State of California Office of Administrative Law

In re:

California Health Benefit Exchange

Regulatory Action:

Title 10, California Code of Regulations

Adopt sections:

6432

Amend sections:

Repeal sections:

NOTICE OF APPROVAL OF EMERGENCY REGULATORY ACTION

Government Code Sections 11346.1 and 11349.6

OAL Matter Number: 2015-0603-02

OAL Matter Type: Emergency Readopt (EE)

This action re-adopts and amends the 2016 Standard Benefit Design, which standardizes the way health insurers design their health plans.

OAL approves this emergency regulatory action pursuant to sections 11346.1 and 11349.6 of the Government Code.

This emergency regulatory action is effective on 6/15/2015 and will expire on 2/22/2017. The Certificate of Compliance for this action is due no later than 2/21/2017.

Date:

June 15, 2015

Mark Storm

Senior Attorney

For:

DEBRA M. CORNEZ

Director

Original

Original: Peter Lee

Copy:

Andrea Rosen

AGENCY WITH RIALDANDING ACTIONS TO FILED ADMINISTRATIVE LAW NOTICE REGULATIONS COORDINATE FROM STREET RIALDANDING ACTION NAMES AND SCRIPTION OF NOTICE (Complete for publication in Notice Register) APPRILICATION OF NOTICE (Complete for publication in Notice Register) APPRILICATION OF NOTICE (Complete for publication in Notice Register) APPRILICATION OF NOTICE (Complete for publication in Notice Register) APPRILICATION OF NOTICE (Complete for publication in Notice Register) APPRILICATION OF NOTICE (Complete for publication in Notice Register) APPRILICATION OF NOTICE (Complete for publication in Notice Register) APPRILICATION OF NOTICE (Complete for publication in Notice Register) APPRILICATION OF NOTICE (Complete for publication in Notice Register) APPRILICATION OF NOTICE (Complete when submitting regulations)		NIAOFFICE OF ADM		HONS U	MISSION	ATTY CARD BANKS	structions on	For use by Secretary of State only
For use by Office of Administrative Law (OAL) only In the date of the Secretary of State of the State of Confidence Notice REGULATIONS ADMINISTRATIVE LAW NOTICE REGULATIONS ADMINISTRATIVE LAW NOTICE REGULATION OF NOTICE (Complete for publication in Notice Register) TOTAL USE ACTIONAL PRINCIPLE (Complete for publication in Notice Register) ADMINISTRATIVE LAW NOTICE (Complete for publication in Notice Register) TOTAL USE ACTIONAL PRINCIPLE (Complete When submitting regulations) ADMINISTRATIVE LAW NOTICE PRINCIPLE (Complete When submitting regulations) ADMINISTRATIVE LAW NOTICE REGISTER NUMBER TOTAL USE ACTIONAL PRINCIPLE (Complete When submitting regulations) ALL PERMONE PROPOSED UTICE ONLY Application of REGULATIONS (Complete When submitting regulations) B. BIRLECTION OF REGULATION OF REGULATION (Complete When submitting regulations) B. BIRLECTION OF REGULATION (Complete When submitted (Co	OAL FILE	NOTICE FILE NUMBER		REGULATORY ACTIO	N NUMBER	EMERGENCY N	UMBER	
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NOTICE PUBLICATION/REGULATIONS SUBMISSION

STD, 400 (REV. 01-2013) (REVERSE)

INSTRUCTIONS FOR PUBLICATION OF NOTICE AND SUBMISSION OF REGULATIONS

Use the form STD. 400 for submitting notices for publication and regulations for Office of Administrative Law (OAL) review.

ALL FILINGS

Enter the name of the agency with the rulemaking authority and agency's file number, if any.

NOTICES

Complete Part A when submitting a notice to OAL for publication in the California Regulatory Notice Register. Submit two (2) copies of the STD. 400 with four (4) copies of the notice and, if a notice of proposed regulatory action, one copy each of the complete text of the regulations and the statement of reasons. Upon receipt of the notice, OAL will place a number in the box marked "Notice File Number." If the notice is approved, OAL will return the STD. 400 with a copy of the notice and will check "Approved as Submitted" or "Approved as Modified." If the notice is disapproved or withdrawn, that will also be indicated in the space marked "Action on Proposed Notice." Please submit a new form STD. 400 when resubmitting the notice.

REGULATIONS

When submitting regulations to OAL for review, fill out STD. 400, Part B. Use the form that was previously submitted with the notice of proposed regulatory action which contains the "Notice File Number" assigned, or, if a new STD. 400 is used, please include the previously assigned number in the box marked "Notice File Number." In filling out Part B, be sure to complete the certification including the date signed, the title and typed name of the signatory. The following must be submitted when filing regulations: seven (7) copies of the regulations with a copy of the STD. 400 attached to the front of each (one copy must bear an original signature on the certification) and the complete rulemaking file with index and sworn statement. (See Gov. Code § 11347.3 for rulemaking file contents.)

RESUBMITTAL OF DISAPPROVED OR WITHDRAWN REGULATIONS

When resubmitting previously disapproved or withdrawn regulations to OAL for review, use a new STD. 400 and fill out Part B, including the signed certification. Enter the OAL file number(s) of all previously disapproved or withdrawn filings in the box marked "All Previous Related OAL Regulatory Action Number(s)" (box lb. of Part B). Submit seven (7) copies of the regulation to OAL with a copy of the STD. 400 attached to the front of each (one copy must bear an original signature on the certification). Be sure to include an index, sworn statement, and (if returned to the agency) the complete rulemaking file. (See Gov. Code §§ 11349.4 and 11347.3 for more specific requirements.)

EMERGENCY REGULATIONS

Fill out only Part B, including the signed certification, and submit seven (7) copies of the regulations with a copy of the STD. 400 attached to the front of each (one copy must bear an original signature on the certification). (See Gov. Code §11346.1 for other requirements.)

NOTICE FOLLOWING EMERGENCY ACTION

When submitting a notice of proposed regulatory action after an emergency filing, use a new STD. 400 and complete Part A and insert the OAL file number(s) for the original emergency filing(s) in the box marked "All Previous Related OAL Regulatory Action Number(s)" (box 1b. of Part B). OAL will return the STD. 400 with the notice upon approval or disapproval. If the notice is disapproved, please fill out a new form when resubmitting for publication.

CERTIFICATE OF COMPLIANCE

When filing the certificate of compliance for emergency regulations, fill out Part B, including the signed certification, on the form that was previously submitted with the notice. If a new STD. 400 is used, fill in Part B including the signed certification, and enter the previously assigned notice file number in the box marked "Notice File Number" at the top of the form. The materials indicated in these instructions for "REGULATIONS" must also be submitted.

EMERGENCY REGULATIONS - READOPTION

When submitting previously approved emergency regulations for readoption, use a new STD. 400 and fill out Part B, including the signed certification, and insert the OAL file number(s) related to the original emergency filing in the box marked "All Previous Related OAL Regulatory Action Number (s)" (box 1b. of Part B).

CHANGES WITHOUT REGULATORY EFFECT

When submitting changes without regulatory effect pursuant to California Code of Regulations, Title 1, section 100, complete Part B, including marking the appropriate box in both B.3. and B.5.

ABBREVIATIONS

Cal. Code Regs. - California Code of Regulations Gov. Code - Government Code SAM - State Administrative Manual

For questions regarding this form or the procedure for filing notices or submitting regulations to OAL for review, please contact the Office of Administrative Law Reference Attorney at (916) 323-6815.

Title 10, California Code of Regulations

Re-adopt Section 6432:

SECTION 6432: 2016 STANDARD BENEFIT PLAN DESIGNS

(a) For plan year and calendar year 2016, The California Health Benefit Exchange adopts the Standard Benefit Plan Designs identified as the 2016 Standard Benefit Plan Designs dated January 29, 2015 May 21, 2015 which are incorporated by reference.

Authority: Government Code Section 100504

Reference: Government Code Sections 100503 and 100504(c); Health and Safety Code Section 1366.6(e) and Insurance Code Section 10112.3(e)

2016 Standard Benefit Plan Designs

January 29, 2015 <u>May 21, 2015</u>

2016 Standard Benefit Plan Designs 10.0 EHB Date: April 16<u>May 21</u>, 2015



	st Share amounts describe the Enrollee's out of pocket costs.	Platinum Coinsurance F 88.5%	Platinum tan Copay Pla 89.5%
		No	89.5% No
	Electrical and the second	\$0 \$0	\$0 \$0
		\$0/\$0/\$0 \$0/\$0/\$0	\$0 / \$0 / \$i \$0 / \$0 / \$i
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ommon Nedical			NA.
Ekratut	Service Type		ductible Member Cost of ppiles Share
	Primary care visit to treat an injury, illness, or condition	\$20	\$20
	Other practitioner office visit	\$20	\$20
	Specialist visit	\$40	\$40
	Preventive care/ screening/ immunization	No charge	5.0
	Laboratory Tests X-rays and Diagnostic Imaging	No charge \$20	No charge \$20
He !	maging (CT/PET scans, MRIs)	\$40	\$40 \$150
	Tier 1	\$5	\$5
9 NJ 1104	Ter2	\$16	\$16
	Tiera	SERVICE -	
	AND DESCRIPTION OF STREET	\$25	\$25
		10% 10 to 5250 per acres	10% up to \$250 per accer
Gent F	Surgery facility fee (e.g., ASC)	10%	\$250
79	Physician frame Outpetters visit	10%	\$40
S-11-47	Emergency room facility fee (warved if admitted)	10%	10%
		\$150	\$150
100	Emergency room physician fee (waived if admitted) Emergency medical transportation	10% \$150	No charge \$150
and a	Urgant care	\$40	\$150
Total Control	English day (see		
atay	Facility fee (e.g. hospital room) Physician/surgeon fee	10%	\$250 per day up to 5 days
	Mental/Behavioral health outpatient office viets	10%	\$40
	mentanoa iavorai reauri outpatent once veits	\$20	\$20
	Mental/Behavioral health other outpatient items and services	\$20	\$20
	Mental/Behavioral health inpatient facility fee (e.g hospital room)	10%	\$250 per day up
-	Mental/Behavioral health inpatient physician/surgeon fee	10%	to 5 days \$40
60 W	Substance Use disorder outpatient office visits	\$20	\$20
	Substance Lieu discuries at her substance in the substanc		
1000	Substance Use disorder other outpatient items and services	\$20	\$20
	Substance Use inpatient facility fee (e.g. hospital room)	10%	\$250 per day up to 5 days
	Substance use disorder inpatient physician/surgeon fee	10%	\$40
CHARGE.	Prenatel care and preconception visits	No charge	No charge
	Defivery and all inpatient Hospital	10%	\$250 per day up to 5 days
	Home health care	10%	\$40
	Outpatient Rehabilitation services Outpatient Habilitation services	\$20	\$20 \$20
NIM HOLE	Skilled nursing care	\$20	\$20 \$150 per devue
	Durable medical equipment	10%	\$150 per day up to 5 days
	Hospice service	10% No charge	10%
	Eye exam	No charge	No charge No charge
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	No charge
ettal. F	Preventive - Cleaning	100	24
F	reventive - X-ray	No charge	56 Inc
WEIT	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	NO CHAIGE	No charge
A	Vmalgem Fill - 1 Surface	20%	\$25
Ā	loot Canal- Molar		
G	ingivectomy per Guid	best	\$300 \$150
- F	otraction-Single Toom Exposed Rest or English Straction-Compage Bury	50%	\$65
	orcelain with Metal Crown		\$160 \$300

