

Oregon Summary of 2016 Standard Plans and 2015 Most Popular Plans

Individual Market Detailed Exhibit

May 18, 2015 Meeting

Benefit as listed on the B 91 Exhibit document	EHB Category as listed on the Plan and Benefits Template	Gold			
		Gold Standard	Gold A	Gold B	Gold C
		ACA	ACA	ACA	ACA
Deductible		Medical: \$1,250; Rx: \$0	Combined Medical and Drug: \$750	Medical: \$0; Rx: \$0	Combined Medical and Drug: \$500
Maximum OOP		Combined Medical and Drug: \$6,350	Combined Medical and Drug: \$4,750	Combined Medical and Drug: \$6,350	Combined Medical and Drug: \$4,500
Family Multiplier		2x Individual	2x Individual	2x Individual	2x Individual
Primary Care Office Visit to Treat an Injury or Illness	<b>Primary Care Visit to Treat an Injury or Illness</b>	\$20	\$15	\$20	\$10
Specialist Office Visit	<b>Specialist Visit</b>	\$40	\$15	\$40	\$30
Other Practitioner Office Visit (Nurse, Physician Assistant)	<b>Other Practitioner Office Visit (Nurse, Physician Assistant)</b>	\$20	\$15	\$20	\$10
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<b>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</b>	10% After Deductible	15% After Deductible	30%	20% After Deductible
Outpatient Surgery physician/Surgical Services	<b>Outpatient Surgery Physician/Surgical Services</b>	10% After Deductible	15% After Deductible	30%	20% After Deductible
Hospice Services	<b>Hospice Services</b>	10% After Deductible	15% After Deductible	No Charge	20% After Deductible
Non-Emergency Care When Traveling Outside the U.S.	<b>Non-Emergency Care When Traveling Outside the U.S.</b>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>
Routine Dental Services (Adult)	<b>Routine Dental Services (Adult)</b>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>
Infertility Treatment	<b>Infertility Treatment</b>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>
Long-Term/Custodial Nursing	<b>Long-Term/Custodial Nursing</b>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>
Private-Duty Nursing	<b>Private-Duty Nursing</b>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>
Routine Eye Exam (Adult)	<b>Routine Eye Exam (Adult)</b>	<i>Not Covered</i>	<i>Not Covered</i>	\$20	<i>Not Covered</i>
Urgent Care Centers or Facilities	<b>Urgent Care Centers or Facilities</b>	\$60	\$15	\$40	\$10
Home Health Care Services	<b>Home Health Care Services</b>	10% After Deductible	15% After Deductible	30%	20% After Deductible
Emergency Room Services	<b>Emergency Room Services</b>	10% After Deductible	15% After Deductible	\$250	\$100 Copay Before Deductible; 20% After Deductible
Emergency Transportation/ Ambulance	<b>Emergency Transportation/ Ambulance</b>	10% After Deductible	15% After Deductible	30%	20% After Deductible
Inpatient Hospital Services (e.g., Hospital Stay)	<b>Inpatient Hospital Services (e.g., Hospital Stay)</b>	10% After Deductible	15% After Deductible	\$500 Copay per Day	20% After Deductible
Inpatient Physician and Surgical Services	<b>Inpatient Physician and Surgical Services</b>	10% After Deductible	15% After Deductible	\$500	20% After Deductible
Bariatric Surgery	<b>Bariatric Surgery</b>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>
Cosmetic Surgery	<b>Cosmetic Surgery</b>	10% After Deductible	15% After Deductible	\$500	20% After Deductible
Skilled Nursing Facility	<b>Skilled Nursing Facility</b>	10% After Deductible	15% After Deductible	\$250 Copay per Day	20% After Deductible

