

2016 Standard Benefit Plan Designs

January 15, 2015

2016 Standard Benefit Plan Designs
10.0 EHB
Date: January 15, 2014



Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

		Platinum Coinsurance Plan	Platinum Copoly Plan
Actuarial Value - AV Calculator		88.59%	89.91%
Plan design includes a deductible?		No	No
Integrated Individual deductible		\$0	\$0
Integrated Family deductible		\$0	\$0
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0	\$0 / \$0 / \$0
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0	\$0 / \$0 / \$0
Individual Out-of-pocket maximum		\$4,000	\$4,000
Family Out-of-pocket maximum		\$8,000	\$8,000
HSA plan: Self-only coverage deductible		N/A	N/A
HSA family plan: Individual deductible		N/A	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	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	
Tests	Laboratory Tests	\$20		\$20	
	X-rays and Diagnostic Imaging	\$40		\$40	
	Imaging (CT/PET scans, MRIs)	10%		\$150	
Drugs to treat illness or condition	Generic drugs	\$5		\$5	
	Preferred brand drugs	\$15		\$15	
	Non-preferred brand drugs	\$25		\$25	
	Specialty drugs	10%		10%	
Outpatient services	Surgery facility fee (e.g., ASC)	10%		\$250	
	Physician/surgeon fees	10%			
	Outpatient visit	10%		10%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fee (waived if admitted)	10%		No charge	
	Emergency medical transportation	\$150		\$150	
	Urgent care	\$40		\$40	
Hospital stay	Facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Physician/surgeon fee	10%			
Mental health, behavioral health, or substance abuse needs	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	\$20		\$20	
	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%			
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	10%		\$250 per day up to 5 days	
	Hospital Professional	10%			
Help recovering or other special health needs	Home health care	10%		\$20	
	Outpatient Rehabilitation services	\$20		\$20	
	Outpatient Habilitation services	\$20		\$20	
	Skilled nursing care	10%		\$150 per day up to 5 days	
	Durable medical equipment	10%		10%	
Child eye care	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam	No charge		No charge	
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
Child Dental Basic Services	Space Maintainers - Fixed				
	Amalgam Fill - 1 Surface	20%		\$25	
Child Dental Major Services	Root Canal- Molar	50%		\$300	
	Gingivectomy per Quad			\$150	
	Extraction- Single Tooth Exposed Root or Erupted			\$65	
	Extraction- Complete Bony			\$160	
	Porcelain with Metal Crown			\$300	
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

		Gold Coinsurance Plan		Gold Coplay Plan	
Actuarial Value - AV Calculator		80.34%		81.05%	
Plan design includes a deductible?		No		No	
Integrated Individual deductible		\$0		\$0	
Integrated Family deductible		\$0		\$0	
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0/ \$0		\$0 / \$0 / \$0	
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0/ \$0		\$0 / \$0 / \$0	
Individual Out-of-pocket maximum		\$6,200		\$6,200	
Family Out-of-pocket maximum		\$12,400		\$12,400	
HSA plan: Self-only coverage deductible		N/A		N/A	
HSA family plan: Individual deductible		N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
	Other practitioner office visit	\$35		\$35	
	Specialist visit	\$55		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$35		\$35	
	X-rays and Diagnostic Imaging	\$50		\$50	
	Imaging (CT/PET scans, MRIs)	20%		\$250	
Drugs to treat illness or condition	Generic drugs	\$15		\$15	
	Preferred brand drugs	\$50		\$50	
	Non-preferred brand drugs	\$70		\$70	
	Specialty drugs	20%		20%	
Outpatient services	Surgery facility fee (e.g., ASC)	20%		\$600	
	Physician/surgeon fees	20%			
	Outpatient visit	20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$250		\$250	
	Emergency room physician fee (waived if admitted)	20%		No charge	
	Emergency medical transportation	\$250		\$250	
	Urgent care	\$60		\$60	
Hospital stay	Facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Physician/surgeon fee	20%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$35		\$35	
	Mental/Behavioral health other outpatient items and services	\$35		\$35	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%		\$600 per day up to 5 days	
	Mental/Behavioral health inpatient physician/surgeon fee	20%			
	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 to 5 days	
	Substance use disorder inpatient physician/surgeon fee	20%			
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	20%		\$600 per day up to 5 days	
Help recovering or other special health needs	Home health care	20%		\$30	
	Outpatient Rehabilitation services	\$35		\$35	
	Outpatient Habilitation services	\$35		\$35	
	Skilled nursing care	20%		\$300 per day up to 5 days	
	Durable medical equipment	20%		20%	
	Hospice service	No charge		No charge	
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam	No charge		No charge	
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
Child Dental Basic Services	Space Maintainers - Fixed	20%		\$25	
	Amalgam Fill - 1 Surface				
Child Dental Major Services	Root Canal- Molar	50%		\$300	
	Gingivectomy per Quad			\$150	
	Extraction- Single Tooth Exposed Root or Erupted			\$65	
	Extraction- Complete Bony			\$160	
	Porcelain with Metal Crown			\$300	
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

