

May 27, 2015

### ADVANCE NOTICE OF INTENT TO FILE EMERGENCY REGULATIONS

This notice is sent in accordance with Government Code Section 11346.1(a)(2), which requires that State of California agencies give advance notice at least five working days of their intent to file emergency regulations with the Office of Administrative Law (OAL). The California Health Benefit Exchange ("Exchange") intends to file an Emergency Rulemaking package with the Office of Administrative Law (OAL) that proposes a readoption of the 2016 Standard Benefit Plan Designs which must be used by Qualified Health Plans that are certified in the Individual and SHOP Exchanges for Plan Year 2016 to be offered through Covered California. The proposed re-adoption offers a few changes from the regulation package adopting Section 6432 approved by OAL on February 19, 2015. As required by subdivisions (a)(2) and (b)(2) of Government Code Section 11346.1, this notice appends the following: (1) the specific language of the proposed regulation and (2) the Finding of Emergency, including specific facts demonstrating the need for immediate action, the authority and reference citations, the informative digest and policy statement overview, attached reports, and required determinations.

The Exchange plans to file the Emergency Rulemaking package with OAL at least five working days from the date of this notice. If you would like to make comments on the Finding of Emergency or the proposed regulations (also enclosed), they must be received by both the Exchange and the Office of Administrative Law within five calendar days of OAL's posting this Advance Notice on its website.

Response to public comments is strictly at the Exchange's discretion.

Comments should be sent simultaneously to:

California Health Benefit Exchange Attn: Andrea Rosen 1601 Exposition Blvd. Sacramento, CA 95815 Andrea.Rosen@covered.ca.gov

Office of Administrative Law 300 Capitol Mall, Suite 1250 Sacramento, CA 95814 staff@oal.ca.gov Upon filing, OAL will have ten (10) calendar days within which to review and make a decision on the proposed emergency rule. If approved, OAL will file the regulations with the Secretary of State, and the emergency regulations will become effective for two years from the date of OAL approval, unless the Exchange either repeals the regulations or makes them permanent through a certification of compliance pursuant to section 11346.1(e) within that two year period. Please note that this advance notice and comment period is not intended to replace the public's ability to comment once the emergency regulations are approved. There will be a 45-day comment period within the two year certification period following the effective date of the emergency regulations.

You may also view the proposed regulatory language and Finding of Emergency on the Exchange's website at the following address: <a href="http://hbex.coveredca.com/regulations/">http://hbex.coveredca.com/regulations/</a>

If you have any questions concerning this Advance Notice, please contact Andrea Rosen at (916) 228-8343.

### FINDING OF EMERGENCY

The Director of the California Health Benefit Exchange finds an emergency exists and that this proposed emergency regulation is necessary to address a situation that calls for immediate action to avoid serious harm to the public peace, health, safety, or general welfare.

### **DEEMED EMERGENCY**

The Exchange may "Adopt rules and regulations, as necessary. Until January 1, 2016, any necessary rules and regulations may be adopted as emergency regulations in accordance with the Administrative Procedures Act. The adoption of these regulations shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare" (Gov. Code § 100504(a)(6)).

### **AUTHORITY AND REFERENCE**

Authority: Government Code Section 100504

Reference: Government Code Sections 100503,100504(c); Health and Safety Code

Section 1366.6 (e) and Insurance Code Section 10112(e)

### **INFORMATIVE DIGEST / POLICY STATEMENT OVERVIEW**

### Documents to be incorporated by reference:

2016 Standard Benefit Plan Designs dated May 21, 2015 as amended on January 29, 2015 will be incorporated by reference in the proposed regulations.

# **Summary of Existing Laws**

Under the federal Patient Protection and Affordable Care Act (PPACA), each state was required, by January 1, 2014, to establish an American Health Benefit Exchange that makes available qualified health plans to qualified individuals and small employers. Existing state law, the California Patient Protection and Affordable Care Act, established the California Health Benefit Exchange within state government. (Gov. Code § 100500 et seq.) The Exchange has the authority to standardize products to be offered through the Exchange. (Gov. Code § 100504 (c)). The Exchange shall establish and use a competitive process to select participating carriers. (Gov. Code §100505). The Exchange has exercised its authority to establish and require Qualified Health Plans to use the 2016 Standard Benefit Plan Designs for the 2016 Plan Year in order to make a side by side comparison of competing plans easier for Covered California enrollees. Using standard benefit plan designs will make it easier for enrollees to make an informed choice and choose the right plan for themselves and their families. The Exchange standard benefit plan designs must also be offered by non-Exchange issuers selling off-Exchange plans.

The proposed regulations amend the Exchange's standard benefit plan designs for Plan Year 2016 which were initially approved by OAL on February 19, 2015 and a subsequent re-adoption with minor changes was approved on March 18, 2015. Specifically, the proposed changes to these regulations will:

- For individual Platinum, Gold, Silver and Silver 73 plans and for SHOP silver plans, a cap of up to \$250 per 30 day script is established for Tier 4 drugs.
- For SHOP Silver plans, the actuarial values were corrected, the individual plan
  pharmacy deductible was reduced from \$500 to \$250 per year, the family plan
  pharmacy deductible was reduced from \$1000 to \$500 per year and a per 30 day
  script cap was established for Tier 4 drugs.
- For the SHOP Silver Health Savings Account plan, the Revenue-Procedure 2015-30 amount for an individual's minimum deductible in a family plan was set.
- For the Silver cost-sharing reduction plans, 94 and 87, a cap of up to \$150 per 30 day script Tier 4 drugs was set.
- For the Bronze plan, the actuarial value was adjusted, the integrated deductible
  was replaced by separate medical and pharmacy deductibles, a cap of up to
  \$500 per 30 day script for all drug tiers was set and the co-insurance amounts up
  to the deductible were clarified.
- The proposed regulations includes amendments to the Endnotes that reflect the above changes to the benefit plan designs.
- The amendments also make minor clarification in the Endnotes that clarify that a recent federal rule regarding publication of all drugs, regardless of tier placement, must be listed in a plan's formulary to increase consumer transparency.
- Revised Endnote 20 which requires the placement of a qualifying Tier 4 drug on another Tier if at least 3 drugs in that class are available to increase clarity.
- The proposed regulations clarify that a plan may offer two in-network facility tiers and the requirements for these plans are established.

The proposed regulations will provide the health insurance issuers who seek to offer Qualified Health Plans for the Plan year 2016 with greater clarity regarding how the 2016 standard benefit plan designs that are required as a condition of certification and re-certification in the individual and SHOP Exchanges must be administered. In addition, the proposed changes to these regulations will guide regulators who approve insurance policy forms and evidence of coverage documents for off-exchange plans who are required by law to offer plans identical to on-exchange plans.

After an evaluation of current regulations, specifically 10 CCR 6460, the Exchange has determined that these proposed regulations are not inconsistent or incompatible with any existing regulations. These regulations comply with applicable federal rules requiring the use of the federal actuarial value calculator, and the 2016 Notice of Benefit and Payment Parameters at 45 CFR 153, 155 and 156, in particular, the federal requirements for publishing an up-to-date, accurate and complete list of covered drugs on plan formularies.

### JUSTIFICATION FOR DUPLICATION

These proposed regulations were developed with significant stakeholder input, including health issuers and consumer representatives and do not duplicate Section 6460 but instead replace them for the 2016 Plan Year. While there are some similarities between 2015 and 2016 Standard Benefit Plan Designs, and they do both govern the enrollee's cost-sharing obligations, the proposed regulations provide greater specificity and details making for greater transparency for 2016 enrollees and the health insurance issuers who are administering these benefit plans. .

# MATTERS PRESCRIBED BY STATUTE APPLICABLE TO THE AGENCY OR TO ANY SPECIFIC REGULATION OR CLASS OF REGULATIONS

None

### LOCAL MANDATE

The Executive Director of the California Health Benefit Exchange has determined that this proposed regulatory action does not impose a mandate on local agencies or school districts.

### **FISCAL IMPACT ESTIMATES**

This proposal does not impose costs on any local agency or school district for which reimbursement would be required pursuant to Section 7 (commencing with Section 17500) of Division 4 of the Government Code. This proposal does not impose other nondiscretionary cost or savings on local agencies.

### COSTS OR SAVINGS TO STATE AGENCIES AND TO FEDERAL FUNDING

The proposal results in some additional costs, mostly to enforce and ensure consistent administration, to the California Health Benefit Exchange, which is funded by participation fees paid by QHP health issuers to the Exchange. Additional savings in federal funding will be realized since no federal funds will be used to adopt and enforce the 2016 Standard Benefit Plan designs.

# 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 May 21, 2015



### Summary of Benefits and Coverage

	hare amounts describe the Enrollee's out of pocket costs.	Platinu Coinsurant	e Plan	Platinu Copay F	lan
	e - AV Calculator	88.5%	6	89.5%	b
	cludes a deductible?	No		No	
	Individual deductible Family deductible	\$0 \$0		\$0 \$0	
Individual	deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 /		\$0 / \$0 /	
Family ded	luctible, NOT integrated: Medical / Pharmacy / Dental -of-pocket maximum	\$0 / \$0 / \$4,00	1\$0 n	\$0 / \$0 / \$4.00	
Family Out-of-	pocket maximum	\$8,00		\$8,00	
HSA plan: Self	-only coverage deductible in: Individual deductible	N/A N/A		N/A N/A	
	in: 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	\$20		\$20	
Health care provider's	Other practitioner office visit	\$20		\$20	
office or clinic visit	Specialist visit	\$40		\$40	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$20		\$20	
resis	Imaging (CT/PET scans, MRIs)	\$40 10%		\$40 \$150	
	Tier 1	\$5		\$5	
Drugs to treat illness or	Tier 2	\$15		\$15	
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%		\$40	
	,	10%		10%	
	Emergency room facility fee (waived if admitted)	\$150		\$150	
Need	Emergency room physician fee (waived if admitted)	10%		No charge	
immediate	Emergency medical transportation	\$150		\$150	
attention	Urgent care	\$40		\$40	
Hospital stay	Facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Physician/surgeon fee	10%		\$40	
	Mental/Behavioral health outpatient office visits	\$20		\$20	
	Mental/Behavioral health other outpatient items and services	\$20		\$20	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%		\$250 per day up	
Mental health,	Mental/Behavioral health inpatient physician/surgeon fee	10%		to 5 days \$40	
behavioral	Mentav Benavioral Health inpatient physician/surgeon ree	10%		\$40	_
health, or substance abuse needs	Substance Use disorder outpatient office visits	\$20		\$20	
	Substance Use disorder other outpatient items and services	\$20		\$20	
	Substance Use inpatient facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Substance use disorder inpatient physician/surgeon fee	10%		\$40	
	Prenatal care and preconception visits	No charge		No charge	
Pregnancy	Delivery and all inpatient Hospital	10%		\$250 per day	
	services Professional	10%		up to 5 days \$40	
	Home health care	10%		\$20	
Help	Outpatient Rehabilitation services Outpatient Habilitation services	\$20		\$20	
recovering or other special		\$20		\$20 \$150 per day up	
health needs	Skilled nursing care	10%		to 5 days	
	Durable medical equipment Hospice service	10% No charge		10% No charge	
Child eye	Eye exam	No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray	1			
and	Sealants per Tooth	No charge		No charge	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Amalgam Fill - 1 Surface	20%		\$25	
Child Device	Root Canal- Molar			\$300	
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted	50%		\$150 \$65	
Services	Extraction- Complete Bony	1		\$160	
	Porcelain with Metal Crown			\$300	
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

			Coinsurance 80.29	6	<del>81.0%</del> 81	lan .1%
	cludes a deductible?		No		No	
Integrated	Individual deductible		\$0		\$0	
	Family deductible	Modical / Pharmacy / Dontal	\$0	/ ¢n	\$0	en.
Family ded	luctible, NOT integrated: Me	Medical / Pharmacy / Dental edical / Pharmacy / Dental	\$0 / \$0 / \$0 / \$0 /	\$0	\$0 / \$0 / \$0 / \$0 /	\$0
	of-pocket maximum		\$6,20 \$12,40		\$6,20 \$12,40	
	f-only coverage deductible		\$12,40 N/A	00	\$12,40 N/A	10
HSA family pla	an: Individual deductible		N/A		N/A	
Common Medical			Member Cost	Deductible	Member Cost	Deductib
Event		rvice Type	Share	Applies	Share	Applies
Health care	Primary care visit to treat an in	njury, illness, or condition	\$35		\$35	
provider's office or clinic visit	Other practitioner office visit		\$35		\$35	
	Specialist visit		\$55		\$55	
	Preventive care/ screening/ in	nmunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagin	g	\$35 \$50		\$35 \$50	
	Imaging (CT/PET scans, MRI	ls)	20%		\$250	
	Tier 1		\$15		\$15	
Drugs to treat	Tier 2		\$50		\$50	
illness or condition	Tier 3		\$70		\$70	
	Tier 4		20% up to \$250 per script		20% up to \$250 per script	
Outpatient	Surgery facility fee (e.g., ASC	)	20%		\$600	
services	Physician/surgeon fees Outpatient visit		20%		\$55 20%	
	Emergency room facility fee (	waived if admitted)	\$250		\$250	
Need	Emergency room physician fee (waived if admitted)		20%		No charge	
mmediate	Emergency medical transport	ation	\$250		\$250	
attention	Urgent care		\$60		\$60	
Hospital stay	Facility fee (e.g. hospital room	n)	20%		\$600 per day up to 5 days	
nospitai stay	Physician/surgeon fee		20%		to 5 days \$55	
	Mental/Behavioral health outp	patient office visits	\$35		\$35	
	Mental/Behavioral health other	er outpatient items and services	\$35		\$35	
	Mental/Behavioral health inna	atient facility fee (e.g.hospital room)	20%		\$600 per day up	
Mental health.					to 5 days	
neaith, behavioral	Mental/Behavioral health inpa	tient physician/surgeon fee	20%		\$55	
health, or substance abuse needs	Substance Use disorder outp	atient office visits	\$35		\$35	
	Substance Use disorder other	r outpatient items and services	\$35		\$35	
	Substance Use inpatient facili	ity fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Substance use disorder inpat	ient physician/surgeon fee	20%		\$55	
	Prenatal care and preconcept	tion visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%		\$600 per day	
	services	Professional	20%		up to 5 days \$55	
	Home health care		20%		\$30	
Help	Outpatient Rehabilitation service  Outpatient Habilitation service	ices is	\$35 \$35		\$35 \$35	
recovering or other special	Skilled nursing care		20%		\$300 per day up	
health needs	Durable medical equipment		=+11		to 5 days	
	Hospice service		20% No charge		20% No charge	
Child eye	Eye exam		No charge		No charge	
care	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge		No charge	
01:11 D	Oral Exam					
Child Dental Diagnostic and Preventive	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application		No charge		No charge	
Child Dental Basic	Space Maintainers - Fixed  Amalgam Fill - 1 Surface		20%		\$25	
	Poot Conel Males				****	
	Root Canal- Molar		-		\$300 \$150	
Services						
Services Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Expo	osed Root or Erupted	50%		\$65	
Services Child Dental Major Services	Gingivectomy per Quad	osed Root or Erupted	50%			