2016 Standard Benefit Plan Designs 10.0 EHB Date: April 16May 21, 2015

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	10 M	80,2%		81 0%	-
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conwon Medical		Member Cost	Deductible	Member Cost	Deductible Applies
Event	Service Type	Shore	Applies	\$35	
	Primary care visit to treat an injury, läness, or condition	\$35		\$55	
-	Other practitioner office visit	\$35		\$35	
N S	Specialist was	\$55		\$55	
	Preventive care/ screening/ immunization	No charge		No charge \$35	
	Laboratory Tests	\$35 \$50		\$50	
0.6	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	20%		\$250	_
	Tier 1	\$15	0.5	\$15	
	Tier 2	\$50		\$50	
MARKET THE PARKET THE	Tier 3	\$70		\$70	
		20% up to \$250		20% uo to \$250	
	Tier 4	ner script	-	\$600	-
-14-1	Surgery facility fee (e.g., ASC)	20%		\$55	
-	Physician/surgeon fees Outpatient visit	20%		20%	
	Emergency room lackity-fee (warved if admitted)	\$260		\$250	LII.S
		20%		No charge	
-	Emergency room physician fee (waived if admitted) Emergency medical transportation	\$250	1	\$250	-
	Urgent care	\$60		\$60	
	Facility fee (e.g. hospital room)	20%	1	\$600 per day up to 5 days	
DALETIC STR	Physician/surgeon fee	20%		\$55	
	Mental/Behavioral health cutpatient office visits	\$35		\$35	
		\$35		\$35	
	Mental/Behavioral health other outpatient items and services			\$600 per day u	
	Mental/Behavioral health inpatient facility fee (e.g hospital room)	20%		to 5 days	100
	Mental/Behavioral health inpatient physician/surgeon fee	20%	-	\$55	-
	Substance Use disorder outpatient office visits	\$35	10	\$35	
	Substance Use disorder other outpatient items and services	\$35		\$35	
	Substance Use inpatient facility fee (e.g. hospital room)	20%	4	\$600 per day u to 5 days	p
	Substance use disorder inpatient physician/surgeon fee	20%		\$55	1
	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all impatient Hospital	20%		\$600 per day up to 5 days	1
	services Professional	20%		\$55	
	Home health care	20% \$35		\$30 \$35	
140	Outpatient Rehabilitation services Outpatient Habilitation services	\$35	11.	\$35	4 -
THE PARTY NAMED IN	Skilled nursing care	20%		\$300 per day to 5 days	1b
Apr. Cale	Durable medical equipment	20%		20%	7.5
	Hospice service	No charge No charge		No charge No charge	18011
-	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
THE REAL PROPERTY.	1 pair of glasses per year to contact lenses in the or guarantee.				1215
CAMP De	Preventive - Cleaning			=1	100
-0111	Preventive - X-ray Sealants per Tooth	No charge		No charge	170
	Topical Fluoride Application Space Maintainers - Fixed		-	-	100
THE EX	Amalgam Fili - 1 Surface	30%		\$25	13
PER IT	Root Canal-Molar			\$300	-
	Ginnivaciomy per Quad	50%	1	\$150 \$65	
STREET, SQUARE, SQUARE	Extraction-Single Tooth Exposed Root or Erupted Extraction-Complete Bony		12-	\$160 \$300	14.74
Service.	Porcelain with Metal Crown				

ember Cost	of Benefits and Coverage	Individua	ıl .	
A	t Share amounts describe the Enrollee's out of pocket costs.	Silver Pla	Plan	
OR SHALL SHA	No. AVENUE	70.4%		
on dealers	Profusion a Madual Data S	Yes, Medical/Ph	armacy	
Integrals Integrals	d halfetenn derfamilie d Carrier finderstald	N/A N/A		
Individua	of deductible, NOT integrated, Medical / Pharmacy / Dental	\$2,250 / \$250		
Family de	eductible, NCT integrated: Medical / Phermacy / Dental ut-of-pocket maximum	\$4,500 / \$500 \$8,250	/\$0	
	of-pocket maximum	\$12,500		
	PARTY CONTROL TO MANUFACTURE	N/A N/A		
Common		Mis		
			Deductif	
	Service Type	Member Cost Share	Applies	
	Primary care visit to treat an injury, illness, or condition	\$45		
	Other practitioner office visit	\$45		
er water	Specialist visit	\$70	THE S	
			23	
	Preventive care/ screening/ immunization Laboratory Tests	No charge \$35	_	
	Laboratory Tests X-rays and Diagnostic Imaging	\$65		
	Imaging (CT/PET scans, MRIs)	\$250		
	Tier 1	\$15		
	Tler 2	850	Pharma: deductib	
-	Tier 3	\$70	Pharmad	
	Tier 4	20% up to \$250 per	Phermac	
		script after pharmacy deductible	deductibl	
Designant -	Surgery facility fee (e.g., ASC) Physician/surgeon fees	20% 20%	-	
	Outpatient visit	20%		
	Emergency room facility fee (waived if admitted)	\$250	×	
	Emergency room physician fee (walved if admitted)	\$50	×	
and the second	Emergency medical transportation	\$250	×	
			-	
	Urgent care	\$90		
	Facility fee (e.g. hospital room)	20%	×	
	Physician/surgeon fee	20%	X	
	Mental/Behavioral health outpatient office visits	\$45		
	Mental/Behavioral health other outpatient items and services	\$45		
	Mental/Behavioral health inpatient facility fee (e.g. hospital room)	20%	100	
Marin Marin	Mental/Behavioral health inpatient physician/surgeon fee		X	
erriers Street	wertalicenswicia: nealin impalient physician/surgeon tee	20%	X	
	Substance Use disorder outpatient office visits	\$45		
	Substance Use disorder other outpatient items and services	\$45		
	Substance Use inpatient facility fee (e.g. hospital room)	2004		
	Substance use disorder inpatient physician/surgeon fee	20%	×	
	Prenatal care and preconception visits		X	
	Delivery and all inpatient Hospital	No charge 20%		
	services Professional	20%	×	
	Home health care	\$45	-	
	Outpatient Rehabilitation services Outpatient Habilitation services	\$45		
	Skilled nursing care	\$45	·	
-	Durable medical equipment	20%	X	
	Hospice service	No charge		
1777	Eye exam	No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses) Oral Exam	No charge		
e de partir de	Preventive - Cleaning	1		
menia.	Preventive - X-ray	No charge	1 10	
Laborator 1	Sealants per Tooth Topical Fluoride Application			
	Space Maintainers - Fixed	New York		
d Damed	Amalgam Fill - 1 Surface	30%		
(Camp)				
	Root Canal- Molar Ginglesclomy per Quad			
d (berna)	Root Cenel-Molar Ging vertilency per Cuest Extraction Strips Toots Exposed Root or Erupted	50%		
	Root Canal- Molar Ginglesclomy per Quad	50%		

