

2017/2018 Patient-Centered Benefit Plan Designs

10.0 EHB

Date: June 16, 2016/January 3, 2017



Summary of Benefits and Coverage

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

		Platinum Coinsurance Plan		Platinum Copoly Plan	
<b>Actuarial Value - AV Calculator</b>		89.7% <del>91.2%</del>		90.3% <del>88.1%</del>	
<b>Plan design includes a deductible?</b>		No		No	
<b>Integrated Individual deductible</b>		\$0		\$0	
<b>Integrated Family deductible</b>		\$0		\$0	
<b>Individual deductible, NOT integrated: Medical / Pharmacy / Dental</b>		\$0 / \$0 / \$0		\$0 / \$0 / \$0	
<b>Family deductible, NOT integrated: Medical / Pharmacy / Dental</b>		\$0 / \$0 / \$0		\$0 / \$0 / \$0	
<b>Individual Out-of-pocket maximum</b>		\$4,000 <del>\$3,350</del>		\$4,000 <del>\$3,350</del>	
<b>Family Out-of-pocket maximum</b>		\$8,000 <del>\$6,700</del>		\$8,000 <del>\$6,700</del>	
<b>HSA plan: Self-only coverage deductible</b>		N/A		N/A	
<b>HSA family plan: Individual deductible</b>		N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$15		\$15	
	Other practitioner office visit	\$15		\$15	
	Specialist visit	\$40 <del>\$30</del>		\$40 <del>\$30</del>	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$20 <del>\$15</del>		\$20 <del>\$15</del>	
	X-rays and Diagnostic Imaging	\$40 <del>\$30</del>		\$40 <del>\$30</del>	
	Imaging (CT/PET scans, MRIs)	10%		\$160 <del>\$75</del>	
Drugs to treat illness or condition	Tier 1	\$5		\$5	
	Tier 2	\$15		\$15	
	Tier 3	\$25		\$25	
	Tier 4	10% up to \$250 per script		10% up to \$250 per script	
Outpatient services	Surgery facility fee (e.g., ASC)	10%		\$250 <del>\$100</del>	
	Physician/surgeon fees	10%		\$40 <del>\$25</del>	
	Outpatient visit	10%		10%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Emergency medical transportation	\$150		\$150	
	Urgent care	\$15		\$15	
Hospital stay	Facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Physician/surgeon fee	10%		\$40 <del>No charge</del>	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$15		\$15	
	Mental/Behavioral health other outpatient items and services	\$15		\$15	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%		\$250 per day up to 5 days	
	Mental/Behavioral health inpatient physician fee	10%		\$40 <del>No charge</del>	
	Substance Use disorder outpatient office visits	\$15		\$15	
	Substance Use disorder other outpatient items and services	\$15		\$15	
	Substance Use inpatient facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	Hospital	10%	\$250 per day up to 5 days	
		Professional	10%	\$40 <del>No charge</del>	
Help recovering or other special health needs	Home health care (cost share per visit)	10%		\$20	
	Outpatient Rehabilitation services	\$15		\$15	
	Outpatient Habilitation services	\$15		\$15	
	Skilled nursing care	10%		\$150 per day up to 5 days	
	Durable medical equipment	10%		10%	
Child eye care	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
	Preventive - X-ray	No charge		No charge	
	Sealants per Tooth				
Child Dental Basic Services	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Major Services	Restorative Procedures	20%		See 2017 Dental Copay Schedule	
	Periodontal Maintenance Services				
Child Orthodontics	Crowns and Casts				
	Endodontics				
	Periodontics (other than maintenance)	50%		See 2017 Dental Copay Schedule	
Child Orthodontics	Prostodontics				
	Oral Surgery				
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

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Summary of Benefits and Coverage

