2017 Standard Benefit Plan Designs

June 16, 2016 Final Board-approved



lember Cost Share amounts describe the Enrollee's out of pocket costs.		Platinum Coinsurance Plan		Platinum Copay Plan	
		89.79	6	90.3%	
Integrated Inc	cludes a deductible? dividual deductible	No \$0		No \$0	
Integrated Fa	mily deductible	\$0 \$0 /\$0	/ C O	\$0 \$0 / \$0 /	100
Family deduc	mily deductible ductible, NOT integrated: Medical / Pharmacy / Dental :tible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0 / \$0 /		\$0 / \$0 /	
ndividual Out-	-of-pocket maximum	\$4,00		\$4,00	0
	ocket maximum -only coverage deductible	\$8,00 N/A	0	\$8,00 N/A	U
	n: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
Health care provider's office or clinic	Other practitioner office visit	\$15		\$15	
/isit	Specialist visit	\$40		\$40	
	Preventive care/ screening/ immunization	No charge		No charge	
ests	Laboratory Tests X-rays and Diagnostic Imaging	\$20 \$40		\$20 \$40	
00.0	Imaging (CT/PET scans, MRIs)	10%		\$150	
	Tier 1	\$5		\$5	
Orugs to treat	Tier 2	\$15		\$15	
Ilness or condition	Tier 3	\$25		\$25	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
Outpatient	Surgery facility fee (e.g., ASC)	10%		\$250	
services	Physician/surgeon fees Outpatient visit	10% 10%		\$40 10%	
	Emergency room facility fee (waived if admitted)	\$150		\$150	
Veed	Emergency room physician fee (waived if admitted)	No charge		No charge	
mmediate	Emergency medical transportation	\$150		\$150	
attention	Urgent care	\$15		\$15	
	Facility for (a.g. becomited years)	10%		\$250 per day up	
Hospital stay	Facility fee (e.g. hospital room)	10%		to 5 days	
	Physician/surgeon fee Mental/Behavioral health outpatient office visits	\$15		\$40 \$15	
	Mental/Behavioral health other outpatient items and services	\$15		\$15	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%		\$250 per day up to 5 days	
Mental health, behavioral	Mental/Behavioral health inpatient physician fee	10%		\$40	
nealth, or substance abuse needs	Substance Use disorder outpatient office visits	\$15		\$15	
	Substance Use disorder other outpatient items and services	\$15		\$15	
	Substance Use innatient facility for (a.g. bestitel room)	10%		\$250 per day up	
	Substance Use inpatient facility fee (e.g. hospital room)			to 5 days	
	Substance use disorder inpatient physician fee	10%		\$40	
	Prenatal care and preconception visits	No charge		No charge \$250 per day up	
Pregnancy	Delivery and all inpatient Hospital services	10%		to 5 days	
	Professional Home health care	10%		\$40 \$20	
-lelp	Outpatient Rehabilitation services	\$15		\$15	
ecovering or	Outpatient Habilitation services	\$15		\$15 \$150 per day up	
other special nealth needs	Skilled nursing care	10%		to 5 days	
	Durable medical equipment Hospice service	10% No charge		10% 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	Oral Exam				
	Preventive - Cleaning Preventive - X-ray	No chares		No oberes	
and Preventive	Sealants per Tooth Topical Fluoride Application	No charge		No charge	
Child Dental	Space Maintainers - Fixed				
Basic	Restorative Procedures	20%		See 2017 Dental Copay Schedule	
Services	Periodontal Maintenance Services			Jopay Julieuule	
N. 11.1 -	Crowns and Casts Endodontics				
Child Dental Major	Periodontics (other than maintenance)	50%		See 2017 Dental	
Services	Prosthodontics	1		Copay Schedule	
	Oral Surgery				
Child	Medically necessary orthodontics	50%		\$1,000	
Orthodontics	,	5076		Ų.,000	

Summary of Benefits and Coverage		
Member Cost Share amounts describe the Enrollee's out of pocket costs.	Gold Coinsurance Plan	Gold Copay Plan
Actuarial Value - AV Calculator	80.9%	81.2%
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

Actuarial Value	e - AV Calculator	80.99	6	81.2%	•
Plan design in	cludes a deductible?	No		No	
	dividual deductible	\$0		\$0	
Integrated Fa	mily deductible	\$0	100	\$0	00
Individual de	ductible, NOT integrated: Medical / Pharmacy / Dental tible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 / \$0 / \$0 /		\$0 / \$0 / \$0 / \$0 /	
	-of-pocket maximum	\$6,75		\$6,75	
Family Out-of-	pocket maximum	\$13,50		\$13,50	
	-only coverage deductible	N/A		N/A N/A	
noa raminy pia	n: Individual deductible	N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an injury, illness, or condition	\$30		\$30	
Health care provider's office or clinic	Other practitioner office visit	\$30		\$30	
visit	Specialist visit	\$55		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
Tanta	Laboratory Tests	\$35		\$35	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	\$55 20%		\$55 \$275	
	Tier 1	\$15		\$15	
Drugs to treat	Tier 2	\$55		\$55	
condition	Tier 3	\$75		\$75	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees	20%		\$600 \$55	
services	Outpatient visit	20%		20%	
	Emergency room facility fee (waived if admitted)	\$325		\$325	
	Emergency room physician fee (waived if admitted)				
Need		No charge		No charge	
immediate attention	Emergency medical transportation	\$250		\$250	
attention	Urgent care	\$30		\$30	
Hospital stay	Facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Physician/surgeon fee Mental/Behavioral health outpatient office visits	20% \$30		\$55 \$30	
	Mental/Behavioral health other outpatient items and services	\$30		\$30	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%		\$600 per day up to 5 days	
Mental health, behavioral	Mental/Behavioral health inpatient physician fee	20%		\$55	
health, or substance abuse needs	Substance Use disorder outpatient office visits	\$30		\$30	
	Substance Use disorder other outpatient items and services	\$30		\$30	
	Substance Use inpatient facility fee (e.g. hospital room)	20%		\$600 per day up	
	Substance use disorder inpatient physician fee	20%		to 5 days \$55	
	1 11				
December	Prenatal care and preconception visits	No charge		No charge \$600 per day up	
Pregnancy	Delivery and all inpatient services Hospital	20%		to 5 days	
	Professional Home health care	20%		\$55 \$30	
Help	Outpatient Rehabilitation services	\$30		\$30	
recovering or	Outpatient Habilitation services	\$30		\$30	
other special	Skilled nursing care	20%		\$300 per day up to 5 days	
health needs	Durable medical equipment	20%		20%	
	Hospice service	No charge No charge		No charge	
Child eye care	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge No charge	
	Oral Exam	ino charge		ivo charge	
Child Dental Diagnostic and Preventive	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application	No charge		No charge	
Child Descript	Space Maintainers - Fixed				
Child Dental Basic Services	Restorative Procedures Periodontal Maintenance Services	20%		See 2017 Dental Copay Schedule	
	Crowns and Casts				
Child Dental	Endodontics			See 2017 Dental	
Major Services	Periodontics (other than maintenance) Prosthodontics	50%		Copay Schedule	
Child	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

	Benefits and Coverage		Individual	
Member Cost S	hare amounts describe the En	rollee's out of pocket costs.	Silver Plan	1
Actuarial Value	e - AV Calculator		71.5%	
	cludes a deductible?		Yes, Medical/Pha	armacy
Integrated In Integrated Fa	dividual deductible mily deductible		N/A N/A	
Individual de	ductible, NOT integrated: Metible, NOT integrated: Medic		\$2,500/ \$250 a \$5,000/ \$500 a	
ndividual Out-	-of-pocket maximum	ai / Filailliacy / Delitai	\$6,800	γ φυ
Family Out-of- HSA plan: Self	pocket maximum -only coverage deductible		\$13,600 N/A	
HSA family pla	n: Individual deductible		N/A	
Common Medical Event	Se	ervice Type	Member Cost Share	Deductible Applies
	D.:	-1		
	Primary care visit to treat an i	njury, illness, or condition	\$35	
Health care				
provider's office or clinic	Other practitioner office visit		\$35	
visit				
	Specialist visit		\$70	
	Preventive care/ screening/ in	nmunization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagin	a a	\$35 \$70	
	Imaging (CT/PET scans, MRI		\$300	
	Tier 1		\$15	
Drugs to treat	Tier 2		\$55	Pharmacy deductible
Ilness or condition				Pharmacv
_ Ja.tion	Tier 3		\$80	deductible
	Tier 4		20% up to \$250 per	Pharmacy
			script after pharmacy deductible	deductible
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	.)	20% 20%	
services	Outpatient visit		20%	
	Emergency room facility fee (waived if admitted)	\$350	
	Emergency room physician fee (waived if admitted)		No charge	
Need mmediate	Emergency medical transportation		\$250	Х
attention				
	Urgent care		\$35	
Hospital stay	Facility fee (e.g. hospital roon	1)	20%	Х
	Physician/surgeon fee		20%	Х
	Mental/Behavioral health outp	patient office visits	\$35	
	Mental/Rehavioral health othe	er outpatient items and services	\$35	
	Wertan Deriavioral ricality of the	a outpatient items and services	ψ03	
	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	20%	Х
Mental health, behavioral	Mental/Behavioral health inpa	atient physician fee	20%	X
nealth, or			==7.7	- 11
	Substance Use disorder outp	atient office visits	\$35	
	Substance Use disorder outp	atient office visits	\$35	
		atient office visits r outpatient items and services	\$35 \$35	
		r outpatient items and services		X
	Substance Use disorder othe	r outpatient items and services ity fee (e.g. hospital room)	\$35 20%	
	Substance Use disorder othe Substance Use inpatient facil Substance use disorder inpat	r outpatient items and services ity fee (e.g. hospital room) ient physician fee	\$35 20% 20%	X X
abuse needs	Substance Use disorder othe Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcept	r outpatient items and services ity fee (e.g. hospital room) ient physician fee tion visits	\$35 20% 20% No charge	Х
abuse needs	Substance Use disorder othe Substance Use inpatient facil Substance use disorder inpat	r outpatient items and services ity fee (e.g. hospital room) ient physician fee tion visits Hospital	\$35 20% 20% No charge 20%	X
abuse needs	Substance Use disorder othe Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcep Delivery and all inpatient services Home health care	r outpatient items and services ity fee (e.g. hospital room) itent physician fee tion visits Hospital Professional	\$35 20% 20% No charge 20% 20% \$45	Х
Pregnancy	Substance Use disorder othe Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Rehabilitation serv	r outpatient items and services ity fee (e.g. hospital room) sient physician fee tion visits Hospital Professional	\$35 20% 20% No charge 20% \$45 \$35	X
Pregnancy Help recovering or	Substance Use disorder othe Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Rehabilitation service	r outpatient items and services ity fee (e.g. hospital room) sient physician fee tion visits Hospital Professional	\$35 20% 20% No charge 20% \$45 \$35 \$35	X
Pregnancy Help recovering or other special	Substance Use disorder othe Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Rehabilitation serv	r outpatient items and services ity fee (e.g. hospital room) sient physician fee tion visits Hospital Professional	\$35 20% 20% No charge 20% \$45 \$35	X X X
Pregnancy Help ecovering or	Substance Use disorder othe Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service	r outpatient items and services ity fee (e.g. hospital room) sient physician fee tion visits Hospital Professional	\$35 20% 20% No charge 20% \$45 \$35 \$35 20% No charge	X X X
Pregnancy Help ecovering or other special realth needs	Substance Use disorder othe Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam	r outpatient items and services ity fee (e.g. hospital room) ient physician fee tion visits Hospital Professional	\$35 20% 20% No charge 20% \$45 \$35 \$35 20% 20% No charge No charge	X X X
Pregnancy Help ecovering or other special realth needs	Substance Use disorder othe Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service	r outpatient items and services ity fee (e.g. hospital room) ient physician fee tion visits Hospital Professional	\$35 20% 20% No charge 20% \$45 \$35 \$35 20% No charge	X X X
Pregnancy Help recovering or other special nealth needs Child eye care	Substance Use disorder othe Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcep 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 oral Exam Preventive - Cleaning	r outpatient items and services ity fee (e.g. hospital room) ient physician fee tion visits Hospital Professional	\$35 20% 20% No charge 20% \$45 \$35 \$20% An orbital orbi	X X X
Pregnancy Help ecovering or other special nealth needs Child eye care Child Dental Diagnostic and	Substance Use disorder othe Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcep Delivery and all inpatient services Home health care Outpatient Habilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or. Oral Exam Preventive - X-ray Sealants per Tooth	r outpatient items and services ity fee (e.g. hospital room) ient physician fee tion visits Hospital Professional	\$35 20% 20% No charge 20% \$45 \$35 \$35 20% 20% No charge No charge	X X X
Pregnancy Help recovering or other special nealth needs Child eye care Child Dental Diagnostic and	Substance Use disorder othe Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Rehabilitation serv Outpatient Rehabilitation serv Outpatient Rehabilitation serv Outpatient Rehabilitation serv Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or. Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application	r outpatient items and services ity fee (e.g. hospital room) ient physician fee tion visits Hospital Professional	\$35 20% 20% No charge 20% \$45 \$35 \$20% An orbital orbi	X X X
Pregnancy Help recovering or other special nealth needs Child eye care Child Dental Diagnostic and Preventive Child Dental	Substance Use disorder othe Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Rehabilitation serv Outpatient Rehabilitation serv Outpatient Rehabilitation serv Outpatient Rehabilitation serv Outpatient Rehabilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or. Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	r outpatient items and services ity fee (e.g. hospital room) ient physician fee tion visits Hospital Professional	\$35 20% 20% No charge 20% \$45 \$35 \$35 20% An orbarge No charge No charge No charge	X X X
Pregnancy Help ecovering or where special nealth needs Child eye care Child Dental Diagnostic and Child Dental Diagnostic Child Dental Diagnostic Child Dental Diagnostic	Substance Use disorder othe Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Rehabilitation serv Outpatient Rehabilitation serv Outpatient Habilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures	r outpatient items and services ity fee (e.g. hospital room) ient physician fee tion visits Hospital Professional rices ps contact lenses in lieu of glasses)	\$35 20% 20% No charge 20% \$45 \$35 \$20% An orbital orbi	X X X
Pregnancy Help ecovering or where special nealth needs Child eye care Child Dental Diagnostic and Child Dental Diagnostic Child Dental Diagnostic Child Dental Diagnostic	Substance Use disorder othe Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcept 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. Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Ser Crowns and Casts	r outpatient items and services ity fee (e.g. hospital room) ient physician fee tion visits Hospital Professional rices ps contact lenses in lieu of glasses)	\$35 20% 20% No charge 20% \$45 \$35 \$35 20% An orbarge No charge No charge No charge	X X X
Pregnancy Help recovering or other special health needs Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental	Substance Use disorder othe Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Rehabilitation serv Outpatient Habilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or. Oral Exam Preventive - Cleaning Preventive - Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Ser Crowns and Casts Endodontics	r outpatient items and services ity fee (e.g. hospital room) ient physician fee tition visits Hospital Professional rices ps contact lenses in lieu of glasses)	\$35 20% 20% No charge 20% 20% \$45 \$35 \$35 \$00 20% No charge No charge No charge No charge	X X X
Pregnancy Help recovering or other special health needs Child Dental Diagnostic and Preventive Child Dental Sasic Child Dental Major	Substance Use disorder othe Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcept 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 or o	r outpatient items and services ity fee (e.g. hospital room) ient physician fee tition visits Hospital Professional rices ps contact lenses in lieu of glasses)	\$35 20% 20% No charge 20% \$45 \$35 \$35 20% An orbarge No charge No charge No charge	X X X
Pregnancy Pregnancy Help recovering or other special health needs Child Dental Diagnostic and Preventive Child Dental Sasic Services Child Dental Major Services	Substance Use disorder othe Substance Use inpatient facil Substance use disorder inpat Prenatal care and preconcept Delivery and all inpatient services Home health care Outpatient Rehabilitation serv Outpatient Habilitation service Skilled nursing care Durable medical equipment Hospice service Eye exam 1 pair of glasses per year (or. Oral Exam Preventive - Cleaning Preventive - Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Ser Crowns and Casts Endodontics	r outpatient items and services ity fee (e.g. hospital room) ient physician fee tition visits Hospital Professional rices ps contact lenses in lieu of glasses)	\$35 20% 20% No charge 20% 20% \$45 \$35 \$35 \$00 20% No charge No charge No charge No charge	X X X

