

Oregon Summary of 2016 Standard and 2015 Most Popular Plans

Small Group 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	Gold D	Gold E	
		ACA	Non-ACA	Non-ACA	ACA	ACA	ACA	
Deductible		Medical: \$1,250; Rx: \$0	Combined Medical and Drug: \$1,000	Combined Medical and Drug: \$500	Combined Medical and Drug: \$4,000	Medical: \$500; Rx: \$0	Medical: Combined In/Out Network \$1000; Rx: Combined In/Out Network \$0	
Maximum OOP		Combined Medical and Drug: \$6,350	Combined Medical and Drug: \$2,000	Combined Medical and Drug: \$2,000	Combined Medical and Drug: \$4,000	Combined Medical and Drug: \$4,000	Combined Medical and Drug In/Out Network: \$4,500	
Family Multiplier		2x Individual	3x Individual	3x 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	\$20	\$20	\$25	\$20	\$30	
Specialist Office Visit	<b>Specialist Visit</b>	\$40	\$20	\$20	\$45	\$30	\$30	
Other Practitioner Office Visit (Nurse, Physician Assistant)	<b>Other Practitioner Office Visit (Nurse, Physician Assistant)</b>	\$20	\$20	\$20	\$45	\$20	\$30	
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<b>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</b>	10% After Deductible	20% After Deductible	20% After Deductible	\$150 Copay after deductible; 0% Coinsurance after deductible	20% After Deductible	15% After Deductible	
Outpatient Surgery physician/Surgical Services	<b>Outpatient Surgery Physician/Surgical Services</b>	10% After Deductible	20% After Deductible	20% After Deductible	No Charge after deductible; 10% Coinsurance after Deductible	20% After Deductible	20% After Deductible	
Hospice Services	<b>Hospice Services</b>	10% After Deductible	\$0	\$0	\$0	\$0	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>	\$0	<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>	<i>Not Covered</i>	<i>Not Covered</i>	
Infertility Treatment	<b>Infertility Treatment</b>	<i>Not Covered</i>	50% After Deductible	50% After Deductible	<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>	<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>	<i>Not Covered</i>	<i>Not Covered</i>	
Routine Eye Exam (Adult)	<b>Routine Eye Exam (Adult)</b>	<i>Not Covered</i>	\$20	\$20	\$30	\$20	<i>Not Covered</i>	
Urgent Care Centers or Facilities	<b>Urgent Care Centers or Facilities</b>	\$60	\$40	\$40	\$45	\$40	\$50	
Home Health Care Services	<b>Home Health Care Services</b>	10% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	
Emergency Room Services	<b>Emergency Room Services</b>	10% After Deductible	20% After Deductible	20% After Deductible	250 Copay; 20% After Deductible	20% After Deductible	\$250 Copay; 20%	
Emergency Transportation/ Ambulance	<b>Emergency Transportation/ Ambulance</b>	10% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	
Inpatient Hospital Services (e.g., Hospital Stay)	<b>Inpatient Hospital Services (e.g., Hospital Stay)</b>	10% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	
Inpatient Physician and Surgical Services	<b>Inpatient Physician and Surgical Services</b>	10% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	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>	<i>Not Covered</i>	<i>Not Covered</i>	
Cosmetic Surgery	<b>Cosmetic Surgery</b>	10% After Deductible	<i>Not Covered</i>	<i>Not Covered</i>	20% After Deductible	20% After Deductible	20% After Deductible	
Skilled Nursing Facility	<b>Skilled Nursing Facility</b>	10% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	
Prenatal and Postnatal Care	<b>Prenatal and Postnatal Care</b>	10% After Deductible	\$0	\$0	\$0	\$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	20% After Deductible	20% After Deductible	20% After Deductible	20% 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.		\$20	\$20	\$25	\$20	\$30

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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	Gold D	Gold E
		ACA	Non-ACA	Non-ACA	ACA	ACA	ACA
*Mental/Behavioral Health Inpatient Services	<b>Mental/Behavioral Health Inpatient Services</b>	10% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	20% 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.	\$20	\$20	\$25	\$20	\$30
Substance Abuse Disorder Inpatient Services	<b>Substance Abuse Disorder Inpatient Services</b>	10% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible
Generic Drugs	<b>Generic Drugs</b>	\$10	\$15	\$15	\$10	\$10	\$15