	ummary of Benefits and Coverage ember Cost Share amounts describe the Enrollee's out of pocket costs.		SHOP Silver Communation		SHOP Silver Copay Plan		
Second Value	The second second		Yes, Medical/Pha		74.4% 7		
Hampleton	III de la company de la compan		N/A	micoy			
grated Family deductible idual deductible, NOT integrated: Medical / Pharmacy / De illy deductible, NOT integrated. Medical / Pharmacy / Dental al Out-of-pocket maximum		\$1,500 / \$500 \$2 \$3,000 / \$4,000 \$ \$6,500		N/A \$1,500 / \$600 \$250 / \$0 \$3,000 / \$1,000 \$500 / \$0 \$6,500			
	pocket maximum		\$13,000 N/A		\$13,000 N/A		
or some law	Conty concept and artists	The second second	N/A		N/A		
Common Medical Event	an.	was Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
	Primary care visit to treat an it	Maria to the same	\$45		\$45		
MARKET NAME OF THE PARTY NAME	Other practitioner office visit		\$45		845		
HIL WHE	Specialist visit		\$70		\$70		
	Preventive care/ screening/ In	nmunization	No charge \$35		No charge \$35	THEFT	
ere ;	Laboratory Tests X-rays and Diagnostic Imagin		\$65	X	\$65 \$260	100	
	Imaging (CT/PET scans, MR Tier 1	s)	\$15		\$15		
	Tier 2		\$65	Phermacy deductible	\$55	Pharmac deductible	
	Tier 3		\$75	Pharmacy deductible	\$75 20% up to \$250 per	Pharmac deductible	
	Tier 4 Surgery facility fee (e.g., ASC		20% up to \$250 per script after pharmacy deductible 20%	Pharmacy deductible	script after pharmacy deductible 20%	Pharmacy	
Carrieri.	Physician/surgeon fees		20%		20%	DES-201	
	Outpatient visit Emergency room facility fee	remand of admitted)	20% \$250	×	\$250	×	
and smodbits Seeller		\$50	×	\$50	×		
	Emergency room physician f Emergency medical transpor	\$250	X	\$250	X		
	Urgent care	Texts	\$90		\$90		
			20%	×	20%	x	
magnification	Facility fee (e.g. hospital roor	n)	20%	x	20%	×	
	Physician/surgeon fee Mental/Behavioral health out	\$45		\$45			
	Mental/Behavioral health oth	\$45		\$45			
	Mantal/Behavioral health inp	20%	×	20%	- x		
SOLD SANS	Mental/Behavioral health inp		20%	×	20%	x	
and or other teams.	Substance Use disorder out	VALUE OF THE PARTY	\$45		\$45	B.	
East made	Substance Lise disorder oth	er outpatient items and services	545		\$45	236.0	
			20%	×	20%	×	
	Substance Use inpatient fac			-	20%	×	
	Substance use disorder inper		20% No charge	X	No charge	1	
mgmille.	Prenatal care and preconce Delivery and all inpatient	Hospital	20%	х	20%	х	
TAX COMMAN	services	Professional	20%	X	20%	X	
	Home health care Outpatient Rehabilitation se		20% \$45		\$45 \$45		
NO.	Outpatient Habilitation service		\$45		\$45	1	
	Skilled nursing care		20%	Х	20%	X	
Vanish of the	Durable medical equipment Hospice service		20% No charge	-	20% No charge		
mid age	Eye exam	A-1/01 (01/A-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-	No charge		No charge		
		contact lenses in lieu of glasses)	No charge		No charge	Company of	
COLUMN TOWNS	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	W. I	No charge		No charge	nes	
Name of Street	Topical Fluonde Application Space Maintainers - Fixed			1			
Children Common Dallata	Amalgam Fit - 1 Surface		20%	100	\$25	1	
	Root Canal- Molar				\$300 \$150	4	
Grande Electrical Mariner	Gingivectomy per Quad Extraction- Single Tooth Ex	posed Root or Erupted	50%		\$150 \$65	1	
Sarata	Extraction- Complete Bony Porcelain with Metal Crown		7	-	\$160 \$300	-	
milet		The Control of the Co	THE PLANE	A Was	\$1.000	1-11	
	Medically necessary orthod	onucs	50%	PRINCE AND	\$1,000	3	

2016 Standard Benefit Plan Designs 10.0 EHB Date: April 16<u>May 71</u>, 2015

fember Cost	Share amounts describe the Enrollee's out of pocket costs.		19V
stiers VA	III - AN CONTRACTOR		Plan 5%
Una office tigm I	Totulate a demonstrate		egrated
Investories	On Owner on Bustidia	\$2,000 kg	ntegrated
dun	I deductible, NOT integrated: Medical / Pharmacy / Den		ntegrated /A
THIT y do	ductible, NOT Integrated: Medical / Pharmacy / Dental	N	W.
	it-of-pocket maximum f-pocket maximum		250 ,500
MA office ha	Forty coverage steriostrile for registrat storiostrile	\$2,	000
MONOTON	and the same of th	See endre	ste \$2.600
Medical South	Selvina Type	Member Cost Shar	e Deductible App
	Primary cere visit to treat an injury, illness, or condition	20%	×
eaith care rovider's	Other practitioner office visit	20%	×
flice or linic visit		20%	A
	Specialist vieit Preventive care/ screening/ immunization	20%	x
	Laboratory Tests	No charge 20%	X
ests	Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	20%	X
		20%	X
	Tier 1	20%	х
ugs to treat	Tier 2	20%	x
ndition	Tier 3	20%	х
	Tier 4	20%	x
utpatient	Surgery facility fee (e.g., ASC)	20%	X
rvices	Physician/surgeon fees	20%	X
	Outpatient visit	20%	X
	Emergency room facility fee (waived if admitted)	20%	×
	Emergency room physician fee (waived if admitted)	20%	×
erroriane.	Emergency medical transportation	20%	X
onthin:	Lrgent care	20%	x
estatists.	Facility fee (e.g. hospital room)	20%	x
	Physician/surgeon fee	20%	X
	Mental/Behavioral health outpatient office visits	20%	×
	Mental/Behavloral health other outpatient items and services	20%	×
	Mental/Behavioral health inpetient facility fee (e.g.hospital room)	20%	×
militi		100 to 100 to 100	-
entition .	Mental/Behavioral health Inpatient physician/surgeon fee	20%	×
Officer meaning permental	Substance Use disorder outpatient office visits	20%	x
	Substance Use disorder other outpatient items and services	20%	×
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X
	Substance use disorder inpatient physician/surgeon fee		
	Prenatal care and preconception visits	20%	х
ghilloy	Delivery and all Inpatient Hospital	No charge	
	Bervices	20%	X
	Home health care	20%	X
mr.	Outpatient Rehabilitation services Outpatient Habilitation services	20%	X X
OWNERS OF	Skilled nursing care	20%	
(Ormenda	rable medical equipment	20%	X
	Hospice service	20%	X
en ege	Eye sxam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
Damed 38	Oral Exam Preventive - Cleaning		
granter	Preventive - X-ray	No charge	
MARKEY.	Sealants per Tooth Topical Fluoride Application	//0/90	NO.
N CHEST	Space Maintainers - Fixed		
	Amalgam Fili - 1 Surface	20%	
	Root Canal-Molar Singivectomy per Quad		171
	Extraction- Single Tooth Exposed Root or Erupted	50%	
Tions .	Extraction- Complete Bony Porcelain with Metal Crown		
100			

ember Cost	Share amounts describe the Enrollee's out of pocket costs.	Silver P 100%-150%		Silver Plan 160%-200% F	PL
Control Colors No Company		93.8%		86.8%86 9%	314.7
ni milijana	umin chiamb)	Yes, Medical/F	harmacy	Yes, Medical/Phar	macy
to provide	Angeles and the Agentale	N/A N/A		N/A	25°C
Individual	deductible, NOT integrated: Medical / Pharmacy / Dental	\$75 / \$0 \$150 / \$0		\$550 / \$50 / \$ \$1,100 / \$100 /	
	ductible, NO1 integrated: Medical / Pharmacy / Dental	\$2,25	0	\$2,250	
mills Datied	April 19 10 Common	\$4,50 N/A	0	\$4,500 N/A	
A feelings	an interest detailed	N/A		NA	
Gammin Medical		Member Cost	Distriction	Member Cost Share	Deductibl
	Service T _i e	Share	Applied		Applies
	Primary care visit to treat an injury, illness, or condition	\$5		\$15	TYPE
marin sales mendada marin sales	Other practitioner office visit	\$5		\$15	
and start	Specialist visit	\$8		\$26	To the
	Preventive care/ screening/ immunization	No charge	202.5	No charge	100
	Laboratory Tests	\$8		\$15	-
ms:	X-rays and Diagnostic Imaging Imaging (CT/PET scens, MRIs)	\$8 \$50		\$25 \$100	
	Tier 1	\$3		\$5	
		-	(D) (S)	\$20	Pharmad
man in the same	Tter 2	\$10			deductib
	Tier 3	\$15		\$35 15% up to \$150 per	deductib
	Tier 4	10% up to \$150 per script		script after phermacy deductible	Pharma
Ottown	Surgery facility fee (e.g., ASC)	10% 10%		15% 15%	57.5
and the same	Physician/surgeon fees Outpatient visit	10%		15%	
	Emergency room facility fee (warved if admitted)	\$30	х	\$75	х
	Emergency room physician fee (waived if admitted)	\$25	х	\$40	х
11	Emergency medical transportation	\$30	х	\$75	X
Monte	Urgent care	\$6		\$30	
	Facility fee (e.g. hospitel room)	10%	×	15%	×
majorania (Physician/surgeon fee	10%	X	15%	X
	Mental/Behavioral health outpatient office visits	\$6		\$15	
	Mental/Behavioral health other outpatient items and services	\$5		\$15	
		105	X	15%	x
Miller	Mental/Behavioral health impatient facility fee (e.g.hospital room)	10%	_		-
MATTICE OF THE PARTY OF T	Mental/Behavioral health inpatient physician/surgeon fee	10%	X	15%	Х
editoret odestante stans const	Substance Use disorder outpatient office visits	\$5	63	\$15	
	Substance Use disorder other outpatient items and services	\$5		\$15	
	Substance Use inpatient facility fee (e.g. hospital room)	10%	×	15%	x
	The second secon	10%	X	15%	×
	Substance use disorder inpatient physician/surgeon fee Prenatal care and preconception visits	No charge		No charge	
name.	Delivery and all Inpatient Hospital	10%	×	15%	х
	services Professional	10%	×	15%	X
	Home health care Cutpatient Rehabilitation services	\$3 \$5	J	\$15 \$15	
islp acovering (Outpolient Hehilitation services	\$5	-	\$15	A
ther specia	Skilled nursing care	10%	х	15%	X
éalth nead	Dutable wedical editibulant	10% No charge	1	15% No cha	
Shild eye	Hospice service Eye exam	No charge	1	No charge	-
òr.	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	-
ild Denta	Oral Exem Preventive - Cleaning				
gnostic d eventive	Preventive - X-ray Sealants per Tooth Topical Fluoride Application	No charge		No charge	
minipipta	Space Maintainers - Fixed	20%		20%	
No.	Amalgam Fill - 1 Surface	20%		20/1	
consistente discu	Root Canal- Molar Ginginectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony	50%		50%	20 TH 19 TH
	Porcelain with Metal Crown				1
		50%		50%	1000