	Benefits and Coverage		Individua Silver Blan	
	hare amounts describe the Er	rollee's out of pocket costs.	Silver Plan	1
	e - AV Calculator		70.4%	
	cludes a deductible? Individual deductible		Yes, Medical/Pha N/A	armacy
Integrated	Family deductible		N/A	
	deductible, NOT integrated: luctible, NOT integrated: Me	Medical / Pharmacy / Dental	\$2,250 / \$250 \$4,500 / \$500	
	of-pocket maximum	dicar/ Filannacy / Dentar	\$6,250	7 40
Family Out-of-	pocket maximum -only coverage deductible		\$12,500 N/A	
HSA family pla	n: Individual deductible		N/A	
Common				
Medical Event	Sa	rvice Type	Member Cost Share	Deductible Applies
270.11	30	vice Type	monipor ocor onaro	пррисо
	Primary care visit to treat an ir	njury, illness, or condition	\$45	
Health care				
provider's	Other practitioner office visit		\$45	
office or clinic visit				
	Specialist visit		\$70	
	Drawantina aasa/aasaaniaa/in		Neckary	
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge \$35	
Tests	X-rays and Diagnostic Imagin		\$65	
	Imaging (CT/PET scans, MR	S)	\$250	
	Tier 1		\$15	
				Dharman
Orugs to treat	Tier 2		\$50	Pharmac deductibl
Iness or ondition			Pharmac	
	Tier 3		\$70	deductible
	Tion 4		20% up to \$250 per	Pharmac
	Tier 4		script after pharmacy deductible	deductible
Outpatient	Surgery facility fee (e.g., ASC	)	20%	
services	Physician/surgeon fees Outpatient visit		20% 20%	
	Emergency room facility fee (	waived if admitted)	\$250	х
			<b>0</b> 50	х
Need	Emergency room physician fee (waived if admitted)  Emergency medical transportation		\$50 \$250	X
mmediate attention	Emolgono managaritation		\$230	^
	Urgent care		\$90	
	Facility fee (e.g. hospital room	1)	20%	х
Hospital stay	Physician/surgeon fee	,	20%	Х
	Mental/Behavioral health outp	patient office visits	\$45	
	Mental/Behavioral health other outpatient items and services		\$45	
Mental	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	х
nealth,	Mental/Behavioral health inpa	tient physician/surgeon fee	20%	х
pehavioral nealth, or				
substance	Substance Use disorder outp	atient office visits	\$45	
abuse needs				
	Substance Heading desider - 11 -	r outpationt itams and anninn	0.45	
	ounstance Use disorder othe	r outpatient items and services	\$45	
	Substance Use inpatient facili	ity fee (e.g. hospital room)	20%	Х
	Substance use disorder inpat		20%	Х
	Prenatal care and preconcep	1	No charge	
Pregnancy	Delivery and all inpatient services	Hospital	20%	Х
	Home health care	Professional	20% \$45	Х
lelp	Outpatient Rehabilitation serv		\$45	
ecovering or	Outpatient Habilitation service	es	\$45	
other special nealth needs	Skilled nursing care		20%	Х
	Durable medical equipment Hospice service		20% No charge	
Child eye	Eye exam		No charge	
are	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge	
	Oral Exam Preventive - Cleaning			
Diagnostic	Preventive - X-ray		No charge	
ind Preventive	Sealants per Tooth Topical Fluoride Application		90	
	Space Maintainers - Fixed			
Child Dental	Amalgam Fill - 1 Surface		20%	
Basic Services	Amaigam Fili - 1 Suriace		20%	
	Root Canal- Molar			
Major	Gingivectomy per Quad Extraction- Single Tooth Expo	osed Root or Erupted	50%	
Services	Extraction- Complete Bony Porcelain with Metal Crown			
Child	Medically necessary orthodor	tion	50%	

	- 10 <u>may 21</u> , 2013					
	Benefits and Coverage		SHOP Silver		SHOP Silver	
Member Cost S	Share amounts describe the E	nrollee's out of pocket costs.	Coinsurance	Plan	Copay Pla	n
<b>Actuarial Value</b>	e - AV Calculator		<del>71.7%</del> <u>71.6</u>	<u>%</u>	<del>71.4%</del> <u>71.3</u>	%
	cludes a deductible?		Yes, Medical/Pha	armacy	Yes, Medical/Pha	armacy
Integrated	Individual deductible Family deductible		N/A N/A		N/A N/A	
Individual	deductible, NOT integrated:	Medical / Pharmacy / Dental	\$1,500 / <del>\$500</del> <u>\$2</u>		\$1,500 / <del>\$500</del> <u>\$2</u>	
Individual Out-	luctible, NOT integrated: Mo -of-pocket maximum	edical / Pharmacy / Dental	\$3,000 / <del>\$1,000</del> <u>\$</u> \$6,500	500 / \$0	\$3,000 / <del>\$1,000</del> <u>\$</u> \$6,500	500 / \$0
Family Out-of-	pocket maximum		\$13,000		\$13,000	
	f-only coverage deductible an: Individual deductible		N/A N/A		N/A N/A	
Common						
Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an i		\$45		\$45	
Health care provider's office or	Other practitioner office visit		\$45		\$45	
clinic visit	Specialist visit		\$70		\$70	
	Preventive care/ screening/ ir	nmunization	No charge		No charge	
	Laboratory Tests		\$35		\$35	
Tests	X-rays and Diagnostic Imagir Imaging (CT/PET scans, MR	ig ls)	\$65 20%	X	\$65 \$250	
		,				
	Tier 1		\$15	Diversion	\$15	Discourse
Drugs to treat	Tier 2		\$55	Pharmacy deductible	\$55	Pharmacy deductible
condition	Tier 3		\$75	Pharmacy deductible	\$75	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%		20% 20%	
services	Outpatient visit		20%		20%	
	Emergency room facility fee (	waived if admitted)	\$250	Х	\$250	Х
	Emergency room physician f	ee (waived if admitted)	\$50	Х	\$50	Х
Need immediate	Emergency medical transportation		\$250	X	\$250	X
attention			120		120	
	Urgent care		\$90		\$90	
Hospital stay	Facility fee (e.g. hospital roon	n)	20%	Х	20%	х
	Physician/surgeon fee		20%	X	20%	X
	Mental/Behavioral health out	patient office visits	\$45		\$45	
	Mental/Behavioral health other outpatient items and services		\$45		\$45	
	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	20%	Х	20%	Х
Mental health,	Mental/Behavioral health inpa	ationt physician/surgeon fee	20%	Х	20%	х
behavioral health, or	Wertar Denavioral ricalitr inpe	ment priyacian/aurgeon rec	20%	^	20%	^
substance abuse needs	Substance Use disorder outp	patient office visits	\$45		\$45	
	Substance Use disorder other	er outpatient items and services	\$45		\$45	
	Substance Use inpatient faci	ity fee (e.g. hospital room)	20%	Х	20%	х
	Substance use disorder inpa	tient physician/surgeon fee	20%	х	20%	х
	Prenatal care and preconcep	tion visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	х	20%	х
	services	Professional	20%	X	20%	X
	Home health care Outpatient Rehabilitation sen	rices	20% \$45		\$45 \$45	
Help recovering or	Outpatient Habilitation service		\$45		\$45	
other special	Skilled nursing care		20%	х	20%	х
health needs	Durable medical equipment		20%		20%	
Child	Hospice service Eye exam		No charge No charge		No charge No charge	
Child eye care		contact lenses in lieu of glasses)	No charge		No charge	
			charge		110 Griange	
Diagnostic and	Preventive - X-ray Sealants per Tooth		No charge		No charge	
Preventive	Topical Fluoride Application					
OLULE .	Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%		\$25	
	Root Canal- Molar				\$300	
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Exp	osed Root or Erupted	50%		\$150 \$65	
Services	Extraction- Complete Bony				\$160	
	Porcelain with Metal Crown				\$300	
Child Orthodontics	Medically necessary orthodo	ntics	50%		\$1,000	

-	Benefits and Coverage		SHOF Silver HSA PL	
Actuarial Value	e - AV Calculator		70.5%	
Plan design in	cludes a deductible?		Yes, integr	ated
	Individual deductible Family deductible		\$2,000 inte \$4,000 inte	
		Medical / Pharmacy / Dental	\$4,000 inte N/A	grateu
	luctible, NOT integrated: Me -of-pocket maximum	edical / Pharmacy / Dental	N/A \$6.250	`
Family Out-of-	pocket maximum		\$12,50	
<b>HSA plan: Self</b>	only coverage deductible in: Individual deductible		\$2,000 See endnote	
	III. IIIulviuuai ueuucubie		Oce enanote	<u>\$2,000</u>
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an i	njury, illness, or condition	20%	Х
Health care provider's office or	Other practitioner office visit		20%	х
clinic visit	Specialist visit		20%	х
	Preventive care/ screening/ ir	nmunization	No charge	
	Laboratory Tests X-rays and Diagnostic Imagir	o a	20% 20%	X
	Imaging (CT/PET scans, MR		20%	X
	Tier 1		20%	Х
Drugs to treat	Tier 2		20%	Х
illness or condition	Tier 3		20%	х
	Tier 4		20%	Х
Outpatient	Surgery facility fee (e.g., ASC	·)	20% 20%	X
services	Physician/surgeon fees Outpatient visit		20%	X
	Emergency room facility fee (	waived if admitted)	20%	X
Need	Emergency room physician fee (waived if admitted)		20%	X
immediate attention	Emergency medical transpor	ation	20%	X
attention	Urgent care		20%	х
Hospital stay	Facility fee (e.g. hospital room	n)	20%	Х
	Physician/surgeon fee		20%	Х
	Mental/Behavioral health outpatient office visits		20%	х
	Mental/Behavioral health othe	er outpatient items and services	20%	х
	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	20%	Х
Mental health,	Mental/Behavioral health inpa	stient physician/surgeon fee	200/	Х
behavioral health, or substance	Substance Use disorder outp		20%	×
abuse needs				
		er outpatient items and services	20%	Х
	Substance Use inpatient facil	ity tee (e.g. hospital room)	20%	Х
	Substance use disorder inpa	ient physician/surgeon fee	20%	х
	Prenatal care and preconcep	tion visits	No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	Х
	services	Professional	20%	X
	Home health care Outpatient Rehabilitation serv	inge	20%	X
Help	Outpatient Rehabilitation service		20%	X
recovering or	Skilled nursing care		20%	X
health needs	Durable medical equipment		20%	X
	Hospice service		0%	X
Offina eye	L pair of glasses per year (ex.	position language in Herri of other	No charge	
care	1 pair of glasses per year (or	connect renses in lieu or grasses)	No charge	
Child Dental	Oral Exam Preventive - Cleaning Preventive - X-ray			
Diagnostic			No charge	
and Preventive	Sealants per Tooth Topical Fluoride Application		90	
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%	
	Root Canal- Molar			
Child Dental Major	Gingivectomy per Quad	need Poot or Frunted	50%	
Services	Extraction- Single Tooth Exp Extraction- Complete Bony Porcelain with Metal Crown	SSSG NOOLOLETUPIEG	30%	
Child	Medically necessary orthodor	ntics	50%	
Orthodontics				