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

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

		SHOP Silver Coinsurance Plan		SHOP Silver Copay Plan	
Actuarial Value - AV Calculator		71.77%		71.45%	
Plan design includes a deductible?		Yes, Medical/Pharmacy		Yes, Medical/Pharmacy	
Integrated Individual deductible		N/A		N/A	
Integrated Family deductible		N/A		N/A	
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$1,500 / \$500 / \$0		\$1,500 / \$500 / \$0	
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$3,000 / \$1,000 / \$0		\$3,000 / \$1,000 / \$0	
Individual Out-of-pocket maximum		\$6,500		\$6,500	
Family Out-of-pocket maximum		\$13,000		\$13,000	
HSA plan: Self-only coverage deductible		N/A		N/A	
HSA family plan: Individual deductible		N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$45		\$45	
	Other practitioner office visit	\$45		\$45	
	Specialist visit	\$70		\$70	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$35		\$35	
	X-rays and Diagnostic Imaging	\$65		\$65	
	Imaging (CT/PET scans, MRIs)	20%	X	\$250	
Drugs to treat illness or condition	Generic drugs	\$15		\$15	
	Preferred brand drugs	\$55	Pharmacy deductible	\$55	Pharmacy deductible
	Non-preferred brand drugs	\$75	Pharmacy deductible	\$75	Pharmacy deductible
	Specialty drugs	20%	Pharmacy deductible	20%	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)	20%		20%	
	Physician/surgeon fees	20%		20%	
	Outpatient visit	20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$250	X	\$250	X
	Emergency room physician fee (waived if admitted)	20%	X	20%	X
	Emergency medical transportation	\$250	X	\$250	X
	Urgent care	\$90		\$90	
Hospital stay	Facility fee (e.g. hospital room)	20%	X	20%	X
	Physician/surgeon fee	20%	X	20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$45		\$45	
	Mental/Behavioral health other outpatient items and services	\$45		\$45	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	20%	X
	Mental/Behavioral health inpatient physician/surgeon fee	20%	X	20%	X
	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%	X	20%	X
	Substance use disorder inpatient physician/surgeon fee	20%	X	20%	X
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	20%	X	20%	X
	Professional	20%	X	20%	X
Help recovering or other special health needs	Home health care	20%		\$45	
	Outpatient Rehabilitation services	\$45		\$45	
	Outpatient Habilitation services	\$45		\$45	
	Skilled nursing care	20%	X	20%	X
	Durable medical equipment	20%		20%	
Child eye care	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam	No charge		No charge	
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
Child Dental Basic Services	Space Maintainers - Fixed	20%		\$25	
	Amalgam Fill - 1 Surface				
Child Dental Major Services	Root Canal- Molar	50%		\$300	
	Gingivectomy per Quad			\$150	
	Extraction- Single Tooth Exposed Root or Erupted			\$65	
	Extraction- Complete Bony			\$160	
	Porcelain with Metal Crown			\$300	
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

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

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

Silver Plan 100%-150% FPL		Silver Plan 150%-200% FPL	
93.93%		86.89%	
Yes, Medical/Pharmacy		Yes, Medical/Pharmacy	
N/A		N/A	
N/A		N/A	
\$75 / \$0 / \$0		\$550 / \$50 / \$0	
\$150 / \$0 / \$0		\$1,100 / \$100 / \$0	
\$2,250		\$2,250	
\$4,500		\$4,500	
N/A		N/A	
N/A		N/A	

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
	Other practitioner office visit	\$5		\$15	
	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$8		\$15	
	X-rays and Diagnostic Imaging	\$8		\$25	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
Drugs to treat illness or condition	Generic drugs	\$3		\$5	
	Preferred brand drugs	\$10		\$20	Pharmacy deductible
	Non-preferred brand drugs	\$15		\$35	Pharmacy deductible
	Specialty drugs	10%		15%	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)	10%		15%	
	Physician/surgeon fees	10%		15%	
	Outpatient visit	10%		15%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$30	X	\$75	X
	Emergency room physician fee (waived if admitted)	10%	X	15%	X
	Emergency medical transportation	\$30	X	\$75	X
	Urgent care	\$6		\$30	
Hospital stay	Facility fee (e.g. hospital room)	10%	X	15%	X
	Physician/surgeon fee	10%	X	15%	X
Mental health, behavioral health, or substance abuse needs	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%	X	15%	X
	Mental/Behavioral health inpatient physician/surgeon fee	10%	X	15%	X
	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%	X	15%	X
	Substance use disorder inpatient physician/surgeon fee	10%	X	15%	X
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	10%	X	15%	X
	Professional	10%	X	15%	X
Help recovering or other special health needs	Home health care	\$3		\$15	
	Outpatient Rehabilitation services	\$5		\$15	
	Outpatient Habilitation services	\$5		\$15	
	Skilled nursing care	10%	X	15%	X
	Durable medical equipment	10%		15%	
Child eye care	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam	No charge		No charge	
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
Child Dental Basic Services	Space Maintainers - Fixed				
	Amalgam Fill - 1 Surface	20%		20%	
Child Dental Major Services	Root Canal- Molar	50%		50%	
	Gingivectomy per Quad				
	Extraction- Single Tooth Exposed Root or Erupted				
	Extraction- Complete Bony				
Child Orthodontics	Porcelain with Metal Crown				
	Medically necessary orthodontics	50%		50%	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