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	Share amounts describe to	ne Enrollee's out of pocket costs.	Silver Pla 200%-250%	
	and the second s	72.8%		
111			Yes, Medical/Ph	влувсу
			\$1.900 / \$250	/\$0
\			\$3,800 / \$500 \$5,450	/\$0
	College Water		\$10,900 N/A	
			N/A N/A	
Common Medical Evers				-
Event		Sarvice Type	Member Cost Share	No. of Lot
	Primary care visit to treat	an Injury, linees, or condition	\$40	
	Other practitioner office v	isit	\$40	
	Specialist visit		\$55	THE .
	Preventive care/ screenin	y immunization	No charge	
0.	Laboratory Tests X-rays and Diagnostic Im-	aging	\$35 \$50	1
	Imaging (CT/PET scans.	MŘIs)	\$250	
	Tier 1		\$15	
in to hear	Tier 2		\$45	Pharmac
	Tier 3		\$70	Pharmac
	Tier 4		20% up to \$250 per scred after pharmacy	Pharmac
SE0	Surgery facility fee (e.g., A Physician/surgeon fees	SC)	deductible 20%	
	Outpatient visit		20%	
	Emergency room facility fe	e (walved # admitted)	\$250	×
	Emergency room physician		\$50	×
and a	Emergency medical transp	ortation	\$260	×
	Urgent care	\$80		
	Facility fee (e.g. hospital ro	orn)	20%	×
	Physician/surgeon fee		20%	×
AUSCO	Wental/Behavioral health or	apatient office visits	\$40	
	Mental/Behavioral health of	her outpatient items and services	\$40	
200	Mental/Behavioral health in	patient facility fee (e.g.hospital room)	CON	
		patient physician/surgeon fee	20%	X
	TO NOT DO THE PARTY OF THE PART	Dament priysiciarysurgeon ree	20%	×
	Substance Use disorder ou	\$40		
	Substance Use disorder oth	er outpatient items and services	\$40	
20	Substance Use inpatient fac	ulity fee (e.g. hospital room)	20%	x
-		atient physician/surgeon fee	20%	
_	renatal care and preconce		No charge	×
	Delivery and all inpatient services	Hospital	20%	х
annesse:	forne health care	Professional	20%	X
	Outpatient Rehabilitation sei	vices	\$40 \$40	127
10000000	Sulpatient Habilitation service	ee	\$40	
Marie III	killed nursing care Jurable medical equipment		20%	x
Harris H	lospice service		20% No charge	
-	ye exam		No charge	
	ral Exam	contact lenses in lieu of glasses)	No charge	
Ownted P	reventive - Cleaning		. P	
	reventive - X-ray ealants per Tooth		No charge	
THE REAL PROPERTY.	opical Fluoride Application	THE PERSON		100
SEEDER !	pace Maintainers - Fixed malgam Fill - 1 Surface	of a street		
ealities .	oot Canal- Molar		20%	
Sullial G	Ingivectorny per Quad draction-Single Tooth Exp	osed Root or Enumer	Eve	1002
E	traction-Complete Bony orcelain with Metal Crown		50%	

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ber Cost S	hare amounts describe the Enrollee's out of pocket costs.	Branus Plan		Bronze HBA Ptr 61 1%	R)
and the	NOTE OF SECTION	et-set/782		.,	
COLUMN TO	CONTRACTOR OF THE PARTY OF THE	Ven, insuproted Medica \$6,600 integrates	Pharmen	Yes, Integr \$4,500 integr	ared
		\$10,000 integrate	# NIS	\$9,000 inte	grated
		N/AST 000 / 810	00.780	N/A N/A	
		\$6,300		\$6,500 \$13,00	
		\$13,000 N/A		\$4,500	
		N/A		\$4,50)
ommon Aedical	MASSING STATES		Deductible	Member Cost	Deduction
Event	SeniceTy	Member Cost Share	Applies After 1st three		Applies
	Primary care visit to treat an injury, liness, or condition	\$70	non-preventive visits After 1st three	40%	^
ride militar	Other practitioner office visit	\$70	non-preventive visits	40%	X
* 61	Specialist visit	\$90	After 1st three non-preventive visite	40%	×
	Preventive care/ screening/ immunization	No charge		No charge	×
	Laboratory Tests	\$40 0%100%	×	40%	x
	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	e%100%	X	40%	x_
	Tier 1	9% 100% up to \$500 per script after pharmacy. deductible	XPharmacy Deductible	40%	×
Age 12 than	Tier 2	ecnot after pharmacy deductible	Pharmacy Deductible	40%	×
Mari of	Tier 3	9%100% up to \$500 per script after pharmacy	XPharmacy Deductible	40%	x
	Tier 4	6% 100% up to \$500 per script after pharmacy.	M-harmacy. Deductible	40%	×
		deductible 9%100%	×	40%	Х
-	Surgery facility fee (e.g. ASC) Physician/surgeon fees	0%·100%	×	40%	X
	Outpatient visit	0%100%	x	40%	X
	Emergency room facility fee (waved if admitted)	0% 100%	×	40%	×
	Emergency room physician fee (waived if admitted)	0% 100%	×	40%	X
n Pos	Emergency medical transportation	0% 100%	×	40%	X
	Urgent care	\$120	After 1st three non-preventive visits	40%	x
	To the to a handel more)	6%100%	х	40%	×
-	Facility fee (e.g. hospital room)	9%100%	×	40%	×
	Physician/surgeon fee Mental/Behavioral health outpatient office visits	\$70	After 1st three non-preventive visits	40%	x
	Mental/Behavioral health other outpatient items and services	\$70	After 1st three non-preventive	40%	×
			visits	40%	×
-	Mental/Behavioral health inpatient facility fee (e.g. hospital room		-	-	×
	Mental/Behavioral health inpatient physician/surgeon fee	0%100%	X	40%	
	Substance Use disorder outpatient office visits	\$70	After 1st three non-preventive visits		×
	Substance Use disorder other outpatient items and services	\$10	After 1st three non-preventive visits		×
		9% <u>100%</u>	X	40%	×
	Substance Use inpatient faculty fee (e.g. hospital room)		41-1-1-1-1	40%	,
	Substance use disorder inpatient physician/surgeon fee	0%100%	×	No charge	-
	Prenatal care and preconception value	No charge		40%	>
-	Delivery and all Inpatient Hospital	6% <u>100%</u>	×	40%	-
	services Professional Home health care	9%100% 9%100%		40%	- 3
	Outpatient Rehabilitation services	\$70		40% 40%	3
Times.	Outpatient Habilitation services	\$70	x	40%	,
Cat to	Skilled nursing care	9% <u>100%</u>	×	40%	,
ļņi lie	Durable medical equipment Hospice service	No charge		0%	
Selle supe	Eye exam	No charge		No charge	
41	1 pair of glasses per year (or contact tenses in lieu of glasses)	No charge		No charge	-
Dail Dail	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth	No charge	DOM:	No charge	, E
	Topical Fluorde Application Space Maintainers - Fixed				-
Diabe Dead	Amaigam Fill - 1 Surface	20%		30%	
Challe Darri Major Tarricas	Root Canal-Molar Gingwedomy per Quad Extraction-Single Tooth Exposed Root or Erupted Extraction-Complete Bony	50%		50%	Ē
	Porcelain with Metal Crown	Markey (ex)	CHECKLO	The City	135
STATE OF THE OWNER, WHEN	Medically necessary orthodontics	50%		50%	

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	Share amounts describe the Enrollee's out of pocket costs.	Catastrophic Plan		
Stancial Val	ue - AV Celaulate	Carrier Street		
Uningrate	Institutes a restautible?	Yes, 1	ntegrated Integrated	
Indicator	I deductible, NOT integrated: Medical / Pharmacy / Dental	\$13,700	integrated	
11 (Taken Barry	Medical / Programme :		N/A N/A	
Family Con-	d-of-poolst maximum		3,850 3,700	
HEAT SHAWN TH	Fronty agreement also applica-	2111-2	N/A	
Common		-	N/A	
Medical Event	Service T	Member Cos Share	t Deductibl Applies	
	Primary care visit to treat an injury, illness, or condition	0%	After 1st three	
nedit see	Other practitioner office visit	0%	After 1st three non-preventi	
distribution .	pecialist visit	2%	visits	
	Freventive care/ screening/ immunization	Manhama		
	Laboratory Tests	No charge 0%	X	
***	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	0%	X	
	Tior 1	0%	×	
-	Tier 2	0%	×	
Property Property Services		MACHE IN		
annuger.	Tier 3	0%	х	
	Tier 4	0%	×	
HODERSON .	Surgery facility fee (e.g., ASC) Physician/surgeon fees	0%	×	
anytean.	Outpatient visit	0%	X	
	Emergency room facility fee (waived if admitted)	0%	х	
	Emergency room physician fee (walved if admitted)	0%	х	
	Emergency medical transportation	0%	×	
	Urgent care	0%	After 1st three non-prevention visits	
Name of the least	Facility fee (e.g. hospital room)	0%	×	
	Physician/surgeon fee	0%	X	
	Mental/Behavioral health outpatient office visits	0%	After 1st three non-preventor visite	
	Mental/Behavloral health other outpatient items and services	0%	After 1st thre	
1000	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	0%	x	
Militi	Mental/Behavloral health inpatient physician/surgeon fee	0%	x	
Marking	Substance Use disorder outpatient office visits	0%	After 1st thre	
			After 1st three	
	Substance Use disorder other outpatient items and services	0%	non-preventiv visits	
	Substance Use inpatient facility fee (e.g. hospital room)	0%	×	
	Substance use disorder inpatient physician/surgeon fee	0%	X	
sgneney:	Frenatal care and preconception visits Delivery and all inpatient Hospital	No charge	10000	
Call Control	Delivery and all inpatient Hospital Bervices Professional	0%	×	
	Home health care	0%	X	
9	Outpatient Rehabilitation services Outpatient Habilitation services	0% 0%	X	
	Skilled nursing care	0%	X	
THE PERSON LABOR.	D rable medical equipment	0%	×	
ildere.	Hospice service	No charge	X	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	×	
nemine.	Oral Exam Preventive - Cleaning		line ne	
against to	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application	No charge		
Of Dental	Space Maintainers - Fixed	1000	-	
eric miles	Amalgam Fill - 1 Surface	0%	x	
Old Daniel	Rogi Cenal-Moler Gingsectomy per Quad		X	
	Extraction- Single Tooth Exposed Root or Erupted	0%	X	
2000	Extraction- Complete Bony Porcelain with Metal Crown		X	