Preferred Brand Drugs	<b>Preferred Brand Drugs</b>	\$30	\$30	\$30	\$40	\$20	\$30
Non-Preferred Brand Drugs	<b>Non-Preferred Brand Drugs</b>	50%	\$50	\$50	30% After Deductible	\$60	50
Specialty Drugs	<b>Specialty Drugs</b>	50%	<b>Not in the Summary</b>	<b>Not in the Summary</b>	30% After Deductible	\$150	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.	\$20 after Deductible	\$20 after Deductible	20% After Deductible	\$30 After Deductible	20% After Deductible
*Inpatient Habilitation Services	<b>Habilitation Services</b>	10% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible
(Non-EHB) Chiropractic Care	<b>(Non-EHB) Chiropractic Care</b>	<b>Not Covered</b>	<b>Not Covered (self-referred)</b>	<b>Not Covered (self-referred)</b>	\$25	\$20	<b>Not Covered</b>
Durable Medical Equipment	<b>Durable Medical Equipment</b>	10% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible
Hearing Aids	<b>Hearing Aids</b>	10% After Deductible	Audiology Services: \$20; Hearing aid per Member age 18 years and younger, or enrollees ages 19 to 25 and enrolled in an accredited educational institution (limited to one hearing aid per ear every four years): 20% After	Audiology Services: \$20; Hearing aid per Member age 18 years and younger, or enrollees ages 19 to 25 and enrolled in an accredited educational institution (limited to one hearing aid per ear every four years): 20% After	20% After Deductible	20% After Deductible	20% After Deductible
Imaging (CT/PET Scans, MRIs)	<b>Imaging (CT/PET Scans, MRIs)</b>	10% After Deductible	\$100	\$100	20% After Deductible	\$300	20% After Deductible
ACA Preventive Services	<b>Preventive Care/ Screening/Immunization</b>	\$0	\$0	\$0	\$0	\$0	\$0
Routine Foot Care	<b>Routine Foot Care</b>	10% After Deductible	<b>Not Covered</b>	<b>Not Covered</b>	20% After Deductible	\$30	\$30
Acupuncture	<b>Acupuncture</b>	<b>Not Covered</b>	\$20 (Physician-referred)	\$20 (Physician-referred)	\$25	\$20	<b>Not Covered</b>
Weight Loss Programs	<b>Weight Loss Programs</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>

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		Gold Standard ACA	Gold A Non-ACA	Gold B Non-ACA	Gold C ACA	Gold D ACA	Gold E ACA
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.	\$20	\$20	\$0	\$0	\$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.	\$0	\$0	\$0	\$0	\$0
Dental Check-Up for Children	Dental Check-Up for Children	Not Covered	Not Covered	Not Covered	\$0	Not Covered	\$0
*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.	20% After Deductible	20% After Deductible	20% After Deductible	\$30 After Deductible	20% After Deductible
	Rehabilitative Occupational and Rehabilitative Physical Therapy						
ACA Preventive Services	Well Baby Visits and Care	\$0	\$0	\$0	\$0	\$0	\$0
Diagnostic Test (X-Ray and Lab Work)	Laboratory Outpatient and Professional Services	10% After Deductible	Inpatient Hospital Services: 20% After Deductible; Outpatient: \$20 per department visit	Inpatient Hospital Services: 20% After Deductible; Outpatient: \$20 per department visit	20% After Deductible	\$20	20% After Deductible
	X-rays and Diagnostic Imaging	10% After Deductible					
Basic Dental Care - Child	Basic Dental Care - Child	Not Covered	Not Covered	Not Covered	50% After Deductible	Not Covered	Not Covered
Orthodontia - Child	Orthodontia - Child	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Major Dental Care - Child	Major Dental Care - Child	Not Covered	Not Covered	Not Covered	50% After Deductible	Not Covered	\$0
Basic Dental Care - Adult	Basic Dental Care - Adult	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Orthodontia - Adult	Orthodontia - Adult	Not Covered	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	Not Covered
Outpatient	Abortion for Which Public Funding is Prohibited	10% After Deductible	Not in the Summary	Not in the Summary	Not Covered	20% After Deductible	20% After Deductible
Organ Transplants	Transplant	10% After Deductible	Not in the Summary	Not in the Summary	20% After Deductible	20% After Deductible	20% After Deductible
Emergency Room Services	Accidental Dental	10% After Deductible	Not in the Summary	Not in the Summary	20% After Deductible	20% After Deductible	20% After Deductible
Outpatient	Dialysis	10% After Deductible	Not in the Summary	Not in the Summary	20% After Deductible	\$30 After Deductible	20% After Deductible