	Benefits and Coverage hare amounts describe the Enr	ollee's out of pocket costs.	CCSB Silver Coinsurance	Plan	CCSB Silver Copay Plai	n
ctuarial Value	e - AV Calculator		71.6%		71.3%	
Plan design inc	cludes a deductible?		Yes, Medical/Ph	armacy	Yes, Medical/Pha	armacy
Integrated Inc	dividual deductible mily deductible		N/A N/A		N/A N/A	
Individual de	ductible, NOT integrated: Me		\$2,000/ \$250		\$2,000/ \$250	
	ctible, NOT integrated: Medic -of-pocket maximum	ai / Pharmacy / Dentai	\$4,000 / \$500 \$6,800	/ \$0	\$4,000 / \$500 \$6,800	/ \$0
amily Out-of-	pocket maximum		\$13,600 N/A		\$13,600	
	only coverage deductible n: Individual deductible		N/A N/A		N/A N/A	
Common				Deductible		Deductible
Medical Event		vice Type	Member Cost Share	Applies	Member Cost Share	Applies
lealth care	Primary care visit to treat an ir	jury, illness, or condition	\$45		\$45	
rovider's office or clinic disit	Other practitioner office visit		\$45		\$45	
	Specialist visit		\$75		\$75	
	Preventive care/ screening/ in Laboratory Tests	munization	No charge \$40		No charge \$40	
ests	X-rays and Diagnostic Imaging		\$70		\$70	
	Imaging (CT/PET scans, MRIs)	20%		\$300	
	Tier 1		\$15		\$15	
liness or	Tier 2		\$55	Pharmacy deductible	\$55	Pharmacy deductible
ondition	Tier 3		\$85	Pharmacy deductible	\$85	Pharmacy deductible
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees		20%		20%	
ervices	Outpatient visit		20%		20% 20%	
	Emergency room facility fee (v	vaived if admitted)	\$350		\$350	
	Emergency room physician fee		No charge		No charge	
leed	Emergency medical transporta		\$250	X	\$250	X
mmediate ittention	Emergency medical danoperto	MOIT	φ200		\$250	
	Urgent care		\$45		\$45	
lospital stay	Facility fee (e.g. hospital room)	20%	Х	20%	Х
	Physician/surgeon fee		20%	X	20%	X
	Mental/Behavioral health outpo	atient office visits	\$45		\$45	
	Mental/Behavioral health other	outpatient items and services	\$45		\$45	
	Mental/Behavioral health inpat	ient facility fee (e.g.hospital room)	20%	Х	20%	Х
Mental health, behavioral	Mental/Behavioral health inpat	ient physician fee	20%	Х	20%	х
nealth, or substance abuse needs	Substance Use disorder outpa	tient office visits	\$45		\$45	
	Substance Use disorder other outpatient items and services		\$45		\$45	
	Substance Use inpatient facilit	y fee (e.g. hospital room)	20%	Х	20%	Х
	Substance use disorder inpati	ent physician fee	20%	х	20%	Х
	Prenatal care and preconcepti		No charge		No charge	- '
	Delivery and all inpatient	Hospital	20%	Х	20%	Х
	services	Professional	20%	X	20%	X
	Home health care		20%		\$45	
lelp ecovering or	Outpatient Rehabilitation servi Outpatient Habilitation service		\$45 \$45		\$45 \$45	
	Skilled nursing care		20%	х	20%	х
ealth needs	Durable medical equipment		20%		20%	
	Hospice service Eye exam		No charge No charge		No charge No charge	
Shilled access assess	1 pair of glasses per year (or c	ontact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam		2 22			
Child Dental	Preventive - Cleaning					
ınd	Preventive - X-ray Sealants per Tooth		No charge		No charge	
Preventive	Topical Fluoride Application Space Maintainers - Fixed					
Child Dental					00047.0	
Basic	Restorative Procedures		20%		See 2017 Dental Copay Schedule	
	Periodontal Maintenance Serv Crowns and Casts	ices			23300.0	
	Endodontics					
Major	Periodontics (other than maint	enance)	50%		See 2017 Dental Copay Schedule	
Services	Prosthodontics				Solidule	
Child	Oral Surgery					
ermu .	Medically necessary orthodon	dee	50%		\$1,000	

2017 Standard Benefit Plan Designs 10.0 EHB

Date: June	16,	2016
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	Benefits and Coverage		CCSB			
-	hare amounts describe the Enr	ollee's out of pocket costs.	Silver HDHP Plan			
	e - AV Calculator		71.3%			
	cludes a deductible?		Yes, integr			
	dividual deductible mily deductible		\$2,000 integ \$4,000 integ			
	ductible, NOT integrated: Me tible, NOT integrated: Medic		N/A N/A			
Individual Out-	-of-pocket maximum	arrinandy / Domai	\$6,550			
HSA plan: Self-	pocket maximum -only coverage deductible		\$13,100 \$2,000			
HSA family pla	n: Individual deductible		\$2,600			
Common						
Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies		
	Primary care visit to treat an in	jury, illness, or condition	20%	х		
Health care provider's office or clinic	Other practitioner office visit		20%	Х		
visit	Specialist visit		20%	х		
	Preventive care/ screening/ im Laboratory Tests	munization	No charge 20%	X		
Tests	X-rays and Diagnostic Imaging		20%	X		
	Imaging (CT/PET scans, MRIs)	20%	X		
	Tier 1		20% up to \$250 per script	Х		
Drugs to treat illness or	Tier 2		20% up to \$250 per script	Х		
condition	Tier 3		20% up to \$250 per script	х		
	Tier 4		20% up to \$250 per script	х		
Outpatient services	Surgery facility fee (e.g., ASC) Physician/surgeon fees		20% 20%	X		
services	Outpatient visit		20%	X		
	Emergency room facility fee (w	raived if admitted)	20%	Х		
Need	Emergency room physician fee		0%	Х		
immediate attention	Emergency medical transporta	tion	20%	Х		
attention	Emergency medical transportation Urgent care Facility fee (e.g. hospital room)		20%	х		
Hospital stay	Facility fee (e.g. hospital room)		20%	Х		
rioopital otay	Physician/surgeon fee		20%	Х		
	Mental/Behavioral health outpatient office visits		20%	Х		
	Mental/Behavioral health other outpatient items and services		20%	х		
	Mental/Behavioral health inpat	ient facility fee (e.g.hospital room)	20%	Х		
Mental health, behavioral	Mental/Behavioral health inpat	ient physician 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%	X		
			20%	X		
	Substance Use inpatient facility fee (e.g. hospital room)					
	Substance use disorder inpatie	1 1	20%	Х		
Pregnancy	Prenatal care and preconcepti Delivery and all inpatient	Hospital	No charge 20%	Х		
,	services	Professional	20%	Х		
	Home health care Outpatient Rehabilitation servi		20% 20%	X		
Help recovering or	Outpatient Habilitation services		20%	X		
other special	Skilled nursing care		20%	х		
health needs	Durable medical equipment		20%	X		
Child	Hospice service Eye exam		0% No charge	^		
Child eye care	1 pair of glasses per year (or o	ontact lenses in lieu of glasses)	No charge			
Child Dental	Oral Exam Preventive - Cleaning					
Diagnostic and	Preventive - X-ray Sealants per Tooth		No charge			
Preventive	Topical Fluoride Application					
Child Dental	Space Maintainers - Fixed					
Basic Services	Restorative Procedures		20%			
Ser vices	Periodontal Maintenance Serv Crowns and Casts	ces				
Child Dental	Endodontics					
Major Services	Periodontics (other than maint Prosthodontics Oral Surgery	enance)	50%			
Child Orthodontics	Medically necessary orthodont	ics	50%			

Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs.		Silver Plan		Silver Plan		
	e - AV Calculator		100%-150 94.19		150%-200% F	rL .
	cludes a deductible?		Yes, Medical/	Pharmacy	Yes, Medical/Pharmacy	
	dividual deductible imily deductible		N/A N/A		N/A N/A	
Individual de	ductible, NOT integrated: Medicatible, NOT integrated: Medicatible, NOT integrated: Medicatible Not integrated: Me	dical / Pharmacy / Dental	\$75 / \$0 \$150 / \$0	/ \$0	\$650 / \$50 / \$0	
Individual Out-	-of-pocket maximum	ar / Pharmacy / Dentai	\$2,35		\$1,300 / \$100 / \$2,350	\$0
	pocket maximum -only coverage deductible		\$4,70 N/A	10	\$4,700 N/A	
	n: Individual deductible		N/A		N/A	
Common Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an in	jury, illness, or condition	\$5		\$10	
Health care provider's office or clinic visit	Other practitioner office visit		\$5		\$10	
	Specialist visit		\$8		\$25	
	Preventive care/ screening/ im Laboratory Tests	munization	No charge \$8		No charge \$15	
Tests	X-rays and Diagnostic Imaging		\$8		\$25	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1		\$3		\$5	
Drugs to treat illness or	Tier 2		\$10		\$20	Pharmacy deductible
condition	Tier 3		\$15		\$35	Pharmacy deductible
	Tier 4		10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharmacy deductible
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees		10% 10%		15% 15%	
services	Outpatient visit		10%		15%	
	Emergency room facility fee (w	aived if admitted)	\$50		\$100	
	Emergency room physician fee (waived if admitted)		No charge		No charge	
Need immediate			\$30	X	\$75	Х
attention	Emergency medical transportation Urgent care Escritiv fae (e.g. bespiral room)		\$5		\$10	
Hospital stay	Facility fee (e.g. hospital room)		10%	Х	15%	Х
	Physician/surgeon fee		10%	X	15%	X
	Mental/Behavioral health outpa	atient office visits	\$5		\$10	
	Mental/Behavioral health other	outpatient items and services	\$5		\$10	
	Mental/Behavioral health inpati	ient facility fee (e.g.hospital room)	10%	Х	15%	Х
Mental health, behavioral	Mental/Behavioral health inpat	ient physician fee	10%	х	15%	х
health, or substance abuse needs	Substance Use disorder outpa		\$5		\$10	
	Substance Use disorder other	outpatient items and services	\$5		\$10	
	Substance Use inpatient facility	y fee (e.g. hospital room)	10%	Х	15%	Х
	Substance use disorder inpatie		10%	Х	15%	Х
	Prenatal care and preconception	on visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	10%	х	15%	х
	services	Professional	10%	X	15%	Х
Holp	Home health care Outpatient Rehabilitation service	ces	\$3 \$5		\$15 \$10	
Help recovering or	Outpatient Habilitation services		\$5		\$10	
other special health needs	Skilled nursing care		10%	Х	15%	Х
nearm needs	Durable medical equipment		10% No charge		15% No charge	
	Hospice service Eye exam		No charge		No charge	
Child eye care	i pair or glasses per year (or co	ontact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Oral Exam					
Diagnostic	Preventive - Cleaning Preventive - X-ray		No charge		No charge	
and Preventive	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed		. so onargo		silaige	
Child Dental Basic	Restorative Procedures		20%		20%	
Services	Periodontal Maintenance Servi Crowns and Casts	ces				
Child Dental	Endodontics					
Major Services	Periodontics (other than mainted Prosthodontics	enance)	50%		50%	
	Oral Surgery					
Child Orthodontics	Medically necessary orthodont	ics	50%		50%	

	hare amounts describe the Er	rollee's out of pocket costs.	Silver Plan 200%-250% FP	'L
	- AV Calculator		73.7%	
	cludes a deductible?		Yes, Medical/Phari N/A	macy
Integrated Fa	mily deductible	ndical / Pharmacy / Dontal	N/A \$2,200 / \$250 / \$	în.
Family deduc	ductible, NOT integrated: M tible, NOT integrated: Medi	cal / Pharmacy / Dental	\$4,400 / \$500 / \$	
	of-pocket maximum		\$5,700 \$11.400	
HSA plan: Self-	only coverage deductible		N/A	
HSA family pla	n: Individual deductible		N/A	
Common				Deductibl
Medical Event		ervice Type	Member Cost Share	Applies
Health care	Primary care visit to treat an	njury, illness, or condition	\$30	
provider's office or clinic visit	Other practitioner office visit		\$30	
	Specialist visit		\$55	
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge \$35	
Tests	X-rays and Diagnostic Imagir		\$65	
	Imaging (CT/PET scans, MRI	S)	\$300	
	Tier 1		\$15	
Drugs to treat	Tier 2		\$50	Pharmac
condition	Tier 3		\$75	Pharmac deductib
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmac deductib
Outpatient	Surgery facility fee (e.g., ASC	:)	20% 20%	
services	Physician/surgeon fees Outpatient visit		20%	
	Emergency room facility fee (waived if admitted)	\$350	
	Emergency room physician fe	e (waived if admitted)	No charge	
Need immediate	Emergency medical transportation		\$250	Х
attention	· · · · · · · · · · · · · · · · · · ·			
	Urgent care		\$30	
Hospital stay	Facility fee (e.g. hospital roon	n)	20%	Х
	Physician/surgeon fee		20%	Х
	Mental/Behavioral health outpatient office visits		\$30	
	Mental/Behavioral health other outpatient items and services		\$30	
	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	20%	Х
Mental health, behavioral	Mental/Behavioral health inpa	atient physician fee	20%	Х
health, or substance abuse needs	Substance Use disorder outp	atient office visits	\$30	
	Substance Use disorder other outpatient items and services		\$30	
	2.1			V
	Substance Use inpatient facil Substance use disorder inpat		20%	X
	Prenatal care and preconcep		No charge	^
Pregnancy	Delivery and all inpatient	Hospital	20%	Х
,,	services	Professional	20%	X
	Home health care		\$40	
Help	Outpatient Rehabilitation service Outpatient Habilitation service		\$30 \$30	
recovering or other special	Skilled nursing care		20%	х
health needs	Durable medical equipment		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	
Child Dental	Oral Exam			
Diagnostic	Preventive - Cleaning Preventive - X-ray		No charge	
and Preventive	Sealants per Tooth Topical Fluoride Application		No charge	
	Space Maintainers - Fixed			
Child Dental Basic	Restorative Procedures		20%	
Services	Periodontal Maintenance Ser Crowns and Casts	vices		
Child Dental	Endodontics			
	Pariadantics (ather than main	tenance)	50%	
Major	Periodontics (other than maintenance)			
Major Services	Prosthodontics Oral Surgery	ionarios)		

	ductible pplies X X X X X X X X X X X X X
Integrated Family deductable Yes, Medical Pharmacy Yes, Modical Pharmacy Test Second Pha	ductible pplies X X X X X X X X X X X X X
Integrated Individual deductible Integrated Family deductible Integrated F	ductible pplies X X X X X X X X X X X X X
Individual deductible, NOT integrated (Medical Pharmacy / Dental \$15,00 / \$1,000 / \$0 \$0.00 \$0	X X X X X X X X X X X X X X X X X X X
individual Dut-op-cocket maximum Sociolo Sociolo Sociolo Raminy dut-of-pocket maximum Sociolo Sociolo Sistano NiA Sistano Sistano NiA Sistano Sistano NiA Sistano Sistano Member Cost Share Permany care visit to treat an injury, liness, or condition Permany care visit to treat an injury, liness, or condition Permany care visit to treat an injury, liness, or condition Permany care visit to treat an injury, liness, or condition Permany care visit to treat an injury, liness, or condition Permany care visit to treat an injury, liness, or condition Permany care visit to treat an injury, liness, or condition Permany care visit to treat an injury, liness, or condition Sistena Permany care visit to treat an injury, liness, or condition Sistena Permany care visit to treat an injury, liness, or condition Sistena Permany care visit to treat an injury, liness, or condition Sistena Permany care visit to treat an injury, liness, or condition Sistena Permany care visit to treat an injury, liness, or condition Sistena Sistena Member Cost Share Member Cost Share After 1st three non-preventive and 40% visits After 1st three non-preventive and 40% visits Sistena Sistena After 1st three non-preventive and 40% visits No charge Ter 1 100% up to 5000 per script after pharmacy deductable and an injury (Physican Assessment Assessmen	X X X X X X X X X X X X X X X X X X X
### A Part of the Common	X X X X X X X X X X X X X X X X X X X
HSA plants Self-emit (orwards deductible RSA family plant individual deductible Common Medical Event Primary care visit to treat an injury, liness, or condition Sorvice Type Primary care visit to treat an injury, liness, or condition Sorvice Type Primary care visit to treat an injury, liness, or condition Sorvice Type Primary care visit to treat an injury, liness, or condition Sorvice Type Primary care visit to treat an injury, liness, or condition Sorvice Type Primary care visit to treat an injury, liness, or condition Sorvice Type Primary care visit to treat an injury, liness, or condition Sorvice Type After 1st three non-preventive visits Soft After 1st three non-preventive visits Test 2	X X X X X X X X X X X X X X X X X X X
Common Medical Event Primary care visit to treat an injury, liness, or condition \$75	X X X X X X X X X X X X X X X X X X X
Primary care visit to treat an injury, liness, or condition Primary care visit to treat an injury, liness, or condition Primary care visit to treat an injury, liness, or condition Primary care visit to treat an injury, liness, or condition Primary care visit to treat an injury, liness, or condition Primary care visit to treat an injury, liness, or condition Primary care visit to treat an injury, liness, or condition Primary care visit to treat an injury, liness, or condition Primary care visit to treat an injury, liness, or condition Preventive care screening immunization Primary care visit to treat an injury, liness, or condition Primary care visit to treat an injury, liness, or condition Primary care visit to treat an injury, liness, or condition Primary care visit to treat an injury, liness, or condition Primary care visit to treat an injury, liness, or condition Primary care visit to treat an injury, liness, or condition Primary care visit to treat an injury, liness, or care visit to the construction of the con	X X X X X X X X X X X X X X X X X X X
Primary care visit to treat an injury, illness, or condition S75	x x x x x x x x x x x x x
Other practitioner office visit Secialist visit Specialist visit	X X X X X X X X X X X X X X X X X X X
Specialist visit Preventive carel' screening/immunization No charge Laboratory Tests Tests Ter 1 100% up to \$500 per script after pharmacy deductible Ter 2 100% up to \$500 per script after pharmacy deductible Ter 3 100% up to \$500 per script after pharmacy deductible Ter 3 100% up to \$500 per script after pharmacy deductible Ter 3 100% up to \$500 per script after pharmacy deductible Ter 3 100% up to \$500 per script after pharmacy deductible Ter 4 100% up to \$500 per script after pharmacy deductible Ter 3 100% up to \$500 per script after pharmacy deductible Ter 4 100% up to \$500 per script after pharmacy deductible Ter 4 100% up to \$500 per script after pharmacy deductible Ter 5 Ter 4 100% up to \$500 per script after pharmacy deductible Ter 6 Ter 7 Ter 8 Surgery facility fee (e.g., ASC) Ter 9 Ter 9 Ter 9 Ter 9 Ter 100% up to \$500 per script after pharmacy deductible Ter 9 Ter 4 100% up to \$500 per script after pharmacy deductible Ter 9 Ter 4 100% up to \$500 per script after pharmacy deductible Ter 9 Ter 4 100% up to \$500 per script after pharmacy deductible Ter 9 Ter 4 100% up to \$500 per script after pharmacy deductible Ter 9 Ter 4 100% up to \$500 per script after pharmacy deductible Ter 9 Ter 4 100% up to \$500 per script after pharmacy deductible Ter 9 Ter 4 100% up to \$500 per script after pharmacy deductible Ter 9 Ter 4 100% up to \$500 per script after pharmacy deductible Ter 9 Ter 4 100% up to \$500 per script after pharmacy deductible Ter 9 Ter 4 100% up to \$500 per script after pharmacy deductible Ter 9 Ter 9 Ter 4 100% up to \$500 per script after pharmacy deductible Ter 9 Ter 100% up to \$500 per script after pharmacy deductible Ter 9 Ter	X X X X X X
Laboratory Tests	X X X X X X X X X X X X X X X X X X X
New	X X X X X X X X X X X X X X X X X X X
Imaging (CT/PET scans, MRIs)	x x x x x x x x x x x x x x x x x x x
Tier 2 100% up to \$500 per script 100% up to \$500 per script 2 100% up to \$500 per script 2 100% up to \$500 per script 3 100% up to \$500 per script 4 100% up to \$500 per script 4 100% up to \$500 per script 4 100% up to \$500 per script 5 100% up to	X X X X X X X
Iter 2	X X X X
Tier 3	X X X
Surgery facility fee (e.g., ASC)	X X X
Physician/surgeon fees 100% X 40%	X X
Services Procession Comparison visit	Х
Emergency room facility fee (waived if admitted) No charge Emergency room physician fee (waived if admitted) Emergency room physician fee (waived if admitted) Emergency medical transportation Urgent care Pacility fee (e.g. hospital room) Physician/surgeon fee Mental/Behavioral health outpatient office visits Mental/Behavioral health other outpatient items and services Mental/Behavioral health inpatient physician fee Mental/Behavioral health inpatient physician fee Mental/Behavioral health inpatient office visits Mental/Behavioral health inpatient physician fee Substance Use disorder outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient physician fee Mental/Behavioral health inpatient office visits Substance Use inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient office visits Substance Use inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient office visits Substance Use inpatient facility fee (e.g. hospital room) Mental/Behavioral health inpatient physician fee Mental/Behavioral health inpatient office visits Mental/Behavioral health inpatient physician fee Mental/Behavioral health inpatient physician fee Mental/Behavioral health inpatient physician fee Mental/Behavioral health inpatient office visits Mental/Behavioral health inpatient physician fee Mental/Behavioral health inpatient office visits Mental/Behavioral health inpatient physician fee Mental/Behavioral health inpatient office visits Mental/Behavioral health outpatient office visits Mental/Behavioral health outpatient office visits Mental/Behavioral health outpatient facility fee (e.g. hospital room) Mental/Behavioral health outpatient office visits Mental/Behavioral health outpatient office visits Mental/Behavioral health ou	
Mental/Behavioral health other outpatient items and services S75 After 1st three non-preventive visits	X
Mental/Behavioral health other outpatient items and services S75 After 1st three non-preventive visits	х
After 1st three A0% Afte	X
Physician/surgeon fee 100% X 40% Mental/Behavioral health outpatient office visits \$75 After 1st three non-preventive visits 40% Mental/Behavioral health other outpatient items and services \$75 After 1st three non-preventive visits 40% Mental/Behavioral health inpatient facility fee (e.g. hospital room) 100% X 40% Mental/Behavioral health inpatient physician fee 100% X 40% Mental/Behavioral health inpatient physician fee 100% X 40% Substance Use disorder outpatient office visits \$75 After 1st three non-preventive visits Substance Use disorder outpatient items and services \$75 After 1st three non-preventive visits Substance Use disorder outpatient items and services \$75 After 1st three non-preventive visits Substance Use inpatient facility fee (e.g. hospital room) 100% X 40% Substance use disorder inpatient physician fee 100% X 40%	x
Mental/Behavioral health outpatient office visits \$75 After 1st three non-preventive visits 40% wish with the conference of the conference	Х
Mental/Behavioral health outpatient office visits \$75 non-preventive visits 40% visits 40% wisits 575 non-preventive visits 575 non-preventive visit	Х
Mental/Behavioral health other outpatient items and services Mental/Behavioral health inpatient facility fee (e.g.hospital room) Mental/Behavioral health inpatient physician fee 100% X 40% After 1st three non-preventive visits Substance Use disorder outpatient items and services Substance Use disorder other outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) 100% X 40% After 1st three non-preventive visits Substance Use inpatient facility fee (e.g. hospital room) 100% X 40% After 1st wree non-preventive visits Substance Use inpatient facility fee (e.g. hospital room) X 40%	Х
Mental/Behavioral health, behavioral health inpatient physician fee 100% X 40%	х
Mental/Behavioral health, behavioral health inpatient physician fee 100% X 40%	Х
health, or substance abuse needs Substance Use disorder outpatient office visits \$75 After 1st three non-preventive visits visits \$75 After 1st three non-preventive visits \$75 After 1st three non-p	х
Substance Use disorder other outpatient items and services \$.75 non-preventive visits 40% visits Substance Use inpatient facility fee (e.g. hospital room) 100% X 40% Substance use disorder inpatient physician fee 100% X 40%	х
Substance Use inpatient facility fee (e.g. hospital room) 100% X 40% Substance use disorder inpatient physician fee 100% X 40%	х
Substance use disorder inpatient physician fee 100% X 40%	Х
Prenatal care and preconception visits No charge No charge	Х
Pregnancy Delivery and all inpatient Hospital 100% X 40%	Х
Services Professional 100% X 40%	X
Outnatient Rehabilitation services \$75	X
recovering or Outpatient Habilitation services \$75 40%	Χ
other special backlib peeds Skilled nursing care 100% X 40%	Х
Durable medical equipment 100% X 40%	X
Eye exam No charge No charge	^_
Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge	
Oral Exam	
Child Dental Preventive - Cleaning Diagnostic Preventive - X-ray No charge	
and Sealants per Tooth No charge No charge	
Preventive Topical Fluoride Application Space Maintainers - Fixed	
Child Dental Procedures	
20% 20%	
Services Periodontal Maintenance Services Crowns and Casts	
Child Dental Endodontics	
Major Periodontics (other than maintenance) 50% 50%	
Services Prosthodontics Oral Surgery	
Child Orthodontics Medically necessary orthodontics 50% 50%	