2016 Standard Benefit Plan Designs 9.5 EHB

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Summary of Benefits and Coverage Platinum Copay Plan Member Cost Share amounts describe the Enrollee's out of pocket costs. Coincurance Plan 88.5% idual deductible, NOT integrated: Medical / Pharmacy / Dantal ly deductible, NOT integrated: Medical / Pharmacy / Dantal al Out-of-pocket maximum \$20 Primary care visit to treat an injury, diness, or condition \$20 \$20 Other practitioner office visit \$20 \$40 \$40 Preventive care/ screening/ immunization Laboratory Tests X-raye and Diagnostic Imaging Imaging (CT/PET scans, MRIs) No charge \$20 \$40 10 \$5 \$5 \$15 Tier 2 \$25 \$25 Tier 3 10% up to \$250 per script 10% up to \$250 per script Tier 4 Surgery facility ee (e.g., ASC) Physician/surgeon fees Outpatient visit \$40 10% 10% \$150 Emergency room facility fee (waived if admitted) \$150 Emergency room physician fee (waived if admitted) 10% No charge Emergency medical transportation \$150 \$150 E40 840 Urgent care \$250 per day up to 5 days 10% Facility fee (e.g. hospital room) \$40 10% Physician/surgeon fee 320 Mental/Behavioral health outpatient office visits \$20 \$20 Mental/Behavioral health other outpatient items and services \$20 \$250 per day up to 5 days Mental/Behavioral health inpatient facility fee (e.g. hospital room) 10% 10% \$40 Mental/Behavioral health inpatient physician/surgeon fee \$20 \$20 Substance Use disorder outpatient office visits \$20 Substance Use disorder other outpatient items and services \$20 \$250 per day up to 5 days Substance Use inpatient facility fee (e.g. hospital room) 10% \$40 10% Substance use disorder inpatient physician/surgeon fee No charge Prenatal care and preconceptor wats No charge \$250 per day up to 5 days \$40 10% Delivery and all inpatient Hospital 10% Home health care Outpatient Rehabilitation services \$20 \$20 \$150 per day up to 5 days 10% 10% Skilled nursing care 10% Durable medical equipment No charge No charge Hospice service Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge Oral Exam
Preventive - Cleaning
Preventive - X-ray
Sealants per Tooth
Topical Fluoride Appli Not Covered Not Covered Space Maintainers - Fixed Not Covered Not Govered Amalgam Fill - 1 Surface Root Canal- Molar Not Covered Not Covered Root Canar Moiar Ginghectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony Not Covered Not Covered Not Covered Not Covered Porcelain with Metal Crown Not Covered Medically necessary orthodontics Not Covered

2016 Standard Benefit Plan Designs 9.5 EHB Date: April 16 May 21, 2015

A LINE OF	The service assume the Enrollee's out of pocket costs.	Coinsuran 80.2	ce Plan	Copuy I	Plan
Print Heavy		No \$0		No \$0	
TOTAL STREET		\$0		\$0	501
1017/		\$0 /\$0 \$0 /\$0	/\$0	\$0 / \$0	/\$0
	A Constitution of the Cons	\$6,20 \$12,4	ю 90	\$6,20 \$12,4	
SA SIMIL	Partierning schooling distributions (After Sint Side of Side	N/A N/A		N/A N/A	
Cummin	The state of the s	Name and Address of the Owner, where		TO A	1000
Medical Event	Sarvice T ₁ Da	Member Cost Share	Cerucitole Applies	Member Cost Share	Deduct
and the	Primary care visit to treat an injury, illness, or condition	\$35		\$35	
(outer a	Other practitioner office visit	\$35		\$35	-
	Specialist visit	\$55		\$65	
	Preventive care/screening/immunization	No charge	-	No charge	-
-	X-rays and Diagnostic Imaging	\$35 \$50	12007	\$35 \$50	2,17
		20%	eni-von	\$250	1134
	Ter 1	\$15		\$15	
own in the	Ter 2	\$50		\$50	
	Tier 3	\$70		\$70	
	Tier 4	20% up to \$250 per scrot		20% up to \$250 per script	
Paraties of	Surgery facility fee (e.g., ASC) Physician/surgeon fees	20%		\$600	
day.	Outpatient visit	20%		\$55 20%	E LFS
	Emergency room facility fee (warved if admitted)	\$250	DIA.	\$250	5.
17/17/1	Emergency room physician fee (waived if admitted)	20%		No charge	
West and	Emergency medical transportation	\$250	500	\$250	
	Urgent care	\$60		\$60	
	Facility fee (e.g. hospital room)	20%	E.1686)	\$600 per day up to 5 days	MS.
STATE OF THE PARTY OF	Physician/surgeon fee	20%		\$55	M. Sant
	Mental/Behavioral health outpatient office visits	\$35		\$35	
	Mental/Behavioral health other outpatient items and services	\$35		\$35	
	Mental/Behavioral health inpatient facility fee (a o hospital room)	20%	85538	\$600 per day	T655
MILE IN	The second secon	1	200	up to 6 days	
tellers	montationavoral near insparent physician/surgeon ree	20%		\$55	
DESCRIPTION OF	Substance Use disorder outpatient office visits	\$35		\$35	
	Substance Use disorder other outpatient items and services	\$35		\$35	
	Substance Use inpatient facility fee (e.g. hospital room)	20%	COLUMN TO SERVICE	\$600 per day	
		20%	mirro	up to 6 days	1,3
		20%		\$55	
of stary		No charge 20%		No charge \$600 per day	
	services Professional	20%		up to 5 days \$55	
	Home health care Outpatient Rehabilitation services	20%	NCI IE-CA	\$30	U.S.
the last week	Outpatient Habittation services	\$35 \$35	Abus	\$35 \$35	5310
The Carrie	Skilled nursing care	20%	-	\$300 per day up to 5 days	
	Durable medical equipment Hospice service	20%	125	20%	(Charles
	Eye exam	No charge	236	No charge No charge	250
		No charge		No charge	
Primary care vost to treat an injury, theses, or condition Other practitioner office visit Specialist visit Preventine cara/ ecreening/ immunization Laboratory Teats X-rays and Diagnostic Imaging traging (TIPET scans, MRIs) Ter 1 Ter 2 Tier 3 Tier 4 Surgery facility fee (e.g., ASC) Physician/surgeon fee Outpatient visit Emergency room facility fee (warved if admitted) Emergency room facility fee (warved if admitted) Emergency room facility fee (warved if admitted) Emergency room physician fee (walved if admitted) Emergency room facility fee (e.g. ASC) Physician fee (e.g. hospital room) Menta/Behavioral health other outpatient items and services Substance Use disorder other outpatient items and services Substance Use disorder other outpatient items and services Substance Use disorder inpatient physician/surgeon fee Prenatal care and preconception viets Substance Use disorder inpatient physician/surgeon fee Prenatal care and preconception viets Substance Use disorder inpatient facility fee (e.g. hospital room) Substance Use disorder inpatient physician/surgeon fee Prenatal care and preconception viets Delivery and all inpatient services Prenatal care and preconception viets Delivery and all inpatient services Prena	- 2				
Prostite.	Preventive - X-ray	Not Covered	100	Not Covered	
4#11	Topical Fluonde Application	-			No.
	A STATE OF THE STA	Not Covered		Nat Covered	13
1000	Root Canal- Molar		4.365	Not Covered	
W BOULD	Singivectomy per Quad Extraction- Single Tooth Exposed Root or Fainted	Not Course	5000	Not Covered	10.1
Acet	Extraction- Complete Bony	Not Covered		Not Covered Not Covered	
		Carlo Carlo		Not Covered	
	Martinality management at the state of	Not Covered		Not Govered	

2016 Standard Benefit Plan Designs 9.5 EHB Date: April 16 May 21, 2015

	Benefits and Coverage hare amounts describe the Enroll	ee's out of pocket costs.	Individual Silver Plan			
TIDEI COST C	Table di Nota No		70.4%	57.50		
Marie Labor	LUI Verand		Yes, Medical/Pher	macv		
والمعاولة			N/A			
			N/A \$2,250 / \$250 /	50		
			\$4,500 / \$500 /			
			\$6.250			
			\$12,500 N/A			
		\	N/A			
Dominion Medical Event	Dental Property of the Party of	ta Tige	Member Cost Share	Carracteria Applies		
1000	Primary care visit to treat an injur		\$45			
400 core	Other practitioner office visit	THE REAL PROPERTY.	\$45			
	Specialist visit		\$70			
	Preventive care/ screening/ imm	kingstion	No charge			
1000	Laboratory Tests	OT NECKOOT	\$35	7 1 2		
NO.	X-rays and Diagnostic Imaging		\$65 \$250			
	Imaging (CT/PET scans, MRIs)		\$230			
	Tier 1		\$15			
	Tier 2		\$50	Pharmacy deductible		
	Tier 3		\$70	Pharmacy deductible		
	Tier 4		20% up to \$250 per senpt after pharmacy deductible	Pharmacy deductible		
Obstant !	Surgery facility fee (e.g. ASC) Physician/surgeon fees	THE PERSON NAMED OF	20%	CERT		
an/C44	Outpatient visit		20%			
No. of Concession, Name of Street, or other Designation, Name of Street, or other Designation, Name of Street, One of Street,	Emergency room facility fee (w	aved if admitted)	\$260	×		
			\$50	×		
64	Emergency room physician fee					
Ton Cale	Emergency medical transporta	tion	\$250	×		
	Urgent care		\$90			
	Facility fee (e.g. hospital room)	KIND OF THE PARTY	20%			
iomin	Physician/surgeon fee	Secretary Constitution	20%	X		
	Merita/Behavioral health outpo	\$45	resi			
	Mental/Behavioral health other	outpatient items and services	\$45			
	increases ours		20%	×		
44	Mental/Behavioral health inpat	. 20%	×			
-	Menta/Benavioral nealtr in par	ish it priyacial tourgest rise	Page of S	1 15		
	Substance Use disorder outpa	\$45	IV-10			
	Substance Use disorder other	outpatient items and services	\$45			
	Substance Use inpatient facilit	ty fee (e.g. hospital room)	20%	x		
	Substance use disorder inpati		20%	x		
	Prenatal care and preconcept		No charge	1.11		
CHA	Delivery and all inpatient	Hospital	20%	x		
Party.	services	Professional	20%	X		
	Home health care	, , Jieowaniek	\$45	digitiv.		
les de la constante de la cons	Outpatient Rehabilitation serv	nces	\$45 \$45	Brut 12		
- Taranty	Outpatient Habilitation service	13		×		
officer speed	Skilled nursing care		20%	^		
	Durable medical equipment		20% No charge	1		
	Hospice service		No charge			
Carl See	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	. No charge			
	Oral Exam		P. 1	525774		
	Preventive - Cleaning Preventive - X-ray	17 61-151	Not Covered	F1625/3		
	Sealants per Tooth Topical Fluoride Application	STATISTICS.		SHOW		
ENN Day	Space Maintainers - Fixed	43 Tow 77 W	11-10:			
Sade Septem	Amalgam Fill - 1 Surface		Not Covered	1183		
	Root Canal-Molar Grigivectomy per Quad	12 St. 19 St. 19 St.		17.55		
	Extraction- Single Tooth Exp Extraction- Complete Bony	osed Root or Erupted	Not Covered	200		
	Porcelain with Metal Crown		Will Asset A	5 85 1		
	Medically necessary orthodo	ntes	Not Covered			