Allergy Injections	Allergy Testing	10% After Deductible	Not in the Summary	Not in the Summary	20% After Deductible	\$30	20% After Deductible
Outpatient	Chemotherapy	10% After Deductible	Not in the Summary	Not in the Summary	20% After Deductible	\$30 After Deductible	20% After Deductible
	Radiation	10% After Deductible	Not in the Summary	Not in the Summary	20% After Deductible	\$30 After Deductible	20% After Deductible
	Diabetes Education	10% After Deductible	Not in the Summary	Not in the Summary	No Charge	\$20	\$30
Oregon Mandates (ORS 743 and 743A)	Prosthetic Devices	10% After Deductible	Not in the Summary	Not in the Summary	20% After Deductible	20% After Deductible	20% After Deductible
Outpatient	Infusion Therapy	10% After Deductible	Not in the Summary	Not in the Summary	20% After Deductible	\$30	20% After Deductible
Treatment for Temporomandibular Joint Disorders	Treatment for Temporomandibular Joint Disorders	Not Covered	Not in the Summary	Not in the Summary	Not Covered	Not Covered	Not Covered

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		Gold Standard	Gold A	Gold B	Gold C	Gold D	Gold E
		ACA	Non-ACA	Non-ACA	ACA	ACA	ACA
Outpatient	Nutritional Counseling	10% After Deductible	Not in the Summary	Not in the Summary	\$45	\$20	\$30
Cosmetic Surgery	Reconstructive Surgery	10% After Deductible	Not in the Summary	Not in the Summary	20% After Deductible	20% After Deductible	20% After Deductible
Oregon Mandates (ORS 743 and 743A)	Clinical Trials	10% After Deductible	Not in the Summary	Not in the Summary	20% After Deductible	\$0	20% After Deductible
	Inherited Metabolic Disorder - PKU	10% After Deductible	Not in the Summary	Not in the Summary	20% After Deductible	\$0	20% After Deductible
Specialty Drugs	Off Label Prescription Drugs	50%	Not in the Summary	Not in the Summary	30% After Deductible	\$60	20%
Specialty Drugs	Prescription Drugs Other	50%	Not in the Summary	Not in the Summary	30% After Deductible	\$150	20%
Breast Reconstruction	Mastectomy-Related Coverage	10% After Deductible	Not in the summary	Not in the summary	Not In the Summary	Not In the Summary	20% After Deductible
*Outpatient Rehabilitation Services	Brain Injury	\$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.	Not in the summary	Not in the summary	20% After Deductible	20% After Deductible	20% After Deductible
Biofeedback	Covered with same cost shares as Non-Specialist Visit	\$20	\$20	\$20	\$25	\$20	\$30
Cardiac Rehabilitation	Covered with the same cost shares as Rehabilitation	\$20	\$20 After Deductible	\$20 After Deductible	20% After Deductible	\$30 After Deductible	20% After Deductible
Hospitalization for Dental Procedures	Covered with the same cost shares and visit limits of Inpatient and Outpatient Hospital Services	10% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible
*Inpatient Rehabilitation Services	Covered with the same cost shares and visit limits of Inpatient Habilitation Services	10% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible	20% After Deductible
*Outpatient Habilitation Services	Covered with the same cost shares and visit limits as Outpatient Rehabilitation Services	\$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.	\$20 After Deductible	\$20 After Deductible	20% After Deductible	\$30 After Deductible	20% After Deductible
Sleep Studies	Covered with the same cost shares as Outpatient Services	10% After Deductible	20% After Deductible	20% After Deductible	No Charge after deductible; 10% Coinsurance after Deductible	20% After Deductible	20% After Deductible
Vasectomy	Covered with the same cost shares as under Outpatient Surgery	10% After Deductible	20% After Deductible	20% After Deductible	No Charge after deductible; 10% Coinsurance after Deductible	20% After Deductible	20% After Deductible

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		Silver Standard	Silver A	Silver B	Silver C	Silver D
		ACA	ACA	ACA	Non-ACA	ACA
Deductible		Medical: \$2,500; Rx: \$0	Medical: \$1,500; Rx: \$0	Combined Medical and Drug: \$6,000	Combined Medical and Drug: \$5,000	Combined Medical and Drug: \$2,000
Maximum OOP		Combined Medical and Drug: \$6,350	Combined Medical and Drug: \$6,350	Combined Medical and Drug: \$6,000	Combined Medical and Drug: \$3,000	Combined Medical and Drug: \$6,600
Family Multiplier		2x Individual	2x Individual	2x Individual	3x 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	\$30	\$25	\$30	\$35