	hare amounts describe the En	rones a out or pocket costs.	Catastro	PING FIAII
	cludes a deductible? dividual deductible		Yes, int \$7,150 ir	egrated stegrated
Integrated Fa	mily deductible		\$14,300 i	
Individual de	ductible, NOT integrated: Me	edical / Pharmacy / Dental	N.	/A
	tible, NOT integrated: Medic	cai / Pharmacy / Dental	\$7,	
amily Out-of-	pocket maximum		\$14.	
HSA plan: Self-	only coverage deductible		N _i	
HSA family pla	n: Individual deductible		N.	A
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies
		Troc Type		After 1st three
	Primary care visit to treat an i	njury, illness, or condition	0%	non-preventive
Health care provider's office or clinic	Other practitioner office visit		0%	After 1st three non-preventive visits
visit	Specialist visit		0%	х
	Dravantiva nava/ annonia a/ in		No. ob come	
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge 0%	X
Гests	X-rays and Diagnostic Imagin	g	0%	X
	Imaging (CT/PET scans, MRI	s)	0%	Х
	Tier 1		0%	Х
Drugs to treat	Tier 2		0%	х
condition	Tier 3		0%	х
	Tier 4		0%	х
Outpatient	Surgery facility fee (e.g., ASC	:)	0%	Х
outpatient services	Physician/surgeon fees		0%	X
	Outpatient visit		0%	X
	Emergency room facility fee (waived if admitted)	0%	Х
	Emergency room physician fe	e (waived if admitted)	No charge	
Need mmediate	Emergency medical transport	ation	0%	Х
attention	Urgent care		0%	After 1st three non-preventive visits
	Escility foo (o.g. bospital room	2)	0%	х
Hospital stay	Facility fee (e.g. hospital room	"		
	Physician/surgeon fee		0%	X
	Mental/Behavioral health outpatient office visits		0%	After 1st three non-preventive visits
	Mental/Behavioral health other	er outpatient items and services	0%	After 1st three non-preventive visits
	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	0%	х
Mental health, behavioral	Mental/Behavioral health inpa	itient physician fee	0%	Х
health, or substance abuse needs	Substance Use disorder outpo	atient office visits	0%	After 1st three non-preventive visits
	Substance Use disorder other	r outpatient items and services	0%	After 1st three
	Substance Use inpatient facili	ity fee (e.g. hospital room)	0%	visits
	Substance use disorder inpat		0%	Х
	Prenatal care and preconcept	tion visits	No charge	
Pregnancy	Delivery and all inpatient	Hospital	0%	Х
	services	Professional	0%	Х
	Home health care		0%	X
Help	Outpatient Rehabilitation service Outpatient Habilitation service		0%	X
ecovering or other special			0%	X
nealth needs	Skilled nursing care			
	Durable medical equipment Hospice service		0%	X
	Eye exam		No charge	^
Child eye care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	0%	Х
	Oral Exam	*,		
Child Dental	Preventive - Cleaning			
Diagnostic	Preventive - X-ray		No charge	
and	Sealants per Tooth Topical Fluoride Application			
	Space Maintainers - Fixed			
Preventive	ental			х
Preventive Child Dental	Restorative Procedures		0%	
Preventive Child Dental Basic	Restorative Procedures			X
Preventive Child Dental Basic	Periodontal Maintenance Sen	vices		
Preventive Child Dental Basic Services		vices		X
Preventive Child Dental Basic Services Child Dental	Periodontal Maintenance Sen Crowns and Casts Endodontics		0%	X
Preventive Child Dental Basic Services Child Dental Major	Periodontal Maintenance Sen Crowns and Casts Endodontics Periodontics (other than main		0%	X X
and Preventive Child Dental Basic Services Child Dental Major Services	Periodontal Maintenance Sen Crowns and Casts Endodontics		0%	X
Preventive Child Dental Basic Services Child Dental Major	Periodontal Maintenance Sen Crowns and Casts Endodontics Periodontics (other than main Prosthodontics	tenance)	0%	X X X



	hare amounts describe the En	rollee's out of pocket costs.	Platinu Coinsurand	e Plan	Platinu Copay F	Plan
	- AV Calculator		89.79	6	90.3%	
	cludes a deductible? dividual deductible		No \$0		No \$0	
Integrated Fa	mily deductible		\$0		\$0	
Individual ded	mily deductible ductible, NOT integrated: M tible, NOT integrated: Medic	edical / Pharmacy / Dental	\$0 / \$0 / \$0 / \$0 /		\$0 / \$0 / \$0 / \$0 /	
ndividual Out-	-of-pocket maximum	Sar / Friannacy / Dentar	\$4,00		\$4,00	
	oocket maximum		\$8,00	0	\$8,00	0
	only coverage deductible n: Individual deductible		N/A N/A		N/A N/A	
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductibl Applies
	Primary care visit to treat an i	njury, illness, or condition	\$15		\$15	
lealth care provider's office or clinic risit	Other practitioner office visit		\$15		\$15	
	Specialist visit		\$40		\$40	
	Preventive care/ screening/ in	mmunization	No charge \$20		No charge \$20	
	Laboratory Tests X-rays and Diagnostic Imagin	q	\$40		\$40	
	Imaging (CT/PET scans, MRI		10%		\$150	
	Tier 1		\$5		\$5	
rugs to treat	Tier 2		\$15		\$15	
Iness or ondition	Tier 3		\$25		\$25	
	Tier 4		10% up to \$250 per script		10% up to \$250 per script	
	Surgery facility fee (e.g., ASC	:)	10%		\$250	
ervices	Physician/surgeon fees		10%		\$40	
	Outpatient visit		10%		10%	
	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fe	ee (waived if admitted)	No charge		No charge	
leed nmediate	Emergency medical transport	ation	\$150		\$150	
attention Urgent care			\$15		\$15	
					\$250 per day up	
lospital stay	Facility fee (e.g. hospital roon	n)	10%		to 5 days	
	Physician/surgeon fee		10%		\$40	
	Mental/Behavioral health outpatient office visits		\$15		\$15	
	Mental/Behavioral health other outpatient items and services		\$15		\$15	
	Mental/Behavioral health inna	atient facility fee (e.g.hospital room)	10%		\$250 per day up	
lental health,					to 5 days	
ealth, or	Mental/Behavioral health inpa		10%		\$40	
buse needs	Substance Use disorder outpatient office visits		\$15		\$15	
	Substance Use disorder othe	\$15		\$15		
	Substance Use inpatient facil	10%		\$250 per day up to 5 days		
	Substance use disorder inpat		10%		\$40	
	Prenatal care and preconcep	tion visits	No charge		No charge	
	Delivery and all inpatient	Hospital	10%		\$250 per day up to 5 days	
	services	Professional	10%		\$40	
	Home health care Outpatient Rehabilitation serv	rices	10% \$15		\$20 \$15	
	Outpatient Habilitation service		\$15		\$15	
ecovering or	Skilled nursing care		10%		\$150 per day up	
ealth needs	Durable medical equipment		10%		to 5 days 10%	
	Hospice service		No charge		No charge	
	Eye exam		No charge		No charge	
hild 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					
nd	Sealants per Tooth		Not Covered		Not Covered	
reventive	Topical Fluoride Application		4			
hild Dental	Space Maintainers - Fixed					
asic	Restorative Procedures		Not Covered		Not Covered	
	Periodontal Maintenance Ser	vices				
	Crowns and Casts Endodontics		-		Not Covered Not Covered	
mild Dental		tononco)	Not Course 1			
Major Services	Periodontics (other than main	tenance)	Not Covered		Not Covered	
	Prosthodontics Oral Surgery		1		Not Covered Not Covered	
No. 11 of						
Orthodontics	Medically necessary orthodor	ntics	Not Covered		Not Covered	