Sheep Plant	Summary of	Benefits and Coverage					
Marchael Annie   Marc	Member Cost S	Share amounts describe the En	rollee's out of pocket costs.			Silver Plan 150%-200% F	PL
International Professional Reduction   No.   N	Actuarial Valu	e - AV Calculator					
Interpretary   Security   Secur					harmacy		macy
Particular Oxide-Circle   100   10	Integrated	Family deductible					
Section   Sect							
March   Marc	Individual Out	of-pocket maximum	alcai / Friaimacy / Demai	\$2,25	0	\$2,250	\$0
Primary Control   Primary Control Note   Primary Control Note   Primary Control to Search in Flyury, Mess, or condition   S.S.	HSA plan: Self	f-only coverage deductible			0		
Monitable   Monitable Cost   Ageinstical Primary care visit to test an injury, liness, or condition   \$5   \$15	HSA family pla	an: Individual deductible		N/A		N/A	
Primary care wild to breat an injury, lineas, or condition				Member Cost	Doductible		Doductible
Month care providers with  Specials visit  Test  Incomparity (Fig. 1987)  Test		Ser	vice Type			Member Cost Share	
Month care providers with  Specials visit  Test  Incomparity (Fig. 1987)  Test		Primary care visit to treat an in	iury illness or condition	<b>\$</b> 5		<b>\$15</b>	
Province or		Trinding said visit to trout air in	jary, imrood, or corramon	ψυ		\$15	
Specialist visit   Specialist   Specialist visit   Specialist   Speci		Other practitioner office visit		<b>\$</b> E		¢15	
Preventive carer screengy immunization	office or	Curior practition of cinico visit		ψυ		\$15	
Preventive care's consensing' immunization No change \$8 \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$15 \$15	Clinic visit	Specialist visit		\$8		\$25	
Each   Control							
Test			munization				
Ter 1	Tests	X-rays and Diagnostic Imaging		\$8		\$25	
Present   Programmer   Progra		imaging (CT/PET scans, MRI	5)	\$50		\$100	
Ter 3		Tier 1		\$3		\$5	
Ter 3		Tior 2		040		200	Pharmacy
Ter 3		Hel Z		\$10		\$20	
The 4		Tier 3		\$15		\$35	
Terr 4  Outpatient Surgery facility fore (e.g., ASC)  Outpatient services  Surgery facility fore (e.g., ASC)  Physician/aurygoon fees  Outpatient services  Emergenory room facility fee (walved if admitted)  Emergenory more including feel (walved if admitted)  Emergeno				ψισ		· ·	deductible
Surgery facility fee (e.g., ASC)   10%   15%   15%		Tier 4		10% up to \$150			
Physician/surgeon fees   10%   15%   15%		Surgery facility fee (e.g., ASC)				deductible	acaactible
Comparison with temperatury come facility fee (walved if admitted)   \$30		Physician/surgeon fees		10%		15%	
Emergency room physician fee (waived if admitted)   \$25							
Commercial attention   Commercial transportation   Comme				\$30	Х	\$75	X
Hospital stay Facility fee (e.g. hospital room) 10% X 15% X  Mental/Behavioral health outpatient office visits \$5 \$15  Mental/Behavioral health other outpatient items and services \$5 \$15  Mental/Behavioral health other outpatient items and services \$5 \$15  Mental/Behavioral health other outpatient items and services \$5 \$15  Mental/Behavioral health inpatient facility fee (e.g. hospital room) 10% X 15% X  behavioral health, or substance abuse needs \$5 \$15  Substance Use disorder outpatient office visits \$5 \$15  Substance Use disorder other outpatient items and services \$5 \$15  Substance Use inpatient facility fee (e.g. hospital room) 10% X 15% X  Substance Use inpatient facility fee (e.g. hospital room) 10% X 15% X  Substance Use inpatient physician/surgeon fee 10% X 15% X  Substance Use disorder outpatient items and services S 5 S15 S15 S15 S15 S15 S15 S15 S15 S15	Need		· · · · · · · · · · · · · · · · · · ·				
Urgent care		Emergency medical transporta	ation	\$30	Х	\$75	X
Hospital stay Projection/surgeon fee  Mental/Behavioral health outpatient office visits  Mental/Behavioral health other outpatient items and services  Sissiphane  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient physician/surgeon fee  bloadvoral health, or substance abuse needs  Substance Use disorder outpatient office visits  Substance Use disorder outpatient office visits  Substance Use disorder outpatient items and services  Substance Use disorder inpatient physician/surgeon fee  10% X 15% X  Substance Use inpatient facility fee (e.g. hospital room)  Substance Use inpatient facility fee (e.g. hospital room)  Substance Use inpatient physician/surgeon fee  10% X 15% X  Substance Use disorder inpatient physician/surgeon fee  10% X 15% X  Pregnancy  Pregnancy  Delivery and all inpatient  services  Pregnancy  Delivery and all inpatient  services  Sissississississississississississississ	uttontion	Urgent care		\$6		\$30	
Mental/Behavioral health outpatient office visits  Mental/Behavioral health other outpatient items and services  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient physician/surgeon fee  10% X 15% X  Mental/Behavioral health inpatient physician/surgeon fee  10% X 15% X  Substance Use disorder outpatient ems and services  Substance Use disorder outpatient ems and services  Substance Use disorder other outpatient fems and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance Use inpatient facility fee (e.g. hospital room)  10% X 15% X  Substance Use inpatient facility fee (e.g. hospital room)  10% X 15% X  Prenatal care and preconception visits  No charge  Pregnancy  Delivery and all inpatient hypisician/surgeon fee  10% X 15% X  15% X  Pregnancy  Delivery and all inpatient hypisician/surgeon fee  10% X 15% X  15% X		Ĭ				•••	
Mental/Behavioral health outpatient office visits  Mental/Behavioral health other outpatient items and services  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient physician/surgeon fee  10% X 15% X  Mental/Behavioral health inpatient physician/surgeon fee  10% X 15% X  Substance Use disorder outpatient ems and services  Substance Use disorder outpatient ems and services  Substance Use disorder other outpatient fems and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance Use inpatient facility fee (e.g. hospital room)  10% X 15% X  Substance Use inpatient facility fee (e.g. hospital room)  10% X 15% X  Prenatal care and preconception visits  No charge  Pregnancy  Delivery and all inpatient hypisician/surgeon fee  10% X 15% X  15% X  Pregnancy  Delivery and all inpatient hypisician/surgeon fee  10% X 15% X  15% X		Facility fee (e.g. hospital room	)	10%	х	15%	×
Mental/Behavioral health other outpatient items and services  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient physician/surgeon fee  10%  X  15%  X  Mental/Behavioral health inpatient physician/surgeon fee  10%  X  15%  X  Substance Use disorder outpatient office visits  Substance Use disorder orther outpatient office visits  Substance Use disorder orther outpatient abuse needs  Substance Use inpatient facility fee (e.g. hospital room)  Substance Use inpatient facility fee (e.g. hospital room)  Delivery and all inpatient physician/surgeon fee  10%  X  15%  X  Prenatal care and preconception visits  No charge  Pregnancy  Delivery and all inpatient physician/surgeon fee  10%  X  15%  X  15%  X  Home health care  Outpatient Rehabilitation services  S5  S15  Outpatient Rehabilitation services  S5  S15  Outpatient Rehabilitation services  S5  S15  Outpatient Habilitation services	Hospital stay			10%			
Mental/Behavioral health other outpatient items and services  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient physician/surgeon fee  10%  X  15%  X  Mental/Behavioral health inpatient physician/surgeon fee  10%  X  15%  X  Substance Use disorder outpatient office visits  Substance Use disorder orther outpatient office visits  Substance Use disorder orther outpatient abuse needs  Substance Use inpatient facility fee (e.g. hospital room)  Substance Use inpatient facility fee (e.g. hospital room)  Delivery and all inpatient physician/surgeon fee  10%  X  15%  X  Prenatal care and preconception visits  No charge  Pregnancy  Delivery and all inpatient physician/surgeon fee  10%  X  15%  X  15%  X  Home health care  Outpatient Rehabilitation services  S5  S15  Outpatient Rehabilitation services  S5  S15  Outpatient Rehabilitation services  S5  S15  Outpatient Habilitation services							
Mental health, health, beath, or substance abuse needs  Substance Use disorder outpatient office visits  Substance Use disorder outpatient items and services  Substance Use disorder outpatient items and services  Substance Use disorder inpatient physician/surgeon fee  10% X 15% X  Substance Use disorder outpatient items and services  Substance Use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Fregnancy  Pregnancy  Pregnancy  Pregnancy  Delivery and all inpatient  Hospital 10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpati		Mental/Behavioral health outp	atient office visits	\$5		\$15	
Mental health, health, beath, or substance abuse needs  Substance Use disorder outpatient office visits  Substance Use disorder outpatient items and services  Substance Use disorder outpatient items and services  Substance Use disorder inpatient physician/surgeon fee  10% X 15% X  Substance Use disorder outpatient items and services  Substance Use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Fregnancy  Pregnancy  Pregnancy  Pregnancy  Delivery and all inpatient  Hospital 10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Substance use disorder inpati							
Mental health, behavioral health inpatient physician/surgeon fee		Mental/Behavioral health other	r outpatient items and services	\$5		\$15	
Mental health, behavioral health inpatient physician/surgeon fee		Montal/Robavioral booth innat	iont facility foo (a a boonital room)	400/	V	450/	- V
behavioral health, or substance abuse needs  Substance Use disorder outpatient items and services  Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician/surgeon fee  Prenatal care and preconception visits  No charge  Prenatal care and preconception visits  No charge  Delivery and all inpatient services  Home health care  Outpatient Ababilitation services  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  15% X							
Substance Use disorder outpatient office visits  Substance Use disorder outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Prenatal care and preconception visits  No charge  Pregnancy	behavioral	Mental/Behavioral health inpat	ient physician/surgeon fee	10%	Х	15%	X
Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Prenatal care and preconception visits  No charge  Pregnancy  Delivery and all inpatient services  Professional  Hospital  Hospital  10% X 15% X  15%		Substance Use disorder outpa	atient office visits	\$5		\$15	
Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician/surgeon fee  Prenatal care and preconception visits  No charge  Prenatal care and preconception visits  No charge  Delivery and all inpatient services  Professional  Hospital  Professional  10% X 15% X  15% X	abuse needs			Ψΰ		<b>\$</b> .0	
Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician/surgeon fee  Prenatal care and preconception visits  No charge  Prenatal care and preconception visits  No charge  Delivery and all inpatient services  Professional  Hospital  Professional  10% X 15% X  15% X							
Substance use disorder inpatient physician/surgeon fee 10% X 15% X  Pregnancy Delivery and all inpatient services Professional Professional 10% X 15% X  15% X		Substance Use disorder other	outpatient items and services	\$5		\$15	
Substance use disorder inpatient physician/surgeon fee 10% X 15% X  Pregnancy Delivery and all inpatient services Professional Professional 10% X 15% X  15% X		Substance Use inpatient facilit	y fee (e.g. hospital room)	10%	X	15%	X
Prenatal care and preconception visits   No charge   No charge							
Pregnancy Services  Delivery and all inpatient services Professional  Hospital Professional  10% X 15% X  1					^		
Services	Pregnancy				х		х
Home health care			· ·	10%		15%	
Outpatient Habilitation services  Stilled nursing care  Other special health needs  Skilled nursing care  Child eye care  Child Dental  Diagnostic and  Child Dental  Diagnostic Sealants per Tooth  Preventive Space Maintainers - Fixed  Child Dental  Basic				\$3		\$15	
cher special health needs beath needs beath needs Durable medical equipment Hospice service Hospice service Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) Child Dental Diagnostic and Sealants per Tooth Preventive Preventive Child Dental Basic Services Root Canal- Molar Services Proto Hospice service Services Force and Sealants per Tooth Space Maintainers - Fried Child Dental Basic Services Root Canal- Molar Ginglyectomy per Quad Extraction - Single Tooth Exposed Root or Erupted Services Services Services Services Services Medically expressant orthordonties Services							
Durable medical equipment Hospice service  Hospice service  No charge No cha	other special	Skilled nursing care		10%	х	15%	х
Child eye care 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No charge  Child Dental Diagnostic Preventive - Cleaning Preventive - Cleaning Preventive - Child Dental Basic Services  Root Canal- Molar  Root Canal- Molar  Root Canal- Molar  Services  Evitacion - Complete Bony Porcelain with Metal Crown  Child Metically necessary orthodonties	neam needs						
Child Dental Basic Services Root Canal-Molar Services Procedia with Metically necessary orthodoxics Services Procedia with Metically necessary orthodoxics Services Procedia with Metically necessary orthodoxics Services Procedia Services Procedia Services	Child eye						
Child Dental Diagnostic Preventive - Cleaning Preventive - Cleaning Preventive - Array No charge Preventive - Array No charge	care		ontact lenses in lieu of glasses)	No charge		No charge	
Diagnostic and Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Services Provided P	Child Dental						
Preventive Topical Fluoride Application Space Maintainers – Fixed		Preventive - X-ray		No charge		No charge	
Child Dental Basic Amalgam Fill - 1 Surface 20% 20% 20% 20% 20% 20% 20% 20% 20% 20%		Topical Fluoride Application					
Amalgam Fill - 1 Surface   20%   20%	Obilet Deserted	Space Maintainers - Fixed					
Root Canal- Molar Child Dental Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted 50% 50% Services Extraction- Complete Bony Porcelain with Metal Crown Child Medically necessary orthodonties 50% 50%	Basic	Amalgam Fill - 1 Surface		20%		20%	
Child Dental Gingivectomy per Quad Services Extraction- Complete Bony Porcelain with Metal Crown  Child Medically necessary orthodontics 50%  Child Medically necessary orthodontics 50%  Sove 50%	Services	Root Canal- Molar					
Services Extraction- Complete Bony Porcelain with Metal Crown  Child Medically necessary orthodontics 50%		Gingivectomy per Quad		FC-1		<b></b> -	
Porcelain with Metal Crown  Child Medically necessary orthodontics 50%, 50%,		Extraction- Complete Bony	seu Koot or Erupted	50%		50%	
		Medically necessary orthodon	tics	50%		50%	

Summary of	Renefits and	Coverage

-	Benefits and Coverage		Silver Plan	
	Share amounts describe the Er e - AV Calculator	nrollee's out of pocket costs.	200%-250% F 72.8%	PL
	cludes a deductible?		Yes, Medical/Phar	macv
Integrated	Individual deductible		N/A	Шасу
Individual	Family deductible deductible, NOT integrated:	Medical / Pharmacy / Dental	N/A \$1,900 / \$250 /	\$0
Family ded	luctible, NOT integrated: Me –of–pocket maximum	dical / Pharmacy / Dental	\$3,800 / \$500 / \$5,450	\$0
Family Out-of-	pocket maximum		\$10,900	
	f-only coverage deductible an: Individual deductible		N/A N/A	
Common				
Medical Event			Member Cost Share	Deductible Applies
Event	Se	rvice Type	Meniber Cost Share	Applies
Health care	Primary care visit to treat an in	njury, illness, or condition	\$40	
provider's office or clinic visit	Other practitioner office visit		\$40	
Cillic Visit	Specialist visit		\$55	
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge \$35	
Tests	X-rays and Diagnostic Imagin		\$50	
	Imaging (CT/PET scans, MR	s)	\$250	
	Tier 1		\$15	
Drugs to treat illness or	Tier 2		\$45	Pharmacy deductible
condition	Tier 3		\$70	Pharmacy deductible
	Tier 4		20% up to \$250 per script after pharmacy	Pharmacy deductible
0	Surgery facility fee (e.g., ASC	)	deductible 20%	
Outpatient services	Physician/surgeon fees		20%	
	Outpatient visit  Emergency room facility fee (	waiwed if admitted)	20% \$250	×
Need	Emergency room physician fe		\$50	X
immediate attention	Emergency medical transpor	ation	\$250	X
	Urgent care		\$80	
Heavital stay	Facility fee (e.g. hospital roon	1)	20%	х
Hospital stay	Physician/surgeon fee	,	20%	Х
	Mental/Behavioral health outpatient office visits		\$40	
	Mental/Behavioral health other outpatient items and services		\$40	
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	х
Mental health,			20%	×
behavioral health, or	Mental/Behavioral health inpatient physician/surgeon fee		20%	^
substance abuse needs	Substance Use disorder outp	atient office visits	\$40	
	Substance Use disorder other	r outpatient items and services	\$40	
	Substance Use inpatient facil	ity fee (e.g. hospital room)	20%	х
	Substance use disorder inpar		20%	х
	Prenatal care and preconcep	* * * * * * * * * * * * * * * * * * * *	No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	х
	services	Professional	20%	X
	Home health care Outpatient Rehabilitation serv		\$40	
Help recovering or	Outpatient Habilitation service		\$40 \$40	
other special	Skilled nursing care		20%	х
health needs	Durable medical equipment		20%	
Child eye	Hospice service Eye exam		No charge No charge	
care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge	
	Oral Exam			
Child Device	Provention Class'	Preventive - Cleaning Preventive - X-ray		
Child Dental Diagnostic				
Diagnostic and	Preventive - X-ray Sealants per Tooth		No charge	
Diagnostic	Preventive - X-ray		No charge	
Diagnostic and	Preventive - X-ray Sealants per Tooth Topical Fluoride Application		20%	
Diagnostic and Preventive Child Dental Basic Services	Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Amalgam Fill - 1 Surface  Root Canal- Molar			
Diagnostic and Preventive Child Dental Basic Services Child Dental Major	Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed  Amalgam Fill - 1 Surface  Root Canal- Molar Gingivectomy per Quad Extraction - Single Tooth Exp	osed Root or Erupted		
Diagnostic and Preventive  Child Dental Basic Services  Child Dental	Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Amalgam Fill - 1 Surface Root Canal- Molar Gingivectomy per Quad		20%	