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		Gold Standard	Gold A	Gold B	Gold C
		ACA	ACA	ACA	ACA
Prenatal and Postnatal Care	<b>Prenatal and Postnatal Care</b>	10% After Deductible	15% After Deductible (Deductible waived for routine nursery care and breastfeeding support.)	\$0	20% After Deductible
Delivery and All Inpatient Services for Maternity Care	<b>Delivery and All Inpatient Services for Maternity Care</b>	10% After Deductible	15% After Deductible (Deductible waived for routine nursery care and breastfeeding support.)	\$500	20% After Deductible
*Mental/Behavioral Health Outpatient Services	<b>Mental/Behavioral Health Outpatient Services</b>	Varies based on type/place of service. Please see the applicable service category.	\$15	\$20	20%
*Mental/Behavioral Health Inpatient Services	<b>Mental/Behavioral Health Inpatient Services</b>	10% After Deductible	15% After Deductible	\$500	20% After Deductible
Substance Abuse Disorder Outpatient Services	<b>Substance Abuse Disorder Outpatient Services</b>	Varies based on type/place of service. Please see the applicable service category.	\$15	\$20	20%
Substance Abuse Disorder Inpatient Services	<b>Substance Abuse Disorder Inpatient Services</b>	10% After Deductible	15% After Deductible	\$500	20% After Deductible
Generic Drugs	<b>Generic Drugs</b>	\$10	\$10	\$10	\$10
Preferred Brand Drugs	<b>Preferred Brand Drugs</b>	\$30	40%	\$30	\$40
Non-Preferred Brand Drugs	<b>Non-Preferred Brand Drugs</b>	50%	50%	30%	50%
Specialty Drugs	<b>Specialty Drugs</b>	50%	50%	30%	20%
*Outpatient Rehabilitation Services	<b>Outpatient Rehabilitation Services</b>	\$20 (Applies to PT, OT, ST provided in an office setting); PT, OT, ST provided in emergency room or urgent care setting is subject to applicable coinsurance.	\$15	\$20	20% After Deductible
*Inpatient Habilitation Services	<b>Habilitation Services</b>	10% After Deductible	15% After Deductible	\$500	20% After Deductible
(Non-EHB) Chiropractic Care	<b>(Non-EHB) Chiropractic Care</b>	<b>Not Covered</b>	\$15	\$40	<b>Not Covered</b>
Durable Medical Equipment	<b>Durable Medical Equipment</b>	10% After Deductible	15% After Deductible	30%	20% After Deductible
Hearing Aids	<b>Hearing Aids</b>	10% After Deductible	15% After Deductible	30%	\$0
Imaging (CT/PET Scans, MRIs)	<b>Imaging (CT/PET Scans, MRIs)</b>	10% After Deductible	15% After Deductible	\$250	20% After Deductible

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		Gold Standard	Gold A	Gold B	Gold C
		ACA	ACA	ACA	ACA
ACA Preventive Services	Preventive Care/ Screening/Immunization	\$0	No charge for most services. \$15 copay/visit or 15% coinsurance for remaining services	\$0	\$0
Routine Foot Care	Routine Foot Care	10% After Deductible	15% After Deductible	\$40	20% After Deductible
Acupuncture	Acupuncture	Not Covered	\$15	\$40	Not Covered
Weight Loss Programs	Weight Loss Programs	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Vision Services	Routine Eye Exam for Children	Exams at \$0 for these codes: 92002/92004, 92012/92014, S0620/S0621; for other codes cost shares may apply.	\$15	\$0	\$30
	Eye Glasses for Children	Contact lenses - Actuarial equivalent of \$150 per year. Frames - Actuarial equivalent of \$150 per year. Lenses at \$0 for codes V2100- 2299, V2300-2399, V2121, V2221, V2321; for other codes cost shares may apply.	15% After Deductible	\$0	\$0
Dental Check-Up for Children	Dental Check-Up for Children	Not Covered	\$0	Not Covered	Not Covered
*Outpatient Rehabilitation Services	Rehabilitative Speech Therapy	\$20 (Applies to PT, OT, ST provided in an office setting); PT, OT, ST provided in emergency room or urgent care setting is subject to applicable coinsurance.	\$15	\$20	20% After Deductible
	Rehabilitative Occupational and Rehabilitative Physical Therapy				
ACA Preventive Services	Well Baby Visits and Care	\$0	\$0	\$0	\$0
Diagnostic Test (X-Ray and Lab Work)	Laboratory Outpatient and Professional Services	10% After Deductible	15% After Deductible	No Charge	20%
	X-rays and Diagnostic Imaging				
Basic Dental Care - Child	Basic Dental Care - Child	Not Covered	15% After Deductible	Not Covered	Not Covered
Orthodontia - Child	Orthodontia - Child	Not Covered	Not covered	Not Covered	Not Covered
Major Dental Care - Child	Major Dental Care - Child	Not Covered	15% After Deductible	Not Covered	Not Covered
Basic Dental Care - Adult	Basic Dental Care - Adult	Not Covered	Not covered	Not Covered	Not Covered
Orthodontia - Adult	Orthodontia - Adult	Not Covered	Not covered	Not Covered	Not Covered
Major Dental Care - Adult	Major Dental Care - Adult	Not Covered	Not covered	Not Covered	Not Covered
Outpatient	Abortion for Which Public Funding is Prohibited	10% After Deductible	15% After Deductible	30%	20% After Deductible
Organ Transplants	Transplant	10% After Deductible	15% After Deductible	\$500	20% After Deductible
Emergency Room Services	Accidental Dental	10% After Deductible	15% After Deductible	\$500	20% After Deductible
Outpatient	Dialysis	10% After Deductible	15% After Deductible	\$20	20% After Deductible

