



February 2, 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 establishes 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. 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](mailto:Andrea.Rosen@covered.ca.gov)

Office of Administrative Law  
300 Capitol Mall, Suite 1250  
Sacramento, CA 95814  
[staff@oal.ca.gov](mailto: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: <http://hbex.coveredca.com/regulations/>

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 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 is 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 Plans 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 proposed regulations establish the Exchange’s standard benefit plan designs for Plan Year 2016 specifically prescribing cost-sharing amounts including co-payments,

co-insurance, deductibles and maximum out of pocket amounts for in-network health services available through health coverage offered by the Exchange that meet the actuarial value requirements required for each metal tier. The proposed regulations will provide the health insurance issuers who seek to offer Qualified Health Plans for the Plan year 2016 with a clear understanding of the standard benefit plan designs that are required as a condition of certification and re-certification in the individual and SHOP Exchanges.

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.

### **JUSTIFICATION FOR DUPLICATION**

These proposed regulations were developed with significant stakeholder input, including health issuers and consumer representatives and are similar to 10 CCR 6460 in place for the 2015 Plan Year, but not identical.

### **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 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

Adopt Section 6432, which is new regulation text to be added, to read:

---

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 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



Summary of Benefits and Coverage

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

		Platinum Coinsurance Plan	Platinum Copay Plan
<b>Actuarial Value - AV Calculator</b>		88.5%	89.5%
<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	\$4,000
<b>Family Out-of-pocket maximum</b>		\$8,000	\$8,000
<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	Platinum Coinsurance Plan		Platinum Copay Plan	
		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	\$20		\$20	
	Other practitioner office visit	\$20		\$20	
	Specialist visit	\$40		\$40	
	Preventive care/ screening/ immunization	No charge		No charge	
<b>Tests</b>	Laboratory Tests	\$20		\$20	
	X-rays and Diagnostic Imaging	\$40		\$40	
	Imaging (CT/PET scans, MRIs)	10%		\$150	
<b>Drugs to treat illness or condition</b>	Generic drugs	\$5		\$5	
	Preferred brand drugs	\$15		\$15	
	Non-preferred brand drugs	\$25		\$25	
	Specialty drugs	10%		10%	
<b>Outpatient services</b>	Surgery facility fee (e.g., ASC)	10%		\$250	
	Physician/surgeon fees	10%		\$40	
	Outpatient visit	10%		10%	
<b>Need immediate attention</b>	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fee (waived if admitted)	10%		No charge	
	Emergency medical transportation	\$150		\$150	
	Urgent care	\$40		\$40	
<b>Hospital stay</b>	Facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Physician/surgeon fee	10%		\$40	
<b>Mental health, behavioral health, or substance abuse needs</b>	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 to 5 days	
	Mental/Behavioral health inpatient physician/surgeon fee	10%		\$40	
	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	
<b>Pregnancy</b>	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	
<b>Help recovering or other special health needs</b>	Home health care	10%		\$20	
	Outpatient Rehabilitation services	\$20		\$20	
	Outpatient Habilitation services	\$20		\$20	
	Skilled nursing care	10%		\$150 per day up to 5 days	
	Durable medical equipment	10%		10%	
<b>Child eye care</b>	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
<b>Child Dental Diagnostic and Preventive</b>	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				
<b>Child Dental Basic Services</b>	Topical Fluoride Application				
	Space Maintainers - Fixed				
<b>Child Dental Major Services</b>	Amalgam Fill - 1 Surface	20%		\$25	
	Root Canal- Molar			\$300	
	Gingivectomy per Quad			\$150	
	Extraction- Single Tooth Exposed Root or Erupted	50%		\$65	
	Extraction- Complete Bony			\$160	
<b>Child Orthodontics</b>	Porcelain with Metal Crown			\$300	
	Medically necessary orthodontics	50%		\$1,000	

**2016 Standard Benefit Plan Designs**  
**10.0 EHB**  
**Date: January 29, 2015**

**Summary of Benefits and Coverage**

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

		Gold Coinsurance Plan	Gold Copoly Plan
<b>Actuarial Value - AV Calculator</b>		80.2%	81.0%
<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>		\$8,200	\$8,200
<b>Family Out-of-pocket maximum</b>		\$12,400	\$12,400
<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	\$35		\$35	
	Other practitioner office visit	\$35		\$35	
	Specialist visit	\$55		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
<b>Tests</b>	Laboratory Tests	\$35		\$35	
	X-rays and Diagnostic Imaging	\$50		\$50	
	Imaging (CT/PET scans, MRIs)	20%		\$250	
<b>Drugs to treat illness or condition</b>	Generic drugs	\$15		\$15	
	Preferred brand drugs	\$50		\$50	
	Non-preferred brand drugs	\$70		\$70	
	Specialty drugs	20%		20%	
<b>Outpatient services</b>	Surgery facility fee (e.g., ASC)	20%		\$600	
	Physician/surgeon fees	20%		\$55	
	Outpatient visit	20%		20%	
<b>Need immediate attention</b>	Emergency room facility fee (waived if admitted)	\$250		\$250	
	Emergency room physician fee (waived if admitted)	20%		No charge	
	Emergency medical transportation	\$250		\$250	
	Urgent care	\$60		\$60	
<b>Hospital stay</b>	Facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Physician/surgeon fee	20%		\$55	
<b>Mental health, behavioral health, or substance abuse needs</b>	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 up to 5 days	
	Mental/Behavioral health inpatient physician/surgeon fee	20%		\$55	
	Substance Use disorder outpatient office visits	\$35		\$35	
	Substance Use disorder other outpatient items and services	\$35		\$35	
	Substance Use inpatient facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Substance use disorder inpatient physician/surgeon fee	20%		\$55	
<b>Pregnancy</b>	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	Hospital	20%	\$600 per day up to 5 days	
		Professional	20%	\$55	
<b>Help recovering or other special health needs</b>	Home health care	20%		\$30	
	Outpatient Rehabilitation services	\$35		\$35	
	Outpatient Habilitation services	\$35		\$35	
	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				
	Sealants per Tooth	No charge		No charge	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
<b>Child Dental Basic Services</b>	Amalgam Fill - 1 Surface	20%		\$25	
<b>Child Dental Major Services</b>	Root Canal- Molar			\$300	
	Gingivectomy per Quad			\$150	
	Extraction- Single Tooth Exposed Root or Erupted	50%		\$65	
	Extraction- Complete Bony			\$160	
	Porcelain with Metal Crown			\$300	
<b>Child Orthodontics</b>	Medically necessary orthodontics	50%		\$1,000	