Member Cost S	hare amounts describe the En	rollee's out of pocket costs.	Gold Coinsurance Plan		Gold Copay Plan	
Actuarial Value	e - AV Calculator		80.9		81.29	
	cludes a deductible?		No		No	
	dividual deductible mily deductible		\$0 \$0		\$0 \$0	
Individual de	ductible, NOT integrated: Me		\$0 / \$0	/\$0	\$0 / \$0 / \$0	
	ctible, NOT integrated: Medic	al / Pharmacy / Dental	\$0 / \$0		\$0 / \$0 .	
	-of-pocket maximum pocket maximum		\$6,75 \$13,5		\$6,75 \$13,50	
ISA plan: Self-	only coverage deductible		N/A		N/A	
ISA family pla	n: Individual deductible		N/A		N/A	
			Name to a control			L
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductibl Applies
		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
	Primary care visit to treat an in	njury, illness, or condition	\$30		\$30	
teetite een						
lealth care rovider's	Other practitioner office visit		\$30		\$30	
office or clinic						
risit						
	Specialist visit	\$55		\$55		
	Preventive care/ screening/ in	nmunization	No charge		No charge	
	Laboratory Tests		\$35		\$35	
ests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs		\$55 20%		\$55 \$275	
	imaging (OT/1 ET Scans, With	2070		ΨΣΙΟ		
	Tier 1		\$15		\$15	
Orugs to treat	Tier 2		\$55		\$55	
liness or						
ondition	Tier 3	\$75		\$75		
	Tier 4	20% up to \$250		20% up to \$250		
		per script		per script		
Outpatient	Surgery facility fee (e.g., ASC)		20%		\$600	
ervices	Physician/surgeon fees Outpatient visit		20%		\$55 20%	
	Emergency room facility fee (v	unived if admitted)	\$325		\$325	
	Emergency room raciity ree (valved ii admitted)	φ323		φ323	
leed	Emergency room physician fe	No charge		No charge		
mmediate	Emergency medical transports	ation	\$250		\$250	
ttention						
	Urgent care		\$30		\$30	
	Facility fee (e.g. hospital room)	20%		\$600 per day up	
Hospital stay		,	20%		to 5 days	
	Physician/surgeon fee		20%		\$55	
	Mental/Behavioral health outpatient office visits		\$30		\$30	
	Mental/Behavioral health other	\$30		\$30		
					\$600 per day up	
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%		to 5 days	
Mental health, behavioral	Mental/Behavioral health inpa	tient physician fee	20%		\$55	
nealth, or						
substance	Substance Use disorder outpa	atient office visits	\$30		\$30	
abuse needs			***		***	
	Substance Use disorder other	\$30		\$30		
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%		\$600 per day up	
					to 5 days	
	Substance use disorder inpati		20%		\$55	
	Prenatal care and preconcept	ion visits	No charge		No charge	
regnancy	Delivery and all inpatient	Hospital	20%		\$600 per day up to 5 days	1
	services	Professional	20%		\$55	
	Home health care	ione	20%		\$30	
lelp	Outpatient Rehabilitation serv Outpatient Habilitation service		\$30 \$30		\$30 \$30	
ecovering or other special	Skilled nursing care		20%		\$300 per day up	
nealth needs	Durable medical equipment		20%		to 5 days	
	Hospice service		No charge		20% No charge	
N. 11.1	Eye exam		No charge		No charge	
Child eye care	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam					
Child Dental Diagnostic	Preventive - Cleaning		-			
ind	Preventive - X-ray Sealants per Tooth		Not Covered		Not Covered	
Preventive	Topical Fluoride Application					
Child Dental	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures		Not Covered		Not Covered	
Services	Periodontal Maintenance Sen	rices				
	Crowns and Casts		_		Not Covered	
Child Dental	Endodontics		Nu C		Not Covered	
Major Services	Periodontics (other than main	enance)	Not Covered		Not Covered	
	Prosthodontics Oral Surgery		4		Not Covered Not Covered	
Child	ourgory					
miu	Medically necessary orthodon	tics	Not Covered		Not Covered	

	Benefits and Coverage	rollon's out of realist each	Individual	
Member Cost S	hare amounts describe the En	rollee's out of pocket costs.	Silver Plan	1
Actuarial Value	e - AV Calculator		71.5%	
	cludes a deductible? dividual deductible		Yes, Medical/Pha N/A	armacy
Integrated Fa	mily deductible		N/A	
Individual de	ductible, NOT integrated: Me tible, NOT integrated: Medic	edical / Pharmacy / Dental	\$2,500/ \$250 \$5,000/ \$500 .	
ndividual Out-	-of-pocket maximum	arr Hamay / Domai	\$6,800	Ψ
Family Out-of- HSA plan: Self	pocket maximum -only coverage deductible		\$13,600 N/A	
	n: Individual deductible		N/A	
Common				Deductible
Medical Event		rvice Type	Member Cost Share	Applies
Health care	Primary care visit to treat an i	njury, illness, or condition	\$35	
provider's office or clinic visit	Other practitioner office visit		\$35	
	Specialist visit		\$70	
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge \$35	
Tests	X-rays and Diagnostic Imagin		\$70	
	Imaging (CT/PET scans, MRI	5)	\$300	
	Tier 1		\$15	
Drugs to treat	Tier 2		\$55	Pharmacy
condition	Tier 3	\$80	Pharmacy deductible	
	Tier 4		20% up to \$250 per script after pharmacy deductible 20%	Pharmacy deductible
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees)	20%	
services	Outpatient visit		20%	
	Emergency room facility fee (vaived if admitted)	\$350	
u d	Emergency room physician fe	e (waived if admitted)	No charge	
Need immediate	Emergency medical transport	ation	\$250	Х
attention	Urgent care		\$35	
Hospital stay	Facility fee (e.g. hospital room)		20%	Х
	Physician/surgeon fee		20%	Х
	Mental/Behavioral health outpatient office visits		\$35	
	Mental/Behavioral health othe	\$35		
	Mental/Behavioral health inpa	20%	Х	
Mental health,	Montal/Pohavioral hoalth inna	20%	×	
behavioral health, or substance	Mental/Behavioral health inpatient physician fee Substance Use disorder outpatient office visits		\$35	^
abuse needs		400		
	Substance Use disorder other	\$35		
	Substance Use inpatient facili	ty fee (e.g. hospital room)	20%	Х
	Substance use disorder inpat	ent physician fee	20%	х
	Prenatal care and preconcept	ion visits	No charge	
Pregnancy	Delivery and all inpatient services	Hospital	20%	Х
	Home health care	Professional	20% \$45	Х
Help	Outpatient Rehabilitation serv		\$35	
recovering or	Outpatient Habilitation service	es	\$35	
other special	Skilled nursing care		20%	Х
	Durable medical equipment		20% No charge	
	Hospice service		No charge	
health needs	Eye exam			
nealth needs	Eye exam 1 pair of glasses per year (or or	contact lenses in lieu of glasses)	No charge	
nealth needs	Eye exam	contact lenses in lieu of glasses)		
Child eye care Child Dental Diagnostic	Eye exam 1 pair of glasses per year (or of or	contact lenses in lieu of glasses)		
Child eye care Child Dental Diagnostic	Eye exam 1 pair of glasses per year (or of Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application	contact lenses in lieu of glasses)	No charge	
Child eye care Child Dental Diagnostic and Preventive	Eye exam 1 pair of glasses per year (or of oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	contact lenses in lieu of glasses)	No charge	
Child eye care Child Dental Diagnostic and Preventive Child Dental Basic	Eye exam 1 pair of glasses per year (or of coral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures		No charge	
Child eye care Child Dental Diagnostic and Preventive Child Dental Basic	Eye exam 1 pair of glasses per year (or of plasses) Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Sen		No charge Not Covered	
Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental	Eye exam 1 pair of glasses per year (or of or of the same preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Sen Crowns and Casts Endodontics	/ices	No charge Not Covered Not Covered	
Child eye care Child Dental Diagnostic and Preventive Child Dental Basic Services	Eye exam 1 pair of glasses per year (or of plasses) Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Sen	/ices	No charge Not Covered	