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

		Gold Coinsurance Plan	Gold Copay Plan
<b>Actuarial Value - AV Calculator</b>		80.9% <del>81.9%</del>	84.2% <del>78.4%</del>
<b>Plan design includes a deductible?</b>		No	No
<b>Integrated Individual deductible</b>		\$0	\$0
<b>Integrated Family deductible</b>		\$0	\$0
<b>Individual deductible, NOT integrated: Medical / Pharmacy / Dental</b>		\$0 / \$0 / \$0	\$0 / \$0 / \$0
<b>Family deductible, NOT integrated: Medical / Pharmacy / Dental</b>		\$0 / \$0 / \$0	\$0 / \$0 / \$0
<b>Individual Out-of-pocket maximum</b>		\$6,750\$6,000	\$6,750\$6,000
<b>Family Out-of-pocket maximum</b>		\$13,500\$12,000	\$13,500\$12,000
<b>HSA plan: Self-only coverage deductible</b>		N/A	N/A
<b>HSA family plan: Individual deductible</b>		N/A	N/A

  

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
<b>Health care provider's office or clinic visit</b>	Primary care visit to treat an injury, illness, or condition	\$30\$25		\$30\$25	
	Other practitioner office visit	\$30\$25		\$30\$25	
	Specialist visit	\$55		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
<b>Tests</b>	Laboratory Tests	\$35		\$35	
	X-rays and Diagnostic Imaging	\$55		\$55	
	Imaging (CT/PET scans, MRIs)	20%		20%	
<b>Drugs to treat illness or condition</b>	Tier 1	\$15		\$15	
	Tier 2	\$55		\$55	
	Tier 3	\$75		\$75	
	Tier 4	20% up to \$250 per script		20% up to \$250 per script	
<b>Outpatient services</b>	Surgery facility fee (e.g., ASC)	20%		\$600\$300	
	Physician/surgeon fees	20%		\$55\$40	
	Outpatient visit	20%		20%	
<b>Need immediate attention</b>	Emergency room facility fee (waived if admitted)	\$325		\$325	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Emergency medical transportation	\$250		\$250	
	Urgent care	\$30		\$30	
<b>Hospital stay</b>	Facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Physician/surgeon fee	20%		\$55No charge	
<b>Mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient office visits	\$30\$25		\$30\$25	
	Mental/Behavioral health other outpatient items and services	\$30\$25		\$30\$25	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%		\$600 per day up to 5 days	
	Mental/Behavioral health inpatient physician fee	20%		\$55No charge	
	Substance Use disorder outpatient office visits	\$30\$25		\$30\$25	
	Substance Use disorder other outpatient items and services	\$30\$25		\$30\$25	
	Substance Use inpatient facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Substance use disorder inpatient physician fee	20%		\$55No charge	
<b>Pregnancy</b>	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	20%		\$600 per day up to 5 days	
	Professional	20%		\$55No charge	
<b>Help recovering or other special health needs</b>	Home health care (cost share per visit)	20%		\$30	
	Outpatient Rehabilitation services	\$30\$25		\$30\$25	
	Outpatient Habilitation services	\$30\$25		\$30\$25	
	Skilled nursing care	20%		\$300 per day up to 5 days	
	Durable medical equipment	20%		20%	
<b>Child eye care</b>	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
<b>Child eye care</b>	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
<b>Child Dental Diagnostic and Preventive</b>	Preventive - Cleaning				
	Preventive - X-ray	No charge		No charge	
	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
<b>Child Dental Basic Services</b>	Restorative Procedures	20%		See 2017 Dental Copay Schedule	
	Periodontal Maintenance Services				
<b>Child Dental Major Services</b>	Crowns and Casts				
	Endodontics				
	Periodontics (other than maintenance)	50%		See 2017 Dental Copay Schedule	
	Prosthodontics				
<b>Child Orthodontics</b>	Oral Surgery				
	Medically necessary orthodontics	50%		\$1,000	

2017-2018 Patient-Centered Benefit Plan Designs

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Summary of Benefits and Coverage