Specialist Office Visit	<b>Specialist Visit</b>	\$70	\$40	\$50	\$30	\$50
Other Practitioner Office Visit (Nurse, Physician Assistant)	<b>Other Practitioner Office Visit (Nurse, Physician Assistant)</b>	\$35	\$30	\$50	\$30 per visit for physician-referred alternative care	\$35
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<b>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</b>	30% After Deductible	20% After Deductible	\$200 Copay after deductible	30% After Deductible	30% After Deductible
Outpatient Surgery physician/Surgical Services	<b>Outpatient Surgery Physician/Surgical Services</b>	30% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible	30% After Deductible
Hospice Services	<b>Hospice Services</b>	30% After Deductible	\$0	\$0	\$0	30% 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>	\$0	<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>	<i>Not Covered</i>
Infertility Treatment	<b>Infertility Treatment</b>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	50% After Deductible	<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>	<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>	<i>Not Covered</i>
Routine Eye Exam (Adult)	<b>Routine Eye Exam (Adult)</b>	<i>Not Covered</i>	\$0	\$30	\$30	\$0
Urgent Care Centers or Facilities	<b>Urgent Care Centers or Facilities</b>	\$90	\$50	\$50	\$50	\$35
Home Health Care Services	<b>Home Health Care Services</b>	30% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible	30% After Deductible
Emergency Room Services	<b>Emergency Room Services</b>	30% After Deductible	20% After Deductible	\$250 Copay After Deductible; 20% After Deductible	30% After Deductible	\$250 Copay After Deductible; 30%
Emergency Transportation/ Ambulance	<b>Emergency Transportation/ Ambulance</b>	30% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible	30% After Deductible
Inpatient Hospital Services (e.g., Hospital Stay)	<b>Inpatient Hospital Services (e.g., Hospital Stay)</b>	30% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible	30% After Deductible
Inpatient Physician and Surgical Services	<b>Inpatient Physician and Surgical Services</b>	30% After Deductible	20% After Deductible	20% After Deductible	30% 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>	<i>Not Covered</i>
Cosmetic Surgery	<b>Cosmetic Surgery</b>	30% After Deductible	20% After Deductible	20% After Deductible	<i>Not Covered</i>	30% After Deductible
Skilled Nursing Facility	<b>Skilled Nursing Facility</b>	30% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible	30% After Deductible
Prenatal and Postnatal Care	<b>Prenatal and Postnatal Care</b>	30% After Deductible	\$0	\$0	\$0	30% After Deductible
Delivery and All Inpatient Services for Maternity Care	<b>Delivery and All Inpatient Services for Maternity Care</b>	30% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible	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.	\$30	\$25	\$30	\$35 Copay Before Deductible; 30% After Deductible

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		Silver Standard	Silver A	Silver B	Silver C	Silver D
		ACA	ACA	ACA	Non-ACA	ACA
*Mental/Behavioral Health Inpatient Services	<b>Mental/Behavioral Health Inpatient Services</b>	30% After Deductible	20% After Deductible	20% After Deductible	30% 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.	\$30	\$25	\$30	\$35
Substance Abuse Disorder Inpatient Services	<b>Substance Abuse Disorder Inpatient Services</b>	30% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible	30% After Deductible
Generic Drugs	<b>Generic Drugs</b>	\$15	\$20	\$15	\$15	\$10
Preferred Brand Drugs	<b>Preferred Brand Drugs</b>	\$50	\$40	\$60	\$30	\$50
Non-Preferred Brand Drugs	<b>Non-Preferred Brand Drugs</b>	50%	30%	20% After Deductible	\$50	\$75
Specialty Drugs	<b>Specialty Drugs</b>	50%	30%	20% After Deductible	<b>Not in the Summary</b>	\$250
*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.	\$40 After Deductible	20% After Deductible	\$30 After Deductible	30% After Deductible
*Inpatient Habilitation Services	<b>Habilitation Services</b>	30% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible	30% After Deductible
(Non-EHB) Chiropractic Care	<b>(Non-EHB) Chiropractic Care</b>	<b>Not Covered</b>	\$40	\$25	<b>Not Covered (self-referred)</b>	\$35
Durable Medical Equipment	<b>Durable Medical Equipment</b>	30% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible	30% After Deductible