		Silver Plan 200%-250% FPL	
Actuarial Value - AV Calculator		72.91%	
Plan design includes a deductible?		Yes, Medical/Pharmacy	
Integrated Individual deductible		N/A	
Integrated Family deductible		N/A	
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$1,900 / \$250 / \$0	
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$3,800 / \$500 / \$0	
Individual Out-of-pocket maximum		\$5,450	
Family Out-of-pocket maximum		\$10,900	
HSA plan: Self-only coverage deductible		N/A	
HSA family plan: Individual deductible		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$40	
	Other practitioner office visit	\$40	
	Specialist visit	\$55	
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests	\$35	
	X-rays and Diagnostic Imaging	\$50	
	Imaging (CT/PET scans, MRIs)	\$250	
Drugs to treat illness or condition	Generic drugs	\$15	
	Preferred brand drugs	\$45	Pharmacy deductible
	Non-preferred brand drugs	\$70	Pharmacy deductible
	Specialty drugs	20%	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)	20%	
	Physician/surgeon fees	20%	
	Outpatient visit	20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$250	X
	Emergency room physician fee (waived if admitted)	20%	X
	Emergency medical transportation	\$250	X
	Urgent care	\$80	
Hospital stay	Facility fee (e.g. hospital room)	20%	X
	Physician/surgeon fee	20%	X
Mental health, behavioral health, or substance abuse needs	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%	X
	Mental/Behavioral health inpatient physician/surgeon fee	20%	X
	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%	X
	Substance use disorder inpatient physician/surgeon fee	20%	X
Pregnancy	Prenatal care and preconception visits	No charge	
	Delivery and all inpatient services	20%	X
		Professional	20%
Help recovering or other special health needs	Home health care	\$40	
	Outpatient Rehabilitation services	\$40	
	Outpatient Habilitation services	\$40	
	Skilled nursing care	20%	X
	Durable medical equipment	20%	
Child eye care	Hospice service	No charge	
	Eye exam	No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
	Preventive - X-ray	No charge	
	Sealants per Tooth		
Child Dental Diagnostic and Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic Services	Amalgam Fill - 1 Surface	20%	
Child Dental Major Services	Root Canal- Molar		
	Gingivectomy per Quad		
	Extraction- Single Tooth Exposed Root or Erupted	50%	
	Extraction- Complete Bony		
Child Orthodontics	Porcelain with Metal Crown		
	Medically necessary orthodontics	50%	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

		Bronze Plan		Bronze HSA Plan	
Actuarial Value - AV Calculator		61.19%		61.06%	
Plan design includes a deductible?		Yes, integrated		Yes, integrated	
Integrated Individual deductible		\$6,500 integrated		\$4,500 integrated Med/Rx	
Integrated Family deductible		\$13,000 integrated		\$9,000 integrated	
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		N/A	
Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		N/A	
Individual Out-of-pocket maximum		\$6,500		\$6,500	
Family Out-of-pocket maximum		\$13,000		\$13,000	
HSA plan: Self-only coverage deductible		N/A		\$4,500	
HSA family plan: Individual deductible		N/A		\$4,500	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$70	After 1st three non-preventive visits	40%	X
	Other practitioner office visit	\$70	After 1st three non-preventive visits	40%	X
	Specialist visit	\$90	After 1st three non-preventive visits	40%	X
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$40		40%	X
	X-rays and Diagnostic Imaging	0%	X	40%	X
	Imaging (CT/PET scans, MRIs)	0%	X	40%	X
	Generic drugs	0%	X	40%	X
Drugs to treat illness or condition	Preferred brand drugs	0%	X	40%	X
	Non-preferred brand drugs	0%	X	40%	X
	Specialty drugs	0%	X	40%	X
Outpatient services	Surgery facility fee (e.g., ASC)	0%	X	40%	X
	Physician/surgeon fees	0%	X	40%	X
	Outpatient visit	0%	X	40%	X
Need immediate attention	Emergency room facility fee (waived if admitted)	0%	X	40%	X
	Emergency room physician fee (waived if admitted)	0%	X	40%	X
	Emergency medical transportation	0%	X	40%	X
	Urgent care	\$120	After 1st three non-preventive visits	40%	X
Hospital stay	Facility fee (e.g. hospital room)	0%	X	40%	X
	Physician/surgeon fee	0%	X	40%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$70	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health other outpatient items and services	\$70	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	0%	X	40%	X
	Mental/Behavioral health inpatient physician/surgeon fee	0%	X	40%	X
	Substance Use disorder outpatient office visits	\$70	After 1st three non-preventive visits	40%	X
	Substance Use disorder other outpatient items and services	\$70	After 1st three non-preventive visits	40%	X
	Substance Use inpatient facility fee (e.g. hospital room)	0%	X	40%	X
	Substance use disorder inpatient physician/surgeon fee	0%	X	40%	X
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	0%	X	40%	X
Help recovering or other special health needs	Home health care	0%	X	40%	X
	Outpatient Rehabilitation services	\$70		40%	X
	Outpatient Habilitation services	\$70		40%	X
	Skilled nursing care	0%	X	40%	X
	Durable medical equipment	0%	X	40%	X
	Hospice service	No charge		0%	X
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam	No charge		No charge	
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
Child Dental Basic Services	Space Maintainers - Fixed	20%		20%	
	Amalgam Fill - 1 Surface				
Child Dental Major Services	Root Canal- Molar	50%		50%	
	Gingivectomy per Quad				
	Extraction- Single Tooth Exposed Root or Erupted				
	Extraction- Complete Bony				
Child Orthodontics	Porcelain with Metal Crown	50%		50%	
	Medically necessary orthodontics				

