2016 Standard Benefit Plan Designs

January 15, 2015

2016 Standard Benefit Plan Designs 10.0 EHB

Summary of Benefits and Coverage

Date: January 15, 2014





Platinum Coinsurance Plan 88.59% Platinum Copay Plan Member Cost Share amounts describe the Enrollee's out of pocket costs. 89.91% Plan design includes a deductible? Integrated Individual deductible Integrated Family deductible Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental Individual Out-of-pocket maximum Family Out-of-pocket maximum Stap plan: Self-only coverage deductible ISA family plan: Individual deductible No \$0 \$0 \$0 / \$0 / \$0 \$0 / \$0 /\$0 \$0 / \$0 /\$0 \$4,000 \$8,000 N/A \$0 / \$0 / \$0 \$4,000 \$8,000 N/A N/A N/A Primary care visit to treat an injury, illness, or condition \$20 \$20 Other practitioner office visit \$20 \$20 Specialist visit \$40 \$40 Preventive care/ screening/ immunization No charge No charge Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs) \$20 Tests \$150 Preferred brand drugs \$15 \$15 Non-preferred brand drugs \$25 \$25 Specialty drugs 10% 10% Surgery facility fee (e.g., ASC) 10% Outpatient services \$250 Physician/surgeon fees Outpatient visit 10% 10% Emergency room facility fee (waived if admitted) \$150 \$150 Emergency room physician fee (waived if admitted) No charge Emergency medical transportation \$150 \$150 Urgent care \$40 \$40 Facility fee (e.g. hospital room) Physician/surgeon fee \$250 per day up to 5 days 10% Mental/Behavioral health outpatient office visits \$20 \$20 Mental/Behavioral health other outpatient items and services \$20 \$20 Mental/Behavioral health inpatient facility fee (e.g.hospital room) 10% \$250 per day up to 5 days Mental/Behavioral health inpatient physician/surgeon fee 10% Substance Use disorder outpatient office visits \$20 \$20 Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) 10% \$250 per day up to 5 days Substance use disorder inpatient physician/surgeon fee 10% Prenatal care and preconception visits lo charge No charge \$250 per day up Hospital Professional Delivery and all inpatient services to 5 days Home health care Outpatient Rehabilitation services \$20 \$20 Outpatient Habilitation services \$20 \$20 \$150 per day up to 5 days Skilled nursing care 10% Durable medical equipment 10% 10% No charge No charge No charge No charge Child eye 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 No charge No charge Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface 20% \$25 Root Canal-Molar Gingivectomy per Quad Extraction-Single Tooth Exposed Root or Erupted Extraction-Complete Bony Porcelain with Metal Crown \$300 \$150 hild Dental Major Services 50% Child Medically necessary orthodontics 50% \$1,000

Summary of	Benefits and Coverage				
Member Cost S	hare amounts describe the Enrollee's out of pocket costs.	Gold Coinsuran		Gold Copay P	lan
Actuarial Value	e - AV Calculator	80.34		81.059	
	cludes a deductible?	No		No	
Integrated	Individual deductible	\$0		\$0	
	Family deductible	\$0 \$0 / \$0/	r ¢ n	\$0 \$0 / \$0 /	© 0
	deductible, NOT integrated: Medical / Pharmacy / Dental luctible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0/		\$0 / \$0 /	
	-of-pocket maximum	\$6,20		\$6,20	
	pocket maximum -only coverage deductible	\$12,44 N/A		\$12,40 N/A	0
HSA family pla	n: Individual deductible	N/A		N/A	
Common Medical Event		Member Cost	Deductible	Member Cost	Deductible
Medical Event	Service Type	Share	Applies	Share	Applies
	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
Health care provider's office or	Other practitioner office visit	\$35		\$35	
clinic visit	Specialist visit	\$55		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$35		\$35	
Tests	X-rays and Diagnostic Imaging	\$50 20%		\$50 \$250	
	Imaging (CT/PET scans, MRIs) Generic drugs	20% \$15		\$250 \$15	
	Preferred brand drugs	\$50		\$50	
Drugs to treat illness or					
condition	Non-preferred brand drugs	\$70		\$70	
	Specialty drugs	20%		20%	
	Surgery facility fee (e.g., ASC)	20%			
Outpatient services	Physician/surgeon fees	20%		\$600	
301 VICC3	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$250		\$250	
	Emergency room physician fee (waived if admitted)	20%		No charge	
Need	Emergency medical transportation	\$250		\$250	
	3,	7200		-	
	Urgent care	\$60		\$60	
Hospital stay	Facility fee (e.g. hospital room)	20%		\$600 per day up	
Troopital olay	Physician/surgeon fee	20%		to 5 days	
	Mental/Behavioral health outpatient office visits	\$35		\$35	
	Mental/Behavioral health other outpatient items and services	\$35		\$35	
Mantal backb	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%		\$600 per day up	
Mental health, behavioral	Mental/Behavioral health inpatient physician/surgeon fee	20%		to 5 days	
health, or substance abuse needs	Substance Use disorder outpatient office visits	\$35		\$35	
	Substance Use disorder other outpatient items and services	\$35		\$35	
	Substance Use inpatient facility fee (e.g. hospital room)	20%			
	Substance use disorder inpatient physician/surgeon fee	20%		\$600 per day up to 5 days	
	Prenatal care and preconception visits	No charge		No charge	
Pregnancy	Delivery and all inpatient Hospital	20%		\$600 per day up	
	services Professional Home health care	20%		to 5 days \$30	
Halm	Outpatient Rehabilitation services	\$35		\$30	
Help recovering or	Outpatient Habilitation services	\$35		\$35	
other special	Skilled nursing care	20%		\$300 per day up to 5 days	
health needs	Durable medical equipment	20%		20%	
	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		No charge No charge	
- Care	Oral Exam	ino criarge		ivo charge	
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Ů		Ĭ	
Child Dental Basic Services	Amalgam Fill - 1 Surface	20%		\$25	
	Root Canal- Molar			\$300	
Child Dental	Gingivectomy per Quad			\$150	
Major Services	Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony	50%		\$65 \$160	
	Porcelain with Metal Crown			\$300	
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

Member Cost S	hare amounts describe the Enrollee's out of pocket costs.	Silver F	Plan
	e - AV Calculator	70.53	
	cludes a deductible? Individual deductible	Yes, Medical/ N/A	
Integrated	Family deductible	N/A	
	deductible, NOT integrated: Medical / Pharmacy / Dental	\$2,250 / \$2	
	uctible, NOT integrated: Medical / Pharmacy / Dental -of-pocket maximum	\$4,500 / \$5 \$6,25	
Family Out-of-	pocket maximum	\$12,5	00
	-only coverage deductible In: Individual deductible	N/A N/A	
noa railily pia	iii. Iliulviduai deductible	IN/A	
Common Medical Event	Service Type	Member Cost Share	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	\$45	
Health care provider's office or clinic visit	Other practitioner office visit	\$45	
Cilline Visit	Specialist visit	\$70	
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$35 \$65	
. 3313	Imaging (CT/PET scans, MRIs)	\$65	
	Generic drugs	\$15	
Drugs to treat	Preferred brand drugs	\$50	Pharmac deductib
illness or	Non-preferred brand drugs	\$70	Pharmad
condition	Specialty drugs	20%	Pharmac deductib
Outpatient	Surgery facility fee (e.g., ASC)	20%	acaucilb
Outpatient services	Physician/surgeon fees	20%	
	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$250	Х
Need	Emergency room physician fee (waived if admitted)	20%	Х
immediate	Emergency medical transportation	\$250	Х
attention	Urgent care	\$90	
Hospital stay	Facility fee (e.g. hospital room)	20%	Х
riospitai stay	Physician/surgeon fee	20%	Х
	Mental/Behavioral health outpatient office visits	\$45	
	Mental/Behavioral health other outpatient items and services	\$45	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	Х
Mental health, behavioral	Mental/Behavioral health inpatient physician/surgeon fee	20%	Х
health, or substance abuse needs	Substance Use disorder outpatient office visits	\$45	
	Substance Use disorder other outpatient items and services	\$45	
	Substance Use inpatient facility fee (e.g. hospital room)	20%	Х
	Substance use disorder inpatient physician/surgeon fee	20%	х
	Prenatal care and preconception visits	No charge	
Pregnancy	Delivery and all inpatient Hospital services Professional	20%	X
	services Professional Home health care	20% \$45	X
Help	Outpatient Rehabilitation services	\$45	
recovering or	Outpatient Habilitation services	\$45	
other special health needs	Skilled nursing care	20%	Х
	Durable medical equipment Hospice service	20% No charge	
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray		
	Sealants per Tooth Topical Fluoride Application	No charge	
and		1	
	Space Maintainers - Fixed		
and	Amalgam Fill - 1 Surface	20%	
and Preventive Child Dental Basic Services	Amalgam Fill - 1 Surface Root Canal- Molar	20%	
and Preventive Child Dental Basic	Amalgam Fill - 1 Surface	20%	
and Preventive Child Dental Basic Services Child Dental	Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad		