Date: April 16May 21, 2015

-	Benefits and Coverage hare amounts describe the Enrollee's out of pocket costs.	Silver HSA Plan 70.5%			
	The state of the s	Yes, integrat	ed		
magnituti	Marine Constitution	\$2,000 integra \$4,000 integra	ated ated		
	deductible, NOT Integrated: Medical / Pharmacy / Dental	N/A N/A			
	luctible, NOT integrated:	\$6,250 \$12,500			
	nocket maximum	\$2,000			
Atlanta	or to the state of	See-endnote \$	2,600		
Common Medical Event	Service Tupe	Member Cost Share	Deductible Appli		
	Primary care visit to treat an injury, filness, or condition	20%	*		
	Other practitioner office visit	20%	*		
tide out.	Specialist visit	20%	*		
	Peventive care/ screening/ immunization	No charge 20%	×		
inte	Leboratory Tests X-rays and Diagnostic Imaging	20%	X		
	Imaging (CT/PET scans, MRIs)	20%	X		
	Tier 1	20%	X		
rage tremen	Tier 2	20%	×		
epitalist.	Tier 3	20%	×		
	Tier 4	20%	×		
Oliverno.	Surgery facility fee (e.g., ASC) Physician/surgeon fees	20%	Х		
annia.	Outpatient visit	20%	×		
Hell Heeline	Emergency room facility fee (waived if admitted)	20%			
	Emergency room physician fee (walved if admitted)	20%	×		
	Emergency medical transportation Ligent care	20%	×		
		20%	x		
Grantis atro	Facility fee (e.g. hospital room) Physician/surgeon fee	20%	×		
	Mental/Behavoral health outpatient office visits	20%) x		
	Mental/Behavioral health other outpatient items and services	20%	х		
		DOB/	x		
0.000	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	100		
and the second	Mental/Behavioral health inpatient physician/surgeon fee	20%	×		
CONTRACTOR CONTRACTOR CONTRACTOR	Substance Use disorder outpetient office visits	20%	*		
	Substance Use disorder other outpatient items and services	20%	×		
	Substance Use inpatient facility fee (e.g. hospital room)	20%	x		
	Substance use disorder inpatient physician/surgeon fee	20%	х		
	renatel care and preconception visits	No charge			
THURSDAY.	Delivery and all Inpatient Hospital	20%	x		
	services Professional	20%	X		
	Home health care Outpatient Rehabilitation services	20%	X		
Maria Maria	Outpatient Habilitation services	20%	×		
Or special	Skilled nursing care	20%	X		
	Durable medical equipment Hospice service	0%	x		
Contract	Eye exam	No charge No charge			
*	1 pair of glasses per year (or contact lenses in lieu of gla) Oral Exam	iso cusiĝe			
DOMESTICAL DESIGNATION OF THE PERSON OF THE	Preventive - Cleaning				
(Kaptoshe stot	Preventive - X-ray Sealants per Tooth	Not Covered			
Francisco.	Topical Fluoride Application Space Maintainers - Fixed		and the same		
naa Denial Isaan		Not Covered			
Sections.	Root Canal- Molar		-		
Load-Dente Rappi Sections	Exerction-Single Tooth Exposed Root or Erupted Exerction-Single Tooth Exposed Root or Erupted Extractor - Complete Bony	Not Covered			
Date	Percelain with Metal Crown	Blot Course	100		
Demodpion	Medically necessary orthodontics	Not Covered	F1 (17 (17 (17 (17 (17 (17 (17 (17 (17 (1		

emper Cosi	t Share amounts describe the Enrollee's out of pocket costs.	Silver F 100%-150° 93.8°	% FPL	150%-200% [PL	
tin manual	Anatonias A designaturis 7	Yes, Medical/		Yes, Medical/Pharmacy N/A N/A \$560 / \$50 / \$0		
Magnet	County displayed	N/A N/A				
Individua	el de Bethur, HD7 Imagratiet: Medical / Pharmacy / House	\$75 / \$0	/\$0			
ramily of ual Or	edu dical / Pharmacy / Ďenta ut-ot-pocus, pagas	\$150 / \$0 \$2,25			/\$0	
Out-c	f-pocket maximum	\$4,50 N/A		\$4,500		
A tarity a	the beginning managing	NA		N/A		
Common Medical		Member Cost	Constitution	-	Doquett	
Event	Service Type	Share	Magnine	Member Cost Share	Applie	
-	Primary care visit to treat an injury, illness or condition	\$5		\$15		
	Other practitioner office visit	\$5		\$15		
	Specialist visit Preventive care/ screening/ immunization	\$8		\$25		
	Leboratory Tests	No charge				
MN.	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	\$8 850		\$25		
		1000		\$100		
	Tier 1	33		\$5		
100 PM	Tier 2	\$10		\$20	Pharma deductil	
	Tier 3	\$15		\$35	Pharma deductit	
	Tier 4	10% up to \$150 per script			Pharma	
	Surgery facility fee (e.g., ASC)	10%		deductible	deductil	
	Physician/surgeon fees Outpatient visit	10%		15%		
	Emergency room facility fee (waived if admitted)	10%		15%	1000	
		\$30	×	\$75	х	
	Emergency room physician fee (walved if admitted)	\$25	×	\$40	×	
and the last	Emergency medical transportation	\$30	X	N/A	X	
	Urgent care	\$6		\$30	7	
*******	Facility fee (e.g. hospitel room)	10%	×	15%	×	
	Physician/surgeon fee	10%	X	15%	X	
	Mental/Behavioral health outpatient office visits	\$5		\$15		
	Mental/Behavioral health other outpatient items and services	\$5		\$15		
	Mentel/Behavioral health inpatient facility fee (e.g.hospital room)	-	-	1440	100	
mad Ma	New About 10 For Make 1 and 15	10%	×	16%	×	
MATERIAL PROPERTY.	Mental/Behavioral health inpatient physician/surgeon fee	10%	X	15%	х	
elle un	Substance Use disorder outpatient office visite	\$ 5		\$15		
	Substance Use disorder other outpatient items and services	\$5		815		
	Substance Use inpatient facility fee (e.g. hospital room)	10%	x	15%	×	
	Substance use disorder inpatient physician/surgeon fee		-		-	
	Prenatal care and preconception visits	10% No charge	Х		×	
	Delivery and all Inpatient Hospital	10%	x		×	
	Services Professional	10%	X			
	Home health care Outpatient Rehabilitation services	\$3		\$15		
	Outpatient Habilitation services	\$5 \$6			E D	
-	Skilled nursing care	10%	х		x	
and the sale	Durable medical equipment	10%		15%		
Maye.	Hospice service Eye exam	No charge		No charge		
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge				
	Oral Exam	-				
	Preventive - Cleaning Preventive - X-ray	10	-			
	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed	Not Covered		Not Covered		
in the stat	Amaigam Fill - 1 Surface	Not Covered		Not Covered	18/7	
	Root Canal- Molar					
A Company	Extraction- Single Tooth Exposed Root or Erupted		2101			
		Not Covered	100	Not Covered		
	Extraction- Complete Bony Porcelain with Metal Crown					