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

		Catastrophic Plan	
Actuarial Value - AV Calculator			
Plan design includes a deductible?		Yes, integrated	
Integrated Individual deductible		\$6,850 integrated	
Integrated Family deductible		\$13,700 integrated	
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A	
Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A	
Individual Out-of-pocket maximum		\$6,850	
Family Out-of-pocket maximum		\$13,700	
HSA plan: Self-only coverage deductible		N/A	
HSA family plan: Individual deductible		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non-preventive visits
	Other practitioner office visit	0%	After 1st three non-preventive visits
	Specialist visit	0%	X
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests	0%	X
	X-rays and Diagnostic Imaging	0%	X
	Imaging (CT/PET scans, MRIs)	0%	X
Drugs to treat illness or condition	Generic drugs	0%	X
	Preferred brand drugs	0%	X
	Non-preferred brand drugs	0%	X
	Specialty drugs	0%	X
Outpatient services	Surgery facility fee (e.g., ASC)	0%	X
	Physician/surgeon fees	0%	X
	Outpatient visit	0%	X
Need immediate attention	Emergency room facility fee (waived if admitted)	0%	X
	Emergency room physician fee (waived if admitted)	0%	X
	Emergency medical transportation	0%	X
	Urgent care	0%	After 1st three non-preventive visits
Hospital stay	Facility fee (e.g. hospital room)	0%	X
	Physician/surgeon fee	0%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	0%	After 1st three non-preventive visits
	Mental/Behavioral health other outpatient items and services	0%	After 1st three non-preventive visits
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	0%	X
	Mental/Behavioral health inpatient physician/surgeon fee	0%	X
	Substance Use disorder outpatient office visits	0%	After 1st three non-preventive visits
	Substance Use disorder other outpatient items and services	0%	After 1st three non-preventive visits
	Substance Use inpatient facility fee (e.g. hospital room)	0%	X
	Substance use disorder inpatient physician/surgeon fee	0%	X
Pregnancy	Prenatal care and preconception visits	No charge	
	Delivery and all inpatient services	0%	X
	Hospital Professional	0%	X
Help recovering or other special health needs	Home health care	0%	X
	Outpatient Rehabilitation services	0%	X
	Outpatient Habilitation services	0%	X
	Skilled nursing care	0%	X
	Durable medical equipment	0%	X
	Hospice service	0%	X
Child eye care	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X
Child Dental Diagnostic and Preventive	Oral Exam	No charge	
	Preventive - Cleaning		
	Preventive - X-ray		
	Sealants per Tooth		
	Topical Fluoride Application		
Child Dental Basic Services	Space Maintainers - Fixed		
	Amalgam Fill - 1 Surface	0%	X
Child Dental Major Services	Root Canal- Molar	0%	X
	Gingivectomy per Quad		X
	Extraction- Single Tooth Exposed Root or Erupted		X
	Extraction- Complete Bony		X
	Porcelain with Metal Crown		X
Child Orthodontics	Medically necessary orthodontics	0%	X

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

		Platinum Coinsurance Plan	Platinum Copoly Plan
Actuarial Value - AV Calculator		88.59%	89.91%
Plan design includes a deductible?		No	No
Integrated Individual deductible		\$0	\$0
Integrated Family deductible		\$0	\$0
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0	\$0 / \$0 / \$0
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0 / \$0	\$0 / \$0 / \$0
Individual Out-of-pocket maximum		\$4,000	\$4,000
Family Out-of-pocket maximum		\$8,000	\$8,000
HSA plan: Self-only coverage deductible		N/A	N/A
HSA family plan: Individual deductible		N/A	N/A

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	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	
Tests	Laboratory Tests	\$20		\$20	
	X-rays and Diagnostic Imaging	\$40		\$40	
	Imaging (CT/PET scans, MRIs)	10%		\$150	
Drugs to treat illness or condition	Generic drugs	\$5		\$5	
	Preferred brand drugs	\$15		\$15	
	Non-preferred brand drugs	\$25		\$25	
	Specialty drugs	10%		10%	
Outpatient services	Surgery facility fee (e.g., ASC)	10%		\$250	
	Physician/surgeon fees	10%			
	Outpatient visit	10%		10%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fee (waived if admitted)	10%		No charge	
	Emergency medical transportation	\$150		\$150	
	Urgent care	\$40		\$40	
Hospital stay	Facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Physician/surgeon fee	10%			
Mental health, behavioral health, or substance abuse needs	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	\$20		\$20	
	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%			
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	10%		\$250 per day up to 5 days	
	Hospital Professional	10%			
Help recovering or other special health needs	Home health care	10%		\$20	
	Outpatient Rehabilitation services	\$20		\$20	
	Outpatient Habilitation services	\$20		\$20	
	Skilled nursing care	10%		\$150 per day up to 5 days	
	Durable medical equipment	10%		10%	
Child eye care	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam				
	Preventive - Cleaning				
	Preventive - X-ray	Not Covered		Not Covered	
	Sealants per Tooth				
	Topical Fluoride Application				
Child Dental Basic Services	Space Maintainers - Fixed				
	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
Child Dental Major Services	Root Canal- Molar			Not Covered	
	Gingivectomy per Quad			Not Covered	
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered		Not Covered	
	Extraction- Complete Bony			Not Covered	
Child Orthodontics	Porcelain with Metal Crown			Not Covered	
	Medically necessary orthodontics	Not Covered		Not Covered	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