**2016 Standard Benefit Plan Designs**  
**10.0 EHB**  
**Date: January 29, 2015**

**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>		70.4%		
<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>		\$2,250 / \$250 / \$0		
<b>Family deductible, NOT integrated: Medical / Pharmacy / Dental</b>		\$4,500 / \$500 / \$0		
<b>Individual Out-of-pocket maximum</b>		\$8,250		
<b>Family Out-of-pocket maximum</b>		\$12,500		
<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	\$45		
	Other practitioner office visit	\$45		
	Specialist visit	\$70		
	Preventive care/ screening/ immunization	No charge		
<b>Tests</b>	Laboratory Tests	\$35		
	X-rays and Diagnostic Imaging	\$65		
	Imaging (CT/PET scans, MRIs)	\$250		
<b>Drugs to treat illness or condition</b>	Generic drugs	\$15		
	Preferred brand drugs	\$50	Pharmacy deductible	
	Non-preferred brand drugs	\$70	Pharmacy deductible	
	Specialty drugs	20%	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)	\$250	X	
	Emergency room physician fee (waived if admitted)	20%	X	
	Emergency medical transportation	\$250	X	
	Urgent care	\$90		
<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	\$45		
	Mental/Behavioral health other outpatient items and services	\$45		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	
	Mental/Behavioral health inpatient physician/surgeon fee	20%	X	
	Substance Use disorder outpatient office visits	\$45		
	Substance Use disorder other outpatient items and services	\$45		
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X	
	Substance use disorder inpatient physician/surgeon 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	\$45		
	Outpatient Rehabilitation services	\$45		
	Outpatient Habilitation services	\$45		
	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			
	Preventive - X-ray			
	Sealants per Tooth	No charge		
	Topical Fluoride Application			
	Space Maintainers - Fixed			
<b>Child Dental Basic Services</b>	Amalgam Fill - 1 Surface	20%		
<b>Child Dental Major Services</b>	Root Canal- Molar			
	Gingivectomy per Quad			
	Extraction- Single Tooth Exposed Root or Erupted	50%		
	Extraction- Complete Bony			
<b>Child Orthodontics</b>	Porcelain with Metal Crown			
	Medically necessary orthodontics	50%		

2016 Standard Benefit Plan Designs  
10.0 EHB  
Date: January 29, 2015

Summary of Benefits and Coverage

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

		SHOP Silver Coinsurance Plan		SHOP Silver Copay Plan	
Actuarial Value - AV Calculator		71.7%		71.4%	
Plan design includes a deductible?		Yes, Medical/Pharmacy		Yes, Medical/Pharmacy	
Integrated Individual deductible		N/A		N/A	
Integrated Family deductible		N/A		N/A	
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$1,500 / \$500 / \$0		\$1,500 / \$500 / \$0	
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$3,000 / \$1,000 / \$0		\$3,000 / \$1,000 / \$0	
Individual Out-of-pocket maximum		\$6,500		\$6,500	
Family Out-of-pocket maximum		\$13,000		\$13,000	
HSA plan: Self-only coverage deductible		N/A		N/A	
HSA family plan: Individual deductible		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	\$45		\$45	
	Other practitioner office visit	\$45		\$45	
	Specialist visit	\$70		\$70	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$35		\$35	
	X-rays and Diagnostic Imaging	\$65		\$65	
	Imaging (CT/PET scans, MRIs)	20%	X	\$250	
Drugs to treat illness or condition	Generic drugs	\$15		\$15	
	Preferred brand drugs	\$55	Pharmacy deductible	\$55	Pharmacy deductible
	Non-preferred brand drugs	\$75	Pharmacy deductible	\$75	Pharmacy deductible
	Specialty drugs	20%	Pharmacy deductible	20%	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)	20%		20%	
	Physician/surgeon fees	20%		20%	
	Outpatient visit	20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$250	X	\$250	X
	Emergency room physician fee (waived if admitted)	20%	X	20%	X
	Emergency medical transportation	\$250	X	\$250	X
	Urgent care	\$90		\$90	
Hospital stay	Facility fee (e.g. hospital room)	20%	X	20%	X
	Physician/surgeon fee	20%	X	20%	X
Mental health, behavioral health, or substance abuse needs	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/surgeon 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
	Substance use disorder inpatient physician/surgeon fee	20%	X	20%	X
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	20%	X	20%	X
Help recovering or other special health needs	Home health care	20%		\$45	
	Outpatient Rehabilitation services	\$45		\$45	
	Outpatient Habilitation services	\$45		\$45	
	Skilled nursing care	20%	X	20%	X
	Durable medical equipment	20%		20%	
Child eye care	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental Diagnostic and Preventive	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth	No charge		No charge	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Amalgam Fill - 1 Surface	20%		\$25	
	Root Canal- Molar			\$300	
Child Dental Major Services	Gingivectomy per Quad			\$150	
	Extraction- Single Tooth Exposed Root or Erupted	50%		\$65	
	Extraction- Complete Bony			\$160	
	Porcelain with Metal Crown			\$300	
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

**2016 Standard Benefit Plan Designs**  
**10.0 EHB**  
**Date: January 29, 2015**

**Summary of Benefits and Coverage**

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

	<b>SHOP</b>
	<b>Silver HSA Plan</b>
<b>Actuarial Value - AV Calculator</b>	70.5%
<b>Plan design includes a deductible?</b>	Yes, integrated
<b>Integrated individual deductible</b>	\$2,000 integrated
<b>Integrated Family deductible</b>	\$4,000 integrated
<b>Individual deductible, NOT integrated: Medical / Pharmacy / Dental</b>	N/A
<b>Family deductible, NOT integrated: Medical / Pharmacy / Dental</b>	N/A
<b>Individual Out-of-pocket maximum</b>	\$6,250
<b>Family Out-of-pocket maximum</b>	\$12,500
<b>HSA plan: Self-only coverage deductible</b>	\$2,000
<b>HSA family plan: Individual deductible</b>	See endnote

<b>Common Medical Event</b>	<b>Service Type</b>	<b>Member Cost Share</b>	<b>Deductible Applies</b>
<b>Health care provider's office or clinic visit</b>	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	
<b>Tests</b>	Laboratory Tests	20%	X
	X-rays and Diagnostic Imaging	20%	X
	Imaging (CT/PET scans, MRIs)	20%	X
<b>Drugs to treat illness or condition</b>	Generic drugs	20%	X
	Preferred brand drugs	20%	X
	Non-preferred brand drugs	20%	X
<b>Outpatient services</b>	Specialty drugs	20%	X
	Surgery facility fee (e.g., ASC)	20%	X
	Physician/surgeon fees	20%	X
<b>Need immediate attention</b>	Outpatient visit	20%	X
	Emergency room facility fee (waived if admitted)	20%	X
	Emergency room physician fee (waived if admitted)	20%	X
	Emergency medical transportation	20%	X
<b>Hospital stay</b>	Urgent care	20%	X
	Facility fee (e.g. hospital room)	20%	X
<b>Mental health, behavioral health, or substance abuse needs</b>	Physician/surgeon fee	20%	X
	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/surgeon 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
<b>Pregnancy</b>	Substance use disorder inpatient physician/surgeon fee	20%	X
	Prenatal care and preconception visits	No charge	
	Delivery and all inpatient services	20%	X
<b>Help recovering or other special health needs</b>	Hospital	20%	X
	Professional	20%	X
	Home health care	20%	X
	Outpatient Rehabilitation services	20%	X
	Outpatient Habilitation services	20%	X
<b>Child eye care</b>	Skilled nursing care	20%	X
	Durable medical equipment	20%	X
<b>Child Dental Diagnostic and Preventive</b>	Hospice service	0%	X
	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning	No charge	
<b>Child Dental Basic Services</b>	Preventive - X-ray		
	Sealants per Tooth		
<b>Child Dental Major Services</b>	Topical Fluoride Application		
	Space Maintainers - Fixed		
	Amalgam Fill - 1 Surface	20%	
<b>Child Orthodontics</b>	Root Canal- Molar		
	Gingivectomy per Quad		
	Extraction- Single Tooth Exposed Root or Erupted	50%	
	Extraction- Complete Bony		
	Porcelain with Metal Crown		