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		Gold Standard	Gold A	Gold B	Gold C
		ACA	ACA	ACA	ACA
Allergy Injections	<b>Allergy Testing</b>	10% After Deductible	15% After Deductible	\$40	20% After Deductible
Outpatient	<b>Chemotherapy</b>	10% After Deductible	15% After Deductible	\$20	20% After Deductible
	<b>Radiation</b>	10% After Deductible	15% After Deductible	\$20	20% After Deductible
	<b>Diabetes Education</b>	10% After Deductible	15% After Deductible	\$20	\$0
Oregon Mandates (ORS 743 and 743A)	<b>Prosthetic Devices</b>	10% After Deductible	15% After Deductible	30%	20% After Deductible
Outpatient	<b>Infusion Therapy</b>	10% After Deductible	15% After Deductible	\$40	20% After Deductible
Treatment for Temporomandibular Joint Disorders	<b>Treatment for Temporomandibular Joint Disorders</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>
Outpatient	<b>Nutritional Counseling</b>	10% After Deductible	15% After Deductible	\$20	\$0
Cosmetic Surgery	<b>Reconstructive Surgery</b>	10% After Deductible	15% After Deductible	\$500	20% After Deductible
Oregon Mandates (ORS 743 and 743A)	<b>Clinical Trials</b>	10% After Deductible	15% After Deductible	No Charge	20% After Deductible
	<b>Inherited Metabolic Disorder - PKU</b>	10% After Deductible	15% After Deductible	No Charge	20% After Deductible
Specialty Drugs	<b>Off Label Prescription Drugs</b>	50%	50%	30%	20% After Deductible
Specialty Drugs	<b>Prescription Drugs Other</b>	50%	50%	30%	20% After Deductible
Breast Reconstruction	<b>Mastectomy-Related Coverage</b>	10% After Deductible	<b>Not in the summary</b>	\$500	20% After Deductible
*Outpatient Rehabilitation Services	<b>Brain Injury</b>	\$20 (Applies to PT, OT, ST provided in an office setting); PT, OT, ST provided in emergency room or urgent care setting is subject to applicable coinsurance.	\$15	\$500	20% After Deductible
Biofeedback	<i>Covered with same cost shares as Non-Specialist Visit</i>	\$20	\$15	\$20	\$10
Cardiac Rehabilitation	<i>Covered with the same cost shares as Rehabilitation</i>	\$20	\$15	\$20	20% After Deductible
Hospitalization for Dental Procedures	<i>Covered with the same cost shares and visit limits of Inpatient and Outpatient Hospital Services</i>	10% After Deductible	15% After Deductible	\$500	20% After Deductible
*Inpatient Rehabilitation Services	<i>Covered with the same cost shares and visit limits of Inpatient Habilitation Services</i>	10% After Deductible	15% After Deductible	\$500	20% After Deductible
*Outpatient Habilitation Services	<i>Covered with the same cost shares and visit limits as Outpatient Rehabilitation Services</i>	\$20 (Applies to PT, OT, ST provided in an office setting); PT, OT, ST provided in emergency room or urgent care setting is subject to applicable coinsurance.	\$15	\$20	20% After Deductible
Sleep Studies	<i>Covered with the same cost shares as Outpatient Services</i>	10% After Deductible	15% After Deductible	30%	20% After Deductible
Vasectomy	<i>Covered with the same cost shares as under Outpatient Surgery</i>	10% After Deductible	15% After Deductible	30%	20% After Deductible