Member Cost S	Share amounts describe the Er	rollee's out of pocket costs.	Bronze Pla	Bronze HSA Plan		
Actuarial Valu	e - AV Calculator		<del>61.2%</del> <u>61.9</u> °	<u>%</u>	61.19	
Plan design in	cludes a deductible?		Yes, integrated Medica	al/Pharmacy	Yes, integ	rated
	Individual deductible		\$6,500 integrate		\$4,500 inte	
Integrated	Family deductible deductible, NOT integrated:	Medical / Pharmacy / Dental	\$13,000 integrat N/A\$6,000 / \$50		\$9,000 inte N/A	
Family dec	luctible, NOT integrated: Me	dical / Pharmacy / Dental	N/A\$12,000 / \$1,0	000 / \$0	N/A	
	of-pocket maximum		\$6,500		\$6,50	
HSA plan: Sel	pocket maximum f-only coverage deductible		\$13,000 N/A		\$13,00 \$4,50	
HSA family pla	an: Individual deductible		N/A		\$4,50	
Common Medical				Deductible	Member Cost	Deductible
Event	Se	rvice Type	Member Cost Share	Applies	Share	Applies
	Primary care visit to treat an in	njury, illness, or condition	\$70	After 1st three non-preventive visits	40%	х
Health care provider's office or	Other practitioner office visit		\$70	After 1st three non-preventive visits	40%	х
clinic visit	Specialist visit		\$90	After 1st three non-preventive visits	40%	х
	Preventive care/ screening/ in	nmunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagin	9	\$40 <del>0%</del> 100%	×	40% 40%	X
	Imaging (CT/PET scans, MR		<del>0%</del> 100%	X	40%	X
	Tier 1		9%100% up to \$500 per script after pharmacy deductible	XPharmacy Deductible	40%	х
Drugs to treat	Tier 2		9%100% up to \$500 per script after pharmacy deductible	XPharmacy Deductible	40%	х
illness or condition	Tier 3		9%100% up to \$500 per script after pharmacy deductible	XPharmacy Deductible	40%	х
	Tier 4		9%100% up to \$500 per script after pharmacy deductible	XPharmacy Deductible	40%	х
Outpatient	Surgery facility fee (e.g., ASC	)	<del>0%</del> 100%	X	40% 40%	X
services	Physician/surgeon fees Outpatient visit		<del>0%100%</del> <del>0%100%</del>	X	40%	X
	Emergency room facility fee (	waived if admitted)	<del>0%100%</del>	X	40%	X
			<del>0%</del> 100%	^		^
Need	Emergency room physician fe	e (waived if admitted)	<del>0%</del> 100%	Х	40%	Х
immediate	Emergency medical transportation		<del>0%</del> 100%	Х	40%	Х
attention	Urgent care		\$120	After 1st three non-preventive visits	40%	х
	Facility fee (e.g. hospital room	1)	<del>0%</del> 100%	Х	40%	Х
Hospital stay	Physician/surgeon fee	•	<del>0%</del> 100%	Х	40%	Х
	Mental/Behavioral health outpatient office visits		\$70	After 1st three non-preventive visits	40%	x
	Mental/Behavioral health other outpatient items and services		\$70	After 1st three non-preventive visits	40%	x
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	<del>0%</del> 100%	X	40%	Х
Mental health,	Mental/Behavioral health inpa	tient physician/surgeon fee	<del>0%</del> 100%	х	40%	х
behavioral health, or substance abuse needs	Substance Use disorder outp		\$70	After 1st three non-preventive visits	40%	х
	Substance Use disorder othe	r outpatient items and services	\$70	After 1st three non-preventive	40%	×
	Substance Use inpatient facil	ty fee (e.g. hospital room)	<del>0%</del> 100%	visits X	40%	Х
	Substance use disorder inpat	ient physician/surgeon fee	<del>0%100%</del>	х	40%	х
	Prenatal care and preconcep					
Pregnancy			No charge	V	No charge	V
геднансу	Delivery and all inpatient services	Hospital	<del>0%</del> 100%	X	40%	X
	Home health care	Professional	<del>0%</del> 100% <del>0%</del> 100%	X	40%	X
Help	Outpatient Rehabilitation serv		\$70	, i	40%	Х
recovering or	Outpatient Habilitation service	s	\$70		40%	Х
other special health needs	Skilled nursing care		<del>0%</del> 100%	Х	40%	Х
neaun neeus	Durable medical equipment		<del>0%</del> 100%	Х	40%	Х
01:11.1	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	
	Oral Exam		. to ondige		onargo	_
Child Dental	Preventive - Cleaning					
Diagnostic and Preventive	Preventive - X-ray Sealants per Tooth Topical Fluoride Application		No charge		No charge	
Child Dental Basic	Space Maintainers - Fixed  Amalgam Fill - 1 Surface		20%		20%	
Services	Root Canal- Molar				2070	
Child Dental Major Services	Gingivectomy per Quad Extraction- Single Tooth Expo Extraction- Complete Bony Porcelain with Metal Crown	osed Root or Erupted	50%		50%	
	I OLOGIANI WILLI MELAN CIUWN					
Child	Medically necessary orthodor		50%		50%	

Plan design in Integrated Integrated Individual of Family ded Individual Out- Family Out-of- HSA plan: Self	luctible, NOT integrated: Me -of-pocket maximum pocket maximum	Medical / Pharmacy / Dental	\$6,850 ir \$13,700 i N	tegrated integrated integrated
Integrated Integrated Individual of Individual of Family ded Individual Out- Family Out- Family Out- HSA plan: Self HSA family pla  Common Medical Event	Individual deductible Family deductible deductible, NOT integrated: luctible, NOT integrated: Me –of–pocket maximum pocket maximum		\$6,850 ir \$13,700 i N	ntegrated integrated
Integrated Individual of Family ded Individual Out- Family Out-of- HSA plan: Self HSA family pla  Common Medical Event	Family deductible deductible, NOT integrated: luctible, NOT integrated: Me –of–pocket maximum pocket maximum		\$13,700 i N	integrated
Family ded individual Out- Family Out-of- HSA plan: Self HSA family pla Common Medical Event	luctible, NOT integrated: Me -of-pocket maximum pocket maximum			/Δ
Individual Out- Family Out-of- HSA plan: Self HSA family pla Common Medical Event	-of-pocket maximum pocket maximum			
Family Out-of- HSA plan: Self HSA family pla Common Medical Event	pocket maximum	Time many / Denial		/A 850
HSA plan: Self HSA family pla Common Medical Event				,700
Common Medical Event	f-only coverage deductible			/A
Medical Event	n: Individual deductible		N.	/A
Event				
Uaalda oo oo	Ser	rvice Type	Member Cost Share	Deductible Applies
Linalita com	Primary care visit to treat an ir	njury, illness, or condition	0%	After 1st three non-prevention visits
provider's office or	Other practitioner office visit		0%	After 1st three non-preventing visits
clinic visit	Specialist visit		0%	х
	Preventive care/ screening/ im	amunization	No oborno	
	Laboratory Tests	imunization	No charge 0%	Х
Tests	X-rays and Diagnostic Imagin	g	0%	X
	Imaging (CT/PET scans, MRI		0%	X
	Tier 1		0%	х
Drugs to treat	Tier 2		0%	х
illness or condition	Tier 3		0%	Х
	Tier 4		0%	X
Outpatient	Surgery facility fee (e.g., ASC)	)	0%	X
services	Physician/surgeon fees Outpatient visit		0%	X
		and and Warder St. D.	0%	X
	Emergency room facility fee (v	waived if admitted)	0%	Х
	Emergency room physician fe	ee (waived if admitted)	0%	Х
leed mmediate	Emergency medical transportation		0%	Х
attention	Urgent care		0%	After 1st thre
	Facility fee (e.g. hospital room	a)	0%	X
Hospital stay	Physician/surgeon fee		0%	X
	Mental/Behavioral health outp	eatient office visits	0%	After 1st three non-prevention visits
	Mental/Behavioral health other outpatient items and services		0%	After 1st three non-prevention visits
Mental	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	0%	х
health,	Mental/Behavioral health inpa	tient physician/surgeon fee	0%	Х
behavioral health, or substance abuse needs	Substance Use disorder outpatient office visits		0%	After 1st thre
	Substance Use disorder other outpatient items and services		0%	After 1st thre
	Substance Use inpatient facility fee (e.g. hospital room)		0%	visits
	Substance use disorder inpati	ient physician/surgeon fee	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
lelp	Outpatient Rehabilitation service Outpatient Habilitation service		0%	X
ecovering or			0%	
other special nealth needs	Skilled nursing care		0%	Х
	Durable medical equipment		0%	X
N. 11.1	Hospice service Eye exam		0% No charge	X
child eye are		contact lenses in lieu of placeae)	0%	х
	1 pair of glasses per year (or contact lenses in lieu of glasses)  Oral Exam		U%	^
Child Dental	Preventive - Cleaning		1	
Diagnostic	Preventive - X-ray		No charge	
ınd	Sealants per Tooth		ivo charge	
Preventive	Topical Fluoride Application Space Maintainers - Fixed		1	
Child Dental	Amalgam Fill - 1 Surface		0%	х
Services				
Child Dental	Root Canal- Molar			X
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Expo	osed Root or Erupted	0%	X
	Extraction- Complete Bony		1	X
Services	Porcelain with Metal Crown			X



### Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.  Actuarial Value - AV Calculator		Platinum Coinsurance Plan 88.5%		Platinum Copay Plan		
	e - AV Calculator cludes a deductible?		88.59 No	0	89.59 No	ю
Integrated	Individual deductible		\$0		\$0	
Integrated Individual	Family deductible	Medical / Pharmacy / Dental	\$0 \$0/\$0/	\$0	\$0 \$0 / \$0 /	\$0
Family ded	luctible, NOT integrated: Me		\$0 / \$0 /	\$0	\$0 / \$0 /	\$0
	-of-pocket maximum pocket maximum		\$4,00 \$8,00		\$4,00 \$8,00	
HSA plan: Self	-only coverage deductible		N/A	U	N/A	o .
HSA family pla	n: Individual deductible		N/A		N/A	
Common Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an i		\$20		\$20	
Health care provider's office or	Other practitioner office visit		\$20		\$20	
clinic visit	Specialist visit		\$40		\$40	
	Preventive care/ screening/ ir	nmunization	No charge		No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagir	ia.	\$20 \$40		\$20 \$40	
16313	Imaging (CT/PET scans, MR		10%		\$150	
	Tier 1		\$5		\$5	
Drugs to treat	Tier 2		\$15		\$15	
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 Physician/surgeon fees	)	10% 10%		\$250 \$40	
services	Outpatient visit		10%		10%	
	Emergency room facility fee (	waived if admitted)	\$150		\$150	
	Emergency room physician for	· · · · · · · · · · · · · · · · · · ·	10%			
Need		,	1470		No charge	
immediate attention	Emergency medical transpor	auon	\$150		\$150	
attention	Urgent care		\$40		\$40	
	Facility fee (e.g. hospital room	1)	10%		\$250 per day	
Hospital stay	Physician/surgeon fee	,	10%		up to 5 days \$40	
	Mental/Behavioral health outp	patient office visits	\$20		\$20	
	Mental/Behavioral health other	er outpatient items and services	\$20		\$20	
	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	10%		\$250 per day	
Mental health.					up to 5 days	
behavioral health, or	Mental/Behavioral health inpa		10%		\$40	
substance abuse needs	Substance Use disorder outp	atient office visits	\$20		\$20	
	Substance Use disorder other	r outpatient items and services	\$20		\$20	
	Substance Use inpatient facil	ity fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Substance use disorder inpar	ient physician/surgeon fee	10%		\$40	
	Prenatal care and preconcep	tion visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	10%		\$250 per day up to 5 days	
	services Home health care	Professional	10%		\$40	
U a la	Outpatient Rehabilitation serv	ices	10% \$20		\$20 \$20	
Help recovering or	Outpatient Habilitation service		\$20		\$20	
other special	Skilled nursing care		10%		\$150 per day up to 5 days	
health needs	Durable medical equipment		10%		10%	
Child arr	Hospice service Eye exam		No charge No charge		No charge No charge	
Child eye care	1 pair of glasses per year (or	contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam		,		Ť	
Child Dental Diagnostic and Preventive	Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application		Not Covered		Not Covered	
Child Dental Basic	Space Maintainers - Fixed  Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Services	Root Canal- Molar				Not Covered	
Child Dental	Gingivectomy per Quad				Not Covered Not Covered	
Major	Extraction- Single Tooth Exp Extraction- Complete Bony	osed Root or Erupted	Not Covered		Not Covered Not Covered	
Services					Not Covered	
Services	Porcelain with Metal Crown				Not Covered	