**2016 Standard Benefit Plan Designs**  
**10.0 EHB**  
**Date: January 29, 2015**

**Summary of Benefits and Coverage**

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>		93.8%		86.8%	
<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		\$550 / \$50 / \$0	
<b>Family deductible, NOT integrated: Medical / Pharmacy / Dental</b>		\$150 / \$0 / \$0		\$1,100 / \$100 / \$0	
<b>Individual Out-of-pocket maximum</b>		\$2,250		\$2,250	
<b>Family Out-of-pocket maximum</b>		\$4,500		\$4,500	
<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		\$15	
	Other practitioner office visit	\$5		\$15	
	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>	Generic drugs	\$3		\$5	
	Preferred brand drugs	\$10		\$20	Pharmacy deductible
	Non-preferred brand drugs	\$15		\$35	Pharmacy deductible
	Specialty drugs	10%		15%	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)	\$30	X	\$75	X
	Emergency room physician fee (waived if admitted)	10%	X	15%	X
	Emergency medical transportation	\$30	X	\$75	X
	Urgent care	\$6		\$30	
<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		\$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
	Mental/Behavioral health inpatient physician/surgeon fee	10%	X	15%	X
	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 disorder inpatient physician/surgeon fee	10%	X	15%	X
<b>Pregnancy</b>	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	10%	X	15%	X
<b>Help recovering or other special health needs</b>	Home health care	\$3		\$15	
	Outpatient Rehabilitation services	\$5		\$15	
	Outpatient Habilitation services	\$5		\$15	
	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				
	Preventive - Cleaning				
	Preventive - X-ray	No charge		No charge	
	Sealants per Tooth				
<b>Child Dental Diagnostic and Preventive</b>	Topical Fluoride Application				
	Space Maintainers - Fixed				
	Amalgam Fill - 1 Surface	20%		20%	
<b>Child Dental Basic Services</b>	Root Canal- Molar				
	Gingivectomy per Quad				
	Extraction- Single Tooth Exposed Root or Erupted	50%		50%	
	Extraction- Complete Bony				
<b>Child Dental Major Services</b>	Porcelain with Metal Crown				
	Medically necessary orthodontics	50%		50%	

**2016 Standard Benefit Plan Designs**  
**10.0 EHB**  
**Date: January 29, 2015**

**Summary of Benefits and Coverage**

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

		Silver Plan 200%-250% FPL	
Actuarial Value - AV Calculator		72.8%	
Plan design includes a deductible?		Yes, Medical/Pharmacy	
Integrated Individual deductible		N/A	
Integrated Family deductible		N/A	
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$1,900 / \$250 / \$0	
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$3,800 / \$500 / \$0	
Individual Out-of-pocket maximum		\$5,450	
Family Out-of-pocket maximum		\$10,900	
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	\$40	
	Other practitioner office visit	\$40	
	Specialist visit	\$55	
	Preventive care/ screening/ immunization	No charge	
Tests	Laboratory Tests	\$35	
	X-rays and Diagnostic Imaging	\$50	
	Imaging (CT/PET scans, MRIs)	\$250	
Drugs to treat illness or condition	Generic drugs	\$15	
	Preferred brand drugs	\$45	Pharmacy deductible
	Non-preferred brand drugs	\$70	Pharmacy deductible
	Specialty drugs	20%	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)	\$250	X
	Emergency room physician fee (waived if admitted)	20%	X
	Emergency medical transportation	\$250	X
	Urgent care	\$80	
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	\$40	
	Mental/Behavioral health other outpatient items and services	\$40	
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X
	Mental/Behavioral health inpatient physician/surgeon fee	20%	X
	Substance Use disorder outpatient office visits	\$40	
	Substance Use disorder other outpatient items and services	\$40	
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X
	Substance use disorder inpatient physician/surgeon fee	20%	X
Pregnancy	Prenatal care and preconception visits	No charge	
	Delivery and all inpatient services	Hospital	20%
		Professional	20%
Help recovering or other special health needs	Home health care	\$40	
	Outpatient Rehabilitation services	\$40	
	Outpatient Habilitation services	\$40	
	Skilled nursing care	20%	X
	Durable medical equipment	20%	
Child eye care	Hospice service	No charge	
	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		
	Preventive - X-ray		
	Sealants per Tooth	No charge	
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic Services	Amalgam Fill - 1 Surface	20%	
Child Dental Major Services	Root Canal- Molar		
	Gingivectomy per Quad		
	Extraction- Single Tooth Exposed Root or Erupted	50%	
	Extraction- Complete Bony		
Child Orthodontics	Porcelain with Metal Crown		
	Medically necessary orthodontics	50%	

2016 Standard Benefit Plan Designs  
10.0 EHB  
Date: January 29, 2015

Summary of Benefits and Coverage

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

		Bronze Plan	Bronze HSA Plan		
Actuarial Value - AV Calculator		61.2%	61.1%		
Plan design includes a deductible?		Yes, integrated	Yes, integrated		
Integrated Individual deductible		\$6,500 integrated	\$4,500 integrated		
Integrated Family deductible		\$13,000 integrated	\$9,000 integrated		
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A	N/A		
Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A	N/A		
Individual Out-of-pocket maximum		\$6,500	\$6,500		
Family Out-of-pocket maximum		\$13,000	\$13,000		
HSA plan: Self-only coverage deductible		N/A	\$4,500		
HSA family plan: Individual deductible		N/A	\$4,500		
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	\$70	After 1st three non-preventive visits	40%	X
	Other practitioner office visit	\$70	After 1st three non-preventive visits	40%	X
	Specialist visit	\$90	After 1st three non-preventive visits	40%	X
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$40		40%	X
	X-rays and Diagnostic Imaging	0%	X	40%	X
	Imaging (CT/PET scans, MRIs)	0%	X	40%	X
Drugs to treat illness or condition	Generic drugs	0%	X	40%	X
	Preferred brand drugs	0%	X	40%	X
	Non-preferred brand drugs	0%	X	40%	X
Outpatient services	Specialty drugs	0%	X	40%	X
	Surgery facility fee (e.g., ASC)	0%	X	40%	X
	Physician/surgeon fees	0%	X	40%	X
Need immediate attention	Outpatient visit	0%	X	40%	X
	Emergency room facility fee (waived if admitted)	0%	X	40%	X
	Emergency room physician fee (waived if admitted)	0%	X	40%	X
Hospital stay	Emergency medical transportation	0%	X	40%	X
	Urgent care	\$120	After 1st three non-preventive visits	40%	X
	Facility fee (e.g. hospital room)	0%	X	40%	X
Mental health, behavioral health, or substance abuse needs	Physician/surgeon fee	0%	X	40%	X
	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 inpatient facility fee (e.g.hospital room)	0%	X	40%	X
	Mental/Behavioral health inpatient physician/surgeon fee	0%	X	40%	X
	Substance Use disorder outpatient office visits	\$70	After 1st three non-preventive visits	40%	X
	Substance Use disorder other outpatient items and services	\$70	After 1st three non-preventive visits	40%	X
	Substance Use inpatient facility fee (e.g. hospital room)	0%	X	40%	X
Pregnancy	Substance use disorder inpatient physician/surgeon fee	0%	X	40%	X
	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	0%	X	40%	X
Help recovering or other special health needs	Home health care	0%	X	40%	X
	Outpatient Rehabilitation services	\$70		40%	X
	Outpatient Habilitation services	\$70		40%	X
Child eye care	Skilled nursing care	0%	X	40%	X
	Durable medical equipment	0%	X	40%	X
	Hospice service	No charge		0%	X
Child Dental Diagnostic and Preventive	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental Basic Services	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth	No charge		No charge	
Child Dental Major Services	Topical Fluoride Application				
	Space Maintainers - Fixed				
	Amalgam Fill - 1 Surface	20%		20%	
Child Orthodontics	Root Canal- Molar				
	Gingivectomy per Quad				
	Extraction- Single Tooth Exposed Root or Erupted	50%		50%	
Child Orthodontics	Extraction- Complete Bony				
	Porcelain with Metal Crown				
Medically necessary orthodontics	50%		50%		

