*PENDING REGULATORY APPROVAL (as of 10/10/2017)

2018 Small Group Summary of Benefits & Coverage

		Non-Mirrored Plans		Mirrored Plans	
		Plan P5*	Plan P20	Plan PM	Plan GM
Rated Metal Tier Level		Platinum	Platinum	Platinum	Gold
Individual/Family Overall Annual Deductible		$0	$0	$0	$0
Individual/Family Annual Out-of-Pocket Maximum		$3,350/$6,700	$3,500/$7,000	$3,350/$6,700	$6,00/$12,000
Medical Event	**Service Type**	**Copay**	**Copay**	**Copay**	**Copay**
Health Care Provider's Office or Clinic Visit	Office Visits - Primary Care (incl Mental Health)	$5 per visit	$20 per visit	$15 per visit	$25 per visit
	Office Visits - Specialist	$10 per visit	$20 per visit	$30 per visit	$55 per visit
	Office Visits - Other Healthcare Practitioners	$5 per visit	$20 per visit	$15 per visit	$25 per visit
	Preventive Care Visits	No Copay	No Copay	No Copay	No Copay
	Screening/Immunization	No Copay	No Copay	No Copay	No Copay
	Dental Exam & Cleaning	No Copay	No Copay	No Copay	No Copay
Tests	Laboratory Tests	$5	$5	$15	$35
	X-rays and Diagnostic Imaging	$5	$5	$30	$55
	Imaging - (CT/ Pet Scans, MRIs)	$100 per visit	$100 per visit	$75 per visit	$275 per visit
Outpatient Prescription Drug Coverage	Tier 1	$10 per drug	$10 per drug	$5 per drug	$15 per drug
	Tier 2	$15 per drug	$20 per drug	$15 per drug	$50 per drug
	Tier 3	$20 per drug	$30 per drug	$25 per drug	$75 per drug
	Tier 4	40%, up to $250	40%, up to $250	10%, up to $250	20%, up to $250
Outpatient Surgery	Facility Fee	$50 per visit	$50 per visit	$100 per visit	$300 per visit
	Physician/ Surgeon Fee	No Copay	No Copay	$24	$40
Need Immediate Attention	Emergency Room Services[6]	25%, up to $150[6]	25%, up to $150[6]	$150	$325
	Emergency Medical Transportation	15%	20%	$150	$250
	Urgent Care in Mexico	$5 per visit	$25 per visit	$15 per visit	$25 per visit
	Urgent Care in the US/Outside of Mexico	$30 per visit	$50 per visit	$15 per visit	$25 per visit
Hospital Stays	Inpatient Hospital Facility Fees	No Copay	$100 per day	$250 per day, 5 day max	$600 per day, 5 day max
	Inpatient Physician/Surgeon Fees	No Copay	No Copay	No Copay	No Copay
Mental Health, Behavioral Health, or Substance Abuse Needs	Outpatient office Visits	$5 per visit	$20 per visit	$15 per visit	$ 25 per visit
	Other outpatient items and services	No Copay	No Copay	$15 per visit	$25 per visit
	Inpatient services (hospital room)	No Copay	$100 per day	$250 per day, 5 day max	$600 per day, 5 day max
	Inpatient Physician/Surgeon Fee	No Copay	No Copay	No Copay	No Copay
Pregnancy	Prenatal care and preconception visits	No Copay	No Copay	No Copay	No Copay
	Delivery & all inpatient services (Hospital & Doctor)	No Copay	$100 per day	$250 per day, 5 day max	$600 per day, 5 day max
Help Recovering or other Special Health Needs	Home health care	No Copay	No Copay	$20 per visit	$30 per visit
	Outpatient Rehabilitation/Habilitation Therapy	$10 per visit	$20 per visit	$15 per visit	$25 per visit
	Skilled Nursing care	No Copay	$50 per day	$150 per day, 5 day max	$300 per day, 5 day max
	Durable Medical Equipment (incl Diabetic Equip)	20%	20%	10%	20%
	Prosthetics/Orthotics	20%	20%	10%	20%
	Hospice Services	$50/day	$50/day	No Copay	No Copay
Child Eye Care	Eye Exam & 1 pair of glasses per year	No Copay	No Copay	No Copay	No Copay
Child Dental Diagnostic and Preventive	Oral exam	No Copay	No Copay	No Copay	No Copay
	Preventive - Cleaning & X-ray	No Copay	No Copay	No Copay	No Copay
	Sealants per Tooth	No Copay	No Copay	No Copay	No Copay
	Topical Fluoride Application	No Copay	No Copay	No Copay	No Copay
	Space Maintainers - Fixed	No Copay	No Copay	No Copay	No Copay
Child Dental Basic Services	Amalgam Fill - 1 Surface	$20	$20	$20	$20
Child Dental Major Services	Root Canal - Molar	$210	$210	$210	$210
	Gingivectomy per Quad	$120	$120	$120	$120
	Extraction - Single Tooth Exposed Root or Erupted	$50	$50	$50	$65
	Extraction - Complete Bony	$130	$130	$130	$130
	Porcelain with Metal Crown	$210	$210	$210	$210
Child Orthodontics	Medically necessary orthodontics	$1,000	$1,000	$1,000	$1,000