Hearing Aids	<b>Hearing Aids</b>	30% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible	<b>Not Covered</b>
Imaging (CT/PET Scans, MRIs)	<b>Imaging (CT/PET Scans, MRIs)</b>	30% After Deductible	20% After Deductible	20% After Deductible	\$100	30%
ACA Preventive Services	<b>Preventive Care/ Screening/Immunization</b>	\$0	\$0	\$0	\$0	\$0
Routine Foot Care	<b>Routine Foot Care</b>	30% After Deductible	\$40	20% After Deductible	<b>Not Covered</b>	30% After Deductible
Acupuncture	<b>Acupuncture</b>	<b>Not Covered</b>	\$40	\$25	\$30	\$35
Weight Loss Programs	<b>Weight Loss Programs</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>

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		Silver Standard	Silver A	Silver B	Silver C	Silver D
		ACA	ACA	ACA	Non-ACA	ACA
Pediatric Vision Services	<b>Routine Eye Exam for Children</b>	Exams at \$0 for these codes: 92002/92004, 92012/92014, S0620/S0621; for other codes cost shares may apply.	\$0	\$0	\$30	\$0
	<b>Eye Glasses for Children</b>	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.	\$0	\$0	\$0	\$0
Dental Check-Up for Children	<b>Dental Check-Up for Children</b>	<i>Not Covered</i>	<i>Not Covered</i>	\$0	<i>Not Covered</i>	<i>Not Covered</i>
*Outpatient Rehabilitation Services	<b>Rehabilitative Speech Therapy</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.	\$40 Copay After Deductible	20% After Deductible	\$30 After Deductible	30% After Deductible
	<b>Rehabilitative Occupational and Rehabilitative Physical Therapy</b>					
ACA Preventive Services	<b>Well Baby Visits and Care</b>	\$0	\$0	\$0	\$0	\$0
Diagnostic Test (X-Ray and Lab Work)	<b>Laboratory Outpatient and Professional Services</b>	30% After Deductible	\$30	20% After Deductible	\$30 per department visit	30%
	<b>X-rays and Diagnostic Imaging</b>	30% After Deductible	\$40	20% After Deductible	\$30 per department visit	30%
Basic Dental Care - Child	<b>Basic Dental Care - Child</b>	<i>Not Covered</i>	<i>Not Covered</i>	50% After Deductible	<i>Not Covered</i>	<i>Not Covered</i>
Orthodontia - Child	<b>Orthodontia - Child</b>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>
Major Dental Care - Child	<b>Major Dental Care - Child</b>	<i>Not Covered</i>	<i>Not Covered</i>	50% After Deductible	<i>Not Covered</i>	<i>Not Covered</i>
Basic Dental Care - Adult	<b>Basic Dental Care - Adult</b>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>
Orthodontia - Adult	<b>Orthodontia - Adult</b>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>
Major Dental Care - Adult	<b>Major Dental Care - Adult</b>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>
Outpatient	<b>Abortion for Which Public Funding is Prohibited</b>	30% After Deductible	20% After Deductible	<i>Not Covered</i>	<i>Not in the Summary</i>	30% After Deductible
Organ Transplants	<b>Transplant</b>	30% After Deductible	20% After Deductible	20% After Deductible	<i>Not in the Summary</i>	\$0 After Deductible
Emergency Room Services	<b>Accidental Dental</b>	30% After Deductible	20% After Deductible	20% After Deductible	<i>Not in the Summary</i>	30% After Deductible
Outpatient	<b>Dialysis</b>	30% After Deductible	\$40 After Deductible	20% After Deductible	<i>Not in the Summary</i>	30%
Allergy Injections	<b>Allergy Testing</b>	30% After Deductible	\$40	20% After Deductible	<i>Not in the Summary</i>	30%
Outpatient	<b>Chemotherapy</b>	30% After Deductible	\$40 After Deductible	20% After Deductible	<i>Not in the Summary</i>	30%
	<b>Radiation</b>	30% After Deductible	\$40 After Deductible	20% After Deductible	<i>Not in the Summary</i>	30%
	<b>Diabetes Education</b>	30% After Deductible	\$30	\$0	<i>Not in the Summary</i>	\$35
Oregon Mandates (ORS 743 and 743A)	<b>Prosthetic Devices</b>	30% After Deductible	20% After Deductible	20% After Deductible	<i>Not in the Summary</i>	30% After Deductible
Outpatient	<b>Infusion Therapy</b>	30% After Deductible	\$40	20% After Deductible	<i>Not in the Summary</i>	30% After Deductible
Treatment for Temporomandibular Joint Disorders	<b>Treatment for Temporomandibular Joint Disorders</b>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not Covered</i>	<i>Not in the Summary</i>	<i>Not Covered</i>

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		Silver Standard	Silver A	Silver B	Silver C	Silver D
		ACA	ACA	ACA	Non-ACA	ACA