Member Cost S	Benefits and Coverage hare amounts describe the Enrollee's out of pocket costs.	Sil Coinsura	IOP liver ance Plan	SHO Silve Copay	er Plan
	e - AV Calculator		77%	71.45	
	cludes a deductible? Individual deductible		al/Pharmacy I/A	Yes, Medical/ N/A	
Integrated I	Family deductible	N	I/A	N/A	
Individual of	deductible, NOT integrated: Medical / Pharmacy / Dental uctible, NOT integrated: Medical / Pharmacy / Dental		\$500 / \$0 \$1,000 / \$0	\$1,500 / \$5 \$3,000 / \$1,	
Individual Out-	-of-pocket maximum	\$6,	500	\$6,50	00
Family Out-of-	pocket maximum -only coverage deductible		i,000 I/A	\$13,0 N/A	
	n: Individual deductible		I/A	N/A	
Common		Member Cost	Deductible	Member Cost	Deductible
Medical Event	Service Type	Share	Applies	Share	Applies
	Primary care visit to treat an injury, illness, or condition	\$45		\$45	
Health care provider's office or clinic visit	Other practitioner office visit	\$45		\$45	
	Specialist visit	\$70		\$70	
	Preventive care/ screening/ immunization Laboratory Tests	No charge		No charge	
Tests	X-rays and Diagnostic Imaging	\$35 \$65		\$35 \$65	
	Imaging (CT/PET scans, MRIs)	20%	X	\$250	
	Generic drugs	\$15	Pharmacy	\$15	Pharmacy
Drugs to treat	Preferred brand drugs	\$55	deductible	\$55	deductible
illness or condition	Non-preferred brand drugs	\$75	Pharmacy deductible	\$75	Pharmacy deductible
	Specialty drugs	20%	Pharmacy deductible	20%	Pharmacy deductible
Outpatient	Surgery facility fee (e.g., ASC)	20%		20%	
services	Physician/surgeon fees Outpatient visit	20% 20%		20%	
	Emergency room facility fee (waived if admitted)	\$250	×	\$250	Х
	Emergency room physician fee (waived if admitted)	20%	х	20%	х
Need immediate attention	Emergency medical transportation	\$250	Х	\$250	Х
attention	Urgent care	\$90		\$90	
Hospital stay	Facility fee (e.g. hospital room) Physician/surgeon fee	20% 20%	X	20% 20%	X
	Mental/Behavioral health outpatient office visits	\$45		\$45	
	Mental/Behavioral health other outpatient items and services	\$45		\$45	
Mental health.	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	х	20%	х
behavioral	Mental/Behavioral health inpatient physician/surgeon fee	20%	Х	20%	Х
health, or substance abuse needs	Substance Use disorder outpatient office visits	\$45		\$45	
	Substance Use disorder other outpatient items and services	\$45		\$45	
	Substance Use inpatient facility fee (e.g. hospital room)	20%	х	20%	х
	Substance use disorder inpatient physician/surgeon fee	20%	Х	20%	Х
Pregnancy	Prenatal care and preconception visits Delivery and all inpatient Hospital	No charge 20%	Х	No charge 20%	Х
	services Professional	20%	X	20%	X
	Home health care	20%		\$45	
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	No charge		No charge	
Child eye	Eye exam	No charge		No charge	
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	Preventive - X-ray	No charge		No charge	
and Preventive	Sealants per Tooth Topical Fluoride Application	110 onlings		. to olarge	
Child Dental Basic	Space Maintainers - Fixed Amalgam Fill - 1 Surface	20%		\$25	
Services	Root Canal- Molar			\$300	
Child Dental	Gingivectomy per Quad			\$150	
Major Services	Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony	50%		\$65 \$160	
	Porcelain with Metal Crown			\$160	
Child	Medically necessary orthodontics	50%		\$1,000	
Orthodontics	modifically floodssary orthodornics	JU%		φ1,000	

Member Cost S	Benefits and Coverage hare amounts describe the Enrollee's out of pocket costs.	SHOP Silver HSA Pla	n
Actuarial Value	e - AV Calculator	70.50%	6
Plan design in	cludes a deductible?	Yes, integr	
	Individual deductible	\$2,000 integ	
Individual of	Family deductible leductible leductible, NOT integrated: Medical / Pharmacy / Dental	\$4,000 integ N/A	grateu
Family ded	uctible, NOT integrated: Medical / Pharmacy / Dental	N/A	
Individual Out-	-of-pocket maximum	\$6,250	
Family Out-of-	pocket maximum	\$12,500	
	-only coverage deductible n: Individual deductible	\$2,000 See Endn	
nort running plu	III III III III III III III III III II	COO Enan	0.0
Common Medical Event	Service Type	Member Cost Share	Deductible Applic
	Primary care visit to treat an injury, illness, or condition	20%	x
Health care provider's office or clinic visit	Other practitioner office visit	20%	х
	Specialist visit	20%	х
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	20%	X
10313	Imaging (CT/PET scans, MRIs)	20%	X
	Generic drugs	20%	X
	Preferred brand drugs	20%	х
Drugs to treat illness or condition	Non-preferred brand drugs	20%	X
	Specialty drugs	20%	Х
		20%	
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees	20%	X
services	Outpatient visit	20%	X
	Emergency room facility fee (waived if admitted)	20%	Х
Need	Emergency room physician fee (waived if admitted)	20%	Х
Need immediate	Emergency medical transportation	20%	Х
attention	Urgent care	20%	x
	Facility fee (e.g. hospital room)	20%	X
Hospital stay	Physician/surgeon fee	20%	X
	Mental/Behavioral health outpatient office visits	20%	х
	Mental/Behavioral health other outpatient items and services	20%	х
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	Х
Mental health, behavioral	Mental/Behavioral health inpatient physician/surgeon fee	20%	Х
health, or substance abuse needs	Substance Use disorder outpatient office visits	20%	х
	Substance Use disorder other outpatient items and services	20%	х
	Substance Use inpatient facility fee (e.g. hospital room)	20%	х
	Substance use disorder inpatient physician/surgeon fee	20%	х
	Prenatal care and preconception visits	No charge	
Pregnancy	Delivery and all inpatient services Hospital Professional	20%	X
	services Professional Home health care	20%	X
dolp	Outpatient Rehabilitation services	20%	X
Help recovering or	Outpatient Habilitation services	20%	X
other special	Skilled nursing care	20%	Х
health needs	Durable medical equipment	20%	Х
	Hospice service	0%	X
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental Diagnostic	Preventive - Cleaning		
and	Preventive - X-ray Sealants per Tooth	No charge	
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic Services	Amalgam Fill - 1 Surface	20%	
	Root Canal- Molar		
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted	50%	
major Services	Extraction- Single Tooth Exposed Root of Erupted Extraction- Complete Bony	30 /6	
	Porcelain with Metal Crown		
Child Orthodontics	Medically necessary orthodontics	50%	

	hare amounts describe the Enrollee's out of pocket costs.	Silver F 100%-150	% FPL	Silver F 150%-200	% FPL
	e - AV Calculator	93.93		86.89	
	cludes a deductible? Individual deductible	Yes, Medical/I	Pharmacy	Yes, Medical/ N/A	Pharmacy
	Family deductible	N/A		N/A	
Individual d	leductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0		\$550 / \$5	
	uctible, NOT integrated: Medical / Pharmacy / Dentalof-pocket maximum	\$150 / \$0 \$2,25		\$1,100 / \$1 \$2,25	
	pocket maximum	\$4,50		\$4,50	
SA plan: Self-	only coverage deductible	N/A		N/A	
SA family pla	n: Individual deductible	N/A		N/A	
Common ledical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
ealth care rovider's ffice or linic visit	Other practitioner office visit	\$5		\$15	
	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests X-rays and Diagnostic Imaging	\$8		\$15 \$25	
	Imaging (CT/PET scans, MRIs)	\$8 \$50	_	\$25 \$100	_
	Generic drugs	\$3		\$5	
rugs to treat	Preferred brand drugs	\$10		\$20	Pharmacy deductible
noce or	Non-preferred brand drugs	\$15		\$35	Pharmacy
bilation	Specialty drugs	10%		15%	deductible Pharmacy
	1 1 1	10%			deductible
utpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees	10%		15% 15%	
	Outpatient visit	10%		15%	
	Emergency room facility fee (waived if admitted)	\$30	Х	\$75	Х
eed	Emergency room physician fee (waived if admitted)	10%	X	15%	X
nmediate tention	Emergency medical transportation	\$30	Х	\$75	Х
	Urgent care	\$6		\$30	
equital atau	Facility fee (e.g. hospital room)	10%	Х	15%	Х
ospital stay	Physician/surgeon fee	10%	X	15%	X
	Mental/Behavioral health outpatient office visits	\$5		\$15	
	Mental/Behavioral health other outpatient items and services	\$5		\$15	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%	х	15%	х
ental health, ehavioral	Mental/Behavioral health inpatient physician/surgeon fee	10%	х	15%	х
ealth, or	Substance Use disorder outpatient office visits	\$5		\$15	
	Substance Use disorder other outpatient items and services	\$5		\$15	
	Substance Use inpatient facility fee (e.g. hospital room)	10%	Х	15%	Х
	Substance use disorder inpatient physician/surgeon fee	10%	X	15%	X
	Prenatal care and preconception visits	No charge		No charge	
regnancy	Delivery and all inpatient Hospital	10%	Х	15%	Х
	services Professional	10%	X	15%	X
	Home health care Outpatient Rehabilitation services	\$3 \$5		\$15 \$15	
elp	Outpatient Reliabilitation services Outpatient Habilitation services	\$5 \$5		\$15	
ecovering or	Skilled nursing care	10%	х	15%	х
ealth needs	Durable medical equipment	10%		15%	
	Hospice service	No charge		No charge	
mia eye	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				
iagnostic	Preventive - X-ray	No charge		No charge	
reventive	Sealants per Tooth Topical Fluoride Application	. to onlinge		. so onarge	
hild Dental	Space Maintainers - Fixed Amalgam Fill - 1 Surface	20%		20%	
ervices	Root Canal- Molar	20%		20%	
hild Dental	Gingivectomy per Quad				
ervices	Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony Porcelain with Metal Crown	50%		50%	