Member Cost S	hare amounts describe the Enrollee's out of pocket costs.	Gold Coinsuran		Gold Copay F	
Actuarial Value	e - AV Calculator	80.29		81.0%81	
	cludes a deductible?	No		No	
	Individual deductible	\$0		\$0	
Integrated	Family deductible	\$0		\$0	
	deductible, NOT integrated: Medical / Pharmacy / Dental	\$0 /\$0		\$0 / \$0 /	
	luctible, NOT integrated: Medical / Pharmacy / Dental	\$0 / \$0 \$6,20		\$0 / \$0 / \$6,20	
	pocket maximum	\$12,4		\$12,40	
	-only coverage deductible	N/A		N/A	
HSA family pla	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	\$35		\$35	
Health care	Other practitioner office visit	\$35		\$35	
office or clinic visit	Specialist visit				
	Preventive care/ screening/ immunization	\$55 No charge		\$55 No charge	
	Laboratory Tests	\$35		\$35	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	\$50		\$50	
	illiaging (CT/FET Scans, WKis)	20%		\$250	
	Tier 1	\$15		\$15	
	Tier 2	\$50		\$50	
	Tier 3	\$70		\$70	
	Tier 4	20% up to \$250		20% up to \$250	
		per script		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)	\$250		\$250	
	Emergency room racinty lee (waived if admitted)	\$250		\$250	
Need	Emergency room physician fee (waived if admitted)	20%		No charge	
immediate attention	Emergency medical transportation	\$250		\$250	
	Urgent care	\$60		\$60	
Hospital stay	Facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Physician/surgeon fee	20%		\$55	
	Mental/Behavioral health outpatient office visits	\$35		\$35	
	Mental/Behavioral health other outpatient items and services	\$35		\$35	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%		\$600 per day	
Mental	Wertar Deriavioral Treatit in patient facility fee (e.g. nospital foorit)	2076		up to 5 days	
nealth, pehavioral	Mental/Behavioral health inpatient physician/surgeon fee	20%		\$55	
nealth, or substance abuse needs	Substance Use disorder outpatient office visits	\$35		\$35	
	Substance Use disorder other outpatient items and services	\$35		\$35	
	Substance Lies innations facility for (a.g. hospital room)	200/		\$600 per day	
	Substance Use inpatient facility fee (e.g. hospital room)	20%		up to 5 days	
	Substance use disorder inpatient physician/surgeon fee	20%		\$55	
	Prenatal care and preconception visits	No charge		No charge	
Pregnancy	Delivery and all inpatient Hospital	20%		\$600 per day	
	services Professional	20%		up to 5 days \$55	
	Home health care	20%		\$30	
lelp	Outpatient Rehabilitation services	\$35		\$35	
ecovering or	Outpatient Habilitation services	\$35		\$35 \$300 per day	
other special nealth needs	Skilled nursing care	20%		up to 5 days	
	Durable medical equipment	20%		20%	
Obild our	Hospice service Eye exam	No charge No charge		No charge No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam	140 Glaige		140 Griange	
Child Dental	Preventive - Cleaning	1			
Diagnostic	Preventive - X-ray	Not Covered		Not Covered	
ind Preventive	Sealants per Tooth Topical Fluoride Application	5576160		00.6160	
.eventive	Topical Fluoride Application Space Maintainers - Fixed	1			
Child Dental	apart manager i mod				
Basic Bervices	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
Objid Day	Root Canal- Molar			Not Covered	
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted	Not Covered		Not Covered Not Covered	
ervices	Extraction- Complete Bony	1401 OUVEIED		Not Covered Not Covered	
	Porcelain with Metal Crown			Not Covered	
Child	Medically necessary orthodontics	Net Comme		Net Course	
	Medically necessary orthodontics	Not Covered		Not Covered	
Orthodontics					

Member Cost S	Benefits and Coverage hare amounts describe the Er		Individua Silver Pla	
	e - AV Calculator		70.4%	
	cludes a deductible? Individual deductible		Yes, Medical/Pha N/A	armacy
Integrated	Family deductible		N/A	
		Medical / Pharmacy / Dental	\$2,250 / \$250	
	uctible, NOT integrated: Me -of-pocket maximum	dicar/ Pharmacy / Dentai	\$4,500 / \$500 \$6,250	/ \$0
Family Out-of-	pocket maximum -only coverage deductible		\$12,500 N/A	
HSA family pla	n: Individual deductible		N/A N/A	
Common				
Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies
	Primary care visit to treat an ir	njury, illness, or condition	\$45	
Health care provider's office or	Other practitioner office visit		\$45	
clinic visit	Specialist visit		\$70	
	Preventive care/ screening/ in	nmunization	No charge	
<b>-</b>	Laboratory Tests		\$35	
Tests	X-rays and Diagnostic Imagin Imaging (CT/PET scans, MR		\$65 \$250	
		-7		
	Tier 1		\$15	Dhama
Drugs to treat illness or condition	Tier 2	\$50	Pharmacy deductible	
	Tier 3		\$70	Pharmacy deductible
	Tier 4 Surgery facility fee (e.g., ASC		20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees		20% 20%	
services	Outpatient visit		20%	
	Emergency room facility fee (	waived if admitted)	\$250	х
	Emergency room physician fee (waived if admitted)		\$50	Х
Need immediate	Emergency medical transportation		\$250	Х
attention	Urgent care		\$90	
	Facility fee (e.g. hospital room	1)	20%	X
Hospital stay	Physician/surgeon fee	,	20%	Х
	Mental/Behavioral health outpatient office visits		\$45	
	Mental/Behavioral health other	er outpatient items and services	\$45	
	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	х
Mental health,				
behavioral health, or substance	Mental/Behavioral health inpa		20% \$45	Х
abuse needs	Substance Use disorder outpatient office visits		940	
	Substance Use disorder othe	r outpatient items and services	\$45	
	Substance Use inpatient facil	ty fee (e.g. hospital room)	20%	Х
	Substance use disorder inpat	ient physician/surgeon fee	20%	х
	Prenatal care and preconcep	tion visits	No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	х
	services	Professional	20%	Х
	Home health care Outpatient Rehabilitation serv	ices	\$45 \$45	
Help recovering or	Outpatient Habilitation service		\$45	
other special	Skilled nursing care		20%	х
health needs	Durable medical equipment		20%	
Child eye	Hospice service Eye exam		No charge No charge	
care	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge	
Child Day	Oral Exam			
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray		Net Comment	
and	Sealants per Tooth		Not Covered	
Preventive	Topical Fluoride Application Space Maintainers - Fixed			
Child Dental Basic	Amalgam Fill - 1 Surface		Not Covered	
Services	Root Canal- Molar			
Child Dental Major Services	Gingivectomy per Quad Extraction- Single Tooth Expo Extraction- Complete Bony	osed Root or Erupted	Not Covered	
OCIVICES				
Child	Porcelain with Metal Crown			

Member Cost S	F Benefits and Coverage Share amounts describe the E e - AV Calculator		SHOP Silver Coinsurance		SHOP Silver Copay Plar 71.4% 71.39	
	cludes a deductible?					
	Individual deductible		Yes, Medical/Pha N/A	шпасу	Yes, Medical/Pha N/A	ппасу
Integrated	Family deductible	Medical / Pharmacy / Dental	N/A \$1,500 / <del>\$500</del> \$2	E0 / 80	N/A \$1,500 / <del>\$500</del> \$25	En / \$n
Family ded	luctible, NOT integrated: Me		\$1,500 / <del>\$500</del> <u>\$2</u> \$3,000 / <del>\$1,000</del> <u>\$</u> 5		\$3,000 / <del>\$1,000</del> <u>\$2</u>	
ndividual Out-	of-pocket maximum		\$6,500 \$13,000		\$6,500 \$13,000	
HSA plan: Self	f-only coverage deductible		N/A		N/A	
HSA family pla	an: Individual deductible		N/A		N/A	
Common Medical			Mambar Cast Share	Deductible	Mambas Coat Share	Deductible
Event	Primary care visit to treat an i	rvice Type	Member Cost Share	Applies	Member Cost Share	Applies
Health care provider's office or clinic visit	Other practitioner office visit	ijury, iliness, or contailori	\$45		\$45	
	Specialist visit					
	Preventive care/ screening/ in	nmunization	\$70		\$70	
	Laboratory Tests	minumization	No charge \$35		No charge \$35	
Tests	X-rays and Diagnostic Imagir	g	\$65		\$65	
	Imaging (CT/PET scans, MR	ls)	20%	X	\$250	
	Tier 1		\$15		\$15	
Drugs to treat illness or condition	Tier 2		\$55	Pharmacy deductible	\$55	Pharmac deductible
	Tier 3		\$75	Pharmacy deductible	\$75	Pharmac deductibl
	Tier 4		20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20% up to \$250 per script after pharmacy deductible	Pharmac deductibl
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees		20% 20%		20% 20%	
services	Outpatient visit		20%		20%	
	Emergency room facility fee	waived if admitted)	\$250	Х	\$250	Х
	Emorgonou room physician f	on (waired if admitted)	<b>650</b>	х	ØFO.	Х
Need	Emergency room physician f Emergency medical transpor		\$50 \$250	X	\$50 \$250	X
immediate attention	Emergency medical transpor	lation	\$250	^	\$250	_ ^
attention	Urgent care		\$90		\$90	
Hospital stay	Facility fee (e.g. hospital roor	n)	20%	Х	20%	Х
, , , , , , , , , , , , , , , , , , , ,	Physician/surgeon fee		20%	Х	20%	Х
	Mental/Behavioral health out	patient office visits	\$45		\$45	
	Mental/Behavioral health oth	er outpatient items and services	\$45		\$45	
	Mental/Behavioral health inpa	atient facility fee (e.g.hospital room)	20%	Х	20%	х
Mental health,						
behavioral health, or substance abuse needs	Mental/Behavioral health inpa		20% \$45	Х	20% \$45	Х
abuse needs	Substance Use disorder other	er outpatient items and services	\$45		\$45	
	Substance Use inpatient faci	ity tee (e.g. hospital room)	20%	Х	20%	Х
	Substance use disorder inpa	tient physician/surgeon fee	20%	х	20%	х
	Prenatal care and preconcep	tion visits	No charge		No charge	
Pregnancy	Delivery and all inpatient	Hospital	20%	х	20%	х
	services	Professional	20%	X	20%	X
	Home health care Outpatient Rehabilitation services	rices	20% \$45		\$45 \$45	
Help recovering or	Outpatient Habilitation service		\$45		\$45	
other special	Skilled nursing care		20%	х	20%	х
health needs	Durable medical equipment		20%		20%	
	Hospice service Eye exam		No charge		No charge	
Child eye care	1 pair of glasses per year (or	contact lenses in lieu of alesses)	No charge		No charge	
	Oral Exam	contact tenses in neu or glasses)	No charge		No charge	
Child Dental	Preventive - Cleaning					
	Preventive - X-ray Sealants per Tooth		Not Covered		Not Covered	
	Topical Fluoride Application Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
	Root Canal- Molar				Not Covered	
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Exp	ased Root or Frunted	Not Covered		Not Covered Not Covered	
	Extraction- Complete Bony	Noor or Eruptou			Not Covered Not Covered	
Services						
	Porcelain with Metal Crown				Not Covered	

-	f Benefits and Coverage Share amounts describe the Er	SHOP Silver HSA Plan			
Actuarial Valu	e - AV Calculator		70.5%		
	cludes a deductible?		Yes, integr		
	Individual deductible Family deductible		\$2,000 integ \$4,000 integ		
Individual	deductible, NOT integrated:	Medical / Pharmacy / Dental	N/A		
<b>Individual Out</b>	luctible, NOT integrated: Me –of–pocket maximum	dicar/ Pharmacy/ Dentai	N/A \$6,250	)	
	pocket maximum f-only coverage deductible		\$12,500 \$2,000		
	an: Individual deductible		See endnote		
Common					
Medical Event	Se	rvice Type	Member Cost Share	Deductible Applies	
	Primary care visit to treat an injury, illness, or condition		20%	Х	
Health care provider's office or clinic visit	Other practitioner office visit		20%	х	
clinic visit	Specialist visit		20%	х	
	Preventive care/ screening/ in Laboratory Tests	irriurilzation	No charge 20%	X	
Tests	X-rays and Diagnostic Imagin	g	20%	Х	
	Imaging (CT/PET scans, MR	S)	20%	X	
	Tier 1		20%	х	
Drugs to treat illness or condition	Tier 2		20%	х	
	Tier 3		20%	х	
	Tier 4		20%	х	
Outpatient	Surgery facility fee (e.g., ASC Physician/surgeon fees	)	20% 20%	X	
services	Outpatient visit		20%	X	
	Emergency room facility fee (waived if admitted)		20%	х	
	Emergency room physician fee (waived if admitted)		20%	×	
Need	Emergency medical transport		20%	X	
immediate attention	Emorgonoy modical danoport	auon	2070	^	
	Urgent care		20%	х	
Hospital stay	Facility fee (e.g. hospital room	)	20%	х	
nospitai stay	Physician/surgeon fee		20%	Х	
	Mental/Behavioral health outpatient office visits		20%	х	
	Mental/Behavioral health other outpatient items and services		20%	х	
Mental	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	Х	
health,	Mental/Behavioral health inpa	tient physician/surgeon fee	20%	х	
behavioral health, or substance	Substance Use disorder outpatient office visits		20%	X	
abuse needs					
		r outpatient items and services	20%	X	
	Substance Use inpatient facili	ty tee (e.g. hospital room)	20%	Х	
	Substance use disorder inpat	ient physician/surgeon fee	20%	х	
	Prenatal care and preconcep	tion visits	No charge		
Pregnancy	Delivery and all inpatient	Hospital	20%	x	
	services	Professional	20%	X	
Hala	Home health care Outpatient Rehabilitation serv	ices	20% 20%	X	
Help recovering or	Outpatient Habilitation service		20%	X	
other special	Skilled nursing care		20%	Х	
health needs	Durable medical equipment		20%	X	
Child eye	Hospice service Eye exam		0% No charge	X	
care	1 pair of glasses per year (or o	contact lenses in lieu of glasses)	No charge		
	Oral Exam				
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray				
and Preventive	Preventive - X-ray Sealants per Tooth Topical Fluoride Application		Not Covered		
Child Dental	Space Maintainers - Fixed				
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		
Child Dental	Root Canal- Molar Gingivectomy per Quad				
Major	Extraction- Single Tooth Expo	sed Root or Erupted	Not Covered		
Services	Extraction- Complete Bony Porcelain with Metal Crown				
Child					
Orthodontics	Medically necessary orthodor	IUCS	Not Covered		