All of the above Plan Designs provide Minimum Essential Coverage (MEC) and have Minimal Value (MV). See Endnotes on following page for general details. See specific Plan Summary of Benefits for all applicable notes, limitations and conditions pertaining to the plan.
*Please note that Plan P5 was previously named Plan P10 in 2016.

Endnotes:

1) Family out-of-pocket maximums are equal to 2 times the individual values. Cost sharing payments (copayments and coinsurance, but not yet premiums) made by each individual in a family contribute to the family out-of-pocket maximums. Once the family out-of-pocket maximum is reached, the plan pays all costs for covered services for all family members. In a family plan, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
2) The cost-sharing payments cannot exceed the out of pocket limits set for self-only coverage and family coverage.
3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount (the maximum amount on which payment is based for covered health care services).
4) For drugs to treat an illness or condition the supply of drugs for which the copay or coinsurance applies is for the prescription term, not to exceed 30 days.
5) Preventive Care Includes checkups; periodic screenings; Well-baby visits up to age 2; Well-woman visits; Pap and HPV tests; Maternity/prenatal care; Immunizations for children; Vision and hearing exams; Dental cleanings; health education classes; and a wellness program.
6) Coinsurance applies to the entire episode of emergency care services for Plan P5 and P20. Maximum patient cost will not exceed $150 for outpatient emergency care services.
7) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's out-of-pocket maximum.
8) Copayments may never exceed the Plan's actual cost of the service. For example, if laboratory tests cost less than the $20 copayment, the lesser amount is the Member's applicable cost-sharing amount.
9) Member's cost-sharing amount for oral anti-cancer drugs shall not exceed $200 per month per state law.
10) 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.
11) 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. See each specific Plan for applicable MHPAEA share of cost.
12) Child Services for pediatric eye care and dental care is for members up to age 19.
13) Drug tiers are defined as follows:

Tier	Definition
1	1) Most generic drugs and low cost preferred brands.
2	1) Non-preferred generic drugs or; 2) Preferred brand name drugs or; 3) Recommended by the plan's pharmaceutical and therapeutics (P&T) committee based on drug safety, efficacy and cost.
3	1) Non-preferred brand name drugs or; 2) Recommended by P&T committee based on drug safety, efficacy and cost or; 3) Generally have a preferred and often less costly therapeutic alternative at a lower tier.
4	1) Food and Drug Administration (FDA) or drug manufacturer limits distribution to specialty pharmacies or; 2) Self administration requires training, clinical monitoring or; 3) Drug was manufactured using biotechnology or; 4) Plan cost (net of rebates) is >$600.