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		Silver Standard	Silver A	Silver B	Silver C
		ACA	ACA	ACA	ACA
Deductible		Medical: \$2,500; Rx: \$0	Combined Medical and Drug: \$1,150	Combined Medical and Drug: \$3,000	Medical: \$1,500; Rx: \$250
Maximum OOP		Combined Medical and Drug: \$6,350	Combined Medical and Drug: \$6,600	Combined Medical and Drug: \$6,000	Combined Medical and Drug: \$6,350
Family Multiplier		2x Individual	2x Individual	2x Individual	2x Individual
Primary Care Office Visit to Treat an Injury or Illness	<b>Primary Care Visit to Treat an Injury or Illness</b>	\$35	\$25	\$15	\$30
Specialist Office Visit	<b>Specialist Visit</b>	\$70	\$25	25% After Deductible	\$50
Other Practitioner Office Visit (Nurse, Physician Assistant)	<b>Other Practitioner Office Visit (Nurse, Physician Assistant)</b>	\$35	\$25	\$15	\$30
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<b>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</b>	30% After Deductible	30% After Deductible	25% After Deductible	30% After Deductible
Outpatient Surgery physician/Surgical Services	<b>Outpatient Surgery Physician/Surgical Services</b>	30% After Deductible	30% After Deductible	25% After Deductible	30% After Deductible
Hospice Services	<b>Hospice Services</b>	30% After Deductible	30% After Deductible	25% After Deductible	\$0
Non-Emergency Care When Traveling Outside the U.S.	<b>Non-Emergency Care When Traveling Outside the U.S.</b>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>
Routine Dental Services (Adult)	<b>Routine Dental Services (Adult)</b>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>
Infertility Treatment	<b>Infertility Treatment</b>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>
Long-Term/Custodial Nursing	<b>Long-Term/Custodial Nursing</b>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>
Private-Duty Nursing	<b>Private-Duty Nursing</b>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>
Routine Eye Exam (Adult)	<b>Routine Eye Exam (Adult)</b>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	\$30
Urgent Care Centers or Facilities	<b>Urgent Care Centers or Facilities</b>	\$90	\$25	\$15 copay/visit for first three; 25% coinsurance for subsequent visits	\$50
Home Health Care Services	<b>Home Health Care Services</b>	30% After Deductible	30% After Deductible	25% After Deductible	30% After Deductible
Emergency Room Services	<b>Emergency Room Services</b>	30% After Deductible	30% After Deductible	25% (Deductible applies to mental health and substance abuse services.)	\$350
Emergency Transportation/ Ambulance	<b>Emergency Transportation/ Ambulance</b>	30% After Deductible	30% After Deductible	25% (Deductible applies to mental health and substance abuse services.)	30% After Deductible
Inpatient Hospital Services (e.g., Hospital Stay)	<b>Inpatient Hospital Services (e.g., Hospital Stay)</b>	30% After Deductible	30% After Deductible	25% After Deductible	30% After Deductible
Inpatient Physician and Surgical Services	<b>Inpatient Physician and Surgical Services</b>	30% After Deductible	30% After Deductible	25% After Deductible	30% After Deductible
Bariatric Surgery	<b>Bariatric Surgery</b>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>
Cosmetic Surgery	<b>Cosmetic Surgery</b>	30% After Deductible	30% After Deductible	25% After Deductible	30% After Deductible
Skilled Nursing Facility	<b>Skilled Nursing Facility</b>	30% After Deductible	30% After Deductible	25% After Deductible	30% After Deductible

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		Silver Standard	Silver A	Silver B	Silver C
		ACA	ACA	ACA	ACA
Prenatal and Postnatal Care	<b>Prenatal and Postnatal Care</b>	30% After Deductible	30% After Deductible (Deductible waived for routine nursery care and breastfeeding support.)	25% After Deductible (Deductible waived for routine nursery care and breastfeeding support.)	\$0
Delivery and All Inpatient Services for Maternity Care	<b>Delivery and All Inpatient Services for Maternity Care</b>	30% After Deductible	30% After Deductible (Deductible waived for routine nursery care and breastfeeding support.)	25% After Deductible (Deductible waived for routine nursery care and breastfeeding support.)	30% After Deductible
*Mental/Behavioral Health Outpatient Services	<b>Mental/Behavioral Health Outpatient Services</b>	Varies based on type/place of service. Please see the applicable service category.	\$25	25% After Deductible	\$30
*Mental/Behavioral Health Inpatient Services	<b>Mental/Behavioral Health Inpatient Services</b>	30% After Deductible	30% After Deductible	25% After Deductible	30% After Deductible
Substance Abuse Disorder Outpatient Services	<b>Substance Abuse Disorder Outpatient Services</b>	Varies based on type/place of service. Please see the applicable service category.	\$25	25% After Deductible	\$30
Substance Abuse Disorder Inpatient Services	<b>Substance Abuse Disorder Inpatient Services</b>	30% After Deductible	30% After Deductible	25% After Deductible	30% After Deductible
Generic Drugs	<b>Generic Drugs</b>	\$15	Value drugs: \$2 copay retail, \$6 copay mail-order; Select tier drugs: \$10 copay retail, \$30 copay mail-order	Value drugs: \$2 copay retail, \$6 copay mail-order; Select tier drugs: \$10 copay retail, \$30 copay mail-order	\$15
Preferred Brand Drugs	<b>Preferred Brand Drugs</b>	\$50	40%	40%	\$45 After Deductible
Non-Preferred Brand Drugs	<b>Non-Preferred Brand Drugs</b>	50%	50%	50%	30% After Deductible
Specialty Drugs	<b>Specialty Drugs</b>	50%	50%	50%	30% After Deductible
*Outpatient Rehabilitation Services	<b>Outpatient Rehabilitation Services</b>	\$35 (Applies to PT, OT, ST provided in an office setting); PT, OT, ST provided in emergency room or urgent care setting is subject to applicable coinsurance.	\$25	25% After Deductible	\$30 After Deductible
*Inpatient Habilitation Services	<b>Habilitation Services</b>	30% After Deductible	30% After Deductible	25% After Deductible	30% After Deductible
(Non-EHB) Chiropractic Care	<b>(Non-EHB) Chiropractic Care</b>	<b>Not Covered</b>	\$25	\$15	\$50
Durable Medical Equipment	<b>Durable Medical Equipment</b>	30% After Deductible	30% After Deductible	25% After Deductible	30% After Deductible
Hearing Aids	<b>Hearing Aids</b>	30% After Deductible	30% After Deductible	25% After Deductible	30% After Deductible
Imaging (CT/PET Scans, MRIs)	<b>Imaging (CT/PET Scans, MRIs)</b>	30% After Deductible	30% After Deductible	25% After Deductible	\$250