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

		Individual		
		Silver Plan		
<b>Actuarial Value - AV Calculator</b>		74.6%/71.9%		
<b>Plan design includes a deductible?</b>		Yes, Medical/Pharmacy		
<b>Integrated individual deductible</b>		N/A		
<b>Integrated family deductible</b>		N/A		
<b>Individual deductible, NOT integrated: Medical / Pharmacy / Dental</b>		\$2,500/ \$250/\$100 / \$0		
<b>Family deductible, NOT integrated: Medical / Pharmacy / Dental</b>		\$5,000/ \$500/\$200 / \$0		
<b>Individual Out-of-pocket maximum</b>		<del>\$6,000</del> \$7,000		
<b>Family Out-of-pocket maximum</b>		<del>\$13,600</del> \$14,000		
<b>HSA plan: Self-only coverage deductible</b>		N/A		
<b>HSA family plan: Individual deductible</b>		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
<b>Health care provider's office or clinic visit</b>	Primary care visit to treat an injury, illness, or condition	\$35		
	Other practitioner office visit	\$35		
	Specialist visit	\$70		
	Preventive care/ screening/ immunization	No charge		
<b>Tests</b>	Laboratory Tests	\$35		
	X-rays and Diagnostic Imaging	\$70		
	Imaging (CT/PET scans, MRIs)	\$300		
<b>Drugs to treat illness or condition</b>	Tier 1	\$15	Pharmacy deductible	
	Tier 2	\$55	Pharmacy deductible	
	Tier 3	\$80	Pharmacy deductible	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	
<b>Outpatient services</b>	Surgery facility fee (e.g., ASC)	20%		
	Physician/surgeon fees	20%		
	Outpatient visit	20%		
<b>Need immediate attention</b>	Emergency room facility fee (waived if admitted)	\$350		
	Emergency room physician fee (waived if admitted)	No charge		
	Emergency medical transportation	\$250	X	
	Urgent care	\$35		
<b>Hospital stay</b>	Facility fee (e.g. hospital room)	20%	X	
	Physician/surgeon fee	20%	X	
<b>Mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient office visits	\$35		
	Mental/Behavioral health other outpatient items and services	\$35		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	
	Mental/Behavioral health inpatient physician fee	20%	X	
	Substance Use disorder outpatient office visits	\$35		
	Substance Use disorder other outpatient items and services	\$35		
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X	
	Substance use disorder inpatient physician fee	20%	X	
<b>Pregnancy</b>	Prenatal care and preconception visits	No charge		
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
<b>Help recovering or other special health needs</b>	Home health care (cost share per visit)	\$45		
	Outpatient Rehabilitation services	\$35		
	Outpatient Habilitation services	\$35		
	Skilled nursing care	20%	X	
	Durable medical equipment	20%		
<b>Child eye care</b>	Hospice service	No charge		
	Eye exam	No charge		
<b>Child eye care</b>	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
	Oral Exam			
<b>Child Dental Diagnostic and Preventive</b>	Preventive - Cleaning	No charge		
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
<b>Child Dental Basic Services</b>	Restorative Procedures	20%		
	Periodontal Maintenance Services			
<b>Child Dental Major Services</b>	Crowns and Casts	50%		
	Endodontics			
	Periodontics (other than maintenance)			
	Prosthodontics			
	Oral Surgery			
<b>Child Orthodontics</b>	Medically necessary orthodontics	50%		

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Summary of Benefits and Coverage