**2016 Standard Benefit Plan Designs**  
**10.0 EHB**  
**Date: January 29, 2015**

**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>			
<b>Plan design includes a deductible?</b>		Yes, integrated	
<b>Integrated individual deductible</b>		\$6,850 integrated	
<b>Integrated Family deductible</b>		\$13,700 integrated	
<b>Individual deductible, NOT integrated: Medical / Pharmacy / Dental</b>		N/A	
<b>Family deductible, NOT integrated: Medical / Pharmacy / Dental</b>		N/A	
<b>Individual Out-of-pocket maximum</b>		\$6,850	
<b>Family Out-of-pocket maximum</b>		\$13,700	
<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	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	
<b>Tests</b>	Laboratory Tests	0%	X
	X-rays and Diagnostic Imaging	0%	X
	Imaging (CT/PET scans, MRIs)	0%	X
<b>Drugs to treat illness or condition</b>	Generic drugs	0%	X
	Preferred brand drugs	0%	X
	Non-preferred brand drugs	0%	X
<b>Outpatient services</b>	Specialty drugs	0%	X
	Surgery facility fee (e.g., ASC)	0%	X
	Physician/surgeon fees	0%	X
<b>Need immediate attention</b>	Outpatient visit	0%	X
	Emergency room facility fee (waived if admitted)	0%	X
	Emergency room physician fee (waived if admitted)	0%	X
<b>Hospital stay</b>	Emergency medical transportation	0%	X
	Urgent care	0%	After 1st three non-preventive visits
	Facility fee (e.g. hospital room)	0%	X
<b>Mental health, behavioral health, or substance abuse needs</b>	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/Behavioral health inpatient facility fee (e.g.hospital room)	0%	X
	Mental/Behavioral health inpatient physician/surgeon 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
<b>Pregnancy</b>	Substance use disorder inpatient physician/surgeon fee	0%	X
	Prenatal care and preconception visits	No charge	
	Delivery and all inpatient services	0%	X
<b>Help recovering or other special health needs</b>	Hospital	0%	X
	Professional	0%	X
	Home health care	0%	X
	Outpatient Rehabilitation services	0%	X
	Outpatient Habilitation services	0%	X
<b>Child eye care</b>	Skilled nursing care	0%	X
	Durable medical equipment	0%	X
	Hospice service	0%	X
<b>Child Dental Diagnostic and Preventive</b>	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X
	Oral Exam		
	Preventive - Cleaning	No charge	
	Preventive - X-ray	No charge	
<b>Child Dental Basic Services</b>	Sealants per Tooth		
	Topical Fluoride Application		
<b>Child Dental Major Services</b>	Space Maintainers - Fixed		
	Amalgam Fill - 1 Surface	0%	X
	Root Canal- Molar		X
	Gingivectomy per Quad		X
	Extraction- Single Tooth Exposed Root or Erupted	0%	X
<b>Child Orthodontics</b>	Extraction- Complete Bony		X
	Porcelain with Metal Crown		X
	Medically necessary orthodontics	0%	X



Summary of Benefits and Coverage

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

		Platinum Coinsurance Plan	Platinum Copay Plan
<b>Actuarial Value - AV Calculator</b>		88.5%	89.5%
<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	\$4,000
<b>Family Out-of-pocket maximum</b>		\$8,000	\$8,000
<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	Platinum Coinsurance Plan		Platinum Copay Plan	
		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	\$20		\$20	
	Other practitioner office visit	\$20		\$20	
	Specialist visit	\$40		\$40	
	Preventive care/ screening/ immunization	No charge		No charge	
<b>Tests</b>	Laboratory Tests	\$20		\$20	
	X-rays and Diagnostic Imaging	\$40		\$40	
	Imaging (CT/PET scans, MRIs)	10%		\$150	
<b>Drugs to treat illness or condition</b>	Generic drugs	\$5		\$5	
	Preferred brand drugs	\$15		\$15	
	Non-preferred brand drugs	\$25		\$25	
	Specialty drugs	10%		10%	
<b>Outpatient services</b>	Surgery facility fee (e.g., ASC)	10%		\$250	
	Physician/surgeon fees	10%		\$40	
	Outpatient visit	10%		10%	
<b>Need immediate attention</b>	Emergency room facility fee (waived if admitted)	\$150		\$150	
	Emergency room physician fee (waived if admitted)	10%		No charge	
	Emergency medical transportation	\$150		\$150	
	Urgent care	\$40		\$40	
<b>Hospital stay</b>	Facility fee (e.g. hospital room)	10%		\$250 per day up to 5 days	
	Physician/surgeon fee	10%		\$40	
<b>Mental health, behavioral health, or substance abuse needs</b>	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 to 5 days	
	Mental/Behavioral health inpatient physician/surgeon fee	10%		\$40	
	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	
<b>Pregnancy</b>	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	
<b>Help recovering or other special health needs</b>	Home health care	10%		\$20	
	Outpatient Rehabilitation services	\$20		\$20	
	Outpatient Habilitation services	\$20		\$20	
	Skilled nursing care	10%		\$150 per day up to 5 days	
	Durable medical equipment	10%		10%	
<b>Child eye care</b>	Hospice service	No charge		No charge	
	Eye exam	No charge		No charge	
<b>Child Dental Diagnostic and Preventive</b>	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
	Preventive - Cleaning				
	Preventive - X-ray	Not Covered		Not Covered	
	Sealants per Tooth				
<b>Child Dental Basic Services</b>	Topical Fluoride Application				
	Space Maintainers - Fixed				
<b>Child Dental Major Services</b>	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
	Root Canal- Molar			Not Covered	
	Gingivectomy per Quad			Not Covered	
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered		Not Covered	
	Extraction- Complete Bony			Not Covered	
<b>Child Orthodontics</b>	Porcelain with Metal Crown			Not Covered	
	Medically necessary orthodontics	Not Covered		Not Covered	

