Mental/Behavioral health inpatient facility fee (e.g.hospital room) Mental/Behavioral health inpatient physician fee Substance Use disorder outpatient office visits Substance Use disorder outpatient items and services Mental/Behavioral health inpatient office visits Mental/Behavioral health inpatient office (e.g. hospital room) After 1st the non-prevent visits \(\) Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient office visits Mental/Behavioral health inpatient office (e.g. hospital room) After 1st the non-prevent visits \(\) Substance Use inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient physician fee O% X After 1st the non-prevent visits \(\) No Charge Pregnancy Delivery and all inpatient physician fee No charge Pregnancy Delivery and all inpatient physician fee Professional Professional Home health care (cost share per visit) No Charge X | | Mental/Behavioral health outp | atient office visits | 0% | After 1st the non-prevent |
| Mental/Behavioral health inpatient facility fee (e.g.hospital room) Mental/Behavioral health inpatient physician fee 0% X Mental/Behavioral health inpatient physician fee 0% After 1st the non-preventivisits Substance Use disorder outpatient office visits Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) X Substance use disorder inpatient physician fee 0% X Substance use disorder inpatient physician fee 0% X Prenatal care and preconception visits No charge Pregnancy Delivery and all inpatient Hospital 0% Services Professional 0% X Home health care (cost share per visit) 0% X | | Mental/Behavioral health othe | r outpatient items and services | 0% | After-1st thi |
| Mental/Behavioral health inpatient physician fee 0% X | | Mental/Behavioral health inpa | tient facility fee (e.g.hospital room) | 0% | Х |
| Substance Use disorder outpatient office visits Substance Use disorder other outpatient items and services O% After 1st the non-preventivisits \(\) Substance Use inpatient facility fee (e.g. hospital room) Substance use disorder inpatient physician fee Pregnancy Pregnancy Delivery and all inpatient Hospital services Professional Professional Home health care (cost share per visit) O% non-preventivisits O% After 1st the non-preventivisits \(\) No \(\) X X After 1st the non-preventivisits \(\) No \(\) X A Professional O% X X | behavioral health, or | Mental/Behavioral health inpa | tient physician fee | 0% | |
| Substance Use disorder other outpatient items and services O% nen-preventivisitsX Substance Use inpatient facility fee (e.g. hospital room) O% X Substance use disorder inpatient physician fee Prenatal care and preconception visits Prenatal care and preconception visits Delivery and all inpatient services Professional Hospital Professional O% X Home health care (cost share per visit) | substance abuse needs | Substance Use disorder outpa | atient office visits | 0% | non-preven |
| Substance use disorder inpatient physician fee 0% X Prenatal care and preconception visits No charge Delivery and all inpatient services Professional 0% X Home health care (cost share per visit) 0% X | | Substance Use disorder other outpatient items and services | | 0% | After 1st thi non-prevent visitsX |
| Pregnancy Delivery and all inpatient Hospital 0% X services Professional 0% X Home health care (cost share per visit) 0% X | | Substance Use inpatient facili | ty fee (e.g. hospital room) | 0% | Х |
| Pregnancy Delivery and all inpatient services Hospital 0% X Professional 0% X Home health care (cost share per visit) 0% X | | <u> </u> | | | Х |
| services Professional 0% X Home health care (cost share per visit) 0% X | | Prenatal care and preconcept | ion visits | No charge | |
| Professional 0% X Home health care (cost share per visit) 0% X | Pregnancy | - | Hospital | 0% | Х |
| | | | | | |
| Outpatient Rehabilitation services 0% X | | | | | _ |

Outpatient Habilitation services

1 pair of glasses per year (or contact lenses in lieu of glasses)

Durable medical equipment

Hospice service

Preventive - Cleaning

Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed

Periodontal Maintenance Services

Periodontics (other than maintenance)

Medically necessary orthodontics

Restorative Procedures

Crowns and Casts

Endodontics

Prosthodontics

Oral Surgery

Preventive - X-ray

Eye exam

Oral Exam

recovering or

health needs

Child eye care

Child Dental

Child Dental

Child Dental

Orthodontics

Diagnostic

and Preventive

Basic

Major

Child

Services

Services

other special Skilled nursing care

0%

0%

0%

0%

No charge

0%

No charge

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