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

		CCSB		CCSB	
		Silver Coinsurance Plan		Silver Copay Plan	
<b>Actuarial Value - AV Calculator</b>		74.6%/71.8%		74.3%/71.4%	
<b>Plan design includes a deductible?</b>		Yes, Medical/Pharmacy		Yes, Medical/Pharmacy	
<b>Integrated Individual deductible</b>		N/A		N/A	
<b>Integrated Family deductible</b>		N/A		N/A	
<b>Individual deductible, NOT integrated: Medical / Pharmacy / Dental</b>		\$2,000 / \$250 / \$100 / \$0		\$2,000 / \$250 / \$100 / \$0	
<b>Family deductible, NOT integrated: Medical / Pharmacy / Dental</b>		\$4,000 / \$500 / \$200 / \$0		\$4,000 / \$500 / \$200 / \$0	
<b>Individual Out-of-pocket maximum</b>		\$6,800		\$6,800	
<b>Family Out-of-pocket maximum</b>		\$13,600		\$13,600	
<b>HSA plan: Self-only coverage deductible</b>		N/A		N/A	
<b>HSA family plan: Individual deductible</b>		N/A		N/A	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
<b>Health care provider's office or clinic visit</b>	Primary care visit to treat an injury, illness, or condition	\$45		\$45	
	Other practitioner office visit	\$45		\$45	
	Specialist visit	\$75		\$75	
	Preventive care/ screening/ immunization	No charge		No charge	
<b>Tests</b>	Laboratory Tests	\$40		\$40	
	X-rays and Diagnostic Imaging	\$70		\$70	
	Imaging (CT/PET scans, MRIs)	20%		\$300	
<b>Drugs to treat illness or condition</b>	Tier 1	\$15	Pharmacy deductible	\$15	Pharmacy deductible
	Tier 2	\$55	Pharmacy deductible	\$55	Pharmacy deductible
	Tier 3	\$85	Pharmacy deductible	\$85	Pharmacy deductible
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible
<b>Outpatient services</b>	Surgery facility fee (e.g., ASC)	20%		20%	
	Physician/surgeon fees	20%		20%	
	Outpatient visit	20%		20%	
<b>Need immediate attention</b>	Emergency room facility fee (waived if admitted)	\$350		\$350	
	Emergency room physician fee (waived if admitted)	No charge		No charge	
	Emergency medical transportation	\$250	X	\$250	X
	Urgent care	\$45		\$45	
<b>Hospital stay</b>	Facility fee (e.g. hospital room)	20%	X	20%	X
	Physician/surgeon fee	20%	X	20%	X
<b>Mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient office visits	\$45		\$45	
	Mental/Behavioral health other outpatient items and services	\$45		\$45	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	20%	X
	Mental/Behavioral health inpatient physician fee	20%	X	20%	X
	Substance Use disorder outpatient office visits	\$45		\$45	
	Substance Use disorder other outpatient items and services	\$45		\$45	
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X	20%	X
<b>Pregnancy</b>	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	20%	X	20%	X
	Professional	20%	X	20%	X
<b>Help recovering or other special health needs</b>	Home health care (cost share per visit)	20%		\$45	
	Outpatient Rehabilitation services	\$45		\$45	
	Outpatient Habilitation services	\$45		\$45	
	Skilled nursing care	20%	X	20%	X
	Durable medical equipment	20%		20%	
<b>Child eye care</b>	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
<b>Child eye care</b>	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
<b>Child Dental Diagnostic and Preventive</b>	Preventive - Cleaning	No charge		No charge	
	Preventive - X-ray	No charge		No charge	
	Sealants per Tooth	No charge		No charge	
	Topical Fluoride Application	No charge		No charge	
	Space Maintainers - Fixed	No charge		No charge	
<b>Child Dental Basic Services</b>	Restorative Procedures	20%		See 2017 Dental Copay Schedule	
	Periodontal Maintenance Services				
<b>Child Dental Major Services</b>	Crowns and Casts				
	Endodontics				
	Periodontics (other than maintenance)	50%		See 2017 Dental Copay Schedule	
	Prosthodontics				
<b>Child Orthodontics</b>	Oral Surgery				
	Medically necessary orthodontics	50%		\$1,000	

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10.0 EHB

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Summary of Benefits and Coverage

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

	CCSB
	Silver HDHP Plan
Actuarial Value - AV Calculator	74.3%/71.7%
Plan design includes a deductible?	Yes, integrated
Integrated Individual deductible	\$2,000 integrated
Integrated Family deductible	\$4,000 integrated
Individual deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Family deductible, NOT integrated: Medical / Pharmacy / Dental	N/A
Individual Out-of-pocket maximum	\$6,550
Family Out-of-pocket maximum	\$13,100
HSA plan: Self-only coverage deductible	\$2,000
HSA family plan: Individual deductible	\$2,600