Actuariat Value - A Plan design inclue Integrated Individual Integrated Family Individual deduction Integrated Family Individual deduction Family deduction Family deduction Has family plan: In Common Medical Event Private Family Out-of- Family o	idea a deductible? idual deductible ity deductible tiple, NOT integrated: Medicetible, NOT integrated: Medicetible individual deductible individual	dical / Pharmacy / Dental al / Pharmacy / Dental vice Type jury, illness, or condition imunization) valved if admitted) b (waived if admitted)	Silver Coinsurance 71.6% Yes, Medical/Ph N/A N/A \$2,000 \$250 \$4,000 / \$500 \$13,600 N/A N/A N/A \$2,001 \$250 \$4,000 / \$500 \$13,600 N/A N/A Member Cost Share \$45 \$45 \$45 \$45 \$75 No charge \$40 \$70 20% \$15 \$555 \$85 20% up to \$250 per script after pharmacy deductible 20% 20% 20% \$20% \$350 No charge \$250	armacy / \$0	Silver Copay Pla 71.3% Yes, Medical/Phi N/A N/A \$2,000/\$250 \$4,000 /\$500 \$13,600 N/A N/A N/A \$2,000 \$250 \$4,000 /\$500 \$13,600 \$13,600 N/A N/A Member Cost Share \$45 \$45 \$45 \$45 \$575 No charge \$40 \$70 \$300 \$115 \$555 \$85 \$85 20% up to \$250 per script after pharmacy deductible 20% 20% 20% \$350 No charge	armacy / \$0
Plan design including programment of the programment of the provided provided programment of the provided p	ides a deductible? idual deductible ity deductible tible, NOT integrated: Medic- pocket maximum chet maximum and coverage deductible Individual deductible	vice Type jury, illness, or condition imunization i)) valved if admitted) b (waived if admitted)	Yes, Medical/Phi N/A N/A \$2,000 \$250 \$4,000 / \$500 \$5,800 \$13,600 N/A N/A N/A Member Cost Share \$45 \$45 \$45 No charge \$40 \$70 20% \$15 \$85 \$85 20% up to \$250 per script after pharmacy deductible deductible 20% \$20% \$350 No charge	Pharmacy deductible Pharmacy deductible Pharmacy deductible	Yes, Medical/Phi N/A N/A \$2,000 { \$250 \$4,000 / \$500 \$13,600 N/A N/A N/A Member Cost Share \$45 \$45 \$45 \$45 \$575 No charge \$40 \$70 \$300 \$15 \$55 \$85 \$85 \$85 20% up to \$250 per script after pharmacy deductible 20% \$20% \$20% \$350	Pharmacy deductible Pharmacy
Integrated Individual Cout- Integrated Famili, Individual Cout- Family deductible Individual Cout- SA plan: Self-onl ISA family plan: Individual Cout- ISA plan: Self-onl ISA family plan: ISA family plan	initial deductible lify deductible ctible, NOT integrated: Medic pocket maximum lify coverage deductible Individual deductible lindividual deductible lindividua	vice Type jury, illness, or condition imunization i)) valved if admitted) b (waived if admitted)	N/A N/A \$2,000 \$250 \$4,000 \$500 \$5,000 \$13,600 \$13,600 N/A	Pharmacy deductible Pharmacy deductible Pharmacy deductible	NIA	Pharmacy deductible Pharmacy
Integrated Familian Individual deduc Family deductible Individual Out-of-amily Out-of-poc ISA plans: Self-ond ISA family Plans: ISA family	Illy deductible cutible, NOT integrated: Medicible, NOT integrated: Medicible, NOT integrated: Medicible, NOT integrated: Medicible, NOT integrated: Medicible control of the Note of the	vice Type jury, illness, or condition imunization i)) valved if admitted) b (waived if admitted)	N/A \$2,00/\$250 \$4,000/\$500 \$4,000/\$500 \$5,8000 \$13,600 N/A N/A Member Cost Share \$45 \$45 \$45 \$75 No charge \$40 \$70 20% \$15 \$85 \$85 20% up to \$250 per script after pharmacy defer pharmacy defer pharmacy defer pharmacy defer pharmacy 20% 20% 20% \$350 No charge	Pharmacy deductible Pharmacy deductible Pharmacy deductible	N/A \$2,000 \$250 \$4,000 \$500 \$6,000 \$13,600 N/A N/A Member Cost Share \$45 \$45 \$45 \$75 No charge \$40 \$70 \$300 \$15 \$55 \$85 20% up to \$250 per script after pharmary deductible 20% 20% 20% \$350	Pharmacy deductible Pharmacy Pharmacy
Individual deduction Family deductible Individual Out-of- amily Out-of- amily Out-of- amily Out-of- amily Out-of- amily Out-of- Is A plan: Self-ont Is A family plan: Is Common Medical Event Common Medical Event Common Medical Event Price Is A family plan: Is Price Is A family	ctible, NOT integrated: Medic pocket maximum chet maximum his coverage deductible Individual deductible Indivi	vice Type jury, illness, or condition imunization i)) valved if admitted) b (waived if admitted)	\$2,000 \$250 \$4,000 \$750 \$5,800 \$13,600 \$13,600 N/A N/A Member Cost Share \$45 \$45 \$45 No charge \$40 \$70 20% \$15 \$85 \$85 20% up to \$250 per script after pharmacy deductible deductible 20% \$20% \$350 No charge	Pharmacy deductible Pharmacy deductible Pharmacy deductible	\$2,000/\$250 \$4,000 / \$500 \$6,800 \$13,600 N/A N/A N/A Member Cost Share \$45 \$45 \$45 \$45 \$575 No charge \$40 \$70 \$300 \$15 \$55 \$85 \$85 20% up to \$250 per script after pharmacy deductible 20% \$20% \$20% \$350	Pharmacy deductible Pharmacy Pharmacy
death care rovider's leath care leath care rovider's leath care leath care rovider's leath care leath	sect maximum hy coverage deductible Individual deductible Individu	vice Type jury, illness, or condition munization) valved if admitted) b (waived if admitted)	\$6,800 \$13,600 \$13,600 \$N/A N/A N/A Member Cost Sharo \$45 \$45 \$45 \$45 No charge \$40 \$70 20% \$15 \$85 \$85 20% up to \$250 per script after pharmacy deduction of the pha	Pharmacy deductible Pharmacy deductible Pharmacy deductible	\$6,800 \$13,600 \$13,600 N/A N/A N/A Member Cost Share \$45 \$45 \$45 \$75 No charge \$40 \$70 \$300 \$15 \$55 \$85 20% up to \$250 per script after pharmacy deductible 20% 20% 20% \$350	Pharmacy deductible Pharmacy deductible Pharmacy
ramity Out-of-poor SISA plans: Self-onlists plans: Is Common Medical Event Private Provider's Out-of-poor SISA plans: Self-onlists Sp. Pre Lat	cket maximum ylv coverage deductible Individual deductible Individ	inunization imunization inunization inunization	\$13,600 N/A N/A N/A N/A Member Cost Share \$45 \$45 \$45 \$75 No charge \$40 \$70 20% \$15 \$55 \$85 20% up to \$250 per script after pharmacy department of the charge of the cha	Pharmacy deductible Pharmacy deductible Pharmacy deductible	\$13,600 N/A N/A N/A N/A N/A Member Cost Share \$45 \$45 \$45 No charge \$40 \$70 \$300 \$15 \$55 \$85 \$85 20% up to \$250 per script after pharmacy deductible 20% 20% 20% \$350	Pharmacy deductible Pharmacy Pharmacy Pharmacy
Common Medical Event Principal Princ	Individual deductible Sei imary care visit to treat an ir ther practitioner office visit becialist visit reventive care/ screening/ ir aboratory Tests rays and Diagnostic Imaging laging (CT/PET scans, MRIs er 1 er 2 er 3 er 4 urgery facility fee (e.g., ASC) nysician/surgeon fees utpatient visit mergency room physician fee mergency room physician fee mergency medical transports rgent care	inunization imunization inunization inunization	### N/A Member Cost Share	Pharmacy deductible Pharmacy deductible Pharmacy deductible	N/A Member Cost Share \$45 \$45 \$45 No charge \$40 \$70 \$300 \$15 \$55 \$85 20% up to \$250 per script after pharmacy deductible 20% 20% 20% \$350	Pharmacy deductible Pharmacy Pharmacy Pharmacy
Common Medical Event Printed and Printed	ther practitioner office visit to treat an in ther practitioner office visit to treat an in ther practitioner office visit obecialist visit reventive care/ screening/ in aboratory Tests rays and Diagnostic Imaging aging (CT/PET scans, MRIs er 1 er 2 er 3 er 4 urgery facility fee (e.g., ASC) hysician/surgeon fees utpatient visit mergency room facility fee (wergency room physician fee mergency medical transportargent care	inunization imunization inunization inunization	### ### ### ### ### ### ### ### ### ##	Pharmacy deductible Pharmacy deductible Pharmacy deductible	### Member Cost Share \$45 \$45 \$45 \$75 No charge \$40 \$70 \$300 \$15 \$55 \$85 20% up to \$250 per script after phramedy deductible 20% 20% 20% \$20% \$350	Pharmacy deductible Pharmacy Pharmacy Pharmacy
Health care provider's Springs to treat Illness or condition Tie Coupenitation Urg. Need In the services Springs to treat Illness or condition Tie Emmediate Intention Urg. Need In the services In the serv	ther practitioner office visit ther practitioner office visit ther practitioner office visit pecialist visit reventive care/ screening/ im boratory Tests rays and Diagnostic Imaging aging (CT/PET scans, MRIs er 1 er 2 er 3 er 4 urgery facility fee (e.g., ASC) ryssician/surgeon fees utpatient visit mergency room facility fee (v mergency room physician fee mergency medical transports rgent care	inunization imunization inunization inunization	\$45 \$45 \$75 No charge \$40 \$70 20% \$15 \$55 \$85 \$85 20% up to \$250 per script after pharmacy deductible deductible 20% 20% 20% No charge	Pharmacy deductible Pharmacy deductible Pharmacy deductible	\$45 \$45 \$75 No charge \$40 \$70 \$300 \$15 \$55 \$85 20% up to \$250 per script after pharmacy deductible 20% 20% 20% \$350	Pharmacy deductible Pharmacy Pharmacy Pharmacy
Health care Provider's Spiffice or clinic risit Spiffice or clinic risit Spiffice or clinic Fests Free Orugs to treat Illness or Condition Tie Outpatient Free Em Em Em Em Em Em Em Em Em	ther practitioner office visit ther practitioner office visit ther practitioner office visit pecialist visit reventive care/ screening/ im boratory Tests rays and Diagnostic Imaging aging (CT/PET scans, MRIs er 1 er 2 er 3 er 4 urgery facility fee (e.g., ASC) ryssician/surgeon fees utpatient visit mergency room facility fee (v mergency room physician fee mergency medical transports rgent care	inunization imunization inunization inunization	\$45 No charge \$40 \$70 20% \$15 \$55 \$85 \$85 20% up to \$250 per script after pharmacy deduction of the charge deduction of t	deductible Pharmacy deductible Pharmacy deductible	\$45 \$75 No charge \$40 \$70 \$300 \$15 \$55 \$85 \$20% up to \$250 per script after pharmacy deductible 20% 20% \$20% \$350	Pharmacy deductible Pharmacy
orovider's Office or clinic sist Springer of the state of	pecialist visit reventive care/ screening/ imatoratory Tests rays and Diagnostic Imaging agging (CT/PET scans, MRIs er 1 er 2 er 3 er 4 urgery facility fee (e.g., ASC) nysician/surgeon fees utpatient visit mergency room facility fee (was mergency room physician fee mergency medical transportargent care	raived if admitted)	\$75 No charge \$40 \$70 20% \$15 \$55 \$85 \$85 20% up to \$250 per script after pharmacy deductible 20% 20% 20% No charge	deductible Pharmacy deductible Pharmacy deductible	\$75 No charge \$40 \$70 \$300 \$15 \$55 \$85 \$85 20% up to \$250 per script after pharmacy deductible 20% 20% \$20% \$350	Pharmacy deductible Pharmacy
Provided in the control of the contr	reventive care/ screening/ imboratory Tests rays and Diagnostic Imaging, aging (CT/PET scans, MRIs er 1 er 2 er 3 er 4 urgery facility fee (e.g., ASC) syscian/surgeon fees utpatient visit mergency room facility fee (v mergency room physician fer mergency medical transporta grent care	raived if admitted)	No charge	deductible Pharmacy deductible Pharmacy deductible	No charge \$40 \$70 \$300 \$15 \$55 \$85 \$85 20% up to \$250 per script after pharmacy deductible 20% 20% \$20% \$350	Pharmacy deductible Pharmacy
Tests X-rac Imm The Drugs to treat Illness or zondition Tie Tie Drugstotition Tie Emmanded Em	aboratory Tests rays and Diagnostic Imaging laging (CT/PET scans, MRIs er 1 er 2 er 3 er 4 urgery facility fee (e.g., ASC) nysician/surgeon fees utpatient visit mergency room facility fee (v mergency room physician fee mergency medical transporta rgent care	raived if admitted)	\$40 \$70 20% \$15 \$55 \$85 20% up to \$250 per script after pharmacy deductible 20% 20% 20% 20% No charge	deductible Pharmacy deductible Pharmacy deductible	\$40 \$70 \$300 \$15 \$55 \$85 20% up to \$250 per script after pharmacy deductible 20% 20% 20% \$350	Pharmacy deductible Pharmacy
Tests X-rac Imm The Drugs to treat Illness or zondition Tie Tie Drugstotition Tie Emmanded Em	aboratory Tests rays and Diagnostic Imaging laging (CT/PET scans, MRIs er 1 er 2 er 3 er 4 urgery facility fee (e.g., ASC) nysician/surgeon fees utpatient visit mergency room facility fee (v mergency room physician fee mergency medical transporta rgent care	raived if admitted)	\$40 \$70 20% \$15 \$55 \$85 20% up to \$250 per script after pharmacy deductible 20% 20% 20% 20% No charge	deductible Pharmacy deductible Pharmacy deductible	\$40 \$70 \$300 \$15 \$55 \$85 20% up to \$250 per script after pharmacy deductible 20% 20% 20% \$350	Pharmacy deductible Pharmacy
Outpatient Provided Head of the Internation Urg. International Internation Internation Urg. Internat	aging (CT/PET scans, MRIs er 1 er 2 er 3 er 4 urgery facility fee (e.g., ASC) nysician/surgeon fees utpatient visit mergency room facility fee (w mergency room physician fee mergency medical transporta rgent care	yaived if admitted) (a (waived if admitted)	20% \$15 \$55 \$85 20% up to \$250 per script after pharmacy deductible deductible 20% 20% 20% 20% No charge	deductible Pharmacy deductible Pharmacy deductible	\$300 \$15 \$55 \$85 20% up to \$250 per script after pharmacy deductible 20% 20% 20% \$350	Pharmacy deductible Pharmacy
Tie Treatment Physics of the Condition Treatment Physics Out Physi	er 1 er 2 er 3 er 4 urgery facility fee (e.g., ASC) nysician/surgeon fees utpatient visit mergency room facility fee (v mergency room physician fer mergency medical transporta rgent care	valved if admitted) b (walved if admitted)	\$15 \$55 \$85 20% up to \$250 per script after pharmacy deductible 20% 20% 20% \$350 No charge	deductible Pharmacy deductible Pharmacy deductible	\$15 \$55 \$85 20% up to \$250 per script after pharmacy deductible 20% 20% 20% \$350	Pharmacy deductible Pharmacy
Drugs to treat Inless or ondition Tie Dutpatient ervices Out Emmediate Emmediate Emtention Urg Iospital stay Physical Stay	er 2 er 3 er 4 urgery facility fee (e.g., ASC) nysician/surgeon fees utpatient visit mergency room facility fee (v mergency room physician fer mergency medical transporta rgent care	vaived if admitted)	\$55 \$85 20% up to \$250 per script after pharmacy deductible 20% 20% 20% \$350 No charge	deductible Pharmacy deductible Pharmacy deductible	\$55 \$85 20% up to \$250 per script after pharmacy deductible 20% 20% 20% \$350	Pharmacy deductible Pharmacy
Illness or condition Tie Tie Dutpatient pervices Em	er 3 er 4 urgery facility fee (e.g., ASC) nysician/surgeon fees utpatient visit mergency room facility fee (v mergency room physician fee mergency medical transporta rgent care	vaived if admitted)	\$85 20% up to \$250 per script after pharmacy deductible 20% 20% 20% \$350 No charge	deductible Pharmacy deductible Pharmacy deductible	\$85 20% up to \$250 per script after pharmacy deductible 20% 20% 20% \$350	Pharmacy deductible Pharmacy
Dutpatient Surphy Our Phy Our	er 4 urgery facility fee (e.g., ASC) nysician/surgeon fees utpatient visit mergency room facility fee (w mergency room physician fee mergency medical transporta rgent care	vaived if admitted)	20% up to \$250 per script after pharmacy deductible 20% 20% 20% \$350 No charge	Pharmacy deductible	20% up to \$250 per script after pharmacy deductible 20% 20% 20% \$350	deductible
Outpatient Physervices Physervices Em Em Em Em Em Em Urg	urgery facility fee (e.g., ASC) nysician/surgeon fees utpatient visit mergency room facility fee (v mergency room physician fee mergency medical transporta rgent care	vaived if admitted)	script after pharmacy deductible 20% 20% 20% 20% No charge	deductible	script after pharmacy deductible 20% 20% 20% \$350	
Need Em	nysician/surgeon fees utpatient visit mergency room facility fee (w mergency room physician fee mergency medical transporta rgent care	vaived if admitted)	20% 20% \$350 No charge	X	20% 20% \$350	
Need Emmediate attention Urs Hospital stay Physics Phy	utpatient visit mergency room facility fee (v mergency room physician fee mergency medical transporta rgent care	e (waived if admitted)	20% \$350 No charge	X	20% \$350	
Need Emmediate attention Urg	mergency room physician fer mergency medical transporta rgent care	e (waived if admitted)	No charge	X		
Weed mmediate attention Urg	mergency medical transporta		-	X	No charge	
Weed mmediate attention Urg	mergency medical transporta		-	X		
Hospital stay Physical Stay	rgent care				\$250	X
Hospital stay Phy					72.0	
Phy	acility fee (e.g. hospital room	Urgent care			\$45	
Phy	, (9)	20%	Х	20%	Х
Me	nysician/surgeon fee		20%	X	20%	Х
	Mental/Behavioral health outpatient office visits		\$45		\$45	
Me	Mental/Behavioral health other outpatient items and services		\$45		\$45	
Me	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	Х	20%	Х
Mental health,	· · · · · · · · · · · · · · · · · · ·					
nealth, or substance	ental/Behavioral health inpat		20%	Х	20%	X
abuse needs	<u> </u>		Ų.0		\$10	
Sul	ubstance Use disorder other	outpatient items and services	\$45		\$45	
Sul	ubstance Use inpatient facilit	y fee (e.g. hospital room)	20%	х	20%	Х
Sul	ubstance use disorder inpation	ent physician fee	20%	х	20%	х
Pre	renatal care and preconcepti	on visits	No charge		No charge	
	elivery and all inpatient	Hospital	20%	Х	20%	х
	ervices	Professional	20%	X	20%	Х
	ome health care		20%		\$45	
неір	utpatient Rehabilitation servi utpatient Habilitation service		\$45 \$45		\$45 \$45	
ecovering or	killed nursing care		20%	X	20%	Х
nealth needs			20%	^	20%	^
	urable medical equipment ospice service		No charge		No charge	
Eye	ye exam		No charge		No charge	
Child eye care 1 p	pair of glasses per year (or c	ontact lenses in lieu of glasses)	No charge		No charge	L
	ral Exam					
	reventive - Cleaning reventive - X-ray		Net Comment		Net Commit	
and Sea	ealants per Tooth		Not Covered		Not Covered	
	opical Fluoride Application oace Maintainers - Fixed					
Child Dental	estorative Procedures		Not Covered		Not Covered	
	eriodontal Maintenance Serv	ices				
Cro	rowns and Casts				Not Covered Not Covered	
Uniid Dentai		onannol	Not Coursed			
Sarvinas	eriodontics (other than maint rosthodontics	cnance)	Not Covered		Not Covered	
PIC			1		Not Covered Not Covered	
	ral Surgery					