		Gold Coinsurance Plan		Gold Coplay Plan	
Actuarial Value - AV Calculator		80.34%		81.05%	
Plan design includes a deductible?		No		No	
Integrated Individual deductible		\$0		\$0	
Integrated Family deductible		\$0		\$0	
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0/ \$0		\$0 / \$0 / \$0	
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$0 / \$0/ \$0		\$0 / \$0 / \$0	
Individual Out-of-pocket maximum		\$6,200		\$6,200	
Family Out-of-pocket maximum		\$12,400		\$12,400	
HSA plan: Self-only coverage deductible		N/A		N/A	
HSA family plan: Individual deductible		N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
	Other practitioner office visit	\$35		\$35	
	Specialist visit	\$55		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$35		\$35	
	X-rays and Diagnostic Imaging	\$50		\$50	
	Imaging (CT/PET scans, MRIs)	20%		\$250	
Drugs to treat illness or condition	Generic drugs	\$15		\$15	
	Preferred brand drugs	\$50		\$50	
	Non-preferred brand drugs	\$70		\$70	
	Specialty drugs	20%		20%	
Outpatient services	Surgery facility fee (e.g., ASC)	20%		\$600	
	Physician/surgeon fees	20%			
	Outpatient visit	20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$250		\$250	
	Emergency room physician fee (waived if admitted)	20%		No charge	
	Emergency medical transportation	\$250		\$250	
	Urgent care	\$60		\$60	
Hospital stay	Facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Physician/surgeon fee	20%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$35		\$35	
	Mental/Behavioral health other outpatient items and services	\$35		\$35	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%		\$600 per day up to 5 days	
	Mental/Behavioral health inpatient physician/surgeon fee	20%			
	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 to 5 days	
	Substance use disorder inpatient physician/surgeon fee	20%			
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	20%		\$600 per day up to 5 days	
Help recovering or other special health needs	Hospital Professional	20%			
	Home health care	20%		\$30	
	Outpatient Rehabilitation services	\$35		\$35	
	Outpatient Habilitation services	\$35		\$35	
	Skilled nursing care	20%		\$300 per day up to 5 days	
	Durable medical equipment	20%		20%	
Child eye care	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental Basic Services	Preventive - Cleaning	Not Covered		Not Covered	
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Major Services	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
	Root Canal- Molar	Not Covered		Not Covered	
	Gingivectomy per Quad			Not Covered	
	Extraction- Single Tooth Exposed Root or Erupted			Not Covered	
	Extraction- Complete Bony			Not Covered	
Child Orthodontics	Porcelain with Metal Crown			Not Covered	
	Medically necessary orthodontics	Not Covered		Not Covered	

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

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

		SHOP Silver Coinsurance Plan		SHOP Silver Copay Plan	
Actuarial Value - AV Calculator		71.77%		71.45%	
Plan design includes a deductible?		Yes, Medical/Pharmacy		Yes, Medical/Pharmacy	
Integrated Individual deductible		N/A		N/A	
Integrated Family deductible		N/A		N/A	
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$1,500 / \$500 / \$0		\$1,500 / \$500 / \$0	
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$3,000 / \$1,000 / \$0		\$3,000 / \$1,000 / \$0	
Individual Out-of-pocket maximum		\$6,500		\$6,500	
Family Out-of-pocket maximum		\$13,000		\$13,000	
HSA plan: Self-only coverage deductible		N/A		N/A	
HSA family plan: Individual deductible		N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$45		\$45	
	Other practitioner office visit	\$45		\$45	
	Specialist visit	\$70		\$70	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$35		\$35	
	X-rays and Diagnostic Imaging	\$65		\$65	
	Imaging (CT/PET scans, MRIs)	20%	X	\$250	
Drugs to treat illness or condition	Generic drugs	\$15		\$15	
	Preferred brand drugs	\$55	Pharmacy deductible	\$55	Pharmacy deductible
	Non-preferred brand drugs	\$75	Pharmacy deductible	\$75	Pharmacy deductible
	Specialty drugs	20%	Pharmacy deductible	20%	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)	20%		20%	
	Physician/surgeon fees	20%		20%	
	Outpatient visit	20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$250	X	\$250	X
	Emergency room physician fee (waived if admitted)	20%	X	20%	X
	Emergency medical transportation	\$250	X	\$250	X
	Urgent care	\$90		\$90	
Hospital stay	Facility fee (e.g. hospital room)	20%	X	20%	X
	Physician/surgeon fee	20%	X	20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$45		\$45	
	Mental/Behavioral health other outpatient items and services	\$45		\$45	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	20%	X
	Mental/Behavioral health inpatient physician/surgeon fee	20%	X	20%	X
	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%	X	20%	X
	Substance use disorder inpatient physician/surgeon fee	20%	X	20%	X
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	20%	X	20%	X
	Professional	20%	X	20%	X
Help recovering or other special health needs	Home health care	20%		\$45	
	Outpatient Rehabilitation services	\$45		\$45	
	Outpatient Habilitation services	\$45		\$45	
	Skilled nursing care	20%	X	20%	X
	Durable medical equipment	20%		20%	
Child eye care	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth				
Child Dental Diagnostic and Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
Child Dental Major Services	Root Canal- Molar			Not Covered	
	Gingivectomy per Quad			Not Covered	
	Extraction- Single Tooth Exposed Root or Erupted			Not Covered	
	Extraction- Complete Bony			Not Covered	
Child Orthodontics	Porcelain with Metal Crown			Not Covered	
	Medically necessary orthodontics	Not Covered		Not Covered	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