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	20%	X
	Other practitioner office visit	20%	X
	Specialist visit	20%	X
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests	20%	X
	X-rays and Diagnostic Imaging	20%	X
	Imaging (CT/PET scans, MRIs)	20%	X
Drugs to treat illness or condition	Tier 1	20% up to \$250 per script	X
	Tier 2	20% up to \$250 per script	X
	Tier 3	20% up to \$250 per script	X
	Tier 4	20% up to \$250 per script	X
Outpatient services	Surgery facility fee (e.g., ASC)	20%	X
	Physician/surgeon fees	20%	X
	Outpatient visit	20%	X
Need immediate attention	Emergency room facility fee (waived if admitted)	20%	X
	Emergency room physician fee (waived if admitted)	0%	X
	Emergency medical transportation	20%	X
	Urgent care	20%	X
Hospital stay	Facility fee (e.g. hospital room)	20%	X
	Physician/surgeon fee	20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	20%	X
	Mental/Behavioral health other outpatient items and services	20%	X
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X
	Mental/Behavioral health inpatient physician fee	20%	X
	Substance Use disorder outpatient office visits	20%	X
	Substance Use disorder other outpatient items and services	20%	X
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X
Pregnancy	Prenatal care and preconception visits	No charge	
	Delivery and all inpatient services	Hospital 20%	X
		Professional 20%	X
Help recovering or other special health needs	Home health care (cost share per visit)	20%	X
	Outpatient Rehabilitation services	20%	X
	Outpatient Habilitation services	20%	X
	Skilled nursing care	20%	X
Child eye care	Durable medical equipment	20%	X
	Hospice service	0%	X
	Eye exam	No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
Child Dental Diagnostic and Preventive	Preventive - Cleaning	No charge	
	Preventive - X-ray		
	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic Services	Restorative Procedures	20%	
	Periodontal Maintenance Services		
Child Dental Major Services	Crowns and Casts	50%	
	Endodontics		
	Periodontics (other than maintenance)		
	Prosthodontics		
Child Orthodontics	Oral Surgery		
	Medically necessary orthodontics	50%	

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

		Silver Plan 100%-150% FPL	Silver Plan 150%-200% FPL
<b>Actuarial Value - AV Calculator</b>		94.1% <del>93.9%</del>	87.6% <del>87.9%</del>
<b>Plan design includes a deductible?</b>		Yes, Medical/Pharmacy	Yes, Medical/Pharmacy
<b>Integrated Individual deductible</b>		N/A	N/A
<b>Integrated Family deductible</b>		N/A	N/A
<b>Individual deductible, NOT integrated: Medical / Pharmacy / Dental</b>		\$75 / \$0 / \$0	\$650 / \$50 / \$0
<b>Family deductible, NOT integrated: Medical / Pharmacy / Dental</b>		\$150 / \$0 / \$0	\$1,300 / \$100 / \$0
<b>Individual Out-of-pocket maximum</b>		\$2,350\$1,000	\$2,350\$2,450
<b>Family Out-of-pocket maximum</b>		\$4,700\$2,000	\$4,700\$4,900
<b>HSA plan: Self-only coverage deductible</b>		N/A	N/A
<b>HSA family plan: Individual deductible</b>		N/A	N/A

  

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
<b>Health care provider's office or clinic visit</b>	Primary care visit to treat an injury, illness, or condition	\$5		\$10		
	Other practitioner office visit	\$5		\$10		
	Specialist visit	\$8		\$25		
	Preventive care/ screening/ immunization	No charge		No charge		
<b>Tests</b>	Laboratory Tests	\$8		\$15		
	X-rays and Diagnostic Imaging	\$8		\$25		
	Imaging (CT/PET scans, MRIs)	\$50		\$100		
<b>Drugs to treat illness or condition</b>	Tier 1	\$3		\$5		
	Tier 2	\$10		\$20	Pharmacy deductible	
	Tier 3	\$15		\$35	Pharmacy deductible	
	Tier 4	10% up to \$150 per script		15% up to \$150 per script after pharmacy deductible	Pharmacy deductible	
<b>Outpatient services</b>	Surgery facility fee (e.g., ASC)	10%		15%		
	Physician/surgeon fees	10%		15%		
	Outpatient visit	10%		15%		
<b>Need immediate attention</b>	Emergency room facility fee (waived if admitted)	\$50		\$100		
	Emergency room physician fee (waived if admitted)	No charge		No charge		
	Emergency medical transportation	\$30	X	\$75	X	
	Urgent care	\$5		\$10		
<b>Hospital stay</b>	Facility fee (e.g. hospital room)	10%	X	15%	X	
	Physician/surgeon fee	10%	X	15%	X	
<b>Mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient office visits	\$5		\$10		
	Mental/Behavioral health other outpatient items and services	\$5		\$10		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	10%	X	15%	X	
	Mental/Behavioral health inpatient physician fee	10%	X	15%	X	
	Substance Use disorder outpatient office visits	\$5		\$10		
	Substance Use disorder other outpatient items and services	\$5		\$10		
	Substance Use inpatient facility fee (e.g. hospital room)	10%	X	15%	X	
	Substance use disorder inpatient physician fee	10%	X	15%	X	
<b>Pregnancy</b>	Prenatal care and preconception visits	No charge		No charge		
	Delivery and all inpatient services	Hospital	10%	X	15%	X
		Professional	10%	X	15%	X
<b>Help recovering or other special health needs</b>	Home health care (cost share per visit)	\$3		\$15		
	Outpatient Rehabilitation services	\$5		\$10		
	Outpatient Habilitation services	\$5		\$10		
	Skilled nursing care	10%	X	15%	X	
	Durable medical equipment	10%		15%		
<b>Child eye care</b>	Hospice service	No charge		No charge		
	Eye exam	No charge		No charge		
<b>Child eye care</b>	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
<b>Child Dental Diagnostic and Preventive</b>	Preventive - Cleaning	No charge		No charge		
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
<b>Child Dental Basic Services</b>	Restorative Procedures	20%		20%		
	Periodontal Maintenance Services					
<b>Child Dental Major Services</b>	Crowns and Casts	50%		50%		
	Endodontics					
	Periodontics (other than maintenance)					
	Prosthodontics					
<b>Child Orthodontics</b>	Oral Surgery					
	Medically necessary orthodontics	50%		50%		