**2016 Standard Benefit Plan Designs**  
**9.5 EHB**  
**Date: January 29, 2015**

**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>		80.2%	81.0%
<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>		\$8,200	\$8,200
<b>Family Out-of-pocket maximum</b>		\$12,400	\$12,400
<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	\$35		\$35	
	Other practitioner office visit	\$35		\$35	
	Specialist visit	\$55		\$55	
	Preventive care/ screening/ immunization	No charge		No charge	
<b>Tests</b>	Laboratory Tests	\$35		\$35	
	X-rays and Diagnostic Imaging	\$50		\$50	
	Imaging (CT/PET scans, MRIs)	20%		\$250	
<b>Drugs to treat illness or condition</b>	Generic drugs	\$15		\$15	
	Preferred brand drugs	\$50		\$50	
	Non-preferred brand drugs	\$70		\$70	
	Specialty drugs	20%		20%	
<b>Outpatient services</b>	Surgery facility fee (e.g., ASC)	20%		\$600	
	Physician/surgeon fees	20%		\$55	
	Outpatient visit	20%		20%	
<b>Need immediate attention</b>	Emergency room facility fee (waived if admitted)	\$250		\$250	
	Emergency room physician fee (waived if admitted)	20%		No charge	
	Emergency medical transportation	\$250		\$250	
	Urgent care	\$60		\$60	
<b>Hospital stay</b>	Facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Physician/surgeon fee	20%		\$55	
<b>Mental health, behavioral health, or substance abuse needs</b>	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 up to 5 days	
	Mental/Behavioral health inpatient physician/surgeon fee	20%		\$55	
	Substance Use disorder outpatient office visits	\$35		\$35	
	Substance Use disorder other outpatient items and services	\$35		\$35	
	Substance Use inpatient facility fee (e.g. hospital room)	20%		\$600 per day up to 5 days	
	Substance use disorder inpatient physician/surgeon fee	20%		\$55	
<b>Pregnancy</b>	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	Hospital	20%	\$600 per day up to 5 days	
		Professional	20%	\$55	
<b>Help recovering or other special health needs</b>	Home health care	20%		\$30	
	Outpatient Rehabilitation services	\$35		\$35	
	Outpatient Habilitation services	\$35		\$35	
	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				
	Sealants per Tooth	Not Covered		Not Covered	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
<b>Child Dental Basic Services</b>	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
<b>Child Dental Major Services</b>	Root Canal- Molar			Not Covered	
	Gingivectomy per Quad			Not Covered	
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered		Not Covered	
	Extraction- Complete Bony			Not Covered	
	Porcelain with Metal Crown			Not Covered	
<b>Child Orthodontics</b>	Medically necessary orthodontics	Not Covered		Not Covered	

**2016 Standard Benefit Plan Designs**  
**9.5 EHB**  
**Date: January 29, 2015**

**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>		70.4%		
<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>		\$2,250 / \$250 / \$0		
<b>Family deductible, NOT integrated: Medical / Pharmacy / Dental</b>		\$4,500 / \$500 / \$0		
<b>Individual Out-of-pocket maximum</b>		\$8,250		
<b>Family Out-of-pocket maximum</b>		\$12,500		
<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	\$45		
	Other practitioner office visit	\$45		
	Specialist visit	\$70		
	Preventive care/ screening/ immunization	No charge		
<b>Tests</b>	Laboratory Tests	\$35		
	X-rays and Diagnostic Imaging	\$65		
	Imaging (CT/PET scans, MRIs)	\$250		
<b>Drugs to treat illness or condition</b>	Generic drugs	\$15		
	Preferred brand drugs	\$50	Pharmacy deductible	
	Non-preferred brand drugs	\$70	Pharmacy deductible	
	Specialty drugs	20%	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)	\$250	X	
	Emergency room physician fee (waived if admitted)	20%	X	
	Emergency medical transportation	\$250	X	
	Urgent care	\$90		
<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	\$45		
	Mental/Behavioral health other outpatient items and services	\$45		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	
	Mental/Behavioral health inpatient physician/surgeon fee	20%	X	
	Substance Use disorder outpatient office visits	\$45		
	Substance Use disorder other outpatient items and services	\$45		
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X	
	Substance use disorder inpatient physician/surgeon 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	\$45		
	Outpatient Rehabilitation services	\$45		
	Outpatient Habilitation services	\$45		
	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			
	Preventive - X-ray			
	Sealants per Tooth	Not Covered		
	Topical Fluoride Application			
	Space Maintainers - Fixed			
<b>Child Dental Basic Services</b>	Amalgam Fill - 1 Surface	Not Covered		
<b>Child Dental Major Services</b>	Root Canal- Molar			
	Gingivectomy per Quad			
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered		
	Extraction- Complete Bony			
<b>Child Orthodontics</b>	Porcelain with Metal Crown			
	Medically necessary orthodontics	Not Covered		

2016 Standard Benefit Plan Designs  
9.5 EHB  
Date: January 29, 2015

Summary of Benefits and Coverage

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

		SHOP Silver Coinsurance Plan		SHOP Silver Copay Plan	
Actuarial Value - AV Calculator		71.7%		71.4%	
Plan design includes a deductible?		Yes, Medical/Pharmacy		Yes, Medical/Pharmacy	
Integrated Individual deductible		N/A		N/A	
Integrated Family deductible		N/A		N/A	
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		\$1,500 / \$500 / \$0		\$1,500 / \$500 / \$0	
Family deductible, NOT integrated: Medical / Pharmacy / Dental		\$3,000 / \$1,000 / \$0		\$3,000 / \$1,000 / \$0	
Individual Out-of-pocket maximum		\$6,500		\$6,500	
Family Out-of-pocket maximum		\$13,000		\$13,000	
HSA plan: Self-only coverage deductible		N/A		N/A	
HSA family plan: Individual deductible		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	\$45		\$45	
	Other practitioner office visit	\$45		\$45	
	Specialist visit	\$70		\$70	
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$35		\$35	
	X-rays and Diagnostic Imaging	\$65		\$65	
	Imaging (CT/PET scans, MRIs)	20%	X	\$250	
Drugs to treat illness or condition	Generic drugs	\$15		\$15	
	Preferred brand drugs	\$55	Pharmacy deductible	\$55	Pharmacy deductible
	Non-preferred brand drugs	\$75	Pharmacy deductible	\$75	Pharmacy deductible
	Specialty drugs	20%	Pharmacy deductible	20%	Pharmacy deductible
Outpatient services	Surgery facility fee (e.g., ASC)	20%		20%	
	Physician/surgeon fees	20%		20%	
	Outpatient visit	20%		20%	
Need immediate attention	Emergency room facility fee (waived if admitted)	\$250	X	\$250	X
	Emergency room physician fee (waived if admitted)	20%	X	20%	X
	Emergency medical transportation	\$250	X	\$250	X
	Urgent care	\$90		\$90	
Hospital stay	Facility fee (e.g. hospital room)	20%	X	20%	X
	Physician/surgeon fee	20%	X	20%	X
Mental health, behavioral health, or substance abuse needs	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/surgeon 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
	Substance use disorder inpatient physician/surgeon fee	20%	X	20%	X
Pregnancy	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	20%	X	20%	X
Help recovering or other special health needs	Home health care	20%		\$45	
	Outpatient Rehabilitation services	\$45		\$45	
	Outpatient Habilitation services	\$45		\$45	
	Skilled nursing care	20%	X	20%	X
	Durable medical equipment	20%		20%	
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	Not Covered		Not Covered	
	Sealants per Tooth				
Child Dental Basic Services	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Major Services	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
	Root Canal- Molar			Not Covered	
	Gingivectomy per Quad			Not Covered	
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered		Not Covered	
	Extraction- Complete Bony			Not Covered	
Child Orthodontics	Porcelain with Metal Crown			Not Covered	
	Medically necessary orthodontics	Not Covered		Not Covered	