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		Silver Standard	Silver A	Silver B	Silver C
		ACA	ACA	ACA	ACA
ACA Preventive Services	Preventive Care/ Screening/Immunization	\$0	\$0	\$0	\$0
Routine Foot Care	Routine Foot Care	30% After Deductible	30% After Deductible	25% After Deductible	\$50
Acupuncture	Acupuncture	Not Covered	\$25	\$15	\$50
Weight Loss Programs	Weight Loss Programs	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Vision Services	Routine Eye Exam for Children	Exams at \$0 for these codes: 92002/92004, 92012/92014, S0620/S0621; for other codes cost shares may apply.	\$25	25%	\$0
	Eye Glasses for Children	Contact lenses - Actuarial equivalent of \$150 per year. Frames - Actuarial equivalent of \$150 per year. Lenses at \$0 for codes V2100- 2299, V2300-2399, V2121, V2221, V2321; for other codes cost shares may apply.	30%	25% After Deductible	\$0
Dental Check-Up for Children	Dental Check-Up for Children	Not Covered	\$0	Not Covered	Not Covered
*Outpatient Rehabilitation Services	Rehabilitative Speech Therapy	\$35 (Applies to PT, OT, ST provided in an office setting); PT, OT, ST provided in emergency room or urgent care setting is subject to applicable coinsurance.	\$25	25% After Deductible	\$30 After Deductible
	Rehabilitative Occupational and Rehabilitative Physical Therapy				
ACA Preventive Services	Well Baby Visits and Care	\$0	\$0	\$0	\$0
Diagnostic Test (X-Ray and Lab Work)	Laboratory Outpatient and Professional Services	30% After Deductible	30% After Deductible	25% After Deductible	30% After Deductible
	X-rays and Diagnostic Imaging				
Basic Dental Care - Child	Basic Dental Care - Child	Not Covered	30% After Deductible	Not Covered	Not Covered
Orthodontia - Child	Orthodontia - Child	Not Covered	Not Covered	Not Covered	Not Covered
Major Dental Care - Child	Major Dental Care - Child	Not Covered	30% After Deductible	Not Covered	Not Covered
Basic Dental Care - Adult	Basic Dental Care - Adult	Not Covered	Not Covered	Not Covered	Not Covered
Orthodontia - Adult	Orthodontia - Adult	Not Covered	Not Covered	Not Covered	Not Covered
Major Dental Care - Adult	Major Dental Care - Adult	Not Covered	Not Covered	Not Covered	Not Covered
Outpatient	Abortion for Which Public Funding is Prohibited	30% After Deductible	30% After Deductible	25% After Deductible	30% After Deductible
Organ Transplants	Transplant	30% After Deductible	30% After Deductible	25% After Deductible	30% After Deductible
Emergency Room Services	Accidental Dental	30% After Deductible	30% After Deductible	25% After Deductible	30% After Deductible
Outpatient	Dialysis	30% After Deductible	30% After Deductible	25% After Deductible	\$30 After Deductible