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Date: June 16, 2016 January 3, 2017

Summary of Benefits and Coverage

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

		Silver Plan 200%-250% FPL		
<b>Actuarial Value - AV Calculator</b>		73.7% <del>73.9%</del>		
<b>Plan design includes a deductible?</b>		Yes, Medical/Pharmacy		
<b>Integrated Individual deductible</b>		N/A		
<b>Integrated Family deductible</b>		N/A		
<b>Individual deductible, NOT integrated: Medical / Pharmacy / Dental</b>		\$2,200 / \$260 <del>\$100</del> / \$0		
<b>Family deductible, NOT integrated: Medical / Pharmacy / Dental</b>		\$4,400 / \$500 <del>\$200</del> / \$0		
<b>Individual Out-of-pocket maximum</b>		\$5,700 <del>\$5,850</del>		
<b>Family Out-of-pocket maximum</b>		\$11,400 <del>\$11,700</del>		
<b>HSA plan: Self-only coverage deductible</b>		N/A		
<b>HSA family plan: Individual deductible</b>		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	\$30		
	Other practitioner office visit	\$30		
	Specialist visit	\$55 <del>\$65</del>		
	Preventive care/ screening/ immunization	No charge		
Tests	Laboratory Tests	\$35		
	X-rays and Diagnostic Imaging	\$65 <del>\$70</del>		
	Imaging (CT/PET scans, MRIs)	\$300		
Drugs to treat illness or condition	Tier 1	\$15	Pharmacy deductible	
	Tier 2	\$50	Pharmacy deductible	
	Tier 3	\$75	Pharmacy deductible	
	Tier 4	20% up to \$250 per script after pharmacy deductible	Pharmacy deductible	
Outpatient services	Surgery facility fee (e.g., ASC)	20%		
	Physician/surgeon fees	20%		
	Outpatient visit	20%		
Need immediate attention	Emergency room facility fee (waived if admitted)	\$350		
	Emergency room physician fee (waived if admitted)	No charge		
	Emergency medical transportation	\$250	X	
	Urgent care	\$30		
Hospital stay	Facility fee (e.g. hospital room)	20%	X	
	Physician/surgeon fee	20%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	\$30		
	Mental/Behavioral health other outpatient items and services	\$30		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	
	Mental/Behavioral health inpatient physician fee	20%	X	
	Substance Use disorder outpatient office visits	\$30		
	Substance Use disorder other outpatient items and services	\$30		
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X	
Pregnancy	Prenatal care and preconception visits	No charge		
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care (cost share per visit)	\$40		
	Outpatient Rehabilitation services	\$30		
	Outpatient Habilitation services	\$30		
	Skilled nursing care	20%	X	
	Durable medical equipment	20%		
Child eye care	Hospice service	No charge		
	Eye exam	No charge		
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		
	Oral Exam			
	Preventive - Cleaning	No charge		
	Preventive - X-ray	No charge		
	Sealants per Tooth	No charge		
Child Dental Basic Services	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Major Services	Restorative Procedures	20%		
	Periodontal Maintenance Services			
Child Orthodontics	Crowns and Casts			
	Endodontics			
	Periodontics (other than maintenance)	50%		
	Prosthetics			
	Oral Surgery			
	Medically necessary orthodontics	50%		