**2016 Standard Benefit Plan Designs**  
**9.5 EHB**  
**Date: January 29, 2015**

**Summary of Benefits and Coverage**

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

	SHOP
	Silver HSA Plan
Actuarial Value - AV Calculator	70.5%
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	\$6,250
Family Out-of-pocket maximum	\$12,500
HSA plan: Self-only coverage deductible	\$2,000
HSA family plan: Individual deductible	See endnote

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	Generic drugs	20%	X
	Preferred brand drugs	20%	X
	Non-preferred brand drugs	20%	X
Outpatient services	Specialty drugs	20%	X
	Surgery facility fee (e.g., ASC)	20%	X
	Physician/surgeon fees	20%	X
Need immediate attention	Outpatient visit	20%	X
	Emergency room facility fee (waived if admitted)	20%	X
	Emergency room physician fee (waived if admitted)	20%	X
	Emergency medical transportation	20%	X
Hospital stay	Urgent care	20%	X
	Facility fee (e.g. hospital room)	20%	X
Mental health, behavioral health, or substance abuse needs	Physician/surgeon fee	20%	X
	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/surgeon 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	Substance use disorder inpatient physician/surgeon fee	20%	X
	Prenatal care and preconception visits	No charge	
	Delivery and all inpatient services	20%	X
Help recovering or other special health needs	Hospital	20%	X
	Professional	20%	X
	Home health care	20%	X
	Outpatient Rehabilitation services	20%	X
	Outpatient Habilitation services	20%	X
Child eye care	Skilled nursing care	20%	X
	Durable medical equipment	20%	X
Child Dental Diagnostic and Preventive	Hospice service	0%	X
	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge	
	Oral Exam		
	Preventive - Cleaning		
Child Dental Basic Services	Preventive - X-ray	Not Covered	
	Sealants per Tooth		
Child Dental Major Services	Topical Fluoride Application		
	Space Maintainers - Fixed		
	Amalgam Fill - 1 Surface	Not Covered	
	Root Canal- Molar		
Child Orthodontics	Gingivectomy per Quad	Not Covered	
	Extraction- Single Tooth Exposed Root or Erupted		
	Extraction- Complete Bony		
	Porcelain with Metal Crown		

**2016 Standard Benefit Plan Designs**  
**9.5 EHB**  
**Date: January 29, 2015**

**Summary of Benefits and Coverage**

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>		93.8%		86.8%		
<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		\$550 / \$50 / \$0		
<b>Family deductible, NOT integrated: Medical / Pharmacy / Dental</b>		\$150 / \$0 / \$0		\$1,100 / \$100 / \$0		
<b>Individual Out-of-pocket maximum</b>		\$2,250		\$2,250		
<b>Family Out-of-pocket maximum</b>		\$4,500		\$4,500		
<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		\$15		
	Other practitioner office visit	\$5		\$15		
	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>	Generic drugs	\$3		\$5		
	Preferred brand drugs	\$10		\$20	Pharmacy deductible	
	Non-preferred brand drugs	\$15		\$35	Pharmacy deductible	
	Specialty drugs	10%		15%	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)	\$30	X	\$75	X	
	Emergency room physician fee (waived if admitted)	10%	X	15%	X	
	Emergency medical transportation	\$30	X	\$75	X	
	Urgent care	\$6		\$30		
<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		\$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	
	Mental/Behavioral health inpatient physician/surgeon fee	10%	X	15%	X	
	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	
<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	\$3		\$15		
	Outpatient Rehabilitation services	\$5		\$15		
	Outpatient Habilitation services	\$5		\$15		
	Skilled nursing care	10%	X	15%	X	
<b>Child eye care</b>	Durable medical equipment	10%		15%		
	Hospice service	No charge		No charge		
	Eye exam	No charge		No charge		
<b>Child Dental Diagnostic and Preventive</b>	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge		
	Oral Exam					
	Preventive - Cleaning					
	Preventive - X-ray	Not Covered		Not Covered		
	Sealants per Tooth					
<b>Child Dental Basic Services</b>	Topical Fluoride Application					
	Space Maintainers - Fixed					
<b>Child Dental Major Services</b>	Amalgam Fill - 1 Surface	Not Covered		Not Covered		
	Root Canal- Molar					
	Gingivectomy per Quad					
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered		Not Covered		
<b>Child Orthodontics</b>	Extraction- Complete Bony					
	Porcelain with Metal Crown					
	Medically necessary orthodontics	Not Covered		Not Covered		

**2016 Standard Benefit Plan Designs**  
**9.5 EHB**  
**Date: January 29, 2015**

**Summary of Benefits and Coverage**

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

		<b>Silver Plan 200%-250% FPL</b>		
<b>Actuarial Value - AV Calculator</b>		72.8%		
<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>		\$1,900 / \$250 / \$0		
<b>Family deductible, NOT integrated: Medical / Pharmacy / Dental</b>		\$3,800 / \$500 / \$0		
<b>Individual Out-of-pocket maximum</b>		\$5,450		
<b>Family Out-of-pocket maximum</b>		\$10,900		
<b>HSA plan: Self-only coverage deductible</b>		N/A		
<b>HSA family plan: Individual deductible</b>		N/A		
<b>Common Medical Event</b>	<b>Service Type</b>	<b>Member Cost Share</b>	<b>Deductible Applies</b>	
<b>Health care provider's office or clinic visit</b>	Primary care visit to treat an injury, illness, or condition	\$40		
	Other practitioner office visit	\$40		
	Specialist visit	\$55		
	Preventive care/ screening/ immunization	No charge		
<b>Tests</b>	Laboratory Tests	\$35		
	X-rays and Diagnostic Imaging	\$50		
	Imaging (CT/PET scans, MRIs)	\$250		
<b>Drugs to treat illness or condition</b>	Generic drugs	\$15		
	Preferred brand drugs	\$45	Pharmacy deductible	
	Non-preferred brand drugs	\$70	Pharmacy deductible	
	Specialty drugs	20%	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)	\$250	X	
	Emergency room physician fee (waived if admitted)	20%	X	
	Emergency medical transportation	\$250	X	
	Urgent care	\$80		
<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	\$40		
	Mental/Behavioral health other outpatient items and services	\$40		
	Mental/Behavioral health inpatient facility fee (e.g.hospital room)	20%	X	
	Mental/Behavioral health inpatient physician/surgeon fee	20%	X	
	Substance Use disorder outpatient office visits	\$40		
	Substance Use disorder other outpatient items and services	\$40		
	Substance Use inpatient facility fee (e.g. hospital room)	20%	X	
	Substance use disorder inpatient physician/surgeon 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	\$40		
	Outpatient Rehabilitation services	\$40		
	Outpatient Habilitation services	\$40		
	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			
	Preventive - X-ray			
	Sealants per Tooth	Not Covered		
	Topical Fluoride Application			
	Space Maintainers - Fixed			
<b>Child Dental Basic Services</b>	Amalgam Fill - 1 Surface	Not Covered		
<b>Child Dental Major Services</b>	Root Canal- Molar			
	Gingivectomy per Quad			
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered		
	Extraction- Complete Bony			
<b>Child Orthodontics</b>	Porcelain with Metal Crown			
	Medically necessary orthodontics	Not Covered		