	hare amounts describe the Enro	llee's out of pocket costs.	Silver P 200%-250	% FPL
Actuarial Valu	e - AV Calculator		72.91	%
	cludes a deductible?		Yes, Medical/F	Pharmacy
	ndividual deductible		N/A	
	Family deductible leductible, NOT integrated: Me	edical / Pharmacy / Dental	N/A \$1,900 / \$2	50 / \$0
	uctible, NOT integrated: Medic		\$3,800 / \$5	
	-of-pocket maximum		\$5,45	
	pocket maximum		\$10,90	00
	only coverage deductible n: Individual deductible		N/A N/A	
	n. marviduai deddetibie			
Common Medical Event	Serv	ісе Туре	Member Cost Share	Deductib Applies
	Primary care visit to treat an inj	ury, illness, or condition	\$40	
Health care provider's office or	Other practitioner office visit		\$40	
clinic visit	Specialist visit		\$55	
	Preventive care/ screening/ imm	nunization	No charge	
	Laboratory Tests		\$35	
Tests	X-rays and Diagnostic Imaging		\$50	
	Imaging (CT/PET scans, MRIs) Generic drugs		\$250 \$15	
	_		\$15	Pharma
Drugs to treat	Preferred brand drugs		\$45	deductit
illness or	Non-preferred brand drugs		\$70	Pharma
condition	prototrou pratiu utugs		φ/0	deductib
	Specialty drugs		20%	Pharma
	Surgery facility fee (e.g., ASC)		20%	deductib
Outpatient	Physician/surgeon fees		20%	
services	Outpatient visit		20%	
	Emergency room facility fee (wa	aived if admitted)	\$250	Х
Need	Emergency room physician fee	(waived if admitted)	20%	Х
Need immediate	Emergency medical transportat	on	\$250	Х
attention	Urgent care		\$80	
Hospital stay	Facility fee (e.g. hospital room) Physician/surgeon fee		20% 20%	X
	Mental/Behavioral health outpat	ient office visits	\$40	
	Mental/Behavioral health other	outpatient items and services	\$40	
	Mental/Behavioral health inpatie	ent facility fee (e.g.hospital room)	20%	х
Mental health, behavioral	Mental/Behavioral health inpatie	ent physician/surgeon fee	20%	х
health, or substance abuse needs	Substance Use disorder outpati	ent office visits	\$40	
	Substance Use disorder other o	utpatient items and services	\$40	
	Substance Use inpatient facility	fee (e.g. hospital room)	20%	Х
	Substance use disorder inpatier	nt physician/surgeon fee	20%	х
		n visits	No charge	
	Prenatal care and preconception			
Pregnancy	Delivery and all inpatient	Hospital	20%	Х
Pregnancy	Delivery and all inpatient services F		20% 20%	X
Pregnancy	Delivery and all inpatient services F Home health care	Hospital Professional	20% 20% \$40	
Help	Delivery and all inpatient services F Home health care Outpatient Rehabilitation service	Hospital Professional	20% 20% \$40 \$40	
Help recovering or	Delivery and all inpatient services Home health care Outpatient Rehabilitation service Outpatient Habilitation services	Hospital Professional	20% 20% \$40 \$40 \$40	X
Help recovering or other special	Delivery and all inpatient services F Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care	Hospital Professional	20% 20% \$40 \$40 \$40 20%	
Help recovering or other special	Delivery and all inpatient services F Home health care Outpatient Rehabilitation service Outpatient Habilitation services Skilled nursing care Durable medical equipment	Hospital Professional	20% 20% \$40 \$40 \$40 20%	X
Help recovering or other special health needs	Delivery and all inpatient services F Home health care Outpatient Rehabilitation service Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service	Hospital Professional	20% 20% \$40 \$40 \$40 20% 20% No charge	X
Help recovering or other special health needs Child eye	Delivery and all inpatient services F Home health care Outpatient Rehabilitation service Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam	dospital Professional as	20% 20% \$40 \$40 \$40 20% No charge No charge	X
Help recovering or other special health needs Child eye	Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or co	dospital Professional as	20% 20% \$40 \$40 \$40 20% 20% No charge	X
Help recovering or other special health needs Child eye care	Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or co Oral Exam	dospital Professional as	20% 20% \$40 \$40 \$40 20% No charge No charge	X
Help recovering or other special health needs Child eye care	Delivery and all inpatient services Fi Home health care Outpatient Rehabilitation service Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or co Oral Exam Preventive - Cleaning	dospital Professional as	20% 20% \$40 \$40 \$40 20% 20% No charge No charge	X
Help recovering or other special health needs Child eye care Child Dental Diagnostic	Delivery and all inpatient services Flome health care Outpatient Rehabilitation service Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or co Oral Exam Preventive - Cleaning Preventive - X-ray	dospital Professional as	20% 20% \$40 \$40 \$40 20% No charge No charge	X
Help recovering or other special health needs Child eye care Child Dental Diagnostic and	Delivery and all inpatient services Fi Home health care Outpatient Rehabilitation service Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or co Oral Exam Preventive - Cleaning	dospital Professional as	20% 20% \$40 \$40 \$40 20% 20% No charge No charge	X
Help recovering or other special health needs Child eye care Child Dental Diagnostic and	Delivery and all inpatient services Home health care Outpatient Rehabilitation service Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or co Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	dospital Professional as	20% 20% \$40 \$40 \$40 20% 20% No charge No charge	X
Pregnancy Help recovering or tother special health needs Child Dental Diagnostic and Preventive Child Dental Basic Services	Delivery and all inpatient services services Home health care Outpatient Rehabilitation service Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or co Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application	dospital Professional as	20% 20% \$40 \$40 \$40 20% 20% No charge No charge	X
Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services	Delivery and all inpatient services Flome health care Outpatient Rehabilitation service Outpatient Rehabilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or co Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal-Molar	dospital Professional as	20% 20% \$40 \$40 \$40 20% No charge No charge No charge	X
Help recovering or other special health needs Child eye care Child Dental Basic Services Child Dental	Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or co Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad	dospital Professional gs ntact lenses in lieu of glasses)	20% 20% \$40 \$40 \$40 20% No charge No charge No charge	X
Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major	Delivery and all inpatient services Former health care Outpatient Rehabilitation service Outpatient Habilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or co Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Glingivectomy per Quad Extraction - Single Tooth Expose	dospital Professional gs ntact lenses in lieu of glasses)	20% 20% \$40 \$40 \$40 20% No charge No charge No charge	X
Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major	Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or co Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad	dospital Professional gs ntact lenses in lieu of glasses)	20% 20% \$40 \$40 \$40 20% No charge No charge No charge	X
Help recovering or other special health needs Child eye care Child Dental Basic Services Child Dental	Delivery and all inpatient services services Home health care Outpatient Rehabilitation service Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or co Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Expost Extraction- Complete Bony	dospital Professional ss ntact lenses in lieu of glasses) and Root or Erupted	20% 20% \$40 \$40 \$40 20% No charge No charge No charge	X

Summary	of Bei	nefits a	nd Cov	erage

	hare amounts describe the Enrollee's out of pocket costs.	Bronze		Bron: HSA P	lan
	e - AV Calculator	61.1		61.06	
	cludes a deductible? Individual deductible	Yes, inte \$6,500 in		Yes, integral \$4,500 integral	
Integrated	Family deductible	\$13,000 ii	ntegrated	\$9,000 inte	egrated
Individual of	deductible, NOT integrated: Medical / Pharmacy / Dental uctible, NOT integrated: Medical / Pharmacy / Dental	N/		N/A N/A	
ndividual Out-	-of-pocket maximum	\$6,5	500	\$6,50	00
	pocket maximum -only coverage deductible	\$13, N/		\$13,0 \$4,50	
	n: Individual deductible	N/		\$4,50	
Common		Member Cost	Deductible	Member Cost	Deductible
Medical Event	Service Type	Share	Applies After 1st three	Share	Applies
	Primary care visit to treat an injury, illness, or condition	\$70	non- preventive visits	40%	х
Health care provider's office or clinic visit	Other practitioner office visit	\$70	After 1st three non- preventive visits	40%	Х
	Specialist visit	\$90	After 1st three non- preventive visits	40%	Х
	Preventive care/ screening/ immunization Laboratory Tests	No charge \$40		No charge 40%	X
Tests .	X-rays and Diagnostic Imaging	0%	Х	40%	Х
	Imaging (CT/PET scans, MRIs)	0%	X	40%	X
	Generic drugs	0%	X	40%	X
Orugs to treat Ilness or	Preferred brand drugs	0%	Х	40%	Х
iness or condition	Non-preferred brand drugs	0%	Х	40%	Х
	Specialty drugs	0%	х	40%	Х
Outpatient	Surgery facility fee (e.g., ASC)	0%	Х	40%	Х
services	Physician/surgeon fees Outpatient visit	0% 0%	X	40% 40%	X
	,		-	-	
	Emergency room facility fee (waived if admitted)	0%	Х	40%	Х
Need	Emergency room physician fee (waived if admitted)	0%	Х	40%	Х
mmediate	Emergency medical transportation	0%	Х	40%	Х
attention	Urgent care	\$120	After 1st three non- preventive visits	40%	х
Hospital stay	Facility fee (e.g. hospital room)	0%	X	40%	Х
ioopiiai olay	Physician/surgeon fee	0%	X After 1st three	40%	X
	Mental/Behavioral health outpatient office visits	\$70	non- preventive visits After 1st three	40%	х
	Mental/Behavioral health other outpatient items and services	\$70	non- preventive visits	40%	х
Montal books	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	0%	Х	40%	Х
Mental health, behavioral	Mental/Behavioral health inpatient physician/surgeon fee	0%	Х	40%	х
health, or substance abuse needs	Substance Use disorder outpatient office visits	\$70	After 1st three non-preventive visits	40%	х
	Substance Use disorder other outpatient items and services	\$70	After 1st three non- preventive visits	40%	х
	Substance Use inpatient facility fee (e.g. hospital room)	0%	х	40%	х
	Substance use disorder inpatient physician/surgeon fee	0%	х	40%	х
	Prenatal care and preconception visits	No charge		No charge	
Pregnancy	Delivery and all inpatient services Hospital Professional	0%	X	40% 40%	X
	Home health care	0%	X	40%	Х
Help	Outpatient Rehabilitation services Outpatient Habilitation services	\$70 \$70		40% 40%	X
recovering or other special	Skilled nursing care	0%	X	40%	X
health needs	-		X		
	Durable medical equipment Hospice service	0% No charge		40% 0%	X
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact 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	No charge		No charge	
	Space Maintainers - Fixed				
Child Dental Basic Services	Amalgam Fill - 1 Surface Root Canal- Molar	20%		20%	
Child Dental Major Services	Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony Porcelain with Metal Crown	50%		50%	
Child Orthodontics	Medically necessary orthodontics	50%		50%	