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Date: June 16, 2016/January 3, 2017

Summary of Benefits and Coverage

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

		Bronze Plan	Bronze HDHP Plan
<b>Actuarial Value - AV Calculator</b>		64.9% <del>60.8%</del>	62.0% <del>61.4%</del>
<b>Plan design includes a deductible?</b>		Yes, Medical/Pharmacy	Yes, integrated
<b>Integrated individual deductible</b>		N/A	\$4,800 integrated
<b>Integrated Family deductible</b>		N/A	\$9,600 integrated
<b>Individual deductible, NOT integrated: Medical / Pharmacy / Dental</b>		\$6,300 / \$500 / \$0	N/A
<b>Family deductible, NOT integrated: Medical / Pharmacy / Dental</b>		\$12,600 / \$1,000 / \$0	N/A
<b>Individual Out-of-pocket maximum</b>		<del>\$6,800</del> \$7,000	\$6,550
<b>Family Out-of-pocket maximum</b>		<del>\$13,600</del> \$14,000	\$13,100
<b>HSA plan: Self-only coverage deductible</b>		N/A	\$4,800
<b>HSA family plan: Individual deductible</b>		N/A	\$4,800

  

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
<b>Health care provider's office or clinic visit</b>	Primary care visit to treat an injury, illness, or condition	\$75	After 1st three non-preventive visits	40%	X	
	Other practitioner office visit	\$75	After 1st three non-preventive visits	40%	X	
	Specialist visit	\$105	After 1st three non-preventive visits	40%	X	
	Preventive care/ screening/ immunization	No charge		No charge		
<b>Tests</b>	Laboratory Tests	\$40		40%	X	
	X-rays and Diagnostic Imaging	100%	X	40%	X	
	Imaging (CT/PET scans, MRIs)	100%	X	40%	X	
<b>Drugs to treat illness or condition</b>	Tier 1	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	X	
	Tier 2	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	X	
	Tier 3	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	X	
	Tier 4	100% up to \$500 per script after pharmacy deductible	Pharmacy Deductible	40% up to \$500 per script	X	
<b>Outpatient services</b>	Surgery facility fee (e.g., ASC)	100%	X	40%	X	
	Physician/surgeon fees	100%	X	40%	X	
	Outpatient visit	100%	X	40%	X	
<b>Need immediate attention</b>	Emergency room facility fee (waived if admitted)	100%	X	40%	X	
	Emergency room physician fee (waived if admitted)	No charge		0%	X	
	Emergency medical transportation	100%	X	40%	X	
	Urgent care	\$75	After 1st three non-preventive visits	40%	X	
<b>Hospital stay</b>	Facility fee (e.g. hospital room)	100%	X	40%	X	
	Physician/surgeon fee	100%	X	40%	X	
<b>Mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient office visits	\$75	After 1st three non-preventive visits	40%	X	
	Mental/Behavioral health other outpatient items and services	\$75	After 1st three non-preventive visits	40%	X	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	100%	X	40%	X	
	Mental/Behavioral health inpatient physician fee	100%	X	40%	X	
	Substance Use disorder outpatient office visits	\$75	After 1st three non-preventive visits	40%	X	
	Substance Use disorder other outpatient items and services	\$75	After 1st three non-preventive visits	40%	X	
	Substance Use inpatient facility fee (e.g. hospital room)	100%	X	40%	X	
<b>Pregnancy</b>	Prenatal care and preconception visits	No charge		No charge		
	Delivery and all inpatient services	Hospital	100%	X	40%	X
		Professional	100%	X	40%	X
<b>Help recovering or other special health needs</b>	Home health care (cost share per visit)	100%	X	40%	X	
	Outpatient Rehabilitation services	\$75		40%	X	
	Outpatient Habilitation services	\$75		40%	X	
	Skilled nursing care	100%	X	40%	X	
	Durable medical equipment	100%	X	40%	X	
<b>Child eye care</b>	Hospice service	No charge		0%	X	
	Eye exam	No charge		No charge		
<b>Child eye care</b>	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
<b>Child Dental Diagnostic and Preventive</b>	Preventive - Cleaning	No charge		No charge		
	Preventive - X-ray					
	Sealants per Tooth					
	Topical Fluoride Application					
	Space Maintainers - Fixed					
<b>Child Dental Basic Services</b>	Restorative Procedures	20%		20%		
	Periodontal Maintenance Services					
<b>Child Dental Major Services</b>	Crowns and Casts	50%		50%		
	Endodontics					
	Periodontics (other than maintenance)					
	Prosthodontics					
<b>Child Orthodontics</b>	Oral Surgery					
	Medically necessary orthodontics	50%		50%		