	hare amounts describe the Er	rollee's out of pocket costs.	Silver Plan 200%-250% FPL 72.8%			
Mary Co.	- ACCRECATE		Yes, Medical/Pharm	acv		
Magazine	COURT IN PROPERTY.		N/A			
Harpatan	Facety demonstric demonstra, MCC housework	Madmata Phorneys Divide	N/A \$1,900 / \$250 / \$			
Sample on t	NATIONAL ROOT INTERPRETATION OF THE	dual Promoty/Dentil	\$3,800 / \$500 / \$ \$5,450	0		
distribution one mits Core of	punkat manana		\$10,900			
SA others Suit	tento propria per distributiva		N/A N/A			
Common		And in case of the last of the				
Medical Event			Member Cost Share	Deductible Applies		
	Primary care visit to treat an u	njury limess, or condition	\$40	N Bri		
united St.	Other practitioner office visit	-	\$40			
	Specialist visit		\$55			
	Preventive care/ screening/ In	nmunization	No charge \$35	dame.		
an .	X-rays and Diagnostic Imagir	lg	\$50 \$250	of later of		
	means (CT/PET scens, MR	18)	\$250			
	Tier 1		\$15			
rupe to the	Tier 2		\$45	Pharmacy deductible		
	Tier 3		\$70 20% up to \$250 per script	Pharmacy deductible Pharmacy		
	Tier 4 Surgery facility fee (e.g., ASC	0)	after pharmacy deductible 20%	deductible		
Deligitations organization	Physician/surgeon fees		20%			
	Outpatient visit Emergency room facility fee	(unamed if admitted)	\$250	×		
			\$50	×		
and medicie	Emergency room physician f		\$250	×		
	Emergency medical transportation		7,200			
	Urgent care		\$80			
	Facility fee (e.g. hospital root	n)	20%	X		
teenstate	hysician/surgeon fee		20%	X		
	Mental/Behavioral health out	patient office visits	\$40			
	Mental/Behavioral health oth	er outpatient items and services	\$40			
	Manual Calana and beath in	abent facility fee (e.g.hospital room)	20%	×		
man .		The same of the same statement of the same same same and the same same same same same same same sam		-		
MARKET AND ADDRESS OF THE PARTY AND ADDRESS OF	Mental/Behavioral health inp	atient physician/surgeon fee	20%	Х		
andity or all a list of the death of the	Bubatance Use disorder out	patient office visits	\$40	ini		
	Substance Use disorder oth	er outpatient items and services	\$40			
	Substance Use inpatient fac	ality fee (e.g. hospital room)	20%	.x:		
	Substance use disorder inpo	atient physician/surgeon fee	20%	X		
	Prenatal care and preconce		No charge			
September 1	Delivery and all Inpatient	Hospital	20%	×		
	services	Professional	20% \$40	X		
	Home health care Outpetient Rehabilitation se		\$40			
-	Outpatient Habilitation serving	>88	\$40	v		
mails made	Skilled nursing care		20%	Х		
	Durable medical equipment Hospice service		No charge			
Contract of	Ly= exam		No charge			
		r contact lenses in lieu of glasses)	No charge	-		
Citata Dennel	Oral Exam Preventive - Cleaning					
Dagements.	Preventive - X-ray Sealants per Tooth	(Landau and Landau and	Not Covered			
-	Topical Fluoride Application Space Maintainers - Fixed			-		
		ELLE WEST SE		SVVA		
سميده	Amalgam Fill - 1 Surface		Not Covered	17.7		
COMMITTEE OF THE PERSON NAMED IN						
	Root Canal- Molar					
Chief Demo	Root Canal- Molar Ginglivectomy per Quad Extraction- Single Tooth Ex Extraction- Complete Bony Porcelain with Metal Crown		Not Covered			

2016 Standard Benefit Plan Designs 9.5 EHB Date: April 16<u>May 21</u>, 2015

Charle Vi	st Share amounts describe the Enrollee's out of pocket costs.	Bronze P		Bro HSA	Plan
Total Control of the	Holling Contactals = Procedure and analytic and analytic and analytic and analytic and analytic analytic and analytic a	Yes, integrated Mgd \$6,500 integra \$12,000 /s N/A\$12,000 /\$ N/A\$12,000 /\$ \$6,500 \$13,000	ed N/A 100 / \$0 100 / \$0	Yes, into \$4,500 in \$9,000 m N/ N/ \$6,5	egrated degrated A A A SOO
A hordy	per hessidouspile	N/A N/A		\$4,5 \$4,5	
Commun Macinal	CANDIDATE AND AND ADDRESS		ina	o Microson	
Gen	Compa I (see	Member Cost Share	Deductale Appli	Member Cost Share	Deduc App
	Primary care visit to freet an injury, limens, or occupance	\$70	After 1st three non-preventive visits		×
ANTO ANCO CONTRACTO ALLO DE COLO OFINE	Other practitioner office year	\$70	After 1st three non-preventive visits		×
	Specialist visit	\$90	After 1st three non-preventive visits		x
	Preventive care/ screening/ immunization Laboratory Tests	No charge \$40	_	No charge	×
	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	0%100%	X	40%	ŝ
	Tier 1	9%100% 9%100% up to \$500 per script after pharmacy deductible	XPharmacv Deductible	40%	x
ogens been	Tier 2	9%100% up to \$500 per script after pharmacy deductible	XPharmacy. Deductible	40%	×
	Tier 3	9%100% up to \$500 per script after pharmacy deductible	XPharmacy Deductible	40%	×
	Tier 4	script after pharmacy deductible	Pharmacy, Deductible	40%	×
Malland.	Surgery facility fee (e.g., ASC) Physician/surgeon fees	9%100%	X	40%	×
1244	Outpatient visit	9%102% 9%100%	X X	40%	X
	Emergency room facility fee (warved if admitted)	##100%	x	40%	×
	Emergency room physician fee (waived if admitted)	64-100%	х	40%	×
mediate:	Emergency medical transportation	9%190%	x	40%	×
	Urgent care	\$120	After 1st three non-preventive visits	40%	×
color other	Facility fee (e.g. hospital room)	9%100%	×	40%	×
HILI TUS	Physician/surgeon fee	9%100%	x	40%	х
	lental/Behavioral health outpatient office visits	\$70	After 1st three non-preventive Visits	40%	×
	Mental/Behavioral health other outpatient items and services	\$70	After 1st three non-preventive visits	40%	×
46	Mental/Behavioral health inpatient-facility fee (e.g. hospital room)	9% 100%	x	40%	×
th. Eviansi	Mental/Behavioral health inpatient physician/surgeon fee	0% 100%	х	40%	x
thouse stapers	Substance Use disorder outpatient office visits	\$70	After 1st three non-preventive	40%	×
	Substance Use disorder other outpatient items and services	21060000000	Visits After 1st three	The second	
		\$70	non-preventive visits	40%	Х
	ll ubstance Use inpatient facility fee (e.g. hospital room)	9%,100%	**	40%	x
	Substance use disorder inpatient physician/surgeon fee	0%_100%	x	40%	×
	Prenatal care and preconception visits Delivery and all inpatient Hospital	No charge	A 100 M	Nacharge	
888	services Professional	0%100%	X	40%	х
SUR!	How e health care	9%100% 9%100%	X	40%	X
1	Outpatient Habitation services	\$70 \$70	SINGLE-	40%	X
	Skilled nursing care	9% <u>100%</u>	X	40%	×
	Durable medical equipment	0%100%	×	40%	×
PAR	Hospice service Eye exam	No charge No charge	70000	0%	X
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge No charge	
Decited 1	Oral Exam Preventive - Cleaning Preventive - X-ray Seatents per Tooth	Not Covered		Not Covered	200
nd-n	Topical Fluoride Application Space Maintainers - Fixed		Lac -	20.0100	
100	Amalgam Fili - 1 Surface	Not Covered		Not Covered	
Diameted (Root Canal-Molar Singleactorny per Quad Extraction- Single Toom Exposed Root or Erupted Extraction- Complete Borry Porcelain with Netal Crown	Not Covered		Not Covered	
-					

2016 Standard Benefit Plan Designs 9.5 EHB Date: April 16 May 21, 2015

HOST COST S	hare amounts describe the Enrollee's out of pocket costs.	Catastrophi	
		Yes, integ \$6,850 inte \$13,700 inte N/A	grated
		N/A \$6,85	
		\$13,70	
7		N/A N/A	100000
Cornatori		11 (2000)	
Medical Event	Sarvico Typu	Member Cost Share	After 1st three
	Primary care visit to treat an injury, liness, or condition	3%	non-preventive visits
MATE OF	Other practitioner office visit	0%	After 1st three non-preventive visits
	Specialist visit	0%	*
	Preventive care/ screening/ immunization	No charge	X
200	Laboratory Teeta X-rays and Diagnostic Imaging	0%	X
3. E	Imaging (CT/PET scans, MRIs)	0%	X
	Tier 1	0%	·X
-	Tier 2	0%	x
	Tier 3	0%	×
	Tier 4	0%	x
	Surgery facility fee (e.g., ASC)	0%	×
-	Physician/surgeon fees	0%	X
	Outpatient visit	0%	×
	Emergency room facility fee (waived if admitted)		×
	Emergency room physician fee (waived if admitted)	0%	×
mater mater	Emergency medical transportation Urgent care	0%	After 1st three non-preventive visits
	Facility fee (e.g. hospital room)	0%	×
	Physician/surgeon fee	0%	•х
	Mental/Behavioral health outpatient office visits	0%	After 1st three non-preventive visits
	Mental/Behavioral health other outpatient items and serv	ices 0%	After 1st three non-preventive visits
	Mental/Behavoral health inpatient facility fee (e.g. hospita	I room) 0%	
erta :			×
market .	Mental/Behavioral health inpatient physician/surgeon fee	0%	
	Substance Use disorder outpatient office visits	0%	After 1st three non-preventive visits
	Substance Use disorder other outpatient items and serv	ices 0%	After 1st three non-preventive visits
	AND DESCRIPTION OF THE PARTY OF	The Charles	-
	Substance Use inpatient facility fee (e.g. hospital room)	0%	×
	Substance use disorder inpatient physician/surgeon fee	0%	X
	P unula care and preconception visits	Naicharge	1
Tragater or T	Delivery and all inpatient Hospital services	0%	X
1 3	Home health-care	0%	X
Wat Tel	Outpatient Rehabilitation services	0%	×
SCHOOL SE	Outpatient Habilitation services	0%	×
	Skilled nursing care	0%	×
1000	D. rable medical equipment Honcice service	0%	x
1200 epa	Eye exam 1 pair of glasses per year (or contact lenses in lieu of glasses	s) 0%	×
One land	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluorde Application Space Maintaners - Food	Not Covered	
Colon David	Amaigam Fill - 1 Surface	Not Covered	
Crys Tees Mage Services	Root Canel-Molar Gingsectomy per Quad Extraction - Single Tooth Exposed Root or Enipted Extraction - Complete Bony Porceigh with Metal Crown	Not Covered	

Endnotes to 2016 Standard Benefit Plan Designs

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 carrier.
- 2) For covered out of network services in a PPO plan, these Standard Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
- 3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
- 4) For <u>all</u> plans <u>including except</u> HDHPs linked to HSA plans, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the carrier pays all costs for covered services for all family members.
- 5) For HDHPs linked to HSAs, in other than self-only coverage, each individual in the family must meet the individual minimum deductible amount established by the Internal Revenue Service for the applicable Plan Year. an individual's payment toward a deductible, if required, must be the higher of the specified deductible amount for individual coverage or \$2600 for Plan Year 2016. 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 the an up to 30-day prescription supply. For example, if the prescription is for a month's supply, one co-pay or co-insurance can be collected. If the prescription is written for a 90 day supply, a single cost-share amount applies. Nothing in this note precludes a carrier from offering mail order prescriptions at a reduced cost-share.