Outpatient	<b>Nutritional Counseling</b>	30% After Deductible	\$30	\$50	<i>Not in the Summary</i>	\$35 Copay Before Deductible
Cosmetic Surgery	<b>Reconstructive Surgery</b>	30% After Deductible	20% After Deductible	20% After Deductible	<i>Not in the Summary</i>	30% After Deductible
Oregon Mandates (ORS 743 and 743A)	<b>Clinical Trials</b>	30% After Deductible	\$0	20% After Deductible	<i>Not in the summary</i>	30% After Deductible
	<b>Inherited Metabolic Disorder - PKU</b>	30% After Deductible	\$0	20% After Deductible	<i>Not in the summary</i>	30% After Deductible
<i>Specialty Drugs</i>	<b>Off Label Prescription Drugs</b>	50%	30%	20% After Deductible	<i>Not in the summary</i>	\$50 Copay Before Deductible
<i>Specialty Drugs</i>	<b>Prescription Drugs Other</b>	50%	30%	20% After Deductible	<i>Not in the summary</i>	\$50 Copay Before Deductible
Breast Reconstruction	<b>Mastectomy-Related Coverage</b>	30% After Deductible	20% After Deductible	<i>Not in the Summary</i>	<i>Not in the summary</i>	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.	20% After Deductible	20% After Deductible	<i>Not in the summary</i>	30% After Deductible
Biofeedback	<i>Covered with same cost shares as Non-Specialist Visit</i>	\$35	\$30	\$25	\$30	\$35
Cardiac Rehabilitation	<i>Covered with the same cost shares as Rehabilitation</i>	\$35	\$40	20% After Deductible	\$30	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	20% After Deductible	20% After Deductible	30% 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	20% After Deductible	20% After Deductible	30% 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.	20% After Deductible	20% After Deductible	\$30 After Deductible	30% After Deductible
Sleep Studies	<i>Covered with the same cost shares as Outpatient Services</i>	30% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible	30% After Deductible
Vasectomy	<i>Covered with the same cost shares as under Outpatient Surgery</i>	30% After Deductible	20% After Deductible	20% After Deductible	30% After Deductible	30% After Deductible

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		Bronze Standard	Bronze A	Bronze B	Bronze C	Bronze D	Bronze E
		ACA	Non-ACA	Non-ACA	ACA	ACA	ACA
Deductible		Combined Medical and Drug: \$5,000	Combined Medical and Drug: \$5,000	Combined In/Out Network, Medical and Drug: \$7,500	Combined Medical and Drug: \$3,500	Combined Medical and Drug: \$4,500	Combined Medical and Drug: \$2,500
Maximum OOP		Combined Medical and Drug: \$6,350	Combined Medical and Drug: \$6,000	Combined Medical and Drug: \$4,000	Integrated Medical/Rx: \$6,500	Integrated Medical/Rx: \$6,350	Integrated Medical/Rx: \$6,250
Family Multiplier		2x Individual	Deductible: 3x Individual; MOOP: 2x Individual	3x 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>	\$60 After Deductible	\$35	\$35	\$50	\$50	50% After Deductible
Specialist Office Visit	<b>Specialist Visit</b>	\$100 After Deductible	<b>Not in the summary</b>	\$70	\$70	\$60	50% After Deductible
Other Practitioner Office Visit (Nurse, Physician Assistant)	<b>Other Practitioner Office Visit (Nurse, Physician Assistant)</b>	\$60 After Deductible	\$35	\$35	\$50	\$50	50% After Deductible
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<b>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</b>	50% After Deductible	30% After Deductible	15%	30% After Deductible	30% After Deductible	50% After Deductible
Outpatient Surgery physician/Surgical Services	<b>Outpatient Surgery Physician/Surgical Services</b>	50% After Deductible	30% After Deductible	20%	30% After Deductible	30% After Deductible	50% After Deductible
Hospice Services	<b>Hospice Services</b>	50% After Deductible	30% After Deductible	20%	\$0	\$0	50% After Deductible
Non-Emergency Care When Traveling Outside the U.S.	<b>Non-Emergency Care When Traveling Outside the U.S.</b>	<b>Not Covered</b>	<b>Not in the summary</b>	<b>Not in the summary</b>	<b>Not Covered</b>	<b>Not Covered</b>	50% After Deductible
Routine Dental Services (Adult)	<b>Routine Dental Services (Adult)</b>	<b>Not Covered</b>	<b>Not in the summary</b>	<b>Not in the summary</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>
Infertility Treatment	<b>Infertility Treatment</b>	<b>Not Covered</b>	<b>Not in the summary</b>	<b>Not in the summary</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>