Member Cost S	hare amounts describe the Enrollee's out of pocket costs.	Catastrop	hic Plan
Actuarial Valu	e - AV Calculator		
lan design in	cludes a deductible?	Yes, inte	enrated
	Individual deductible	\$6,850 in	
	Family deductible	\$13,700 ir	
	deductible, NOT integrated: Medical / Pharmacy / Dental	N/	
	luctible, NOT integrated: Medical / Pharmacy / Dental	N/.	
	-of-pocket maximum pocket maximum	\$6,8 \$13,	
	-only coverage deductible	N/	
	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	0%	After 1st three non- preventive visits
Health care provider's office or clinic visit	Other practitioner office visit	0%	After 1st three non- preventive visits
Simile Visit	Specialist visit	0%	х
	Preventive care/ screening/ immunization	No charge	
	Laboratory Tests	0%	X
ests	X-rays and Diagnostic Imaging	0%	X
	Imaging (CT/PET scans, MRIs) Generic drugs	0%	X
Orugs to treat	Preferred brand drugs	0%	X
liness or condition	Non-preferred brand drugs	0%	х
	Specialty drugs	0%	х
		0%	X
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees	0%	X
ervices	Outpatient visit	0%	X
	Emergency room facility fee (waived if admitted)	0%	Х
	Emergency room physician fee (waived if admitted)	0%	х
leed			X
nmediate	Emergency medical transportation	0%	
attention	Urgent care	0%	After 1st thr non- preventive
	Facility fee (e.g. hospital room)	0%	visits
Hospital stay	Physician/surgeon fee	0%	X
	Mental/Behavioral health outpatient office visits	0%	After 1st three non-
	Mental/Behavioral health other outpatient items and services	0%	visits After 1st thre
	·		preventive visits
Montel be to	Mental/Behavioral health inpatient facility fee (e.g.hospital ro	om) 0%	Х
Mental health, behavioral	Mental/Behavioral health inpatient physician/surgeon fee	0%	Х
ealth, or ubstance	Substance Use disorder outpatient office visits	0%	After 1st thr
abuse needs		0,0	preventive visits After 1st thr
	Substance Use disorder other outpatient items and services	0%	preventive visits
	Substance Use inpatient facility fee (e.g. hospital room)	0%	Х
	Substance use disorder inpatient physician/surgeon fee	0% No charge	Х
			Х
regnancy	Prenatal care and preconception visits Delivery and all inpatient Hospital	0%	
regnancy	Delivery and all inpatient services Hospital Professional	0% 0%	X
regnancy	Delivery and all inpatient services Hospital Professional Home health care	0% 0%	X
	Delivery and all inpatient services Professional Home health care Outpatient Rehabilitation services	0% 0% 0%	X X X
lelp ecovering or	Delivery and all inpatient services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services	0% 0% 0% 0%	X X X X
lelp ecovering or ther special	Delivery and all inpatient services Professional Home health care Outpatient Rehabilitation services	0% 0% 0%	X X X
lelp ecovering or ther special	Delivery and all inpatient services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services	0% 0% 0% 0%	X X X X
lelp ecovering or ther special	Delivery and all inpatient services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service	0% 0% 0% 0% 0% 0%	X X X X
elp ecovering or ther special ealth needs	Delivery and all inpatient services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment	0% 0% 0% 0% 0% 0%	X X X X X
lelp ecovering or ther special ealth needs	Delivery and all inpatient services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service	0% 0% 0% 0% 0% 0%	X X X X
lelp ecovering or ther special ealth needs	Delivery and all inpatient services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Usurable medical equipment Hospice service Eye exam	0% 0% 0% 0% 0% 0% 0% 0% 0% No charge	X X X X X
lelp ecovering or ther special ealth needs child eye are	Delivery and all inpatient services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	0% 0% 0% 0% 0% 0% 0% 0% 0% No charge	X X X X X
delp ecovering or ther special lealth needs Child eye are Child Dental Diagnostic	Delivery and all inpatient services Professional Home health care Outpatient Rehabilitation services Outpatient Rehabilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray	0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0	X X X X X
ecovering or other special realth needs child eye are child Dental Diagnostic and	Delivery and all inpatient services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	0% 0% 0% 0% 0% 0% 0% 0% 0% No charge	X X X X X
ecovering or other special realth needs child eye are child Dental Diagnostic and	Delivery and all inpatient services Professional Home health care Outpatient Rehabilitation services Outpatient Rehabilitation services Outpatient Rehabilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application	0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0	X X X X X
delp ecovering or other special lealth needs child eye lare child Dental biagnostic and reventive	Delivery and all inpatient services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0	X X X X X
Help ecovering or wher special health needs Child eye hare Child Dental Diagnostic hare Preventive Child Dental Sasic	Delivery and all inpatient services Professional Home health care Outpatient Rehabilitation services Outpatient Rehabilitation services Outpatient Rehabilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application	0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0% 0	X X X X X
Help ecovering or other special nealth needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic	Delivery and all inpatient services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	0% 0% 0% 0% 0% 0% 0% 0% 0% No charge	x x x x x x x x x x x x x x x x x x x
Help ecovering or other special earth needs Child eye are Child Dental blagnostic and orreventive services Child Dental basic Services Child Dental basic Services Child Dental Child Dental Child Dental Basic Services	Delivery and all inpatient services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad	0% 0% 0% 0% 0% 0% 0% 0% 0% No charge 0%	X X X X X X
telp ecovering or ther special sealth needs Child eye are Child Dental lagnostic and Preventive Child Dental sasic services Child Dental sasic services Child Dental sasic services Child Dental sasic services	Delivery and all inpatient services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - Toghication Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted	0% 0% 0% 0% 0% 0% 0% 0% 0% No charge	X X X X X X X X X X X X X X X X X X X
Help ecovering or the special earlth needs child eye care child openal Diagnostic and Preventive Help exercises child Dental Sasic Services child Dental Child De	Delivery and all inpatient services Professional Home health care Outpatient Rehabilitation services Outpatient Rehabilitation services Outpatient Rehabilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad Extraction - Single Tooth Exposed Root or Erupted Extraction - Complete Bony	0% 0% 0% 0% 0% 0% 0% 0% 0% No charge 0%	X
telp ecovering or ther special eealth needs child eye are child Dental lagnostic and reventive child Dental lasic cervices	Delivery and all inpatient services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - Cleaning Preventive - Toghication Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted	0% 0% 0% 0% 0% 0% 0% 0% 0% No charge 0%	X X X X X X X X X X X X X X X X X X X

2016 Standard Benefit Plan Designs 9.5 EHB

Date: January 15, 2014





	Benefits and Coverage hare amounts describe the Enrollee's out of pocket costs.	Platinu	••••	Platinu	
	- AV Calculator	Coinsurance 88.599		Copay P 89.91%	
	cludes a deductible?	No		No	
	ndividual deductible Family deductible	\$0 \$0		\$0 \$0	
Individual o	leductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /		\$0/\$0	
	uctible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$4,00		\$0 / \$0 . \$4,000	
Family Out-of-	pocket maximum	\$8,00		\$8,000	
	only coverage deductible n: Individual deductible	N/A N/A		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	\$20		\$20	
Health care provider's office or	Other practitioner office visit	\$20		\$20	
clinic visit	Specialist visit	\$40		\$40	
	Preventive care/ screening/ immunization	No charge		No charge	
Toete	Laboratory Tests	\$20		\$20	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	\$40 10%		\$40 \$150	
	Generic drugs	\$5		\$5	
Drugs to treat	Preferred brand drugs	\$15		\$15	
illness or	Non-preferred brand drugs	\$25		\$25	
condition					
	Specialty drugs	10%		10%	
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees	10%		\$250	
services	Outpatient visit	10%		10%	
	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fee (waived if admitted)	10%		No charge	
Need immediate	Emergency medical transportation	\$150		\$150	
attention	Urgent care	\$40		\$40	
Hospital stay	Facility fee (e.g. hospital room)	10%		\$250 per day up	
noophui olay	Physician/surgeon fee	10%		to 5 days	
	Mental/Behavioral health outpatient office visits	\$20		\$20	
	Mental/Behavioral health other outpatient items and services	\$20		\$20	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%		\$250 per day up	
Mental health,	Mental/Behavioral health inpatient physician/surgeon fee	10%		to 5 days	
behavioral health, or	The state of the s	1070			
substance abuse needs	Substance Use disorder outpatient office visits	\$20		\$20	
	Substance Use disorder other outpatient items and services	\$20		\$20	
	Substance Use inpatient facility fee (e.g. hospital room)	10%		\$250 per de	
	Substance use disorder inpatient physician/surgeon fee			\$250 per day up to 5 days	
	Prenatal care and preconception visits	10% No charge		No oborgo	
Pregnancy	Delivery and all inpatient Hospital	10%		No charge \$250 per day up	
	services Professional Home health care	10%		to 5 days \$20	
Help	Outpatient Rehabilitation services	\$20		\$20	
Help recovering or	Outpatient Habilitation services	\$20		\$20 \$150 per day up	
other special health needs	Skilled nursing care	10%		\$150 per day up to 5 days	
sam necus	Durable medical equipment Hospice service	10%		10% No charge	
Child eye	Eye exam	No charge No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
OLUA E	Oral Exam				
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray	Not Comment		Not Comme	
and	Sealants per Tooth	Not Covered		Not Covered	
Preventive	Topical Fluoride Application Space Maintainers - Fixed				
Child Dental Basic Services	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
	Root Canal- Molar			Not Covered	
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted	Not Covered		Not Covered Not Covered	
Services	Extraction- Complete Bony	. TOT GOVERED		Not Covered	
	Porcelain with Metal Crown			Not Covered	
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