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		Silver Standard	Silver A	Silver B	Silver C
		ACA	ACA	ACA	ACA
Allergy Injections	<b>Allergy Testing</b>	30% After Deductible	30% After Deductible	25% After Deductible	\$50
Outpatient	<b>Chemotherapy</b>	30% After Deductible	30% After Deductible	25% After Deductible	\$30 After Deductible
	<b>Radiation</b>	30% After Deductible	30% After Deductible	25% After Deductible	\$30 After Deductible
	<b>Diabetes Education</b>	30% After Deductible	30% After Deductible	25% After Deductible	\$30
Oregon Mandates (ORS 743 and 743A)	<b>Prosthetic Devices</b>	30% After Deductible	30% After Deductible	25% After Deductible	30% After Deductible
Outpatient	<b>Infusion Therapy</b>	30% After Deductible	30% After Deductible	25% After Deductible	\$50
Treatment for Temporomandibular Joint Disorders	<b>Treatment for Temporomandibular Joint Disorders</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>
Outpatient	<b>Nutritional Counseling</b>	30% After Deductible	30% After Deductible	25% After Deductible	\$30
Cosmetic Surgery	<b>Reconstructive Surgery</b>	30% After Deductible	30% After Deductible	25% After Deductible	30% After Deductible
Oregon Mandates (ORS 743 and 743A)	<b>Clinical Trials</b>	30% After Deductible	30% After Deductible	25% After Deductible	\$0
	<b>Inherited Metabolic Disorder - PKU</b>	30% After Deductible	30% After Deductible	25% After Deductible	\$0
Specialty Drugs	<b>Off Label Prescription Drugs</b>	50%	50%	50%	30% After Deductible
Specialty Drugs	<b>Prescription Drugs Other</b>	50%	50%	50%	30% After Deductible
Breast Reconstruction	<b>Mastectomy-Related Coverage</b>	30% After Deductible	30% After Deductible	30% After Deductible	30% After Deductible
*Outpatient Rehabilitation Services	<b>Brain Injury</b>	\$35 (Applies to PT, OT, ST provided in an office setting); PT, OT, ST provided in emergency room or urgent care setting is subject to applicable coinsurance.	\$25	25% After Deductible	30% After Deductible
Biofeedback	<i>Covered with same cost shares as Non-Specialist Visit</i>	\$35	\$25	\$15	\$30
Cardiac Rehabilitation	<i>Covered with the same cost shares as Rehabilitation</i>	\$35	\$25	25% After Deductible	\$30 After Deductible
Hospitalization for Dental Procedures	<i>Covered with the same cost shares and visit limits of Inpatient and Outpatient Hospital Services</i>	30% After Deductible	30% After Deductible	25% After Deductible	30% After Deductible
*Inpatient Rehabilitation Services	<i>Covered with the same cost shares and visit limits of Inpatient Habilitation Services</i>	30% After Deductible	30% After Deductible	25% After Deductible	30% After Deductible
*Outpatient Habilitation Services	<i>Covered with the same cost shares and visit limits as Outpatient Rehabilitation Services</i>	\$35 (Applies to PT, OT, ST provided in an office setting); PT, OT, ST provided in emergency room or urgent care setting is subject to applicable coinsurance.	\$25	25% After Deductible	\$30 After Deductible
Sleep Studies	<i>Covered with the same cost shares as Outpatient Services</i>	30% After Deductible	30% After Deductible	25% After Deductible	30% After Deductible
Vasectomy	<i>Covered with the same cost shares as under Outpatient Surgery</i>	30% After Deductible	30% After Deductible	25% After Deductible	30% After Deductible

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		Bronze Standard	Bronze A	Bronze B	Bronze C	Bronze D
		ACA	ACA	ACA	ACA	ACA
Deductible		Combined Medical and Drug: \$5,000	Combined Medical and Drug: \$5,250	Combined Medical and Drug: \$6,350	Combined Medical and Drug: \$5,250	Medical: \$4,500; Rx: \$500
Maximum OOP		Combined Medical and Drug: \$6,350	Combined Medical and Drug: \$6,350	Combined Medical and Drug: \$6,350	Combined Medical and Drug: \$5,250	Combined Medical and Drug: \$6,350
Family Multiplier		2x Individual				
Primary Care Office Visit to Treat an Injury or Illness	<b>Primary Care Visit to Treat an Injury or Illness</b>	\$60 After Deductible	40% After Deductible	\$20	0% After Deductible	\$50
Specialist Office Visit	<b>Specialist Visit</b>	\$100 After Deductible	40% After Deductible	\$50	0% After Deductible	\$70
Other Practitioner Office Visit (Nurse, Physician Assistant)	<b>Other Practitioner Office Visit (Nurse, Physician Assistant)</b>	\$60 After Deductible	40% After Deductible	\$20	0% After Deductible	\$50
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<b>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</b>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	20% After Deductible
Outpatient Surgery physician/Surgical Services	<b>Outpatient Surgery Physician/Surgical Services</b>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	20% After Deductible
Hospice Services	<b>Hospice Services</b>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	\$0
Non-Emergency Care When Traveling Outside the U.S.	<b>Non-Emergency Care When Traveling Outside the U.S.</b>	<i>Not Covered</i>				
Routine Dental Services (Adult)	<b>Routine Dental Services (Adult)</b>	<i>Not Covered</i>				
Infertility Treatment	<b>Infertility Treatment</b>	<i>Not Covered</i>				
Long-Term/Custodial Nursing	<b>Long-Term/Custodial Nursing</b>	<i>Not Covered</i>				
Private-Duty Nursing	<b>Private-Duty Nursing</b>	<i>Not Covered</i>				
Routine Eye Exam (Adult)	<b>Routine Eye Exam (Adult)</b>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	\$50
Urgent Care Centers or Facilities	<b>Urgent Care Centers or Facilities</b>	\$120 After Deductible	40% After Deductible	\$20	0% After Deductible	\$70
Home Health Care Services	<b>Home Health Care Services</b>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	20% After Deductible
Emergency Room Services	<b>Emergency Room Services</b>	50% After Deductible	40% After Deductible	\$250	0% After Deductible	20% After Deductible
Emergency Transportation/ Ambulance	<b>Emergency Transportation/ Ambulance</b>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	20% After Deductible
Inpatient Hospital Services (e.g., Hospital Stay)	<b>Inpatient Hospital Services (e.g., Hospital Stay)</b>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	20% After Deductible
Inpatient Physician and Surgical Services	<b>Inpatient Physician and Surgical Services</b>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	20% After Deductible
Bariatric Surgery	<b>Bariatric Surgery</b>	<i>Not Covered</i>				
Cosmetic Surgery	<b>Cosmetic Surgery</b>	50% After Deductible	40% After Deductible	20%	0% After Deductible	20% After Deductible
Skilled Nursing Facility	<b>Skilled Nursing Facility</b>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	20% After Deductible