2016 Standard Benefit Plan Designs  
9.5 EHB  
Date: January 29, 2015

Summary of Benefits and Coverage

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

		Bronze Plan	Bronze HSA Plan		
Actuarial Value - AV Calculator		61.2%	61.1%		
Plan design includes a deductible?		Yes, integrated	Yes, integrated		
Integrated Individual deductible		\$6,500 integrated	\$4,500 integrated		
Integrated Family deductible		\$13,000 integrated	\$9,000 integrated		
Individual deductible, NOT integrated: Medical / Pharmacy / Dental		N/A	N/A		
Family deductible, NOT integrated: Medical / Pharmacy / Dental		N/A	N/A		
Individual Out-of-pocket maximum		\$6,500	\$6,500		
Family Out-of-pocket maximum		\$13,000	\$13,000		
HSA plan: Self-only coverage deductible		N/A	\$4,500		
HSA family plan: Individual deductible		N/A	\$4,500		
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	\$70	After 1st three non-preventive visits	40%	X
	Other practitioner office visit	\$70	After 1st three non-preventive visits	40%	X
	Specialist visit	\$90	After 1st three non-preventive visits	40%	X
	Preventive care/ screening/ immunization	No charge		No charge	
Tests	Laboratory Tests	\$40		40%	X
	X-rays and Diagnostic Imaging	0%	X	40%	X
	Imaging (CT/PET scans, MRIs)	0%	X	40%	X
Drugs to treat illness or condition	Generic drugs	0%	X	40%	X
	Preferred brand drugs	0%	X	40%	X
	Non-preferred brand drugs	0%	X	40%	X
Outpatient services	Specialty drugs	0%	X	40%	X
	Surgery facility fee (e.g., ASC)	0%	X	40%	X
	Physician/surgeon fees	0%	X	40%	X
Need immediate attention	Outpatient visit	0%	X	40%	X
	Emergency room facility fee (waived if admitted)	0%	X	40%	X
	Emergency room physician fee (waived if admitted)	0%	X	40%	X
Hospital stay	Emergency medical transportation	0%	X	40%	X
	Urgent care	\$120	After 1st three non-preventive visits	40%	X
	Facility fee (e.g. hospital room)	0%	X	40%	X
Mental health, behavioral health, or substance abuse needs	Physician/surgeon fee	0%	X	40%	X
	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 inpatient facility fee (e.g.hospital room)	0%	X	40%	X
	Mental/Behavioral health inpatient physician/surgeon fee	0%	X	40%	X
	Substance Use disorder outpatient office visits	\$70	After 1st three non-preventive visits	40%	X
	Substance Use disorder other outpatient items and services	\$70	After 1st three non-preventive visits	40%	X
	Substance Use inpatient facility fee (e.g. hospital room)	0%	X	40%	X
Pregnancy	Substance use disorder inpatient physician/surgeon fee	0%	X	40%	X
	Prenatal care and preconception visits	No charge		No charge	
	Delivery and all inpatient services	0%	X	40%	X
Help recovering or other special health needs	Home health care	0%	X	40%	X
	Outpatient Rehabilitation services	\$70		40%	X
	Outpatient Habilitation services	\$70		40%	X
Child eye care	Skilled nursing care	0%	X	40%	X
	Durable medical equipment	0%	X	40%	X
	Hospice service	No charge		0%	X
Child Dental Diagnostic and Preventive	Eye exam	No charge		No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No charge		No charge	
	Oral Exam				
Child Dental Basic Services	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth	Not Covered		Not Covered	
Child Dental Major Services	Topical Fluoride Application				
	Space Maintainers - Fixed				
	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
Child Orthodontics	Root Canal- Molar				
	Gingivectomy per Quad				
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered		Not Covered	
Child Orthodontics	Extraction- Complete Bony				
	Porcelain with Metal Crown				
Medically necessary orthodontics	Not Covered		Not Covered		

**2016 Standard Benefit Plan Designs**  
**9.5 EHB**  
**Date: January 29, 2015**

**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>			
<b>Plan design includes a deductible?</b>		Yes, integrated	
<b>Integrated individual deductible</b>		\$6,850 integrated	
<b>Integrated Family deductible</b>		\$13,700 integrated	
<b>Individual deductible, NOT integrated: Medical / Pharmacy / Dental</b>		N/A	
<b>Family deductible, NOT integrated: Medical / Pharmacy / Dental</b>		N/A	
<b>Individual Out-of-pocket maximum</b>		\$6,850	
<b>Family Out-of-pocket maximum</b>		\$13,700	
<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	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	
<b>Tests</b>	Laboratory Tests	0%	X
	X-rays and Diagnostic Imaging	0%	X
	Imaging (CT/PET scans, MRIs)	0%	X
<b>Drugs to treat illness or condition</b>	Generic drugs	0%	X
	Preferred brand drugs	0%	X
	Non-preferred brand drugs	0%	X
<b>Outpatient services</b>	Specialty drugs	0%	X
	Surgery facility fee (e.g., ASC)	0%	X
	Physician/surgeon fees	0%	X
<b>Need immediate attention</b>	Outpatient visit	0%	X
	Emergency room facility fee (waived if admitted)	0%	X
	Emergency room physician fee (waived if admitted)	0%	X
<b>Hospital stay</b>	Emergency medical transportation	0%	X
	Urgent care	0%	After 1st three non-preventive visits
	Facility fee (e.g. hospital room)	0%	X
<b>Mental health, behavioral health, or substance abuse needs</b>	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/Behavioral health inpatient facility fee (e.g.hospital room)	0%	X
	Mental/Behavioral health inpatient physician/surgeon 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
<b>Pregnancy</b>	Substance use disorder inpatient physician/surgeon fee	0%	X
	Prenatal care and preconception visits	No charge	
	Delivery and all inpatient services	0%	X
<b>Help recovering or other special health needs</b>	Hospital	0%	X
	Professional	0%	X
	Home health care	0%	X
	Outpatient Rehabilitation services	0%	X
	Outpatient Habilitation services	0%	X
<b>Child eye care</b>	Skilled nursing care	0%	X
	Durable medical equipment	0%	X
	Hospice service	0%	X
<b>Child Dental Diagnostic and Preventive</b>	Eye exam	No charge	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	0%	X
	Oral Exam		
	Preventive - Cleaning		
	Preventive - X-ray	Not Covered	
<b>Child Dental Basic Services</b>	Sealants per Tooth		
	Topical Fluoride Application		
<b>Child Dental Major Services</b>	Space Maintainers - Fixed		
	Amalgam Fill - 1 Surface	Not Covered	
	Root Canal- Molar		
	Gingivectomy per Quad	Not Covered	
<b>Child Orthodontics</b>	Extraction- Single Tooth Exposed Root or Erupted		
	Extraction- Complete Bony	Not Covered	
	Porcelain with Metal Crown		
	Medically necessary orthodontics	Not Covered	

## Endnotes to 2016 Standard Benefit Plan Designs

### Notes:

- 1) 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. In-network 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) 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 a deductible of [insert IRS-determined amount for an individual in other than self-only coverage for the 2016 Plan Year] until the family as a whole meets the family deductible. For HDHPs linked to HSAs, in other than self-only coverage, each individual in the family must meet the individual out of pocket maximum amount that is the same as that for self-only coverage until the family as a whole meets the family out of pocket maximum amount.
- 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. Note that a benefit may be considered illusory if the co-payment covers most of the plan's cost of the service.
- 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 coinsurance applies to the prescription supply. For example, if the prescription is for a month's supply, one co-pay or co-insurance amount 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.