	Paradia and Carren				
	Benefits and Coverage		CCSB Silver		
	hare amounts describe the Enr	ollee's out of pocket costs.	HDHP PI	an	
	e - AV Calculator		71.3%		
	cludes a deductible? dividual deductible		Yes, integr \$2,000 integr		
Integrated Fa	mily deductible		\$4,000 integ		
Family deduc	ductible, NOT integrated: Me ctible, NOT integrated: Medic	dical / Pharmacy / Dental al / Pharmacy / Dental	N/A N/A		
Individual Out-	-of-pocket maximum		\$6,550		
	pocket maximum -only coverage deductible		\$13,10 \$2,000		
	n: Individual deductible		\$2,600		
Common Medical Event	Sei	vice Type	Member Cost Share	Deductible Applies	
	Primary care visit to treat an ir	jury, illness, or condition	20%	Х	
Health care					
provider's office or clinic	Other practitioner office visit		20%	Х	
visit					
	Specialist visit		20%	Х	
	Preventive care/ screening/ im	munization	No charge		
Tests	Laboratory Tests		20% 20%	X	
16313	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs		20%	X	
	Tier 1		20% up to \$250 per	Х	
			script	^	
Druge to t	Tier 2		20% up to \$250 per	Х	
Drugs to treat illness or			script		
condition	Tier 3		20% up to \$250 per script	х	
	Tier 4		20% up to \$250 per script	Х	
	Surgery facility fee (e.g., ASC)		20%	X	
Outpatient services	Physician/surgeon fees		20%	X	
	Outpatient visit	1 1W 1 5 0	20%	X	
	Emergency room facility fee (v	valved if admitted)	20%	Х	
Need	Emergency room physician fee		0%	Х	
immediate attention	Emergency medical transporta	tion	20%	X	
attention	Urgent care		20%	×	
	9		2070	^	
	Facility fee (e.g. hospital room)		20%	X	
Hospital stay	Physician/surgeon fee		20%	X	
	Friysician/surgeon ree		2076	^	
	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 inpat	ient physician fee	20%	х	
health, or					
substance abuse needs	Substance Use disorder outpa	tient office visits	20%	х	
	Substance Use disorder other	outpatient items and services	20%	х	
			2070	^	
	Substance Use inpatient facilit	y fee (e.g. hospital room)	20%	Х	
	Substance use disorder inpatie		20%	Х	
	Prenatal care and preconcepti		No charge	^	
Pregnancy	Delivery and all inpatient	Hospital	20%	Х	
J,	services	Professional	20%	X	
	Home health care		20%	X	
Help	Outpatient Rehabilitation servi Outpatient Habilitation service		20% 20%	X	
recovering or other special	Skilled nursing care		20%	Х	
health needs	Durable medical equipment		20%	Х	
	Hospice service Eye exam		0% No charge	Х	
Child eye care	1 pair of glasses per year (or c	ontact lenses in lieu of glasses)	No charge		
	Oral Exam				
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray				
and	Sealants per Tooth		Not Covered		
Preventive	Topical Fluoride Application Space Maintainers - Fixed				
Child Dental	Restorative Procedures				
Basic Services	Periodontal Maintenance Serv	ires	Not Covered		
	Crowns and Casts				
Child Dental	Endodontics		Net Comment		
Major Services	Periodontics (other than maint Prosthodontics	enance)	Not Covered		
	Oral Surgery				
Child	Medically necessary orthodon	ics	Not Covered		
Orthodontics	, , , , , ,				

Summary of	Renefits	and Co	overage

Summary of Benefits and Coverage						
Member Cost S	hare amounts describe the Enr	ollee's out of pocket costs.	Silver Plan 100%-150% FPL		Silver Plan 150%-200% FPL	
Actuarial Value	e - AV Calculator		94.1%		87.5%	
	cludes a deductible?		Yes, Medical/Pharmacy		Yes, Medical/Pharmacy	
	dividual deductible		N/A N/A		N/A N/A	
Individual de	ductible, NOT integrated: Me	dical / Pharmacy / Dental	\$75 / \$0	/ \$0	\$650 / \$50 / \$	
	ctible, NOT integrated: Medica -of-pocket maximum	al / Pharmacy / Dental	\$150 / \$0 / \$0 \$2,350		\$1,300 / \$100 / \$2,350	\$0
Family Out-of-	pocket maximum		\$4,70		\$4,700	
HSA plan: Self	only coverage deductible in: Individual deductible		N/A N/A		N/A N/A	
TION failing pla	in. marviduai deddetibie		19/79		IVA	
Common Medical Event	Ser	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an in	jury, illness, or condition	\$5		\$10	
Health care provider's office or clinic visit	Other practitioner office visit		\$5		\$10	
Tion.	Specialist visit		\$8		\$25	
	Preventive care/ screening/ im Laboratory Tests	munization	No charge \$8		No charge \$15	
Tests	X-rays and Diagnostic Imaging		\$8		\$25	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
	Tier 1		\$3		\$5	
Drugs to treat	Tier 2		\$10		\$20	Pharmacy deductible
condition	Tier 3		\$15		\$35	Pharmacy deductible
	Tier 4	10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharmacy deductible	
Outpatient	Surgery facility fee (e.g., ASC)		10% 10%		15% 15%	
services	Physician/surgeon fees Outpatient visit		10%		15%	
	Emergency room facility fee (waived if admitted)		\$50		\$100	
	Emergency room physician fee (waived if admitted)		No oboses		No oboses	
Need	Emergency medical transportation		No charge \$30	X	No charge \$75	X
immediate attention			\$30	^	\$/5	^
	Urgent care	\$5		\$10		
	Facility fee (e.g. hospital room)		10%	×	15%	Х
Hospital stay			10%	X	15%	X
	Physician/surgeon fee		10%	^_	15%	
	Mental/Behavioral health outpatient office visits Mental/Behavioral health other outpatient items and services		\$5		\$10	
			\$5		\$10	
	Mental/Behavioral health inpat	ient facility fee (e.g.hospital room)	10%	Х	15%	Х
Mental health,	Mental/Behavioral health inpat	iont physician foo	10%	х	15%	Х
behavioral health, or	wentarbenavioral nealth inpat	ient physician ree	1078	^	1376	
substance abuse needs	Substance Use disorder outpa	tient office visits	\$5		\$10	
	Substance Use disorder other	outpatient items and services	\$5		\$10	
	Substance Use inpatient facilit	y fee (e.g. hospital room)	10%	Х	15%	х
	Substance use disorder inpatie	ent physician fee	10%	х	15%	Х
	Prenatal care and preconception	on visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	10%	х	15%	х
	services	Professional	10%	X	15%	X
	Home health care Outpatient Rehabilitation servi	ces	\$3 \$5		\$15 \$10	
Help recovering or	Outpatient Habilitation services		\$5		\$10	
other special	Skilled nursing care		10%	х	15%	х
health needs	Durable medical equipment		10%		15%	
	Hospice service Eye exam		No charge No charge		No charge No charge	
Child eye care	1 pair of glasses per year (or or	ontact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam					
Child Dental Diagnostic	Preventive - Cleaning					
and	Preventive - X-ray Sealants per Tooth		Not Covered		Not Covered	
Preventive	Topical Fluoride Application Space Maintainers - Fixed					
Child Dental						
Basic	Restorative Procedures		Not Covered		Not Covered	
Services	Periodontal Maintenance Serv Crowns and Casts	ices				
Child Dental	Endodontics					
Major	Periodontics (other than mainte	enance)	Not Covered		Not Covered	
Services	Prosthodontics Oral Surgery		1			
Child Orthodontics	Medically necessary orthodont	ics	Not Covered		Not Covered	
J Juonitius						

Restorative Procedures

Prosthodontics Oral Surgery Medically necessary orthodontics

Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance)