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		Bronze Standard	Bronze A	Bronze B	Bronze C	Bronze D
		ACA	ACA	ACA	ACA	ACA
Prenatal and Postnatal Care	<b>Prenatal and Postnatal Care</b>	50% After Deductible	40% After Deductible (Deductible waived for routine nursery care and breastfeeding support.)	0% After Deductible	0% After Deductible	\$0
Delivery and All Inpatient Services for Maternity Care	<b>Delivery and All Inpatient Services for Maternity Care</b>	50% After Deductible	40% After Deductible (Deductible waived for routine nursery care and breastfeeding support.)	0% After Deductible	0% After Deductible	20% After Deductible
*Mental/Behavioral Health Outpatient Services	<b>Mental/Behavioral Health Outpatient Services</b>	Varies based on type/place of service. Please see the applicable service category.	40% After Deductible	0% After Deductible	0% After Deductible	\$50
*Mental/Behavioral Health Inpatient Services	<b>Mental/Behavioral Health Inpatient Services</b>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	20% After Deductible
Substance Abuse Disorder Outpatient Services	<b>Substance Abuse Disorder Outpatient Services</b>	Varies based on type/place of service. Please see the applicable service category.	40% After Deductible	0% After Deductible	0% After Deductible	\$50
Substance Abuse Disorder Inpatient Services	<b>Substance Abuse Disorder Inpatient Services</b>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	20% After Deductible
Generic Drugs	<b>Generic Drugs</b>	\$20 After Deductible	50% After Deductible	0% After Deductible	0% After Deductible	\$25
Preferred Brand Drugs	<b>Preferred Brand Drugs</b>	\$80 After Deductible	50% After Deductible	0% After Deductible	0% After Deductible	50% After Deductible
Non-Preferred Brand Drugs	<b>Non-Preferred Brand Drugs</b>	50% After Deductible	50% After Deductible	0% After Deductible	0% After Deductible	50% After Deductible
Specialty Drugs	<b>Specialty Drugs</b>	50% After Deductible	50% After Deductible	0% After Deductible	0% After Deductible	50% After Deductible
*Outpatient Rehabilitation Services	<b>Outpatient Rehabilitation Services</b>	\$60 After Deductible (Applies to PT, OT, ST provided in an office setting); PT, OT, ST provided in emergency room or urgent care setting is subject to applicable coinsurance.	40% After Deductible	0% After Deductible	0% After Deductible	\$50 After Deductible
*Inpatient Habilitation Services	<b>Habilitation Services</b>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	20% After Deductible
(Non-EHB) Chiropractic Care	<b>(Non-EHB) Chiropractic Care</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>	\$70
Durable Medical Equipment	<b>Durable Medical Equipment</b>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	20% After Deductible
Hearing Aids	<b>Hearing Aids</b>	50% After Deductible	40% After Deductible	\$0	\$0	20% After Deductible
Imaging (CT/PET Scans, MRIs)	<b>Imaging (CT/PET Scans, MRIs)</b>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	\$500 After Deductible