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

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

Actuarial Value - AV Calculator		Silver Plan 100%-150% FPL		Silver Plan 150%-200% FPL	
Plan design includes a deductible?		93.93%		86.89%	
Integrated Individual deductible		Yes, Medical/Pharmacy		Yes, Medical/Pharmacy	
Integrated Family deductible		N/A		N/A	
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		N/A	
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$75 / \$0 / \$0		\$550 / \$50 / \$0	
Individual Out-of-pocket maximum		\$150 / \$0 / \$0		\$1,100 / \$100 / \$0	
Family Out-of-pocket maximum		\$2,250		\$2,250	
HSA plan: Self-only coverage deductible		\$4,500		\$4,500	
HSA family plan: Individual deductible		N/A		N/A	
N/A		N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$5		\$15	
	Other practitioner office visit	\$5		\$15	
	Specialist visit	\$8		\$25	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$8		\$15	
	X-rays and Diagnostic Imaging	\$8		\$25	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
Drugs to treat illness or condition	Generic drugs	\$3		\$5	
	Preferred brand drugs	\$10		\$20	Pharmacy deductible
	Non-preferred brand drugs	\$15		\$35	Pharmacy deductible
	Specialty drugs	10%		15%	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)	10%		15%	
	Physician/surgeon fees	10%		15%	
	Outpatient visit	10%		15%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$30	X	\$75	X
	Emergency room physician fee (waived if admitted)	10%	X	15%	X
	Emergency medical transportation	\$30	X	\$75	X
	Urgent care	\$6		\$30	
Hospital stay	Facility fee (e.g. hospital room)	10%	X	15%	X
	Physician/surgeon fee	10%	X	15%	X
Mental health, behavioral health, or substance abuse needs	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%	X	15%	X
	Mental/Behavioral health inpatient physician/surgeon fee	10%	X	15%	X
	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%	X	15%	X
	Substance use disorder inpatient physician/surgeon fee	10%	X	15%	X
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	10%	X	15%	X
	Professional	10%	X	15%	X
Help recovering or other special health needs	Home health care	\$3		\$15	
	Outpatient Rehabilitation services	\$5		\$15	
	Outpatient Habilitation services	\$5		\$15	
	Skilled nursing care	10%	X	15%	X
	Durable medical equipment	10%		15%	
Child eye care	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam				
	Preventive - Cleaning				
	Preventive - X-ray	Not Covered		Not Covered	
	Sealants per Tooth				
	Topical Fluoride Application				
Child Dental Basic Services	Space Maintainers - Fixed				
	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
Child Dental Major Services	Root Canal- Molar				
	Gingivectomy per Quad				
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered		Not Covered	
	Extraction- Complete Bony				
Child Orthodontics	Porcelain with Metal Crown				
	Medically necessary orthodontics	Not Covered		Not Covered	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

		Silver Plan 200%-250% FPL	
Actuarial Value - AV Calculator		72.91%	
Plan design includes a deductible?		Yes, Medical/Pharmacy	
Integrated Individual deductible		N/A	
Integrated Family deductible		N/A	
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$1,900 / \$250 / \$0	
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$3,800 / \$500 / \$0	
Individual Out-of-pocket maximum		\$5,450	
Family Out-of-pocket maximum		\$10,900	
HSA plan: Self-only coverage deductible		N/A	
HSA family plan: Individual deductible		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$40	
	Other practitioner office visit	\$40	
	Specialist visit	\$55	
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests	\$35	
	X-rays and Diagnostic Imaging	\$50	
	Imaging (CT/PET scans, MRIs)	\$250	
Drugs to treat illness or condition	Generic drugs	\$15	
	Preferred brand drugs	\$45	Pharmacy deductible
	Non-preferred brand drugs	\$70	Pharmacy deductible
	Specialty drugs	20%	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)	20%	
	Physician/surgeon fees	20%	
	Outpatient visit	20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$250	X
	Emergency room physician fee (waived if admitted)	20%	X
	Emergency medical transportation	\$250	X
	Urgent care	\$80	
Hospital stay	Facility fee (e.g. hospital room)	20%	X
	Physician/surgeon fee	20%	X
Mental health, behavioral health, or substance abuse needs	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%	X
	Mental/Behavioral health inpatient physician/surgeon fee	20%	X
	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%	X
	Substance use disorder inpatient physician/surgeon fee	20%	X
Pregnancy	Prenatal care and preconception visits	No charge	
	Delivery and all inpatient services	20%	X
	Professional	20%	X
Help recovering or other special health needs	Home health care	\$40	
	Outpatient Rehabilitation services	\$40	
	Outpatient Habilitation services	\$40	
	Skilled nursing care	20%	X
	Durable medical equipment	20%	
Child eye care	Hospice service	No charge	
	Eye exam	No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
Child Dental Diagnostic and Preventive	Oral Exam		
	Preventive - Cleaning		
	Preventive - X-ray	Not Covered	
	Sealants per Tooth		
	Topical Fluoride Application		
Child Dental Basic Services	Space Maintainers - Fixed		
	Amalgam Fill - 1 Surface	Not Covered	
Child Dental Major Services	Root Canal- Molar		
	Gingivectomy per Quad		
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered	
	Extraction- Complete Bony		
Child Orthodontics	Porcelain with Metal Crown		
	Medically necessary orthodontics	Not Covered	

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Member Cost Share amounts describe the Enrollee's out of pocket costs.