2016 Standard Benefit Plan Designs 9.5 EHB

Date: January 15, 2014

Summary of	f Benefits and Coverage				
Member Cost S	Share amounts describe the Enrollee's out of pocket costs.	Gold Coinsurand		Gold Copay P	lan
Actuarial Valu	e - AV Calculator	80.34		81.059	
	cludes a deductible?	No		No	
	Individual deductible Family deductible	\$0 \$0		\$0 \$0	
Individual	deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0/		\$0 / \$0 /	
	luctible, NOT integrated: Medical / Pharmacy / Dental -of-pocket maximum	\$0 / \$0/ \$6,20		\$0 / \$0 / \$6,200	
Family Out-of-	pocket maximum	\$12,40		\$12,40	
HSA family pla	f-only coverage deductible an: Individual deductible	N/A N/A		N/A N/A	
Common		Member Cost	Deductible	Member Cost	Deductible
Medical Event	Service Type	Share	Applies	Share	Applies
	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
Health care provider's office or clinic visit	Other practitioner office visit	\$35		\$35	
cimic visit	Specialist visit	\$55		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$35 \$50		\$35 \$50	
.0010	Imaging (CT/PET scans, MRIs)	20%		\$250	
	Generic drugs	\$15		\$15	
Drugs to treat	Preferred brand drugs	\$50		\$50	
illness or condition	Non-preferred brand drugs	\$70		\$70	
	Specialty drugs	20%		20%	
Outpatient	Surgery facility fee (e.g., ASC)	20%		\$600	
services	Physician/surgeon fees Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$250		\$250	
	Emergency room physician fee (waived if admitted)				
Need	Emergency medical transportation	20% \$250		No charge \$250	
immediate attention	Emorganoy modical transportation	\$250		Ψ230	
	Urgent care	\$60		\$60	
Hospital stay	Facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Physician/surgeon fee Mental/Behavioral health outpatient office visits	\$35		\$35	
	Mental/Behavioral health other outpatient items and services	\$35		\$35	
Mental health,	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%		\$600 per day up	
behavioral	Mental/Behavioral health inpatient physician/surgeon fee	20%		to 5 days	
health, or substance abuse needs	Substance Use disorder outpatient office visits	\$35		\$35	
	Substance Use disorder other outpatient items and services	\$35		\$35	
	Substance Use inpatient facility fee (e.g. hospital room)	20%		\$600 per day up	
	Substance use disorder inpatient physician/surgeon fee	20%		to 5 days	
Drognen	Prenatal care and preconception visits	No charge		No charge	
Pregnancy	Delivery and all inpatient Hospital services Professional	20% 20%		\$600 per day up to 5 days	
	Home health care Outpatient Rehabilitation services	20%		\$30	
Help recovering or	Outpatient Rehabilitation services Outpatient Habilitation services	\$35 \$35		\$35 \$35	
other special	Skilled nursing care	20%		\$300 per day up to 5 days	
health needs	Durable medical equipment	20%		20%	
	Hospice service Eye exam	No charge No charge		No charge No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray				
and Preventive	Sealants per Tooth Topical Fluoride Application	Not Covered		Not Covered	
	Space Maintainers - Fixed				
Child Dental Basic Services	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
Child Dental	Root Canal- Molar Gingivectomy per Quad			Not Covered Not Covered	
Major	Extraction- Single Tooth Exposed Root or Erupted	Not Covered		Not Covered	
Services	Extraction- Complete Bony Porcelain with Metal Crown			Not Covered Not Covered	
Child		Not Course			
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

	Benefits and Coverage hare amounts describe the Enrollee's out of pocket costs.	Silver I	Plan
	e - AV Calculator	70.53	
	cludes a deductible? Individual deductible	Yes, Medical/ N/A	
Integrated I	Family deductible	N/A	
	deductible, NOT integrated: Medical / Pharmacy / Dental uctible, NOT integrated: Medical / Pharmacy / Dental	\$2,250 / \$2 \$4,500 / \$5	
Individual Out-	-of-pocket maximum	\$6,25	i0
	pocket maximum -only coverage deductible	\$12,5 N/A	
	n: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	\$45	
Health care provider's office or	Other practitioner office visit	\$45	
clinic visit	Specialist visit	\$70	
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$35 \$65	
	Imaging (CT/PET scans, MRIs)	\$250	
	Generic drugs	\$15	Dk
Drugs to treat	Preferred brand drugs	\$50	Pharmad deductib
illness or condition	Non-preferred brand drugs	\$70	Pharmad
	Specialty drugs	20%	Pharmad
Outpatient	Surgery facility fee (e.g., ASC)	20%	GOUGUID
Services	Physician/surgeon fees	20%	
	Outpatient visit Emergency room facility fee (waived if admitted)	20% \$250	X
Need	Emergency room physician fee (waived if admitted) Emergency medical transportation	20% \$250	X
immediate attention	Urgent care	\$90	Ä
Hospital stay	Facility fee (e.g. hospital room) Physician/surgeon fee	20% 20%	X
	Mental/Behavioral health outpatient office visits	\$45	
	Mental/Behavioral health other outpatient items and services	\$45	
Manuali	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	Х
Mental health, behavioral	Mental/Behavioral health inpatient physician/surgeon fee	20%	х
health, or substance abuse needs	Substance Use disorder outpatient office visits	\$45	
	Substance Use disorder other outpatient items and services	\$45	
	Substance Use inpatient facility fee (e.g. hospital room)	20%	х
	Substance use disorder inpatient physician/surgeon fee	20%	х
	Prenatal care and preconception visits	No charge	
Pregnancy	Delivery and all inpatient services Hospital Professional	20%	X
	Home health care	\$45	
Help	Outpatient Rehabilitation services Outpatient Habilitation services	\$45 \$45	
recovering or other special	Skilled nursing care	20%	Х
health needs	Durable medical equipment	20%	_^
	Hospice service	No charge	
Chila eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	No charge	
Child Dental	Preventive - Cleaning	1	
Diagnostic and	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application		
Child Dental Basic	Space Maintainers - Fixed Amalgam Fill - 1 Surface	Not Covered	
Services	Root Canal- Molar		
Child Dental	Gingivectomy per Quad	No. 0	
Major	Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony	Not Covered	
Services	Porcelain with Metal Crown		

	iary 15, 2014					
Summary of	Benefits and Coverage			IOP	SHO	
Member Cost S	hare amounts describe the Enrollee's	out of pocket costs.	Coinsura	ver ince Plan	Silver Copay Plan	
Actuarial Value	e - AV Calculator		71.7	77%	71.45	%
	cludes a deductible?		Yes, Medica	al/Pharmacy	Yes, Medical/I	Pharmacy
Integrated	Individual deductible Family deductible		N	/A	N/A	
	Individual deductible, NOT integrated: Medical / Pharmacy / Dental Family deductible, NOT integrated: Medical / Pharmacy / Dental			\$500 / \$0 1,000 / \$0	\$1,500 / \$500 / \$0 \$3,000 / \$1,000 / \$0	
Individual Out-	-of-pocket maximum	namacy / Dentai	\$6,	500	\$6,50	0
Family Out-of- HSA plan: Self	pocket maximum -only coverage deductible		\$13 N	,000 /A	\$13,00 N/A	00
	n: Individual deductible		N		N/A	
Common Medical Event	Service T	ype	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, il	lness, or condition	\$45		\$45	
Health care provider's office or clinic visit	Other practitioner office visit		\$45		\$45	
cimio visit	Specialist visit		\$70		\$70	
	Preventive care/ screening/ immunization Laboratory Tests	ation	No charge \$35		No charge \$35	
Tests	X-rays and Diagnostic Imaging		\$65		\$65	
	Imaging (CT/PET scans, MRIs) Generic drugs		20% \$15	X	\$250 \$15	
	Preferred brand drugs		\$55	Pharmacy	\$55	Pharmacy
Drugs to treat illness or				deductible Pharmacy		deductible
condition	Non-preferred brand drugs		\$75	deductible	\$75	deductible
	Specialty drugs		20%	Pharmacy deductible	20%	Pharmacy deductible
Outpatient	Surgery facility fee (e.g., ASC)		20%	doddolibio	20%	GOGGOLIDIC
services	Physician/surgeon fees Outpatient visit		20%		20%	
	Emergency room facility fee (waived	if admitted)	\$250	Х	\$250	Х
	, ,					
Need	Emergency room physician fee (waiv	ed if admitted)	20%	X	20%	X
immediate attention	Emergency medical transportation		\$250	X	\$250	X
attention	Urgent care		\$90		\$90	
Hospital stay	Facility fee (e.g. hospital room) Physician/surgeon fee		20% 20%	X X	20% 20%	X
	Mental/Behavioral health outpatient of	ffice visits	\$45		\$45	
	Mental/Behavioral health other outpa	tient items and services	\$45		\$45	
	Mental/Behavioral health inpatient fac	cility fee (e.g.hospital room)	20%	Х	20%	Х
Mental health, behavioral	Mental/Behavioral health inpatient ph	ysician/surgeon fee	20%	х	20%	х
health, or substance abuse needs	Substance Use disorder outpatient of		\$45		\$45	
	Substance Use disorder other outpati	ent items and services	\$45		\$45	
	Substance Use inpatient facility fee (e.g. hospital room)	20%	х	20%	Х
	Substance use disorder inpatient phy	sician/surgeon fee	20%	х	20%	×
	Prenatal care and preconception visit		No charge		No charge	
Pregnancy	Delivery and all inpatient Hospit services Profes	tal ssional	20% 20%	X	20%	X X
	Home health care		20%		\$45	
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	1 pair of glasses per year (or contact le	enses in lieu of glasses)	No charge		No charge	
	Oral Exam	Ţ,				
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray					
and Preventive	Sealants per Tooth Topical Fluoride Application		Not Covered		Not Covered	
Child Dental	Space Maintainers - Fixed					
Child Dental Basic	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Services	Root Canal- Molar				Not Covered Not Covered	
Services	Gingivectomy per Quad					
Services Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Exposed Ro	ot or Erupted	Not Covered		Not Covered	
Services Child Dental	Gingivectomy per Quad	ot or Erupted	Not Covered			

