



# 2016 Standard Benefit Designs and Medical Cost Shares

Benefits in blue are NOT subject to a deductible

Coverage Category	Minimum Coverage	Bronze	Silver	Enhanced Silver 73	Enhanced Silver 87	Enhanced Silver 94	Gold	Platinum
Percent of cost coverage	Covers <b>0%</b> until out-of-pocket maximum is met	Covers <b>60%</b> average annual cost	Covers <b>70%</b> average annual cost	Covers <b>73%</b> average annual cost	Covers <b>87%</b> average annual cost	Covers <b>94%</b> average annual cost	Covers <b>80%</b> average annual cost	Covers <b>90%</b> average annual cost
Cost-sharing Reduction Single Income Range	N/A	N/A	N/A	<b>\$23,451 to \$29,425</b> (>200% to ≤250% FPL)	<b>\$17,656 to \$23,450</b> (>150% to ≤200% FPL)	<b>up to \$17,655</b> (100% to ≤150% FPL)	N/A	N/A
Annual Wellness Exam	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Primary Care Vist	after first 3 non-preventive visits, pay negotiated carrier rate per instance until out-of-pocket maximum is met	\$70*	\$45	\$40	\$15	\$5	\$35	\$20
Specialist Visit	pay negotiated carrier rate per service until out-of-pocket maximum is met	\$90*	\$70	\$55	\$25	\$8	\$55	\$40
Urgent Care		\$120*	\$90	\$80	\$30	\$6	\$60	\$40
Emergency Room		Full cost until deductible is met	\$250	\$250	\$75	\$30	\$250	\$150
Laboratory Tests		\$40	\$35	\$35	\$15	\$8	\$35	\$20
X-Rays and Diagnostics		Full cost until deductible is met	\$65	\$50	\$25	\$8	\$50	\$40
Imaging		\$250	\$250	\$100	\$50	\$250 copay 20% coinsurance***	\$150 copay 10% coinsurance***	
Tier 1 (Generic Drugs)		\$15	\$15	\$5	\$3	\$15	\$5	
Tier 2 (Preferred Drugs)	pay negotiated carrier rate per script until out-of-pocket maximum is met	Full cost up to \$500 after drug deductible is met	\$50**	\$45**	\$20**	\$10	\$50 or less	\$15 or less
Tier 3 (Non-preferred Drugs)			\$70**	\$70**	\$35**	\$15	\$70 or less	\$25 or less
Tier 4 (Specialty Drugs)			20% up to \$250** per script	20% up to \$250** per script	15% up to \$150** per script	10% up to \$150 per script	20% up to \$250 per script	10% up to \$250 per script
Medical Deductible	N/A	Individual: \$6,000 Family: \$12,000	Individual: \$2,250 Family: \$4,500	Individual: \$1,900 Family: \$3,800	Individual: \$550 Family: \$1,100	Individual: \$75 Family: \$150	N/A	N/A
Pharmacy Deductible	N/A	Individual: \$500 Family: \$1,000	Individual: \$250 Family: \$500	Individual: \$250 Family: \$500	Individual: \$50 Family: \$100	N/A	N/A	N/A
Annual Out-of-Pocket Maximum	\$6,850 individual only	\$6500 individual \$13,000 family	\$6,250 individual \$12,500 family	\$5,450 individual \$10,900 family	\$2,250 individual \$4,500 family	\$2,250 individual \$4,500 family	\$6,200 individual \$12,400 family	\$4,000 individual \$8,000 family

Drug prices are for a 30 day supply.

\* Copay is for any combination of the first three visits. After three visits, future visits will be at full cost until the out-of-pocket maximum is met.

\*\* Price is after pharmacy deductible amount is met. \*\*\* See plan Evidence of Coverage for imaging cost share.