Principate included as designated principated as designated production   No.	Member Cost S	f Benefits and Coverage		Silver F 100%-150	% FPL	Silver Plan 150%-200% F	PL
Images between desirable and exclusions   No.   No.				93.89		86.8%86.9%	
Microsoft Parmity deductions   Microsoft Microsoft Pharmacy / Neural 1975 (9.7) (9					Pharmacy		rmacy
Sealing debut-block NOT Intergraded: Moderal Pharmacy / Dental   \$150, 30, 750   \$1.00, 13.00, 12.00   \$2.00	Integrated	Family deductible		N/A		N/A	
Section   Sect							
NA	Individual Out	-of-pocket maximum		\$2,25	0	\$2,250	
Manual Common   Medical   Service Type							
Member Cost   Service Type							
Private value to test at in kjury, lines, or condition  Ches practitioner office vies  Ches practitioner office vies  Ches practitioner office vies  Ches practitioner office vies  Specials valid  Specials valid  Specials valid  Private Conditioner  Test Specials valid  Specials valid  Private Conditioner  Test Specials valid  Test Specials val	Medical	50	ruine Turne			Member Cost Share	Deductible Applies
Chick practiconer office visit   Sp.   Sp.   Sp.   Sp.	Lvent	Se	rvice Type	Onare	Applies	member dost onare	Applies
Collicio Visit   Septimization   Septimizati	Health care	Primary care visit to treat an in	njury, illness, or condition	\$5		\$15	
Personal Carel Science and June 1997  Tests  Any Ampliance Sea Sits  Any Ampliance Sea Sits  Any Ampliance Sea Sits  Any Ampliance Sea Sits  Ter 1  Ter 2  S10  S20  Floring to Press  Ter 2  S10  S20  Floring to Press  Ter 3  Ter 3  S15  Ter 4  S15  Ter 3  S15  Ter 4  S15  Ter 5  S20  Cupstient Sea Sits  Ter 6  Diffusion Sea Sits  Ter 7  Ter 2  S10  S20  Cupstient Sea Sits  Ter 8  S20  S20  S20  Ter 9  S20  S20  S20  S20  S20  S20  S20  S2	office or	Other practitioner office visit		\$5		\$15	
Capta   Capt			nmunization				
Test   Signature		Laboratory Tests		\$8		\$15	
Ter 1	Tests	X-rays and Diagnostic Imagin Imaging (CT/PFT scans, MR)	g (s)				
Product   Part		inaging (01/1 E1 dound, mix	5)	330		\$100	
Drugs to reak time 2  Ter 4  Ter 4  Ter 4  Ter 4  Douglation services  Programment of the		Tier 1		\$3		\$5	
Ter 3	illness or condition	Tier 2		\$10		\$20	Pharmacy deductible
Ter 4  Outpatient Services  Services  Outpatient view of the property facility fee (e.g., ASC)   10%   15%		Tier 3					Pharmacy deductible
Displace   Physician   Physi				per script		script after pharmacy deductible	Pharmacy deductible
Comparison with   10%			)				
Emergency room physician fee (waked if admitted)   \$2.5	services	Outpatient visit		10%		15%	
Mental Behavioral health other outpatient diffice visits   S5   \$15		Emergency room facility fee (	waived if admitted)	\$30	Х	\$75	Х
### Authorition    Comparison   Comparison   Comparison   Comparison   Covered   Control Residue   Con		Emergency room physician fee (waived if admitted)		\$25	Х	\$40	х
Urgent care		Emergency medical transportation		\$30	Х	\$75	Х
Physician/surgeon fee 10% X 15% X  Mental/Behavioral health orther outpatient office visits \$5 \$15 \$15 \$  Mental/Behavioral health orther outpatient items and services \$5 \$15 \$15 \$  Mental/Behavioral health inpatient facility fee (e.g. hospital room) 10% X 15% X 1	attention	Urgent care		\$6		\$30	
Mental/Behavioral health outpatient office visits  Mental/Behavioral health or outpatient items and services  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient physician/surgeon fee behavioral health, or substance substance substance substance Use disorder outpatient office visits  Substance Use disorder outpatient office visits  Substance Use disorder outpatient office visits  Substance Use disorder outpatient fems and services  Substance Use disorder inpatient physician/surgeon fee  Pregnancy  Pregnated care and preconception visits  No charge  Pregnancy  Delivery and all inpatient services  Hospital  Hospital  Home health care  Outpatient Rehabilitation services  Sissississississississississississississ	Hospital stay		n)				
Mental/Behavioral health other outpatient items and services  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient facility fee (e.g. hospital room)  Mental/Behavioral health inpatient physician/surgeon fee  10% X 15% X  Substance Use disorder outpatient office visits  Substance Use disorder outpatient facility fee (e.g. hospital room)  Substance Use inpatient facility fee (e.g. hospital room)  Substance Use inpatient physician/surgeon fee  10% X 15% X  Substance Use inpatient physician/surgeon fee  10% X 15% X  Substance Use inpatient physician/surgeon fee  10% X 15% X  Pregnancy  Delivery and all inpatient services  Delivery and all inpatient services  Hospital 10% X 15% X  Home health care  Hospital 10% X 15% X  Substance Use inpatient physician/surgeon fee  10% X 15% X  Duratient Rehabilitation services  SS S S S S S S S S S S S S S S S S S		Physician/surgeon fee		10%	X	15%	X
Mental health, health, beath, beath in patient facility fee (e.g. hospital room)  Mental/Behavioral health in patient physician/surgeon fee  10% X 15% X  15% X  15% X  Substance Use disorder outpatient office visits  Substance Use disorder outpatient office visits  Substance Use disorder outpatient items and services  Substance Use disorder outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  10% X 15% X  Substance Use inpatient facility fee (e.g. hospital room)  10% X 15% X  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Prenatal care and preconception visits  No charge  Pregnancy  Pregnancy  Delivery and all inpatient physician/surgeon fee  10% X 15% X  15% X  Home health care  Sa 1515  Outpatient Habilitation services  Sp 1515  Skilled nursing care  10% X 15% X  15% X		Mental/Behavioral health outpatient office visits		\$5		\$15	
Mental health, behavioral health inpatient physician/surgeon fee 10% X 15% X 15% Substance due to disorder outpatient office visits Substance Use disorder outpatient items and services Substance Use disorder outpatient items and services Substance Use inpatient facility fee (e.g. hospital room) 10% X 15% X 15% X Substance use disorder inpatient physician/surgeon fee 10% X 15%		Mental/Behavioral health other outpatient items and services		\$5		\$15	
health, behavioral health inpatient physician/surgeon fee 10% X 15% X  substance abuse needs  Substance Use disorder outpatient office visits \$  Substance Use disorder outpatient items and services \$5 \$15  Substance Use inpatient facility fee (e.g. hospital room) 10% X 15% X  Substance use disorder inpatient physician/surgeon fee 10% X 15% X  Substance use disorder inpatient physician/surgeon fee 10% X 15% X  Prenatal care and preconception visits No charge  Pregnancy Delivery and all inpatient services 100 No		Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	10%	Х	15%	х
hehalth, or substance abuse needs  Substance Use disorder outpatient office visits  Substance Use disorder outpatient items and services  Substance Use disorder outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician/surgeon fee  Prenatal care and preconception visits  No charge  Pregnancy  Delivery and all inpatient services  Professional  Home health care  Outpatent Rehabilitation services  Sission  Outpatent Rehabilitation services  Sission  Skilled nursing care  health needs  Hospice service  Durable medical equipment Hospic service  To piral Fluoride Application Space Maintainers - Fixed  Child Dental Basic Services  Root Canal-Molar Ginglevetown per Quad Extraction- Single Tooth Exposed Root or Enupted Extraction- Complete Bony Procelain with Metal Crown		Mental/Rehavioral health inna	tient physician/surgeon fee				~
Substance Use disorder other outpatient items and services  Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Prenatal care and preconception visits  No charge  Pregnancy  Pregnancy  Pregnancy  Pregnancy  Pregnancy  Pregnancy  Presential care and preconception visits  No charge  No charge  Professional  10% X 15% X  15% X  Home health care  Professional  10% X 15% X  15% X  Substance Use inpatient physician/surgeon fee  10% X 15% X  15% X  A 15% X  Inspection of the professional  10% X 15% X  Inspection of the professional  Inspection of the profession of the professional  Inspection of the profession of the profe	behavioral health, or substance				^		^
Substance Use inpatient facility fee (e.g. hospital room)  Substance use disorder inpatient physician/surgeon fee  10% X 15% X  Prenatal care and preconception visits  No charge  Pregnancy  Delivery and all inpatient hospital 10% X 15% X  Professional 10% X 15% X  Home health care  Outpatient Rehabilitation services  SS 1515  Outpatient Habilitation services  SS 5 \$15 S15  Outpatient Habilitation services  SS 5 \$15 S15  Outpatient Habilitation services  Nother special Rehabilitation services  SS 155  Outpatient Habilitation services  Notified precovering or outpatient Habilitation services  SS 155  Outpatient Habilitation services  SS 155  Outpatient Habilitation services  Notified precovering or outpatient Habilitation services  Notified precovering or outpatient Habilitation services  SS 155  Outpatient Habilitation services  Notified precovering or outpatient Habilitation services  Not Charge 10% X 15%	abuse needs						
Substance use disorder inpatient physician/surgeon fee 10% X 15% X  Prenatal care and preconception vists No charge No charge  Pregnancy  Delivery and all inpatient Hospital 10% X 15% X  Home health care 33 515  Outpatient Rehabilitation services 55 515  Outpatient Habilitation services 755 7515  Outpatient Habilitation 8715  Outpa			·			***	
Pregnancy Pregnancy Delivery and all inpatient services Professional Hospital Hospital 10% X 15%		Substance Use inpatient facil	ity ree (e.g. hospital room)	10%	X	15%	Х
Pregnancy   Delivery and all inpatient   Hospital   10%   X   15%   X		Substance use disorder inpat	ient physician/surgeon fee	10%	Х	15%	х
Services		Prenatal care and preconcep	tion visits	No charge		No charge	
Home health care	Pregnancy		Hospital	10%	Х	15%	Х
Help recovering or obtained and precovering or obtained an			Professional		X		X
Outpatient Habilitation services \$\$ \$15  Skilled nursing care 10% X 15% X  Skilled nursing care 10% X 15% X  Skilled nursing care 10% X 15% X  Durable medical equipment 10% 15% Hospice service No charge No charge No charge No charge No charge No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No char	Help	Outpatient Rehabilitation serv					
other special health needs     Skilled nursing care     10%     X     15%     X       breath needs     10% breath needs and provided in the provi	recovering or		es			\$15	
Durable medical equipment 10% 15% 15% Hospice service No charge No charge No charge No charge 1 pair of glasses per year (or contact lenses in lieu of glasses) No charge No cha	other special				Х	15%	Х
Child eye care   Eye exam	carar neeus						
The content of the co	Child eve						
Child Dental Dental Preventive - Cleaning Preventive - X-ray Sealants per Tooth Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Services Rot Canal- Molar Gingivectomy per Quad Extraction - Single Tooth Exposed Root or Erupted Not Covered Not Covered Not Covered Services Rovices Rotor Single Tooth Exposed Root or Erupted Not Covered Services Reviews Porcelain with Metal Crown							
Diagnostic and Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed Not Covered Services Not Covered Not Covered Not Covered Services Not Canal- Molar Gingivectomy per Quad Services Not Covered Not Covered Not Covered Services Not Covered Services Not Covered Not Covered Services Not Covered Not Covered Services Not Covered Services Not Covered Not Covered Not Covered Not Covered Services Not Covered Not Cov		Oral Exam					
and Sealants per Tooth Preventive Topical Fluoride Application Space Maintainers - Fixed Services Root Canal- Molar Gingvectomy per Quad Services Root Canal- Molar Gingvectomy per Quad Extraction - Single Tooth Exposed Root or Erupted Not Covered Not Covered Not Covered Services Root Canal- Molar Gingvectomy per Quad Extraction - Single Tooth Exposed Root or Erupted Not Covered Services Services Root canal- Metal Crown Not Covered Not Covered Services Root or Evapted Not Covered Not Cov							
Child Dental Basic Services Root Canal- Molar Child Dental Major Estration- Single Tooth Exposed Root or Erupted Services Extraction- Complete Bony Porcelain with Metal Crown	and	Sealants per Tooth Topical Fluoride Application		Not Covered		Not Covered	
Root Canal- Molar  Child Dental Gingivectomy per Quad  Major Extraction - Single Tooth Exposed Root or Erupted Not Covered  Services Extraction - Complete Bony Porcelain with Metal Crown	Basic			Not Covered		Not Covered	
Child	Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Expo Extraction- Complete Bony	osed Root or Erupted	Not Covered		Not Covered	
Child Orthodontics Medically necessary orthodontics Not Covered Not Covered	Child Orthodontics		ntics	Not Covered		Not Covered	

Summary of	Benefits and Coverage	•	Silver Plan	
	hare amounts describe the Er	nrollee's out of pocket costs.	200%-250% FPI	_
	e - AV Calculator		72.8%	
	cludes a deductible?		Yes, Medical/Pharm N/A	acy
	Family deductible	Medical / Pharmacy / Dental	N/A \$1,900 / \$250 / \$	0
Family ded	uctible, NOT integrated: Me		\$3,800 / \$500 / \$	
Family Out-of-	-of-pocket maximum pocket maximum		\$5,450 \$10,900	
HSA plan: Self HSA family pla	only coverage deductible in: Individual deductible		N/A N/A	
Common				
Medical Event	Sei	rvice Type	Member Cost Share	Deductit Applie
	Primary care visit to treat an ir	njury, illness, or condition	\$40	
Health care provider's office or	Other practitioner office visit		\$40	
clinic visit	Specialist visit		\$55	
	Preventive care/ screening/ in Laboratory Tests	nmunization	No charge \$35	
Tests	X-rays and Diagnostic Imagin Imaging (CT/PET scans, MRI		\$50	
	Imaging (CT/PET scans, MRI	S)	\$250	
	Tier 1		\$15	
Drugs to treat	Tier 2		\$45	Pharma deducti
condition	Tier 3		\$70	Pharma deducti
	Tier 4 Surgery facility fee (e.g., ASC		20% up to \$250 per script after pharmacy deductible	Pharma deducti
Outpatient services	Physician/surgeon fees	)	20%	
Services	Outpatient visit		20%	
	Emergency room facility fee (		\$250	Х
Need	Emergency room physician fe		\$50	Х
immediate attention	Emergency medical transportation		\$250	Х
	Urgent care		\$80	
Hospital stay	Facility fee (e.g. hospital room	n)	20%	Х
,	Physician/surgeon fee		20%	Х
	Mental/Behavioral health outp	patient office visits	\$40	
	Mental/Behavioral health othe	er outpatient items and services	\$40	
Mental	Mental/Behavioral health inpa	tient facility fee (e.g.hospital room)	20%	х
health, behavioral	Mental/Behavioral health inpa	tient physician/surgeon fee	20%	х
health, or substance abuse needs	Substance Use disorder outp	atient office visits	\$40	
	Substance Use disorder other outpatient items and services		\$40	
	Substance Use inpatient facili	ity fee (e.g. hospital room)	20%	х
	Substance use disorder inpatient physician/surgeon fee		20%	х
	Prenatal care and preconcept	tion visits	No charge	
Pregnancy	Delivery and all inpatient services	Hospital	20%	х
		Professional	20%	Х
Heln	Home health care Outpatient Rehabilitation serv		\$40 \$40	
Help recovering or	Outpatient Habilitation service		\$40	
	Skilled nursing care		20%	Х
neath needs	Durable medical equipment		20%	
Child our	Hospice service Eye exam		No charge No charge	
Child eye	1 pair of glasses per year (or o		No charge	

Lye exam

1 pair of glasses per year (or contact lenses in lieu of glasses)

Oral Exam

Preventive - Cleaning

Preventive - X-ray

Sealants per Tooth

Topical Fluoride Application

Space Maintainers - Fixed

Root Canal-Molar Gingivectomy per Quad Extraction-Single Tooth Exposed Root or Erupted Extraction-Complete Bony Porcelain with Metal Crown