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		Bronze Standard	Bronze A	Bronze B	Bronze C	Bronze D
		ACA	ACA	ACA	ACA	ACA
ACA Preventive Services	Preventive Care/ Screening/Immunization	\$0	\$0	\$0	\$0	\$0
Routine Foot Care	Routine Foot Care	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	\$70
Acupuncture	Acupuncture	Not Covered	Not Covered	Not Covered	Not Covered	\$70
Weight Loss Programs	Weight Loss Programs	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Pediatric Vision Services	Routine Eye Exam for Children	Exams at \$0 for these codes: 92002/92004, 92012/92014, S0620/S0621; for other codes cost shares may apply.	40% After Deductible	\$50	20%	\$0
	Eye Glasses for Children	Contact lenses - Actuarial equivalent of \$150 per year. Frames - Actuarial equivalent of \$150 per year. Lenses at \$0 for codes V2100- 2299, V2300-2399, V2121, V2221, V2321; for other codes cost shares may apply.	40% After Deductible	\$0	\$0	\$0
Dental Check-Up for Children	Dental Check-Up for Children	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
*Outpatient Rehabilitation Services	Rehabilitative Speech Therapy	\$60 After Deductible (Applies to PT, OT, ST provided in an office setting); PT, OT, ST provided in emergency room or urgent care setting is subject to applicable coinsurance.	40% After Deductible	0% After Deductible	0% After Deductible	\$50 After Deductible
	Rehabilitative Occupational and Rehabilitative Physical Therapy					
ACA Preventive Services	Well Baby Visits and Care	\$0	\$0	\$0	\$0	\$0
Diagnostic Test (X-Ray and Lab Work)	Laboratory Outpatient and Professional Services	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	\$20 After Deductible
	X-rays and Diagnostic Imaging					
Basic Dental Care - Child	Basic Dental Care - Child	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Orthodontia - Child	Orthodontia - Child	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Major Dental Care - Child	Major Dental Care - Child	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Basic Dental Care - Adult	Basic Dental Care - Adult	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Orthodontia - Adult	Orthodontia - Adult	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Major Dental Care - Adult	Major Dental Care - Adult	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Outpatient	Abortion for Which Public Funding is Prohibited	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	20% After Deductible
Organ Transplants	Transplant	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	20% After Deductible
Emergency Room Services	Accidental Dental	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	20% After Deductible
Outpatient	Dialysis	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	\$50 After Deductible

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		Bronze Standard	Bronze A	Bronze B	Bronze C	Bronze D
		ACA	ACA	ACA	ACA	ACA
Allergy Injections	<b>Allergy Testing</b>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	\$70
Outpatient	<b>Chemotherapy</b>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	\$50 After Deductible
	<b>Radiation</b>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	\$50 After Deductible
	<b>Diabetes Education</b>	50% After Deductible	40% After Deductible	\$0	\$0	\$50
Oregon Mandates (ORS 743 and 743A)	<b>Prosthetic Devices</b>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	20% After Deductible
Outpatient	<b>Infusion Therapy</b>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	\$70
Treatment for Temporomandibular Joint Disorders	<b>Treatment for Temporomandibular Joint Disorders</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>
Outpatient	<b>Nutritional Counseling</b>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	\$50
Cosmetic Surgery	<b>Reconstructive Surgery</b>	50% After Deductible	40% After Deductible	20% After Deductible	0% After Deductible	20% After Deductible
Oregon Mandates (ORS 743 and 743A)	<b>Clinical Trials</b>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	\$0
	<b>Inherited Metabolic Disorder - PKU</b>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	\$0
Specialty Drugs	<b>Off Label Prescription Drugs</b>	50% After Deductible	50% After Deductible	0% After Deductible	0% After Deductible	50% After Deductible
Specialty Drugs	<b>Prescription Drugs Other</b>	50% After Deductible	50% After Deductible	0% After Deductible	0% After Deductible	50% After Deductible
Breast Reconstruction	<b>Mastectomy-Related Coverage</b>	50% After Deductible	30% After Deductible	0% After Deductible	0% After Deductible	20% After Deductible
*Outpatient Rehabilitation Services	<b>Brain Injury</b>	\$60 After Deductible (Applies to PT, OT, ST provided in an office setting); PT, OT, ST provided in emergency room or urgent care setting is subject to applicable coinsurance.	40% After Deductible	0% After Deductible	0% After Deductible	20% After Deductible
Biofeedback	<i>Covered with same cost shares as Non-Specialist Visit</i>	\$60 After Deductible	40% After Deductible	\$20	0% After Deductible	\$50
Cardiac Rehabilitation	<i>Covered with the same cost shares as Rehabilitation</i>	\$60 After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	\$50 After Deductible
Hospitalization for Dental Procedures	<i>Covered with the same cost shares and visit limits of Inpatient and Outpatient Hospital Services</i>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	20% After Deductible
*Inpatient Rehabilitation Services	<i>Covered with the same cost shares and visit limits of Inpatient Habilitation Services</i>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	20% After Deductible
*Outpatient Habilitation Services	<i>Covered with the same cost shares and visit limits as Outpatient Rehabilitation Services</i>	\$60 After Deductible (Applies to PT, OT, ST provided in an office setting); PT, OT, ST provided in emergency room or urgent care setting is subject to applicable coinsurance.	40% After Deductible	0% After Deductible	0% After Deductible	\$50 After Deductible
Sleep Studies	<i>Covered with the same cost shares as Outpatient Services</i>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	20% After Deductible
Vasectomy	<i>Covered with the same cost shares as under Outpatient Surgery</i>	50% After Deductible	40% After Deductible	0% After Deductible	0% After Deductible	20% After Deductible