- 11) As applicable, for the child dental portion of the benefit design, a carrier may choose the copay or coinsurance child dental Standard Benefit Plan Design, regardless of whether the carrier selects the copay or the coinsurance design for the non-child dental portion of the benefit design. In the Catastrophic plan, the deductible must apply to non-preventive child dental benefits.
- 12) Cost-sharing terms and accumulation requirements for non-Essential Health Benefits that are covered services are not addressed by these Standard Benefit Plan Designs.
- 13) Mental Health/Substance Use Disorder Outpatient Items and Services include post-discharge ancillary care services, such as counseling and other outpatient support services, which may be provided as part of the offsite recovery component of a residential treatment plan.
- 14) Residential substance abuse treatment that employs highly intensive and varied therapeutics in a highly-structured environment and occurs in settings including, but not limited to, community residential rehabilitation, case management, and aftercare programs, is categorized as substance use disorder inpatient services.
- 15) Specialists include physicians with a specialty as follows: allergy, anesthesiology, dermatology, cardiology and other internal medicine specialists, neonatology, neurology, oncology, ophthalmology, orthopedics, pathology, psychiatry, radiology, any surgical specialty, otolaryngology, urology, and other designated as appropriate (28 CCR § 1300.51(I)(1)).
- 16) The Other Practitioner category includes Nurse Practitioners, Certified Nurse Midwives, Physical Therapists, Occupational Therapists, Respiratory Therapists, Speech and Language Therapists, Licensed Clinical Social Worker, Marriage and Family Therapists, Applied Behavior Analysis Therapists, acupuncture practitioners, Registered Dieticians and other nutrition advisors and other practitioners included in 28 CCR § 1300.67(a)(1).
- 17) The Outpatient Visit line item within the Outpatient Services category includes but is not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.
- 18) Cost-sharing for services subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) may be less than those listed in these standard benefit plan designs if necessary for compliance with MHPAEA.
- 19) Drug tiers are defined as follows:

Tier	Definition
1	Most generic drugs and low cost preferred brands.
	Non-preferred generic drugs or;
	2) Preferred brand name drugs or;
2	3) 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;
ļ	3) 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;
	3) Drug was manufactured using biotechnology or;
	4) Plan cost (net of rebates) is >\$600.

- 20) If a drug would otherwise qualify for placement on tier 4 and at least 3 treatment options are available for that particular condition as determined by either a plan's pharmaceutical and therapeutics (P&T) committee or indicated by the Food and Drug Administration (FDA) or according to applicable treatment guidelines for that condition, one drug used to treat that condition must be placed on either tier 1, 2 or 3. Plan formularies must include at least one drug in Tiers 1 or 2 or 3 if all FDA-approved drugs in the same drug class would otherwise qualify for Tier 4 and at least 3 drugs in that class are available as FDA-approved drugs.
- 21) All drugs covered in tier 4 must be expressly listed in the plan's formulary. All drugs placed in tiers 1 through 3 to treat the following conditions must be expressly listed in the plan's formulary: HIV/AIDs, hepatitis C, rheumatoid arthritis, multiple soler sis, systemic in the crystament sus. 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.
- 22) A plan's formulary must include a statement that other drugs that are covered may not be listed on the formulary for tiers 1-3.
- 2322) 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.
- 23) For 2016, a carrier may offer a plan with two in-network facility tiers if the lowest-cost tier network (Tier 1), complies with the cost-sharing requirements in the standard benefit plan design, meets state network adequacy and timeliness standards as applied by the applicable regulator and the carrier demonstrates that the two in-network facility tiers are in the best interest of the consumer as determined by Covered California on a case-by-case basis, based on premium stability, price, quality, choice and value. For non-Qualified Health Plans, the applicable regulator will review.



2016 Dental Standard Benefit Plan Designs

Date: April 16May 21	, 2015				
Summary of Benefits		Standalone Children's Dental Plan		Standalone Children's Dental Plan	
Member Cost Share amou	ints describe the Enrollee's out of pocket	Pediatric Dei Copay F		Pediatric Der Coinsurance	
		Up to Ag	je 19	Up to Ag	e 19
Actuarial Value		83.09	6	86.89	6
Individual Deductible (waived for Diagnostic &	Preventive)	\$0		\$65 In Ne \$65 Out of I	
Family Deductible (Two (waived for Diagnostic 8	or more children)	\$0		\$130 In Ne \$130 Out of	
Individual Out of Pocket		\$350		\$350	
Family Out of Pocket Ma	ximum (Two or More Children)	\$700		\$700)
Office Copay		\$0		\$0	
Walting Period (Walvered Condition provision, a 1357 50 (a)(3)(J)(4) and Insuran	is delined in Health & Safety Code	None	е	None	9
Annual Benefit Limit	l plan will pay in the ben ी। करेंग)	None	е	None	е
Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
CONTRACTOR OF THE	Oral Exam	\$0		0%	
	Preventive - Cleaning	\$0		0%	
m. d. D. D	Preventive - X-ray	\$0		0%	
Diagnostic & Preventive	Sealants per Tooth	\$0	CSM/M/CS	0%	NAME OF STREET
	Topical Fluoride Application	\$0		0%	
	Space Maintainers - Fixed	\$0	1.14 000 22.00	0%	
Basic Services	Amalgam Fill - One Surface	\$25		20%	<u> </u>
The second	Root Canal - Molar	\$300	C-SHIRT		
Major Services - Gr. With	Gingivectomy per Quad	\$150			
and Casts, Endodontics, Periodontics,	Extraction- Single Tooth Exposed Root or Erupted	\$65		50%	×
Prosthodontics, Oral	Extraction - Complete Bony	\$160			
Surgery	Crown - Porcelain with Metal	\$300		AND TAKE	
				50%	X

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

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

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

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



2016 Dental Standard Benefit Plan Designs

Date: April 16May 21, 2015

Summary of Benefit	Summary of Benefits and Coverage		Family Dental Plan				
Member Cost Share amo costs.	unts describe the Enrollee's out of pocket	Pediatric Dental EHB Copay Plan Up to Age 19		Adult Dental Copay Plan Age 19 and Older			
Actuarial Value		83.0%		Not Calc	ulated		
Individual Deductible (waived for Diagnostic &	Preventive)	\$	0	\$0			
Family Deductible (Two (waived for Diagnostic 8	Preventive)	\$	0	\$0			
		\$3	50	Not Appli	icable		
	ximum (Two or More Children)	\$7	00	Not Appli	icable		
Office Copay		\$0		\$0			
1357.50 (a)(3)(J)(4) and Insuran	is defined in Health & Safety Code co Code 10198.6 (10)(d)	No	ne	Non	Э		
Annual Benefit Limit (the maximum amount the dent	plan will pay in the benefit year)	No	ne	None	Э		
Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies		
	Oral Exam	\$0		\$0	Steel Heaven Strift Strings		
Control of the Park	Preventive - Cleaning	\$0		\$0	1		
Diagnostic & Preventive	Preventive - X-ray	\$0		\$0			
	Sealants per Tooth	\$0		Not Covered			
HOLD BUSINESS	Topical Fluoride Application	\$0		Not Covered			
	Space Maintainers - Fixed	\$0		Not Covered			
Basic Services	Amalgam Fill - One Surface	\$25		\$25			
	Root Canal - Molar	\$300		\$300			
	Gingivectomy per Quad	\$150		\$150			
Periodontics,	Extraction- Single Tooth Exposed Root or Erupted	\$65		\$65			
Actuarial Value Individual Deductible waived for Diagnostic & family Deductible (Two waived for Diagnostic & family Deductible (Two waived for Diagnostic & family Out of Pocket Ma Diffice Copay Vaiting Period Valvered Condition provision, 6 837.50 (a)(3)(J)(4) and Insurar unnual Benefit Limit he maximum amount the dent Procedure Category diagnostic & Preventive asic Services lajor Services - Crowns and Casts, Endodontics, eriodontics, rosthodontics, Oral urgery	Extraction - Complete Bony	\$160		\$160			
40.30.)	Crown - Porcelain with Metal	\$300		\$300			
Orthodontia	Medically Necessary Orthodontia	\$350		Not Covered			

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

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

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

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



Date: April 16May 21, 2015

2016 Dental Standard Benefit Plan Designs

Summary of Benefits and Coverage

Family	Dental	Plan		

Summary of Benefits	and Coverage		ramily De	mai rian		
Member Cost Share amour	nts describe the Enrollee's out of pocket	Pediatric Dental EHB Coinsurance Plan Up to Age 19		Adult Dental Coinsurance Plan Age 19 and Older		
	3					
Actuarial Value		86.8%	,	Not Calcu	lated	
Individual Deductible (waived for Diagnostic &	Preventive)	\$65 In Net \$65 Out of N		\$50 In Ne \$50 Out of I		
Family Deductible (Two or more children) (waived for Diagnostic & Preventive)		\$130 In Network/ \$130 Out of Network		Not Appli		
Individual Out of Pocket		\$350		Not Appli		
	kimum (Two or More Children)	\$700		Not Appli	cable	
Office Copay	CALIFORNIA DE LA CONTRACTOR DE LA CONTRA	\$0		\$0		
Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d)		None		6 months for Major Services, Waived with Pro of Prior Coverage		
Annual Benutit Limit	Spring Port Edit Eller	None	•	\$1,50	00	
Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
	Oral Exam	0%	F	0%	t	
	Preventive - Cleaning	0%	1	0%		
	Preventive - X-ray	0%		0%		
Diagnostic & Preventive	Sealants per Tooth	0%		Not Covered		
	Topical Fluoride Application	0%		Not Covered		
	Space Maintainers - Fixed	0%		Not Covered		
Basic Services	Amalgam Fill - One Surface	20%	×	20%	X	
	Root Canal - Molar		ŧ.		1	
Major Services - Count and Casts, Endodontics, Periodontics,	Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted	50%	×	50%	x	
Prosthodontics, Oral	Extraction - Complete Bony	2	1	1	1	
Surgery	Crown - Porcelain with Metal					
Orthodontia	Medically Necessary Orthodontia	50%	X	Not Covered	1	

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

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

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

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