	Benefits and Coverage			
Member Cost S	hare amounts describe the Enr	ollee's out of pocket costs.	Silver Plan 200%-250% FP	'L
Actuarial Value	e - AV Calculator		73.7%	
	cludes a deductible?		Yes, Medical/Pharr	nacy
Integrated Fa	dividual deductible mily deductible		N/A N/A	
Individual de	ductible, NOT integrated: Me		\$2,200 / \$250 / \$	
	ctible, NOT integrated: Medic -of-pocket maximum	ai / Pharmacy / Dentai	\$4,400 / \$500 / \$ \$5,700	ÞU
Family Out-of-	pocket maximum		\$11,400 N/A	
HSA family pla	only coverage deductible n: Individual deductible		N/A	
Common Medical Event	Ser	vice Type	Member Cost Share	Deductib Applies
	Primary care visit to treat an in	jury, illness, or condition	\$30	
Health care provider's office or clinic visit	Other practitioner office visit		\$30	
visit	Specialist visit	\$55		
	Preventive care/ screening/ immunization		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging		\$35 \$65	
	Imaging (CT/PET scans, MRIs)	\$300	
	Tier 1		\$15	
Drugs to treat illness or condition	Tier 2		\$50	Pharmac deductib
	Tier 3	\$75	Pharmad deductib	
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmad deductib
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees		20%	
services	Outpatient visit		20%	
	Emergency room facility fee (v	vaived if admitted)	\$350	
	Emergency room physician fee	(waived if admitted)	No charge	
Need immediate	Emergency medical transportation		\$250	Х
attention	Urgent care		\$30	
Hospital stay	Facility fee (e.g. hospital room)	20%	Х
	Physician/surgeon fee		20%	Х
	Mental/Behavioral health outpatient office visits		\$30	
	Mental/Behavioral health other outpatient items and services		\$30	
Montal back	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		20%	Х
Mental health, behavioral	Mental/Behavioral health inpat	ient physician fee	20%	Х
health, or substance abuse needs	Substance Use disorder outpa	tient office visits	\$30	
	Substance Use disorder other	outpatient items and services	\$30	
	Substance Use inpatient facilit		20%	Х
	Substance use disorder inpatie	* *	20%	Х
	Prenatal care and preconcepti		No charge	
Pregnancy	Delivery and all inpatient services	Hospital	20%	X
	Home health care	Professional	20% \$40	X
Help	Outpatient Rehabilitation servi Outpatient Habilitation service		\$30 \$30	
recovering or other special	Skilled nursing care	3	20%	Х
health needs	Durable medical equipment		20%	^
	Hospice service		No charge	
Child eye care	Eye exam		No charge	
omiu eye care	1 pair of glasses per year (or c	ontact lenses in lieu of glasses)	No charge	
	Oral Exam			
Child Dental	Preventive - Cleaning			
Diagnostic	Preventive - X-ray	Preventive - X-ray		
Child Dental Diagnostic and Preventive			Not Covered	

Not Covered

Not Covered

Not Covered

-	lember Cost Share amounts describe the Enrollee's out of pocket costs.		Bronze Pla	Bronze HDHP Plan		
	e - AV Calculator	·	61.9%		62.0%	
Plan design in	cludes a deductible?		Yes, Medical/Pha	ırmacy	Yes, integrated	
	dividual deductible amily deductible		N/A N/A		\$4,800 inte \$9,600 inte	
Individual de	ductible, NOT integrated: Me	dical / Pharmacy / Dental	\$6,300 / \$500		N/A	
	ctible, NOT integrated: Medic	al / Pharmacy / Dental	\$12,600 / \$1,000 \$6,800	0/\$0	N/A \$6,550	
Family Out-of-	pocket maximum		\$13,600		\$13,10	0
HSA plan: Self-	only coverage deductible in: Individual deductible		N/A N/A		\$4,800 \$4,800	
	1					
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an in	njury, illness, or condition	\$75	After 1st three non-preventive visits	40%	х
Health care provider's office or clinic	Other practitioner office visit		\$75	After 1st three non-preventive visits	40%	Х
visit	Specialist visit		\$105	After 1st three non-preventive visits	40%	Х
	Preventive care/ screening/ in	nmunization	No charge		No charge	X
Tests	Laboratory Tests X-rays and Diagnostic Imaging	9	\$40 100%	Х	40% 40%	X
	Imaging (CT/PET scans, MRIs	3)	100%	X	40%	Х
	Tier 1		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	х
Drugs to treat illness or	Tier 2		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х
condition	Tier 3		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х
	Tier 4		100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	Х
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees)	100% 100%	X	40% 40%	X
services	Outpatient visit		100%	X	40%	Х
	Emergency room facility fee (v	vaived if admitted)	100%	Х	40%	Х
	Emergency room physician fee (waived if admitted)		No charge		0%	Х
Need immediate	Emergency medical transporta		100%	X	40%	X
attention	Urgent care		\$75	After 1st three non-preventive visits	40%	x
Hospital stay			100%	X	40%	Х
	Physician/surgeon fee		100%	X After 1et three	40%	X
	Menta/Behavioral health outpatient office visits Menta/Behavioral health other outpatient items and services		\$75	After 1st three non-preventive visits	40%	Х
			\$75	After 1st three non-preventive visits	40%	х
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	100%	X	40%	Х
Mental health, behavioral	Mental/Behavioral health inpa	tient physician fee	100%	Х	40%	Х
health, or substance abuse needs	Substance Use disorder outpa		\$75	After 1st three non-preventive visits	40%	х
	Substance Use disorder other	outpatient items and services	\$75	After 1st three non-preventive visits	40%	х
	Substance Use inpatient facili	ty fee (e.g. hospital room)	100%	X	40%	Х
	Substance use disorder inpati	ent physician fee	100%	Х	40%	Х
	Prenatal care and preconcept	ion visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	100%	Х	40%	х
	services	Professional	100%	X	40%	X
H-I-	Home health care Outpatient Rehabilitation serv	ices	100% \$75	X	40% 40%	X
Help recovering or	Outpatient Habilitation service		\$75		40%	X
other special	Skilled nursing care		100%	Х	40%	Х
health needs	Durable medical equipment		100%	Х	40%	X
	Hospice service Eye exam		No charge No charge		0% No charge	X
Child eye care	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge		No charge	
Child Dental	Oral Exam Preventive - Cleaning					
Diagnostic			Net Covered		Net Covered	
and Preventive	Preventive - X-ray Sealants per Tooth Topical Fluoride Application		Not Covered		Not Covered	
	Space Maintainers - Fixed					
Child Dental Basic	Restorative Procedures		Not Covered		Not Covered	
Services	Periodontal Maintenance Sen	rices			. tot Govereu	
	Crowns and Casts					
Child Dental	Endodontics Periodontics (other than main)	enance)	Not Covered		Not Covered	
Major Services	Periodontics (other than main Prosthodontics Oral Surgery	enance)	INOT Covered		NUL Covered	
Child Orthodontics	Medically necessary orthodon	tics	Not Covered		Not Covered	
	Medically necessary orthodon	tics	Not Covered		Not Covered	

	there amounts describe the Enrollee's out of pocket costs.	Catastrophic Plan		
	e - AV Calculator			
Plan design in	cludes a deductible?	Yes, int	egrated	
Integrated In	dividual deductible	\$7,150 ir	ntegrated	
Integrated Fa	amily deductible ductible, NOT integrated: Medical / Pharmacy / Dental	\$14,300 i		
Family deduc	ctible, NOT integrated: Medical / Pharmacy / Dental	N.	/A	
Individual Out- Family Out-of-	-of-pocket maximum pocket maximum	\$7,° \$14		
HSA plan: Self	-only coverage deductible	N.		
HSA family pla	n: Individual deductible	N,	/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non-preventive visits	
Health care provider's office or clinic	Other practitioner office visit	0%	After 1st three non-preventive visits	
visit	Specialist visit	0%	х	
	Preventive care/ screening/ immunization	No charge		
Tanta	Laboratory Tests	0%	X	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	0%	X	
	Tier 1	0%	×	
Drugs to treat	Tier 2	0%	Х	
illness or condition	Tier 3	0%	х	
	Tier 4	0%	х	
	Surgery facility fee (e.g., ASC)	0%	X	
Outpatient	Surgery facility fee (e.g., ASC) Physician/surgeon fees	0%	X	
services	Outpatient visit	0%	X	
	Emergency room facility fee (waived if admitted)	0%	Х	
Need	Emergency room physician fee (waived if admitted)	No charge		
immediate	Emergency medical transportation	0%	Х	
attention	Urgent care	0%	After 1st three non-preventive visits	
	Facility fee (e.g. hospital room)	0%	Х	
Hospital stay			X	
	Physician/surgeon fee	0%		
	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%	Х	
Mental health, behavioral	Mental/Behavioral health inpatient physician fee	0%	х	
health, or substance abuse needs	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	
	Substance Use inpatient facility fee (e.g. hospital room)	0%	visits	
			^	
	Substance use disorder inpatient physician fee	0%	Х	
	Prenatal care and preconception visits	No charge		
Pregnancy	Delivery and all inpatient Hospital services	0%	Х	
	Professional Home health care	0%	X	
Unio	Outpatient Rehabilitation services	0%	X	
Help recovering or	Outpatient Habilitation services	0%	X	
other special	Skilled nursing care	0%	Х	
health needs	Durable medical equipment	0%	Х	
	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%	Х	
	Oral Exam Preventive - Cleaning			
Child Dental		Not Covered		
Diagnostic	Preventive - X-ray			
Diagnostic and	Sealants per Tooth			
Diagnostic and	Sealants per Tooth Topical Fluoride Application			
Diagnostic and Preventive Child Dental	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed			
Diagnostic and Preventive Child Dental Basic	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures	Not Covered		
Diagnostic and Preventive Child Dental Basic Services	Sealants per Totoh Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts			
Diagnostic and Preventive Child Dental Basic Services Child Dental	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics	Not Covered		
Diagnostic and Preventive Child Dental Basic Services Child Dental Major	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance)			
Child Dental Diagnostic and Preventive Child Dental Basic Services Child Dental Major Services	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance) Prosthodontics	Not Covered		
Diagnostic and Preventive Child Dental Basic Services Child Dental Major	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Restorative Procedures Periodontal Maintenance Services Crowns and Casts Endodontics Periodontics (other than maintenance)	Not Covered		

Endnotes to 2017 Standard Benefit Plan Designs

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

Notes:

- Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. Innetwork services include services provided by an out-of-network provider but are approved as in-network by the issuer.
- 2) For covered out of network services in a PPO plan, these Standard Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-ofpocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
- 3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
- 4) For plans except HDHPs, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the issuer pays all costs for covered services for all family members.
- 5) For HDHPs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of the specified deductible amount for individual coverage or \$2,600 for Plan Year 2017. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
- 6) Co-payments may never exceed the plan's actual cost of the service. For example, if laboratory tests cost less than the \$45 copayment, the lesser amount is the applicable cost-sharing amount.
- 7) For the Bronze and Catastrophic plans, the deductible is waived for the first three non-preventive visits, which may include urgent care visits or outpatient Mental Health/Substance Use Disorder visits.
- 8) Member cost-share for oral anti-cancer drugs shall not exceed \$200 per month per state law.
- 9) In the Platinum and Gold Copay Plans, inpatient and skilled nursing facility stays have no additional cost share after the first 5 days of a continuous stay.
- 10) For drugs to treat an illness or condition, the copay or co-insurance applies to an up to 30-day prescription supply. Nothing in this note precludes an issuer from offering mail order prescriptions at a reduced cost-share.
- 11) As applicable, for the child dental portion of the benefit design, an issuer may choose the child dental standard benefit copay or coinsurance design, regardless of whether the issuer selects the copay or the coinsurance design

- for the non-dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.
- 12) A health plan benefit design that utilizes the child dental standard benefit copay design must adhere to the Covered California 2017 Dental Copay Schedule.
- 13) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.
- 14) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Standard Benefit Plan Designs.
- 15) Mental Health/Substance Use Disorder Other Outpatient Items and Services include, but are not limited to, partial hospitalization, multidisciplinary intensive outpatient psychiatric treatment, day treatment programs, intensive outpatient programs, behavioral health treatment for PDD/autism delivered at home, and other outpatient intermediate services that fall between inpatient care and regular outpatient office visits.
- 16) Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
- 17) Specialists are physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate.
- 18) The Other Practitioner category may include Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Clinical Psychologists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors. Nothing in this note precludes a plan from using another comparable benefit category other than specialist for a service provided by one of these practitioners.
- 19) The Outpatient Visit line item within the Outpatient Services category includes but is not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.
- 20) The inpatient physician cost share may apply for any physician who bills separately from the facility (e.g. surgeon). A member's primary care physician or specialist may apply the office visit cost share when conducting a visit to the member in a hospital or skilled nursing facility.

- 21) Cost-sharing for services subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) may be different but not more than those listed in these standard benefit plan designs if necessary for compliance with MHPAEA.
- 22) Behavioral health treatment for autism and pervasive developmental disorder is covered under Mental/Behavioral health outpatient services.
- 23) Drug tiers are defined as follows:

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

- 24) Issuers must comply with 45 CFR Section 156.122(d) dated February 27, 2015 which requires the health plan to publish an up-to-date, accurate and complete list of all covered drugs on its formulary list including any tiering structure that is adopted.
- 25) A plan's formulary must include a clear written description of the exception process that an enrollee could use to obtain coverage of a drug that is not included on the plan's formulary.
- 26) The health issuer may not impose a member cost share for Diabetes Self-Management which is defined as services that are provided for diabetic outpatient self-management training, education and medical nutrition therapy to enable a member to properly use the devices, equipment, medication, and supplies, and any additional outpatient self-management training, education and medical nutrition therapy when directed or prescribed by the member's physician. This includes but is not limited to instruction that will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy, in order to avoid frequent hospitalizations and complications.