		Bronze Plan		Bronze HSA Plan	
Actuarial Value - AV Calculator		61.19%		61.06%	
Plan design includes a deductible?		Yes, integrated		Yes, integrated	
Integrated Individual deductible		\$6,500 integrated		\$4,500 integrated Med/Rx	
Integrated Family deductible		\$13,000 integrated		\$9,000 integrated	
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		N/A	
Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		N/A	
Individual Out-of-pocket maximum		\$6,500		\$6,500	
Family Out-of-pocket maximum		\$13,000		\$13,000	
HSA plan: Self-only coverage deductible		N/A		\$4,500	
HSA family plan: Individual deductible		N/A		\$4,500	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$70	After 1st three non-preventive visits	40%	X
	Other practitioner office visit	\$70	After 1st three non-preventive visits	40%	X
	Specialist visit	\$90	After 1st three non-preventive visits	40%	X
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$40		40%	X
	X-rays and Diagnostic Imaging	0%	X	40%	X
	Imaging (CT/PET scans, MRIs)	0%	X	40%	X
Drugs to treat illness or condition	Generic drugs	0%	X	40%	X
	Preferred brand drugs	0%	X	40%	X
	Non-preferred brand drugs	0%	X	40%	X
	Specialty drugs	0%	X	40%	X
Outpatient services	Surgery facility fee (e.g., ASC)	0%	X	40%	X
	Physician/surgeon fees	0%	X	40%	X
	Outpatient visit	0%	X	40%	X
Need immediate attention	Emergency room facility fee (waived if admitted)	0%	X	40%	X
	Emergency room physician fee (waived if admitted)	0%	X	40%	X
	Emergency medical transportation	0%	X	40%	X
	Urgent care	\$120	After 1st three non-preventive visits	40%	X
Hospital stay	Facility fee (e.g. hospital room)	0%	X	40%	X
	Physician/surgeon fee	0%	X	40%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$70	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health other outpatient items and services	\$70	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	0%	X	40%	X
	Mental/Behavioral health inpatient physician/surgeon fee	0%	X	40%	X
	Substance Use disorder outpatient office visits	\$70	After 1st three non-preventive visits	40%	X
	Substance Use disorder other outpatient items and services	\$70	After 1st three non-preventive visits	40%	X
	Substance Use inpatient facility fee (e.g. hospital room)	0%	X	40%	X
	Substance use disorder inpatient physician/surgeon fee	0%	X	40%	X
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	0%	X	40%	X
	Hospital Professional	0%	X	40%	X
Help recovering or other special health needs	Home health care	0%	X	40%	X
	Outpatient Rehabilitation services	\$70		40%	X
	Outpatient Habilitation services	\$70		40%	X
	Skilled nursing care	0%	X	40%	X
	Durable medical equipment	0%	X	40%	X
	Hospice service	No charge		0%	X
Child eye care	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
Child Dental Diagnostic and Preventive	Oral Exam	Not Covered		Not Covered	
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
Child Dental Basic Services	Space Maintainers - Fixed	Not Covered		Not Covered	
	Amalgam Fill - 1 Surface				
Child Dental Major Services	Root Canal- Molar	Not Covered		Not Covered	
	Gingivectomy per Quad				
	Extraction- Single Tooth Exposed Root or Erupted				
	Extraction- Complete Bony				
Child Orthodontics	Porcelain with Metal Crown	Not Covered		Not Covered	
	Medically necessary orthodontics				

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

		Catastrophic Plan	
Actuarial Value - AV Calculator			
Plan design includes a deductible?		Yes, integrated	
Integrated Individual deductible		\$6,850 integrated	
Integrated Family deductible		\$13,700 integrated	
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A	
Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A	
Individual Out-of-pocket maximum		\$6,850	
Family Out-of-pocket maximum		\$13,700	
HSA plan: Self-only coverage deductible		N/A	
HSA family plan: Individual deductible		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non-preventive visits
	Other practitioner office visit	0%	After 1st three non-preventive visits
	Specialist visit	0%	X
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests	0%	X
	X-rays and Diagnostic Imaging	0%	X
	Imaging (CT/PET scans, MRIs)	0%	X
Drugs to treat illness or condition	Generic drugs	0%	X
	Preferred brand drugs	0%	X
	Non-preferred brand drugs	0%	X
	Specialty drugs	0%	X
Outpatient services	Surgery facility fee (e.g., ASC)	0%	X
	Physician/surgeon fees	0%	X
	Outpatient visit	0%	X
Need immediate attention	Emergency room facility fee (waived if admitted)	0%	X
	Emergency room physician fee (waived if admitted)	0%	X
	Emergency medical transportation	0%	X
	Urgent care	0%	After 1st three non-preventive visits
Hospital stay	Facility fee (e.g. hospital room)	0%	X
	Physician/surgeon fee	0%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	0%	After 1st three non-preventive visits
	Mental/Behavioral health other outpatient items and services	0%	After 1st three non-preventive visits
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	0%	X
	Mental/Behavioral health inpatient physician/surgeon fee	0%	X
	Substance Use disorder outpatient office visits	0%	After 1st three non-preventive visits
	Substance Use disorder other outpatient items and services	0%	After 1st three non-preventive visits
	Substance Use inpatient facility fee (e.g. hospital room)	0%	X
	Substance use disorder inpatient physician/surgeon fee	0%	X
Pregnancy	Prenatal care and preconception visits	No charge	
	Delivery and all inpatient services	0%	X
	Hospital Professional	0%	X
Help recovering or other special health needs	Home health care	0%	X
	Outpatient Rehabilitation services	0%	X
	Outpatient Habilitation services	0%	X
	Skilled nursing care	0%	X
	Durable medical equipment	0%	X
Child eye care	Hospice service	0%	X
	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X
Child Dental Diagnostic and Preventive	Oral Exam		
	Preventive - Cleaning		
	Preventive - X-ray	Not Covered	
	Sealants per Tooth		
	Topical Fluoride Application		
Child Dental Basic Services	Space Maintainers - Fixed		
	Amalgam Fill - 1 Surface	Not Covered	
Child Dental Major Services	Root Canal- Molar		
	Gingivectomy per Quad		
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered	
	Extraction- Complete Bony		
Child Orthodontics	Porcelain with Metal Crown		
	Medically necessary orthodontics	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. In-network 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 Dietitians 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, 2015