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Date: June 16, 2016 January 3, 2017

Summary of Benefits and Coverage

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

		Catastrophic Plan		
<b>Actuarial Value - AV Calculator</b>				
Plan design includes a deductible?		Yes, integrated		
Integrated individual deductible		\$7,150 \$7,350 integrated		
Integrated family deductible		\$14,300 \$14,700 integrated		
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		
Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A		
Individual Out-of-pocket maximum		\$7,150 \$7,350		
Family Out-of-pocket maximum		\$14,300 \$14,700		
HSA plan: Self-only coverage deductible		N/A		
HSA family plan: Individual deductible		N/A		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Health care provider's office or clinic visit	Primary care visit to treat an injury, illness, or condition	0%	After 1st three non-preventive visits	
	Other practitioner office visit	0%	After 1st three non-preventive visits	
	Specialist visit	0%	X	
	Preventive care/ screening/ immunization	No charge		
Tests	Laboratory Tests	0%	X	
	X-rays and Diagnostic Imaging	0%	X	
	Imaging (CT/PET scans, MRIs)	0%	X	
Drugs to treat illness or condition	Tier 1	0%	X	
	Tier 2	0%	X	
	Tier 3	0%	X	
	Tier 4	0%	X	
Outpatient services	Surgery facility fee (e.g., ASC)	0%	X	
	Physician/surgeon fees	0%	X	
	Outpatient visit	0%	X	
Need immediate attention	Emergency room facility fee (waived if admitted)	0%	X	
	Emergency room physician fee (waived if admitted)	No charge		
	Emergency medical transportation	0%	X	
	Urgent care	0%	After 1st three non-preventive visits	
Hospital stay	Facility fee (e.g. hospital room)	0%	X	
	Physician/surgeon fee	0%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient office visits	0%	After 1st three non-preventive visits	
	Mental/Behavioral health other outpatient items and services	0%	After 1st three non-preventive visits	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	0%	X	
	Mental/Behavioral health inpatient physician fee	0%	X	
	Substance Use disorder outpatient office visits	0%	After 1st three non-preventive visits	
	Substance Use disorder other outpatient items and services	0%	After 1st three non-preventive visits	
	Substance Use inpatient facility fee (e.g. hospital room)	0%	X	
Pregnancy	Prenatal care and preconception visits	No charge		
	Delivery and all inpatient services	Hospital	0%	X
		Professional	0%	X
Help recovering or other special health needs	Home health care (cost share per visit)	0%	X	
	Outpatient Rehabilitation services	0%	X	
	Outpatient Habilitation services	0%	X	
	Skilled nursing care	0%	X	
	Durable medical equipment	0%	X	
Child eye care	Hospice service	0%	X	
	Eye exam	No charge		
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X	
	Oral Exam			
Child Dental Diagnostic and Preventive	Preventive - Cleaning	No charge		
	Preventive - X-ray			
	Sealants per Tooth			
	Topical Fluoride Application			
	Space Maintainers - Fixed			
Child Dental Basic Services	Restorative Procedures	0%	X	
	Periodontal Maintenance Services		X	
	Crowns and Casts		X	
Child Dental Major Services	Endodontics	0%	X	
	Periodontics (other than maintenance)		X	
	Prosthodontics		X	
	Oral Surgery		X	
Child Orthodontics	Medically necessary orthodontics	0%	X	