Long-Term/Custodial Nursing	<b>Long-Term/Custodial Nursing</b>	<b>Not Covered</b>	<b>Not in the summary</b>	<b>Not in the summary</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>
Private-Duty Nursing	<b>Private-Duty Nursing</b>	<b>Not Covered</b>	<b>Not in the summary</b>	<b>Not in the summary</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>
Routine Eye Exam (Adult)	<b>Routine Eye Exam (Adult)</b>	<b>Not Covered</b>	<b>Not in the summary</b>	<b>Not in the summary</b>	\$50	\$50	<b>Not Covered</b>
Urgent Care Centers or Facilities	<b>Urgent Care Centers or Facilities</b>	\$120 After Deductible	\$35	\$50	\$70	\$70	50% After Deductible
Home Health Care Services	<b>Home Health Care Services</b>	50% After Deductible	\$0	\$0	30% After Deductible	30% After Deductible	50% After Deductible
Emergency Room Services	<b>Emergency Room Services</b>	50% After Deductible	\$250 co-pay/visit plus 30% co-insurance	20%	30% After Deductible	30% After Deductible	50% After Deductible
Emergency Transportation/ Ambulance	<b>Emergency Transportation/ Ambulance</b>	50% After Deductible	30% After Deductible	20%	30% After Deductible	30% After Deductible	50% After Deductible
Inpatient Hospital Services (e.g., Hospital Stay)	<b>Inpatient Hospital Services (e.g., Hospital Stay)</b>	50% After Deductible	30% After Deductible	20%	30% After Deductible	30% After Deductible	50% After Deductible
Inpatient Physician and Surgical Services	<b>Inpatient Physician and Surgical Services</b>	50% After Deductible	30% After Deductible	20%	30% After Deductible	30% After Deductible	50% After Deductible
Bariatric Surgery	<b>Bariatric Surgery</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not in the summary</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>
Cosmetic Surgery	<b>Cosmetic Surgery</b>	50% After Deductible	<b>Not Covered</b>	<b>Not in the summary</b>	30% After Deductible	30% After Deductible	50% After Deductible
Skilled Nursing Facility	<b>Skilled Nursing Facility</b>	50% After Deductible	30% After Deductible	20%	30% After Deductible	30% After Deductible	50% After Deductible
Prenatal and Postnatal Care	<b>Prenatal and Postnatal Care</b>	50% After Deductible	\$0	\$0	\$0	\$0	50% After Deductible
Delivery and All Inpatient Services for Maternity Care	<b>Delivery and All Inpatient Services for Maternity Care</b>	20% After Deductible	\$0	20%	30% After Deductible	30% After Deductible	50% 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.	\$35	\$35	\$50	\$50	50% After Deductible

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		Bronze Standard	Bronze A	Bronze B	Bronze C	Bronze D	Bronze E
		ACA	Non-ACA	Non-ACA	ACA	ACA	ACA
*Mental/Behavioral Health Inpatient Services	<b>Mental/Behavioral Health Inpatient Services</b>	50% After Deductible	30% After Deductible	20%	30% After Deductible	30% After Deductible	50% 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.	\$35	\$35	\$50	\$50	50% After Deductible
Substance Abuse Disorder Inpatient Services	<b>Substance Abuse Disorder Inpatient Services</b>	50% After Deductible	30% After Deductible	20%	30% After Deductible	30% After Deductible	50% After Deductible
Generic Drugs	<b>Generic Drugs</b>	\$20 After Deductible	\$10	<b>Not in the summary</b>	\$20 After Deductible	\$20 After Deductible	50% After Deductible
Preferred Brand Drugs	<b>Preferred Brand Drugs</b>	\$80 After Deductible	\$50	<b>Not in the summary</b>	\$75 After Deductible	\$60 After Deductible	50% After Deductible
Non-Preferred Brand Drugs	<b>Non-Preferred Brand Drugs</b>	50% After Deductible	\$75	<b>Not in the summary</b>	50% After Deductible	50% After Deductible	50% After Deductible
Specialty Drugs	<b>Specialty Drugs</b>	50% After Deductible	\$100 or 20%, whichever is less	<b>Not in the summary</b>	50% After Deductible	50% 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.	30% After Deductible	20%	\$60 After Deductible	\$60 After Deductible	50% After Deductible
*Inpatient Habilitation Services	<b>Habilitation Services</b>	50% After Deductible	30% After Deductible	20%	30% After Deductible	30% After Deductible	50% After Deductible
(Non-EHB) Chiropractic Care	<b>(Non-EHB) Chiropractic Care</b>	<b>Not Covered</b>	<b>Not in the summary</b>	<b>Not in the summary</b>	\$70	\$60	<b>Not Covered</b>
Durable Medical Equipment	<b>Durable Medical Equipment</b>	50% After Deductible	30% After Deductible	20%	30% After Deductible	30% After Deductible	50% After Deductible