Member Cost S	f Benefits and Coverage share amounts describe the Enrollee's out of pocket costs.	SHOF Silver HSA Pla	an
Actuarial Value	e - AV Calculator	70.50%	6
Plan design in	cludes a deductible?	Yes, integr	
	Individual deductible	\$2,000 integ	
Individual	Family deductible deductible NoT integrated: Medical / Pharmacy / Dental	\$4,000 integ N/A	grated
	luctible, NOT integrated: Medical / Pharmacy / Dental	N/A	
	dual Out-of-pocket maximum \$6,250		
Family Out-of-	pocket maximum	\$12,50	
HSA plan: Self	- only coverage deductible an: Individual deductible	\$2,000 See Endr	
noA laililly pla	in: individual deductible	See Endi	iote
Common Medical Event	Service Type	Member Cost Share	Deductible Applie
	Primary care visit to treat an injury, illness, or condition	20%	х
Health care provider's office or	Other practitioner office visit	20%	х
clinic visit	Specialist visit	20%	х
	Preventive care/ screening/ immunization	No charge	
Foete	Laboratory Tests	20%	X
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	20% 20%	X
	Generic drugs	20%	X
	Preferred brand drugs		
Drugs to treat	Preferred brand drugs	20%	Х
Ilness or condition	Non-preferred brand drugs	20%	X
	Specialty drugs	20%	Х
Outpatient	Surgery facility fee (e.g., ASC)	20%	X
services	Physician/surgeon fees Outnotient visit	20%	X
	Outpatient visit	20%	X
	Emergency room facility fee (waived if admitted)	20%	Х
	Emergency room physician fee (waived if admitted)	20%	х
Need	Emergency medical transportation	20%	X
mmediate attention	Emergency medical transportation	20%	X
attention	Urgent care	20%	х
Heenitel eterr	Facility fee (e.g. hospital room)	20%	X
Hospital stay	Physician/surgeon fee	20%	X
	Mental/Behavioral health outpatient office visits	20%	х
	Mental/Behavioral health other outpatient items and services	20%	х
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	х
Mental health, behavioral	Mental/Behavioral health inpatient physician/surgeon fee	20%	X
nealth, or substance abuse needs	Substance Use disorder outpatient office visits	20%	х
	Substance Use disorder other outpatient items and services	20%	х
	Substance Use inpatient facility fee (e.g. hospital room)	20%	х
	Substance use disorder inpatient physician/surgeon fee	20%	х
	Prenatal care and preconception visits	No charge	
Pregnancy	Delivery and all inpatient Hospital	20%	X
	services Professional Home health care	20%	X
	Outpatient Rehabilitation services	20%	X
lelp ecovering or	Outpatient Habilitation services	20%	X
other special	Skilled nursing care	20%	х
nealth needs	Durable medical equipment	20%	Х
	Hospice service	0%	X
Child eye	Eye exam	No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	No charge	
Child Dental	Preventive - Cleaning		
Diagnostic	Preventive - X-ray	Not Covered	
and Preventive	Sealants per Tooth		
Preventive	Topical Fluoride Application Space Maintainers - Fixed		
Child Dental Basic Services	Amalgam Fill - 1 Surface	Not Covered	
	Root Canal- Molar		
Child Dental	Gingivectomy per Quad		
Major	Extraction- Single Tooth Exposed Root or Erupted	Not Covered	
Services	Extraction- Complete Bony Porcelain with Metal Crown		
	Porcelain with Metal Crown		
Child	Medically necessary orthodontics	Not Covered	

Member Cost S	Cost Share amounts describe the Enrollee's out of pocket costs. Silve 100%-19			Silver Plan 150%-200% FPL	
	e - AV Calculator	93.93		86.89	%
	esign includes a deductible? egrated Individual deductible		Yes, Medical/Pharmacy		Pharmacy
	Family deductible	Incibile N/A NOT integrated: Medical / Pharmacy / Dental \$75 / \$0 / \$0 T integrated: Medical / Pharmacy / Dental \$150 / \$0 / \$0		N/A N/A	
Individual	deductible, NOT integrated: Medical / Pharmacy / Dental			\$550 / \$50 / \$0 \$1,100 / \$100 / \$0 \$2,250	
	luctible, NOT integrated: Medical / Pharmacy / Dental –of–pocket maximum				
	pocket maximum	\$2,25 \$4,50		\$4,50	
SA plan: Self	-only coverage deductible	N/A		N/A	
SA family pla	an: Individual deductible	N/A		N/A	
Common ledical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
ealth care rovider's ffice or	Other practitioner office visit	\$5		\$15	
inic visit	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
	Laboratory Tests	\$8		\$15	
ests	X-rays and Diagnostic Imaging	\$8		\$25	
	Imaging (CT/PET scans, MRIs) Generic drugs	\$50 \$3		\$100 \$5	
	Preferred brand drugs	\$10		\$20	Pharmacy
rugs to treat Iness or					deductible
ondition	Non-preferred brand drugs	\$15		\$35	Pharmacy deductible
	Specialty drugs	10%		15%	Pharmacy deductible
utmetlet	Surgery facility fee (e.g., ASC)	10%		15%	GGGGGIDIE
utpatient ervices	Physician/surgeon fees	10%		15%	
	Outpatient visit	10%		15%	
	Emergency room facility fee (waived if admitted)	\$30	Х	\$75	Х
	Emergency room physician fee (waived if admitted)	10%	Х	15%	х
eed nmediate	Emergency medical transportation	\$30	Х	\$75	Х
tention	Urgent care	\$6		\$30	
	Facility fee (e.g. hospital room)	10%	X	15%	X
ospital stay	Physician/surgeon fee	10%	X	15%	X
	Mental/Behavioral health outpatient office visits	\$5		\$15	
	Mental/Behavioral health other outpatient items and services	\$5		\$15	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%	х	15%	Х
lental health, ehavioral	Mental/Behavioral health inpatient physician/surgeon fee	10%	Х	15%	Х
ealth, or ubstance buse needs	Substance Use disorder outpatient office visits	\$5		\$15	
	Substance Use disorder other outpatient items and services	\$5		\$15	
	Substance Use inpatient facility fee (e.g. hospital room)	10%	х	15%	х
	Substance use disorder inpatient physician/surgeon fee	10%	х	15%	х
	Prenatal care and preconception visits	No charge		No charge	
regnancy	Delivery and all inpatient Hospital services Professional	10%	X	15% 15%	X
	Home health care	\$3		\$15	
elp	Outpatient Rehabilitation services	\$5		\$15	
ecovering or	Outpatient Habilitation services	\$5		\$15	
ther special ealth needs	Skilled nursing care	10%	Х	15%	Х
	Durable medical equipment Hospice service	10% No charge		15% No charge	
hild eye	Eye exam	No charge		No charge No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
are hild Dental	Preventive - Cleaning				
hild Dental liagnostic nd reventive	Preventive - X-ray Sealants per Tooth Topical Fluoride Application	Not Covered		Not Covered	
hild Dental iagnostic nd reventive hild Dental asic	Preventive - X-ray Sealants per Tooth	Not Covered		Not Covered Not Covered	
hild Dental iagnostic nd reventive hild Dental asic ervices	Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar				
hild Dental iagnostic nd reventive hild Dental asic ervices	Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad	Not Covered		Not Covered	
hild Dental iagnostic nd reventive hild Dental asic ervices	Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar				