Amalgam Fill - 1 Surface

Medically necessary orthodontics

Child Dental Basic Services

Child Dental Major Services No charge

Not Covered

Not Covered

Not Covered

Not Covered

### Summary of Benefits and Coverage

Summary of	Summary of Benefits and Coverage  Member Cost Share amounts describe the Enrollee's out of pocket costs.			Bronze		
Member Cost S	share amounts describe the En	rollee's out of pocket costs.	Bronze Plan	n	HSA Plan	
Actuarial Value	e - AV Calculator		<del>61.19%</del> <u>61.9</u> °	<u>%</u>	61.1%	
	cludes a deductible?		Yes, integrated Medica		Yes, integ	
	Individual deductible Family deductible		\$6,500 integrate \$13,000 integrate		\$4,500 inte \$9,000 inte	
Individual	deductible, NOT integrated:	Medical / Pharmacy / Dental	N/A\$6,000 / \$50	0/\$0	N/A	
	luctible, NOT integrated: Me -of-pocket maximum	dical / Pharmacy / Dental	N/A <u>\$12,000 / \$10</u> \$6,500	00 / \$0	N/A \$6,500	
Family Out-of-	pocket maximum		\$13,000		\$13,000	
	f-only coverage deductible an: Individual deductible		N/A N/A		\$4,50 \$4,50	
Common						
Medical Event	Sei	vice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Primary care visit to treat an ir	jury, illness, or condition	\$70	After 1st three non-preventive visits	40%	х
Health care provider's office or clinic visit	Other practitioner office visit		\$70	After 1st three non-preventive visits	40%	х
	Specialist visit		\$90	After 1st three non-preventive visits	40%	х
	Preventive care/ screening/ in Laboratory Tests	munization	No charge \$40		No charge 40%	X
Tests	X-rays and Diagnostic Imagin		<del>0%</del> 100%	Х	40%	Х
	Imaging (CT/PET scans, MRI	s)	<del>0%</del> 100%	X	40%	X
	Tier 1		9%100% up to \$500 per script after pharmacy deductible	XPharmacy Deductible	40%	х
Drugs to treat illness or	Tier 2		9%100% up to \$500 per script after pharmacy deductible	XPharmacy Deductible	40%	х
condition	Tier 3		9%100% up to \$500 per script after pharmacy deductible	XPharmacy Deductible	40%	х
	Tier 4  Surgery facility fee (e.g., ASC)		9%100% up to \$500 per script after pharmacy deductible	XPharmacy Deductible	40%	х
Outpatient	Surgery facility fee (e.g., ASC)		<del>0%</del> 100% <del>0%</del> 100%	X	40% 40%	X
services	Physician/surgeon fees Outpatient visit		<del>0%</del> 100% <del>0%</del> 100%	X	40%	X
	Emergency room facility fee (waived if admitted)		<del>0%</del> 100%	х	40%	Х
	Emergency room physician fe	e (waived if admitted)		X	40%	x
Need	Emergency medical transport	· ,	<del>0%100%</del> <del>0%</del> 100%	X	40%	X
immediate attention	Urgent care		\$120	After 1st three non-preventive visits	40%	х
Hospital stay	Facility fee (e.g. hospital room	)	<del>0%</del> 100%	X	40%	Х
	Physician/surgeon fee		<del>0%</del> 100%	X	40%	Х
	Mental/Behavioral health outpatient office visits		\$70	After 1st three non-preventive visits	40%	х
	Mental/Behavioral health other outpatient items and services		\$70	After 1st three non-preventive visits	40%	х
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		<del>0%</del> 100%	Х	40%	х
Mental health,				X	40%	Х
behavioral	Mental/Behavioral health inpatient physician/surgeon fee		<del>0%</del> 100%		40%	_ ^
health, or substance abuse needs	Substance Use disorder outpatient office visits		\$70	After 1st three non-preventive visits	40%	х
	Substance Use disorder other outpatient items and services		\$70	After 1st three non-preventive visits	40%	х
	Substance Use inpatient facili	ty fee (e.g. hospital room)	<del>0%</del> 100%	Х	40%	Х
	Substance use disorder inpat			Х	40%	х
	Prenatal care and preconcept		<del>0%100%</del>			^_
Pregnancy	Delivery and all inpatient	Hospital	No charge <del>0%100%</del>	Х	No charge 40%	х
. /og.ianoy	services	Professional	<del>0%100%</del>	X	40%	X
	Home health care		<del>0%</del> 100% 0%100%	X	40%	X
Help	Outpatient Rehabilitation serv		\$70		40%	Х
recovering or	Outpatient Habilitation service	8	\$70		40%	X
other special health needs	Skilled nursing care		<del>0%100%</del>	X	40%	X
	Durable medical equipment Hospice service		0%100% No charge	X	40% 0%	X
Child eye	Eye exam		No charge		No charge	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)		No charge		No charge	
Child Dental	Oral Exam Preventive - Cleaning					
Diagnostic	Preventive - X-ray		Not Covered		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed		Not covered		Not Govered	
Child Dental Basic Services	Space Maintainers - Fixed  Amalgam Fill - 1 Surface		Not Covered		Not Covered	
	Root Canal- Molar					
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Expo	sed Root or Erupted	Not Covered		Not Covered	
Services	Extraction- Complete Bony Porcelain with Metal Crown	·				
Child Orthodontics	Medically necessary orthodon	tics	Not Covered		Not Covered	

Summary of Benefits and Coverage	
Member Cost Share amounts describe the Enrollee's out of pocket costs.	Catastrophic Plan
Actuarial Value - AV Calculator	
Plan design includes a deductible?	Yes, integrated
Integrated Individual deductible	\$6,850 integrated
Integrated Family deductible	\$13,700 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Individual Out-of-pocket maximum	\$6,850
Family Out-of-pocket maximum	\$13,700
HSA plan: Self-only coverage deductible	N/A
HSA family plan: Individual deductible	N/A

Integrated	Family deductible deductible. NOT integrated:	Medical / Pharmacy / Dental	\$13,700 i	
Family dec	luctible, NOT integrated: Me	dical / Pharmacy / Dental	N/	'A
	of-pocket maximum		\$6,8 \$13,	
HSA plan: Sel	f-only coverage deductible		N/	'A
	n: Individual deductible		IN/	A
Common Medical			Member Cost	Deductible
Event	Sei	rvice Type	Share	Applies
	Primary care visit to treat an ir	njury, illness, or condition	0%	After 1st three non-preventive visits
Health care provider's office or	Other practitioner office visit		0%	After 1st three non-preventive visits
clinic visit	Specialist visit		0%	х
	Preventive care/ screening/ in	nmunization	No charge	
Tests	Laboratory Tests X-rays and Diagnostic Imagin	g	0%	X
	Imaging (CT/PET scans, MRI		0%	X
	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%	X
services	Physician/surgeon fees Outpatient visit		0%	X
	Emergency room facility fee (	waived if admitted)	0%	X
	Emergency room physician fe	·	0%	X
Need immediate	Emergency medical transport	0%	X	
immediate attention	Urgent care		0%	After 1st three non-preventive visits
	Facility fee (e.g. hospital room)		0%	X
Hospital stay	Physician/surgeon fee	,	0%	X
	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	Mental/Behavioral health inpatient facility fee (e.g.hospital room)		0%	Х
health, behavioral	Mental/Behavioral health inpa	0%	Х	
health, or substance abuse needs	Substance Use disorder outp	0%	After 1st three non-preventive visits	
	Substance Use disorder other outpatient items and services		0%	After 1st three non-preventive visits
	Substance Use inpatient facili	0%	Х	
	Substance use disorder inpat		0%	Х
Dunaman	Prenatal care and preconcept		No charge	
Pregnancy	Delivery and all inpatient services	Hospital	0%	X
	Home health care	Professional	0%	X
Help	Outpatient Rehabilitation services Outpatient Habilitation services		0% 0%	X
recovering or other special	Skilled nursing care	•	0%	X
health needs	Durable medical equipment		0%	X
	Hospice service		0% No charge	X
Child eye care	Eye exam  1 pair of glasses per year (or contact lenses in lieu of glasses)		0%	х
Child Dantal	Oral Exam			
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray		Not Covered	
and Preventive	Sealants per Tooth Topical Fluoride Application		Not Covered	
	Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered	
	Root Canal- Molar			
Child Dental Major	Gingivectomy per Quad Extraction- Single Tooth Expo	osed Root or Erupted	Not Covered	
Services	Extraction- Complete Bony Porcelain with Metal Crown			
Child	Medically necessary orthodon	ition	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 <u>an up to 30-day</u> 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	1) Most generic drugs and low cost preferred brands.
	1) 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;
	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;
	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 sclerosis, systemic lupus erythematosus. 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 16 May 21, 2015

Summary of Benefits	Standalone Children's Dental Plan		<del>Standalone</del> <u>Children's</u> Dental Plan		
Member Cost Share amou costs.	nts describe the Enrollee's out of pocket	Pediatric Dental EHB Copay Plan		Pediatric Dental EHB Coinsurance Plan	
		Up to Ag	je 19	Up to Aզ	je 19
Actuarial Value		83.09	%	86.89	6
Individual Deductible (waived for Diagnostic & Preventive)		\$0		\$65 In Network/ \$65 Out of Network	
(waived for Diagnostic &	Family Deductible (Two or more children) (waived for Diagnostic & Preventive)			\$130 In Ne \$130 Out of	
Individual Out of Pocket		\$350		\$350	
	ximum (Two or More Children)	\$700 \$0	)	\$700	)
	Office Copay			\$0	
Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d)		None		None	
Annual Benefit Limit (the maximum amount the dental	plan will pay in the benefit year)	None		None	
Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Oral Exam	\$0		0%	
	Preventive - Cleaning	\$0		0%	
Diagnostic & Preventive	Preventive - X-ray	\$0		0%	
	Sealants per Tooth	\$0		0%	
	Topical Fluoride Application	\$0		0%	
	Space Maintainers - Fixed	\$0		0%	
Basic Services	Amalgam Fill - One Surface	\$25		20%	X
Major Services - Crowns	Root Canal - Molar Gingivectomy per Quad	\$300 \$150			
and Casts, Endodontics, Periodontics, Prosthodontics, Oral	Periodontics, or Erupted			50%	х
Surgery	Extraction - Complete Bony	\$160			
	Crown - Porcelain with Metal	\$300			
Orthodontia	Medically Necessary Orthodontia	\$350		50%	Х

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

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

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

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



# 2016 Dental Standard Benefit Plan Designs

Date: April 16 May 21, 2015

Summary of Benefits	and Coverage		Family D	ental Plan	
Member Cost Share amou costs.	nts describe the Enrollee's out of pocket		Dental EHB y Plan	Adult De Copay F	
		Up to	Age 19	Age 19 and	l Older
<b>Actuarial Value</b>		83.	0%	Not Calcu	lated
Individual Deductible (waived for Diagnostic &	Preventive)	\$	0	\$0	
Family Deductible (Two of waived for Diagnostic &		\$	0	\$0	
<b>Individual Out of Pocket</b>			50	Not Appli	
	ximum (Two or More Children)		00	Not Appli	cable
Office Copay		\$	0	\$0	
Waiting Period (Waivered Condition provision, as 1357.50 (a)(3)(J)(4) and Insurance		No	ne	None	)
Annual Benefit Limit (the maximum amount the dental	plan will pay in the benefit year)	No	ne	None	<b>;</b>
Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Oral Exam	\$0		\$0	
	Preventive - Cleaning	\$0		\$0	
Diagnostic & Preventive	Preventive - X-ray	\$0		\$0	
Diagnostic & Freventive	Sealants per Tooth	\$0		Not Covered	
	Topical Fluoride Application	\$0		Not Covered	
	Space Maintainers - Fixed	\$0		Not Covered	
Basic Services	Amalgam Fill - One Surface	\$25		\$25	
Malan Oamila	Root Canal - Molar	\$300		\$300	
Major Services - Crowns	Gingivectomy per Quad	\$150		\$150	
and Casts, Endodontics, Periodontics,	Extraction- Single Tooth Exposed Root or Erupted	\$65		\$65	
Prosthodontics, Oral	Extraction - Complete Bony	\$160		\$160	
Surgery	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.



# 2016 Dental Standard Benefit Plan Designs

Date: April 16 May 21, 2015

Summary of Benefits	and Coverage		Family De	ental Plan	
Member Cost Share amou costs.	nts describe the Enrollee's out of pocket	Pediatric Der Coinsurance		Adult De Coinsurance	
		Up to Ag	e 19	Age 19 and	l Older
Actuarial Value		86.8%	6	Not Calcu	ılated
Individual Deductible (waived for Diagnostic &		\$65 In Net \$65 Out of N	Network	\$50 In Ne \$50 Out of N	
Family Deductible (Two of waived for Diagnostic &	Preventive)	\$130 In Ne \$130 Out of	Network	Not Appli	
Individual Out of Pocket		\$350		Not Appli	
<del>-</del>	kimum (Two or More Children)	\$700		Not Appli \$0	cable
Office Copay		\$0			- N4-i
Waiting Period (Waivered Condition provision, as 1357.50 (a)(3)(J)(4) and Insurance	s defined in Health & Safety Code se Code 10198.6 (10)(d)	None	)	6 months for Services, Waive of Prior Co	d with Proof
Annual Benefit Limit (the maximum amount the dental	plan will pay in the benefit year)	None	;	\$1,50	0
Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
	Oral Exam	0%		0%	
	Preventive - Cleaning	0%		0%	
Diagnostic & Preventive	Preventive - X-ray	0%		0%	
	Sealants per Tooth	0%		Not Covered	
	Topical Fluoride Application	0%		Not Covered	
	Space Maintainers - Fixed	0%		Not Covered	
Basic Services	Amalgam Fill - One Surface	20%	Х	20%	X
Major Services - Crowns and Casts, Endodontics, Periodontics, Prosthodontics, Oral Surgery	Root Canal - Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Erupted Extraction - Complete Bony Crown - Porcelain with Metal	50%	х	50%	х
Orthodontia	Medically Necessary Orthodontia	50%	Х	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-
- 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.

pocket maximum.

- 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.