- 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 Dietitians 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.



## 2016 Dental Standard Benefit Plan Designs

Date: January 15, 2015

### Summary of Benefits and Coverage

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

	Standalone Dental Plan	Standalone Dental Plan
	Pediatric Dental EHB Copay Plan	Pediatric Dental EHB Coinsurance Plan
	Up to Age 19	Up to Age 19
<b>Actuarial Value</b>	83.0%	86.8%
<b>Individual Deductible (waived for Diagnostic &amp; Preventive)</b>	\$0	\$65 In Network/ \$65 Out of Network
<b>Family Deductible (Two or more children) (waived for Diagnostic &amp; Preventive)</b>	\$0	\$130 In Network/ \$130 Out of Network
<b>Individual Out of Pocket Maximum</b>	\$350	\$350
<b>Family Out of Pocket Maximum (Two or More Children)</b>	\$700	\$700
<b>Office Copay</b>	\$0	\$0
<b>Waiting Period</b> <small>(Waived Condition provision, as defined in Health &amp; Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d))</small>	None	None
<b>Annual Benefit Limit</b> <small>(the maximum amount the dental plan will pay in the benefit year)</small>	None	None

  

Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
<b>Diagnostic &amp; Preventive</b>	Oral Exam	\$0		0%	
	Preventive - Cleaning	\$0		0%	
	Preventive - X-ray	\$0		0%	
	Sealants per Tooth	\$0		0%	
	Topical Fluoride Application	\$0		0%	
	Space Maintainers - Fixed	\$0		0%	
<b>Basic Services</b>	Amalgam Fill - One Surface	\$25		20%	x
<b>Major Services - Crowns and Casts, Endodontics, Periodontics, Prosthodontics, Oral Surgery</b>	Root Canal - Molar	\$300		50%	x
	Gingivectomy per Quad	\$150			
	Extraction- Single Tooth Exposed Root or Erupted	\$65			
	Extraction - Complete Bony	\$160			
	Crown - Porcelain with Metal	\$300			
<b>Orthodontia</b>	Medically Necessary Orthodontia	\$350		50%	x

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

- 1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.
- 2) Cost sharing payments made by each individual child for in-network 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: January 15, 2015

### Summary of Benefits and Coverage

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

		Family Dental Plan			
		Pediatric Dental EHB Copay Plan		Adult Dental Copay Plan	
		Up to Age 19		Age 19 and Older	
<b>Actuarial Value</b>		83.0%		Not Calculated	
<b>Individual Deductible (waived for Diagnostic &amp; Preventive)</b>		\$0		\$0	
<b>Family Deductible (Two or more children) (waived for Diagnostic &amp; Preventive)</b>		\$0		\$0	
<b>Individual Out of Pocket Maximum</b>		\$350		Not Applicable	
<b>Family Out of Pocket Maximum (Two or More Children)</b>		\$700		Not Applicable	
<b>Office Copay</b>		\$0		\$0	
<b>Waiting Period</b> <small>(Waivered Condition provision, as defined in Health &amp; Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d))</small>		None		None	
<b>Annual Benefit Limit</b> <small>(the maximum amount the dental plan will pay in the benefit year)</small>		None		None	
Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
<b>Diagnostic &amp; Preventive</b>	Oral Exam	\$0		\$0	
	Preventive - Cleaning	\$0		\$0	
	Preventive - X-ray	\$0		\$0	
	Sealants per Tooth	\$0		Not Covered	
	Topical Fluoride Application	\$0		Not Covered	
	Space Maintainers - Fixed	\$0		Not Covered	
<b>Basic Services</b>	Amalgam Fill - One Surface	\$25		\$25	
<b>Major Services - Crowns and Casts, Endodontics, Periodontics, Prosthodontics, Oral Surgery</b>	Root Canal - Molar	\$300		\$300	
	Gingivectomy per Quad	\$150		\$150	
	Extraction- Single Tooth Exposed Root or Erupted	\$65		\$65	
	Extraction - Complete Bony	\$160		\$160	
	Crown - Porcelain with Metal	\$300		\$300	
<b>Orthodontia</b>	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 in-network 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: January 15, 2015**

**Summary of Benefits and Coverage**

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

		Family Dental Plan			
		Pediatric Dental EHB Coinsurance Plan		Adult Dental Coinsurance Plan	
		Up to Age 19		Age 19 and Older	
<b>Actuarial Value</b>		86.8%		Not Calculated	
<b>Individual Deductible (waived for Diagnostic &amp; Preventive)</b>		\$65 In Network/ \$65 Out of Network		\$50 In Network/ \$50 Out of Network	
<b>Family Deductible (Two or more children) (waived for Diagnostic &amp; Preventive)</b>		\$130 In Network/ \$130 Out of Network		Not Applicable	
<b>Individual Out of Pocket Maximum</b>		\$350		Not Applicable	
<b>Family Out of Pocket Maximum (Two or More Children)</b>		\$700		Not Applicable	
<b>Office Copay</b>		\$0		\$0	
<b>Waiting Period</b> <small>(Waivered Condition provision, as defined in Health &amp; Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d))</small>		None		6 months for Major Services, Waived with Proof of Prior Coverage	
<b>Annual Benefit Limit</b> <small>(the maximum amount the dental plan will pay in the benefit year)</small>		None		\$1,500	
Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
<b>Diagnostic &amp; Preventive</b>	Oral Exam	0%		0%	
	Preventive - Cleaning	0%		0%	
	Preventive - X-ray	0%		0%	
	Sealants per Tooth	0%		Not Covered	
	Topical Fluoride Application	0%		Not Covered	
	Space Maintainers - Fixed	0%		Not Covered	
<b>Basic Services</b>	Amalgam Fill - One Surface	20%	x	20%	x
<b>Major Services - Crowns and Casts, Endodontics, Periodontics, Prosthodontics, Oral Surgery</b>	Root Canal - Molar	50%	x	50%	x
	Gingivectomy per Quad				
	Extraction- Single Tooth Exposed Root or Erupted				
	Extraction - Complete Bony				
	Crown - Porcelain with Metal				
<b>Orthodontia</b>	Medically Necessary Orthodontia	50%	x	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 in-network 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.