	hare amounts describe the Enrollee's out of pocket costs.	Silver F 200%-250	% FPL
Actuarial Value	e - AV Calculator	72.91	%
	cludes a deductible?	Yes, Medical/I	Pharmacy
	ndividual deductible Family deductible	N/A N/A	
	leductible, NOT integrated: Medical / Pharmacy / Dental	\$1,900 / \$2	
Family ded	uctible, NOT integrated: Medical / Pharmacy / Dental	\$3,800 / \$5	
	-of-pocket maximum pocket maximum	\$5,45 \$10,90	
HSA plan: Self	only coverage deductible	N/A	30
HSA family pla	n: Individual deductible	N/A	
Common Medical Event	Service Type	Member Cost Share	Deductib Applies
	Primary care visit to treat an injury, illness, or condition	\$40	
Health care provider's office or	Other practitioner office visit	\$40	
clinic visit	Specialist visit	\$55	
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests	\$35	
16212	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	\$50 \$250	
	Generic drugs	\$15	
	Preferred brand drugs	\$45	Pharma
Drugs to treat illness or			deductib
condition	Non-preferred brand drugs	\$70	Pharma deductib
	Specialty drugs	20%	Pharma
	Surgery facility fee (e.g., ASC)	20%	deductib
Outpatient	Physician/surgeon fees	20%	
services	Outpatient visit	20%	
	Emergency room facility fee (waived if admitted)	\$250	Х
	Emergency room physician fee (waived if admitted)	20%	х
Need	Emergency medical transportation	\$250	X
immediate attention	Emorgonoy modical transportation	φ200	
	Urgent care	\$80	
Hospital stay	Facility fee (e.g. hospital room) Physician/surgeon fee	20% 20%	X
	Mental/Behavioral health outpatient office visits	\$40	
	Mental/Behavioral health other outpatient items and services	\$40	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	Х
Mental health, behavioral health, or	Mental/Behavioral health inpatient physician/surgeon fee	20%	Х
substance abuse needs	Substance Use disorder outpatient office visits	\$40	
	Substance Use disorder other outpatient items and services	\$40	
	Substance Use inpatient facility fee (e.g. hospital room)	20%	Х
	Substance use disorder inpatient physician/surgeon fee	20%	Х
	Prenatal care and preconception visits Delivery and all inpatient Hospital	No charge 20%	V
Prognancy			X
Pregnancy	services Professional	20%	
Pregnancy	services Professional Home health care	\$40	
	services Professional Home health care Outpatient Rehabilitation services	\$40 \$40	
Help recovering or	services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services	\$40 \$40 \$40	
Help recovering or other special	services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care	\$40 \$40 \$40 \$20%	X
Help recovering or other special	Services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service	\$40 \$40 \$40	
Help recovering or other special health needs Child eye	services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment	\$40 \$40 \$40 20%	
Help recovering or other special health needs Child eye	services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	\$40 \$40 \$40 20% 20% No charge	
Help recovering or other special health needs Child eye care	Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam T pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	\$40 \$40 \$40 20% 20% No charge No charge	
Help recovering or other special health needs Child eye care	services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	\$40 \$40 \$40 20% 20% No charge No charge	
Help recovering or other special health needs Child eye care Child Dental Diagnostic and	Services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	\$40 \$40 \$40 20% 20% No charge No charge	
Help recovering or other special health needs Child eye care Child Dental Diagnostic and	services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - Aray Sealants per Tooth Topical Fluoride Application	\$40 \$40 \$40 20% 20% No charge No charge	
Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic	Services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	\$40 \$40 \$40 20% 20% No charge No charge	
Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive	Services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	\$40 \$40 \$40 20% 20% No charge No charge No charge	
Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental	services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal-Molar Gingivectomy per Quad	\$40 \$40 \$40 20% 20% No charge No charge No charge No charge	
Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major	services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal-Molar Ginglivectomy per Quad Extraction - Single Tooth Exposed Root or Erupted	\$40 \$40 \$40 20% 20% No charge No charge No charge	
Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental	services Professional Home health care Outpatient Rehabilitation services Outpatient Habilitation services Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal-Molar Gingivectomy per Quad	\$40 \$40 \$40 20% 20% No charge No charge No charge No charge	

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Date: January 15, 2014

Summary of	Benefits and Coverage			_	
	hare amounts describe the Enrollee's out of pocket costs.	Bronze		Bron: HSA P	lan
Actuarial Value	e - AV Calculator	61.1	9%	61.06	%
	cludes a deductible? Individual deductible	Yes, inte \$6,500 in		Yes, integral \$4,500 integral	
Integrated	Family deductible	\$13,000 ii		\$9,000 integral	
	deductible, NOT integrated: Medical / Pharmacy / Dental uctible, NOT integrated: Medical / Pharmacy / Dental	N/ N/		N/A N/A	
	-of-pocket maximum	\$6,500		\$6,500	
Family Out-of-	pocket maximum	\$13,		\$13,000 \$4,500	
	-only coverage deductible In: Individual deductible	N/ N/		\$4,50	
Common		Member Cost	Deductible	Member Cost	Deductible
Medical Event	Service Type	Share	Applies After 1st three	Share	Applies
	Primary care visit to treat an injury, illness, or condition	\$70	non- preventive visits	40%	х
Health care provider's office or	Other practitioner office visit	\$70	After 1st three non- preventive visits	40%	х
clinic visit	Specialist visit	\$90	After 1st three non-preventive	40%	х
	Preventive care/ screening/ immunization	No charge	visits	No charge	
	Laboratory Tests	\$40		40%	Х
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	0%	X	40% 40%	X
	Generic drugs	0%	X	40%	X
Drugs to treat	Preferred brand drugs	0%	x	40%	х
illness or condition	Non-preferred brand drugs	0%	×	40%	х
	Specialty drugs	0%	х	40%	Х
Outpatient	Surgery facility fee (e.g., ASC)	0%	X	40%	X
services	Physician/surgeon fees Outpatient visit	0%	X	40%	X
	Emergency room facility fee (waived if admitted)	0%	X	40%	X
Need	Emergency room physician fee (waived if admitted)	0%	Х	40%	Х
immediate	Emergency medical transportation	0%	X	40%	X
attention	Urgent care	\$120	After 1st three non- preventive visits	40%	х
Hospital stay	Facility fee (e.g. hospital room)	0%	X	40%	X
noopital olay	Physician/surgeon fee	0%	X After 1st three	40%	X
	Mental/Behavioral health outpatient office visits	\$70	non- preventive visits After 1st three	40%	х
	Mental/Behavioral health other outpatient items and services	\$70	non- preventive visits	40%	х
Many 11	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	0%	х	40%	Х
Mental health, behavioral	Mental/Behavioral health inpatient physician/surgeon fee	0%	х	40%	х
health, or substance abuse needs	Substance Use disorder outpatient office visits	\$70	After 1st three non-preventive visits	40%	х
	Substance Use disorder other outpatient items and services	\$70	After 1st three non- preventive visits	40%	х
	Substance Use inpatient facility fee (e.g. hospital room)	0%	х	40%	х
	Substance use disorder inpatient physician/surgeon fee	0%	х	40%	х
Prognessor	Prenatal care and preconception visits	No charge	V	No charge	
Pregnancy	Delivery and all inpatient services Hospital Professional	0%	X	40% 40%	X
	Home health care	0%	X	40%	X
Help	Outpatient Rehabilitation services Outpatient Habilitation services	\$70 \$70		40% 40%	X
recovering or other special	Skilled nursing care	0%	Х	40%	Х
health needs	Durable medical equipment	0%	X	40%	X
	Hospice service	No charge		0%	X
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	No charge		No charge	
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray Scalante per Tooth	Not Covered		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed				
Child Dental Basic Services	Space Maintainers - Fixed Amalgam Fill - 1 Surface	Not Covered		Not Covered	
	Root Canal- Molar				
Child Dental Major Services	Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony Porcelain with Metal Crown	Not Covered		Not Covered	
Child Orthodontics	Porcelain with Metal Crown Medically necessary orthodontics	Not Covered		Not Covered	

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Date: January 15, 2014

	hare amounts describe the Enrollee	s out of pocket costs.	Catastrop	hic Plan
	e - AV Calculator			
	cludes a deductible?		Yes, inte	
	Individual deductible Family deductible		\$6,850 in \$13,700 in	
Individual of	deductible, NOT integrated: Medic		N/a	A
Family ded	uctible, NOT integrated: Medical /		N/A	A
	-of-pocket maximum pocket maximum		\$6,8 \$13,	
	only coverage deductible		\$15,	
ISA family pla	n: Individual deductible		N/A	A
Common Medical Event	Service Service	Tyne	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury,		0%	After 1st thr non- preventive visits
lealth care provider's office or clinic visit	Other practitioner office visit		0%	After 1st thr non- preventive visits
illiic visit	Specialist visit		0%	х
	Preventive care/ screening/ immuni	zation	No charge	
	Laboratory Tests		0%	Х
ests	X-rays and Diagnostic Imaging		0%	X
	Imaging (CT/PET scans, MRIs) Generic drugs		0%	X
rugs to treat Iness or	Preferred brand drugs		0%	Х
ondition	Non-preferred brand drugs		0%	Х
	Specialty drugs		0%	Х
utnationt	Surgery facility fee (e.g., ASC)		0%	Х
utpatient ervices	Physician/surgeon fees		0%	Х
	Outpatient visit		0%	X
	Emergency room facility fee (waive	d if admitted)	0%	Х
	Emergency room physician fee (wa	ved if admitted)	0%	Х
eed nmediate	Emergency medical transportation	·	0%	X
ttention	,			After 1st the
	Urgent care		0%	non- preventive visits
lospital stay	Facility fee (e.g. hospital room)		0%	X
iospitai stay	Physician/surgeon fee		0%	X After details
	Mental/Behavioral health outpatient	office visits	0%	After 1st the non- preventive visits
	Mental/Behavioral health other outp	atient items and services	0%	After 1st the non- preventive visits
	Mental/Behavioral health inpatient f	acility fee (e.g.hospital room)	0%	Х
lental health, ehavioral	Mental/Behavioral health inpatient p	hysician/surgeon fee	0%	Х
ealth, or ubstance buse needs	Substance Use disorder outpatient	office visits	0%	After 1st the non-preventive
	Substance Use disorder other outpa	tient items and services	0%	After 1st the non- preventive
	Substance Use inpatient facility fee	(e.g. hospital room)	0%	visits
	Substance use disorder inpatient ph			
			0%	Х
regnancy	Prenatal care and preconception vis Delivery and all inpatient Hosp		No charge 0%	Х
gy		essional	0%	X
	Home health care		0%	X
elp	Outpatient Rehabilitation services Outpatient Habilitation services		0% 0%	X
ecovering or ther special	Skilled nursing care		0%	X
ealth needs	-			
	Durable medical equipment Hospice service		0%	X
hild ave	Eye exam		0% No charge	X
hild eye are	1 pair of glasses per year (or contact	lenses in lieu of glasses)	0%	х
	Oral Exam			
hild Dental	Preventive - Cleaning			
iagnostic nd	Preventive - X-ray Sealants per Tooth		Not Covered	
reventive	Topical Fluoride Application			
	Space Maintainers - Fixed			
hild Dental asic	Amalgam Fill - 1 Surface		Not Covered	
ervices	Root Canal- Molar			
	Root Canal- Molar		a contract of	
Child Dental	Gingivectomy per Quad	tal Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony		
child Dental Iajor iervices	Extraction- Single Tooth Exposed R	oot or Erupted	Not Covered	