STATE OF ALIFORNIA — DEPARTMENT OF FINANCE

# **ECONOMIC AND FISCAL IMPACT STATEMENT** (REGULATIONS AND ORDERS) STD. 399 (REV. 12/2013)

## ECONOMIC IMPACT STATEMENT

	Economic IVII	ACIBIAI			
DEPARTMENT NAME	CONTACT PERSON		EMAIL ADDRESS		TELEPHONE NUMBER
California Health Benefit Exchange	Andrea Rosen		andrea.rosen@co	vered.cas	916-228-8343
DESCRIPTIVE TITLE FROM NOTICE REGISTER OR FORM 400 2016 Standard Benefit Plan Designs					NOTICE FILE NUMBER
A. ESTIMATED PRIVATE SECTOR COST IMPA	CTS Include calculations and	d assumptions ir	the rulemaking record	1.	
a. Impacts business and/or employees b. Impacts small businesses c. Impacts jobs or occupations d. Impacts California competitiveness	e. Imposes rep f. Imposes pres g. Impacts indi		of performance		
	a through g is checked, con is checked, complete the Fi				
2. The(Agency/Department)	estimates that the ed	conomic impact	of this regulation (whic	ch includes th	ne fiscal impact) is:
Below \$10 million					
Between \$10 and \$25 million					
Between \$25 and \$50 million					
Over \$50 million [If the economic impact i	s over \$50 million, agencies are i	reauired to subm	<b>it a</b> Standardized Reauld	atory Impact	Assessment
	ent Code Section 11346.3(c)]		o de la desta de l	itory impacts	155C55ITICITE
3. Enter the total number of businesses impacted:  Describe the types of businesses (Include nonp					
Enter the number or percentage of total businesses impacted that are small businesses:					
1. Enter the number of businesses that will be crea	ated:	eliminated:			
Explain:					
5. Indicate the geographic extent of impacts:	Statewide  Local or regional (List areas):				
5. Enter the number of jobs created:	and eliminated:				
Describe the types of jobs or occupations impa	cted:			W. W. Co.	
. Will the regulation affect the ability of California other states by making it more costly to produc	businesses to compete with e goods or services here?	YES	NO		
If YES, explain briefly:					

STATE OF CALIFORNIA — DEPARTMENT OF FINANCE

# **ECONOMIC AND FISCAL IMPACT STATEMENT** (REGULATIONS AND ORDERS) STD. 399 (REV. 12/2013)

# **ECONOMIC IMPACT STATEMENT (CONTINUED)**

B. ESTIMATED COSTS Include calculations	and assumptions in the	e rulemaking record.	
What are the total statewide dollar costs tha	t businesses and indivi	iduals may incur to comply with this re	egulation over its lifetime? \$
a. Initial costs for a small business: \$			
b. Initial costs for a typical business: \$			
			Years:
d. Describe other economic costs that may			
2. If multiple industries are impacted, enter the	e share of total costs fo	er each industry:	
		9	
3. If the regulation imposes reporting requirem Include the dollar costs to do programming, red	ents, enter the annual cord keeping, reporting,	costs a typical business may incur to a and other paperwork, whether or not ti	comply with these requirements. the paperwork must be submitted. \$
4. Will this regulation directly impact housing c	osts? YES	NO	
	If YES, enter the	e annual dollar cost per housing unit:	\$
		Number of units:	
5. Are there comparable Federal regulations?	YES	NO	
Explain the need for State regulation given the	ie existence or absence	e of Federal regulations:	
Enter any additional costs to businesses and/	or individuals that may	be due to State - Federal differences:	\$
C. ESTIMATED BENEFITS Estimation of the c			
Briefly summarize the benefits of the regulat			my and an enteringen.
health and welfare of California residents, we	orker safety and the Sta	ate's environment:	
2. Are the benefits the result of: specific sta	atutory requirements, c	or goals developed by the agend	y based on broad statutory authority?
Explain:			
3. What are the total statewide benefits from th	is regulation over its lif	tetime? \$	
4. Briefly describe any expansion of businesses	currently doing busine	ess within the State of California that w	ould result from this regulation:
D. ALTERNATIVES TO THE REGULATION In specifically required by rulemaking law, but	nclude calculations and encouraged.	d assumptions in the rulemaking reco	rd. Estimation of the dollar value of benefits is not
1. List alternatives considered and describe the	m below. If no alternat	ives were considered, explain why no	:
		30 ± 6€ 1	
	-1	77	
			PAGE 2

STATE OF JALIFORNIA — DEPARTMENT OF FINANCE

# **ECONOMIC AND FISCAL IMPACT STATEMENT** (REGULATIONS AND ORDERS) STD. 399 (REV. 12/2013)

# **ECONOMIC IMPACT STATEMENT (CONTINUED)**

2.	Summarize the to	total statewide costs and benefits	from this regulation and each alternative c	onsidered:	
	Regulation:	Benefit: \$	Cost: \$		
	Alternative 1:	Benefit: \$	Cost: \$		
	Alternative 2:	Benefit: \$	Cost: \$		
3.	Briefly discuss an of estimated co	ny quantification issues that are rel osts and benefits for this regulati	evant to a comparison on or alternatives:		
	- Markett - Aller St. Totals				
4.	regulation mand actions or proce	dates the use of specific technol edures. Were performance stand	erformance standards as an alternative, if ogies or equipment, or prescribes specific ards considered to lower compliance cost		
=	MAJOR REGUL	ATIONS Include calculations a	nd assumptions in the rulemaking record.		
<u></u>	MAJON NEGOL				
			Protection Agency (Cal/EPA) boards, g (per Health and Safety Code sectio		
1.	Will the estimate	ed costs of this regulation to Califo	ornia business enterprises exceed \$10 mill	ion? YES NO	
			If YES, complete E2. and If NO, skip to E4	E3	
2.	Briefly describe e	each alternative, or combination o	of alternatives, for which a cost-effectivenes	s analysis was performed:	
	Alternative 1:	AT TOUR CO. IN SO. HOUSE CO.			
	Alternative 2:				
	(Attach additiona	al pages for other alternatives)			
2	Facility and letter				
э.			ibed, enter the estimated total cost and ov		
	Alternative 1: To	otal Cost \$	Cost-effectiveness ratio: \$ Cost-effectiveness ratio: \$		-
					<del></del>
25110	Alternative 2: To		Cost-effectiveness ratio: \$		-
4.	exceeding \$50 m	on subject to OAL review have an one of the control of the control of the control of the fully regulation is estimated to be fully	estimated economic impact to business ent tween the date the major regulation is esti implemented?	terprises and individuals locate mated to be filed with the Secr	d in or doing business in California etary of State through12 months
	-	NO			
	If YES, agencies a Government Cod	are required to submit a <u>Standardiz</u> de Section 11346.3(c) and to include	ed Regulatory Impact Assessment (SRIA) as sp the SRIA in the Initial Statement of Reasons.	ecified in	
5.	Briefly describe th	he following:			
	The increase or c	decrease of investment in the Sta	re:		
	The incentive for	r innovation in products, material	s or processes:		
	The benefits of the residents, worker	the regulations, including, but not er safety, and the state's environm	limited to, benefits to the health, safety, ar ent and quality of life, among any other be	nd welfare of California nefits identified by the agency:	

PAGE 3

STATE OF LALIFORNIA — DEPARTMENT OF FINANCE

# **ECONOMIC AND FISCAL IMPACT STATEMENT** (REGULATIONS AND ORDERS) STD. 399 (REV. 12/2013)

# FISCAL IMPACT STATEMENT

A. FISCAL EFFECT ON LOCAL GOVERNMENT Indicate current year and two subsequent Fiscal Years.	e appropriate boxes 1 t	hrough 6 and attach calculations and assumpt	ions of fiscal impact for the
1. Additional expenditures in the current State Fiscal (Pursuant to Section 6 of Article XIII B of the Californ	Year which are reimbur nia Constitution and Se	rsable by the State. (Approximate) ctions 17500 et seq. of the Government Code).	
\$			
a. Funding provided in			
Budget Act of	or Chapter	, Statutes of	
b. Funding will be requested in the Governor's Bu	udget Act of		
	Fiscal Year:		
2. Additional expenditures in the current State Fiscal \( (Pursuant to Section 6 of Article XIII B of the Californ	ear which are NOT reir lia Constitution and Sec	mbursable by the State. (Approximate) ctions 17500 et seq. of the Government Code).	
\$			
Check reason(s) this regulation is not reimbursable and p  a. Implements the Federal mandate contained in		information:	
_	7		
b. Implements the court mandate set forth by the			Court.
Case of:		vs	
c. Implements a mandate of the people of this Sta	ate expressed in their a	pproval of Proposition No.	
Date of Election:			
d. Issued only in response to a specific request fro	om affected local entity	(s).	
Local entity(s) affected:			957
e. Will be fully financed from the fees, revenue, et	c. from:		
Authorized by Section:	0	of the	Code;
f. Provides for savings to each affected unit of loc	al government which w		
g. Creates, eliminates, or changes the penalty for	a new crime or infraction	on contained in	
3. Annual Savings. (approximate)			
\$			
4. No additional costs or savings. This regulation makes	only technical, non-subs	stantive or clarifying changes to current law regula	ations.
S. No fiscal impact exists. This regulation does not affect	t any local entity or prog	gram.	
6. Other. Explain			
	18		PAGE 4

STATE O CALIFORNIA — DEPARTMENT OF FINANCE

# **ECONOMIC AND FISCAL IMPACT STATEMENT** (REGULATIONS AND ORDERS) STD. 399 (REV. 12/2013)

# FISCAL IMPACT STATEMENT (CONTINUED)

B. FISCAL EFFECT ON STATE GOVERNMENT Indicate appropriate boxes 1 through 4 and attach calculations and a year and two subsequent Fiscal Years.	ssumptions of fiscal impact for the current
1. Additional expenditures in the current State Fiscal Year. (Approximate)	
\$	
It is anticipated that State agencies will:	
a. Absorb these additional costs within their existing budgets and resources.	
b. Increase the currently authorized budget level for theFiscal Year	
2. Savings in the current State Fiscal Year. (Approximate)	
\$	
3. No fiscal impact exists. This regulation does not affect any State agency or program.	
4. Other. Explain State (sustainability) funds will be utilized if Federal funds are insufficient to	o cover costs in
Fiscal Year (FY) 2014/15. State (sustainability) funds that may be utilized are not	from the General Fund.
C. FISCAL EFFECT ON FEDERAL FUNDING OF STATE PROGRAMS Indicate appropriate boxes 1 through 4 and attain impact for the current year and two subsequent Fiscal Years.	ach calculations and assumptions of fiscal
1. Additional expenditures in the current State Fiscal Year. (Approximate)	
\$	
2. Savings in the current State Fiscal Year. (Approximate)	
ē.	
3. No fiscal impact exists. This regulation does not affect any federally funded State agency or program.	
4. Other. Explain Estimated cost impact of Federal Funds (Grant) is \$169,293 in FY2014/15. F	lequires no additional
funding authority. This proposal has no impact on the General Fund. For details	see Attachment.
FISCAL OFFICER SIGNATURE	DATE
alu Valu	2/6/15
The signature attests that the agency has completed the STD. 399 according to the instructions in SAM sect	ions 6601-6616, and understands
he impacts of the proposed rulemaking. State boards, offices, or departments not under an Agency Secreta highest ranking official in the organization.	ry must have the form signed by the
AGENCY SECRETARY /	DATE
a Hathlat Busha	2.6.15
Finance approval and signature is required when SAM sections $6601$ - $6616$ require completion of Fiscal Im	pact Statement in the STD. 399.
DEPARTMENT OF FINANCE PROGRAM BUDGET MANAGER	DATE
	·

# Personal Services (PS) & Operating Expenses & Equipment (OE&E) Costs

				Cos	t (pe	Cost (per classification	=						
Classification	Sal	Salary Cost1/	B	Benefits <sup>2/</sup>		Total PS	CC 5883	OE&E3/	PS	PS + OE&E	Staffing Level <sup>4/</sup>		Total Cost
C.E.A Level B @ 10%	ક્ક	3,506	↔	1,367	4	4,873	69	267	8	5,140	1.0	49	5,140
PMD Director @ 25%	↔	7,500	↔	2,925	4	10,425	↔	299	4	11,092	1.0	69	11,092
Assoc. Gov. Program Analyst (AGPA) @ 50%	↔	10,106	8	3,941	69	14,047	↔	1,333	49	15,380	2.0	4	30,761
OL	Total \$	21,112	8	8,233	\$	29,345	↔	2,267	49	31,612	4.0	43	46,993

Salary calculations based off of mid-step of classification and prorated based on the amount of time dedicated to the development of the recertification and new entrant application.
 Benefits calculated via standard benefit rate (39%).
 OE&E includes annual standard complement at \$\$,000, prorated based on the same parameters as salary.
 Staffing level and associated classifications provided by program.

# Contract Costs

Contract/Contractor		1	Amount
Ted von Glahn		\$	5,225
Bertko Acturial Associates, LLC		8	2,325
Milliman, Inc.		8	36,000
Tori Group		\$	78,750
	Total	\$	122,300

# Total Summary

Amount	\$ 46,993	\$ 122,300	169 293
ory			Total Cost
Cost Category	Total PS & OE&E	Total Contracts	

Personal Services -Salary	SACRAGE THE SECOND		THE RESERVE THE PERSON NAMED IN			Charles Andrews and Control of the C		
		Salary						
			_	Duration/Tenure (in				
Classification	Bottom	Mid	Тор	months)	Time Allocation 2	Salary Cost	Staffing Level	Total Salary Cost"
C.E.A. Level B		8,766		4.0	2 months @ 10%	\$ 3,506	1.0	1.0 \$ 3.506
PMD Director		15,000		2.0	4 months @ 25%	\$ 7,500		\$ 7.500
Assoc. Gov. Program Analyst (AGPA)	4,488	5,053	5,618	4.0	4 months @ 50%	\$ 10,106		\$ 20,212
Color of the second sec							Total Salary Cost	\$ 31,218 [A]

 $^1$  Salary calculations based on mid-step of classification,  $^2$  The (4) month measurement period is 02/01/14 - 05/31/2014

Classification	Benefit Rate	Total Salary Cost	Benefit Amount	Staffing Level	Total Benefit Cost
S.E.A. Level B	\$ %68	3,506	\$ 1,367	1.0 \$	1.367
PMD Director	39% \$	7,500	\$ 2.925	1.0 \$	2 925
Assoc. Gov. Program Analyst (AGPA)	38% \$	10,106	\$ 3,941	2.0 \$	7,882
				Total Benefit Cost \$	12.174 [B]

				[]
Total OE&E Cost	267	299	2,667	3,601
Staffing Level	1.0 \$	1.0 \$	2.0 \$	Total OE&E cost \$
OE&E Proration	\$ 267	\$ 667	\$ 1,333	
Time Allocation 2	2 months @ 10%	4 months @ 25%	4 months @ 50%	
Standard EO&E	8,000	8,000	8,000	
	8	€Э	49	
Classification	C.E.A. Level B	PMD Director	Assoc. Gov. Program Analyst (AGPA)	

Operating Expenses & Equipment

46,993 [A + B +C] TOTAL PS & OE&E COST