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

Summary of Benefits and Coverage		Standalone Dental Plan		Standalone Dental Plan	
		Pediatric Dental EHB Copay Plan		Pediatric Dental EHB Coinsurance Plan	
		Up to Age 19		Up to Age 19	
Member Cost Share amounts describe the Enrollee's out of pocket costs.		83.0%		86.8%	
		\$0		\$65 In Network/ \$65 Out of Network	
Individual Deductible (waived for Diagnostic & Preventive)		\$0		\$130 In Network/ \$130 Out of Network	
Family Deductible (Two or more children) (waived for Diagnostic & Preventive)		\$0			
Individual Out of Pocket Maximum		\$350		\$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
Diagnostic & Preventive	Oral Exam	\$0		0%	
	Preventive - Cleaning	\$0		0%	
	Preventive - X-ray	\$0		0%	
	Sealants per Tooth	\$0		0%	
	Topical Fluoride Application	\$0		0%	
	Space Maintainers - Fixed	\$0		0%	
Basic Services	Amalgam Fill - One Surface	\$25		20%	x
Major Services - Crowns and Casts, Endodontics, Periodontics, Prosthodontics, Oral Surgery	Root Canal - Molar	\$300		50%	x
	Gingivectomy per Quad	\$150			
	Extraction- Single Tooth Exposed Root or Erupted	\$65			
	Extraction - Complete Bony	\$160			
	Crown - Porcelain with Metal	\$300			
Orthodontia	Medically Necessary Orthodontia	\$350		50%	x

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 in-network 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.



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Date: January 15, 2015

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

Summary of Benefits and Coverage		Family Dental Plan			
		Pediatric Dental EHB Copay Plan		Adult Dental Copay Plan	
		Up to Age 19		Age 19 and Older	
Actuarial Value		83.0%		Not Calculated	
Individual Deductible (waived for Diagnostic & Preventive)		\$0		\$0	
Family Deductible (Two or more children) (waived for Diagnostic & Preventive)		\$0		\$0	
Individual Out of Pocket Maximum		\$350		Not Applicable	
Family Out of Pocket Maximum (Two or More Children)		\$700		Not Applicable	
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
Diagnostic & Preventive	Oral Exam	\$0		\$0	
	Preventive - Cleaning	\$0		\$0	
	Preventive - X-ray	\$0		\$0	
	Sealants per Tooth	\$0		Not Covered	
	Topical Fluoride Application	\$0		Not Covered	
	Space Maintainers - Fixed	\$0		Not Covered	
Basic Services	Amalgam Fill - One Surface	\$25		\$25	
Major Services - Crowns and Casts, Endodontics, Periodontics, Prosthodontics, Oral Surgery	Root Canal - Molar	\$300		\$300	
	Gingivectomy per Quad	\$150		\$150	
	Extraction- Single Tooth Exposed Root or Erupted	\$65		\$65	
	Extraction - Complete Bony	\$160		\$160	
	Crown - Porcelain with Metal	\$300		\$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 in-network 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

Member Cost Share amounts describe the Enrollee's out of pocket costs.

Family Dental Plan					
		Pediatric Dental EHB Coinsurance Plan	Adult Dental Coinsurance Plan		
		Up to Age 19	Age 19 and Older		
Actuarial Value		86.8%	Not Calculated		
Individual Deductible (waived for Diagnostic & Preventive)		\$65 In Network/ \$65 Out of Network	\$50 In Network/ \$50 Out of Network		
Family Deductible (Two or more children) (waived for Diagnostic & Preventive)		\$130 In Network/ \$130 Out of Network	Not Applicable		
Individual Out of Pocket Maximum		\$350	Not Applicable		
Family Out of Pocket Maximum (Two or More Children)		\$700	Not Applicable		
Office Copay		\$0	\$0		
Waiting Period <small>(Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d))</small>		None	6 months for Major Services, Waived with Proof of Prior Coverage		
Annual Benefit Limit <small>(the maximum amount the dental plan will pay in the benefit year)</small>		None	\$1,500		
Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Diagnostic & Preventive	Oral Exam	0%		0%	
	Preventive - Cleaning	0%		0%	
	Preventive - X-ray	0%		0%	
	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%	x	20%	x
Major Services - Crowns and Casts, Endodontics, Periodontics, Prosthodontics, Oral Surgery	Root Canal - Molar	50%	x	50%	x
	Gingivectomy per Quad				
	Extraction- Single Tooth Exposed Root or Erupted				
	Extraction - Complete Bony				
	Crown - Porcelain with Metal				
Orthodontia	Medically Necessary Orthodontia	50%	x	Not Covered	

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

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