Endnotes to 2016 Standard Benefit Plan Designs

Notes:

- 1) Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. Innetwork services include services provided by an out-of-network provider but are approved as in-network by the carrier.
- 2) For covered out of network services in a PPO plan, these Standard Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
- 3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
- 4) In coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the carrier pays all costs for covered services for all family members.
- 5) For HDHPs linked to HSAs, in other than self-only coverage, each individual in the family must meet a deductible of [insert IRS-determined amount for an individual in other than self-only coverage for the 2016 Plan Year] until the family as a whole meets the family deductible. For HDHPs linked to HSAs, in other than self-only coverage, each individual in the family must meet the individual out of pocket maximum amount that is the same as that for self-only coverage until the family as a whole meets the family out of pocket maximum amount.
- 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. Note that a benefit may be considered illusory if the co-payment covers most of the plan's cost of the service.
- 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 coinsurance applies to the prescription supply. For example, if the prescription is for a month's supply, one co-pay or co-insurance amount can be collected. If the prescription is written for a 90 day supply, a single cost-share amount applies. Nothing in this note precludes a carrier from offering mail order prescriptions at a reduced cost.

- 11) As applicable, for the child dental portion of the benefit design, a carrier may choose the copay or coinsurance child dental Standard Benefit Plan Design, regardless of whether the carrier selects the copay or the coinsurance design for the non-child dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.
- 12) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Standard Benefit Plan Designs.
- 13) Mental Health/Substance Use Disorder Outpatient Items and Services include post-discharge ancillary care services, such as counseling and other outpatient support services, which may be provided as part of the offsite recovery component of a residential treatment plan.
- 14) Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
- 15) Specialists include physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate (28 CCR § 1300.51(I)(1)).
- 16) The Other Practitioner category includes Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors and other practitioners included in 28 CCR § 1300.67(a)(1).
- 17) The Outpatient Visit line item within the Outpatient Services category includes but is not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.
- 18) Cost-sharing for services subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) may be less than those listed in these standard benefit plan designs if necessary for compliance with MHPAEA.
- 19) When a QHP operates an integrated health plan and generates a single bill for an enrollee's use of the emergency room, the only cost-share that applies is for the emergency room facility fee. No emergency room physician fee cost share applies unless a separate emergency room physician bill is received by the QHP.



2016 Dental Standard Benefit Plan Designs

Date: January 15, 20	15					
Summary of Benefits	Summary of Benefits and Coverage			Standalone Dental Plan		
Member Cost Share amounts describe the Enrollee's out of pocket costs.		Pediatric Dental EHB Copay Plan		Pediatric Dental EHB Coinsurance Plan		
		Up to A	ge 19	Up to Aç	ge 19	
Actuarial Value		83.0%		86.8%		
Individual Deductible (waived for Diagnostic & Preventive)		\$0		\$65 In Network/ \$65 Out of Network		
Family Deductible (Two of waived for Diagnostic &	or more children) Preventive)	\$0		\$130 In Network/ \$130 Out of Network		
Individual Out of Pocket		\$35		\$350		
	Family Out of Pocket Maximum (Two or More Children)		\$700		\$700	
	Office Copay		\$0		\$0	
Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d)		None		None		
Annual Benefit Limit (the maximum amount the dental	plan will pay in the benefit year)	None		None		
Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
	Oral Exam	\$0		0%		
	Preventive - Cleaning	\$0		0%		
Diagnostic & Preventive	Preventive - X-ray	\$0		0%		
Diagnostic & Freventive	Sealants per Tooth	\$0		0%		
	Topical Fluoride Application	\$0		0%		
	Space Maintainers - Fixed	\$0		0%		
Basic Services	Amalgam Fill - One Surface	\$25		20%	Х	
	Root Canal - Molar	\$300				
Major Services - Crowns	Gingivectomy per Quad	\$150				
and Casts, Endodontics, Periodontics,	Extraction- Single Tooth Exposed Root or Erupted	\$65		50%	x	
Prosthodontics, Oral Surgery	Extraction - Complete Bony	\$160				
Surgery	Crown - Porcelain with Metal	\$300				

\$350

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

Medically Necessary Orthodontia

Orthodontia

- 1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.
- 2) Cost sharing payments made by each individual child for innetwork services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.

 3) In a plan with two or more children, cost sharing payments.
- 3) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family deductible, if applicable, as well as the family out-of-pocket maximum.
- 4) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.

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

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



2016 Dental Standard Benefit Plan Designs

Date: January 15, 2015

Summary of Benefits	Family Dental Plan					
Member Cost Share amounts describe the Enrollee's out of pocket costs.		Pediatric Dental EHB Copay Plan		Adult Dental Copay Plan		
		Up to	Age 19	Age 19 and Older		
Actuarial Value		83.	0%	Not Calcu	ılated	
Individual Deductible (waived for Diagnostic & Preventive)		\$0		\$0		
Family Deductible (Two of waived for Diagnostic &	Preventive)		0	\$0		
	Maximum ximum (Two or More Children)	\$7	00	Not Applicable Not Applicable		
Waiting Period (Waivered Condition provision, as	Office Copay Waiting Period Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d)		\$0 None		\$0 None	
Annual Benefit Limit (the maximum amount the dental	plan will pay in the benefit year)	None		None		
Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
	Oral Exam Preventive - Cleaning	\$0 \$0		\$0 \$0		
Diagnostic & Preventive	Preventive - X-ray Sealants per Tooth Topical Fluoride Application	\$0 \$0 \$0		\$0 Not Covered Not Covered		
Basic Services	Space Maintainers - Fixed Amalgam Fill - One Surface	\$0 \$25		Not Covered \$25		
Major Services - Crowns	Root Canal - Molar Gingivectomy per Quad	\$300 \$150		\$300 \$150		
and Casts, Endodontics, Periodontics, Prosthodontics, Oral	Extraction- Single Tooth Exposed Root or Erupted	\$65		\$65		
Surgery	Extraction - Complete Bony Crown - Porcelain with Metal	\$160 \$300		\$160 \$300		
Orthodontia	Medically Necessary Orthodontia	\$350		Not Covered		

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

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

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

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



2016 Dental Standard Benefit Plan Designs

Date: January 15, 2015 Summary of Benefits and Coverage Family Dental Plan Pediatric Dental EHB Adult Dental Member Cost Share amounts describe the Enrollee's out of pocket **Coinsurance Plan** Coinsurance Plan costs. Up to Age 19 Age 19 and Older **Actuarial Value** 86.8% Not Calculated **Individual Deductible** \$65 In Network/ \$50 In Network/ \$50 Out of Network (waived for Diagnostic & Preventive) \$65 Out of Network Family Deductible (Two or more children) \$130 In Network/ Not Applicable (waived for Diagnostic & Preventive) \$130 Out of Network **Individual Out of Pocket Maximum** \$350 Not Applicable Family Out of Pocket Maximum (Two or More Children) \$700 Not Applicable \$0 Office Copay 6 months for Major **Waiting Period** aivered Condition provision, as defined in Health & Safety Code None Services, Waived with Proof 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d) of Prior Coverage **Annual Benefit Limit** None \$1,500 (the maximum amount the dental plan will pay in the benefit year) Member Cost **Deductible Member Cost Deductible Service Type Procedure Category Share Share** Oral Exam 0% 0% Preventive - Cleaning 0% 0% Preventive - X-ray 0% 0% Diagnostic & Preventive Sealants per Tooth 0% Not Covered Topical Fluoride Application 0% Not Covered Space Maintainers - Fixed 0% Not Covered **Basic Services** Amalgam Fill - One Surface 20% х 20% х Root Canal - Molar Major Services - Crowns Gingivectomy per Quad and Casts, Endodontics, Extraction- Single Tooth Exposed Root 50% 50% Periodontics. Х Х or Erupted Prosthodontics, Oral Extraction - Complete Bony Surgery

50%

Not Covered

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

Orthodontia

1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.

Crown - Porcelain with Metal

Medically Necessary Orthodontia

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

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

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