Hearing Aids	<b>Hearing Aids</b>	50% After Deductible	<b>Not in the summary</b>	<b>Not in the summary</b>	30% After Deductible	30% After Deductible	50% After Deductible
Imaging (CT/PET Scans, MRIs)	<b>Imaging (CT/PET Scans, MRIs)</b>	50% After Deductible	\$100 co-pay/test plus 30% co-insurance	20%	30% After Deductible	30% After Deductible	50% After Deductible
ACA Preventive Services	<b>Preventive Care/ Screening/Immunization</b>	\$0	\$0	\$0	\$0	\$0	\$0
Routine Foot Care	<b>Routine Foot Care</b>	50% After Deductible	<b>Not in the summary</b>	<b>Not in the summary</b>	\$70	\$60	50% After Deductible
Acupuncture	<b>Acupuncture</b>	<b>Not Covered</b>	<b>Not in the summary</b>	<b>Not in the summary</b>	\$70	\$60	<b>Not Covered</b>
Weight Loss Programs	<b>Weight Loss Programs</b>	<b>Not Covered</b>	<b>Not in the summary</b>	<b>Not in the summary</b>	<b>Not Covered</b>	<b>Not Covered</b>	<b>Not Covered</b>

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		Bronze Standard	Bronze A	Bronze B	Bronze C	Bronze D	Bronze E
		ACA	Non-ACA	Non-ACA	ACA	ACA	ACA
Pediatric Vision Services	Routine Eye Exam for Children	\$0	Not in the summary	Not in the summary	\$0	\$0	\$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.	Not in the summary	Not in the summary	\$0	\$0	\$0
Dental Check-Up for Children	Dental Check-Up for Children	Not Covered	Not in the summary	Not in the summary	Not Covered	Not Covered	\$0
*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.	30% After Deductible	20%	\$60 After Deductible	\$60 After Deductible	50% After Deductible
	Rehabilitative Occupational and Rehabilitative Physical Therapy						
ACA Preventive Services	Well Baby Visits and Care	\$0	\$0	\$0	\$0	\$0	\$0
Diagnostic Test (X-Ray and Lab Work)	Laboratory Outpatient and Professional Services	50% After Deductible	No charge for the first \$400 of covered expense; then 30% co-insurance	20%	\$50	\$50	50% After Deductible
	X-rays and Diagnostic Imaging	50% After Deductible	No charge for the first \$400 of covered expense; then 30% co-insurance	20%	\$60	\$60	
Basic Dental Care - Child	Basic Dental Care - Child	Not Covered	Not in the summary	Not in the summary	Not Covered	Not Covered	20%
Orthodontia - Child	Orthodontia - Child	Not Covered	Not in the summary	Not in the summary	Not Covered	Not Covered	50%
Major Dental Care - Child	Major Dental Care - Child	Not Covered	Not in the summary	Not in the summary	Not Covered	Not Covered	50%
Basic Dental Care - Adult	Basic Dental Care - Adult	Not Covered	Not in the summary	Not in the summary	Not Covered	Not Covered	Not Covered
Orthodontia - Adult	Orthodontia - Adult	Not Covered	Not in the summary	Not in the summary	Not Covered	Not Covered	Not Covered
Major Dental Care - Adult	Major Dental Care - Adult	Not Covered	Not in the summary	Not in the summary	Not Covered	Not Covered	Not Covered
Outpatient	Abortion for Which Public Funding is Prohibited	50% After Deductible	Not in the summary	Not in the summary	30% After Deductible	30% After Deductible	50% After Deductible
Organ Transplants	Transplant	50% After Deductible	Not in the summary	Life Time Max Unlimited	30% After Deductible	30% After Deductible	50% After Deductible
Emergency Room Services	Accidental Dental	50% After Deductible	Not in the summary	Not in the summary	30% After Deductible	30% After Deductible	50% After Deductible
Outpatient	Dialysis	50% After Deductible	Not in the summary	Not in the summary	\$60 After Deductible	\$60 After Deductible	50% After Deductible
Allergy Injections	Allergy Testing	50% After Deductible	\$5	20%	\$70	\$60	50% After Deductible
Outpatient	Chemotherapy	50% After Deductible	Not in the summary	20%	\$60 After Deductible	\$60 After Deductible	50% After Deductible
	Radiation	50% After Deductible	Not in the summary	Not in the summary	\$60 After Deductible	\$60 After Deductible	50% After Deductible
	Diabetes Education	50% After Deductible	Not in the summary	Not in the summary	\$50	\$50	50% After Deductible
Oregon Mandates (ORS 743 and 743A)	Prosthetic Devices	50% After Deductible	Not in the summary	Not in the summary	30% After Deductible	30% After Deductible	50% After Deductible
Outpatient	Infusion Therapy	50% After Deductible	Not in the summary	Not in the summary	\$70	\$60	50% After Deductible
Treatment for Temporomandibular Joint Disorders	Treatment for Temporomandibular Joint Disorders	Not Covered	Not in the summary	50%	Not Covered	Not Covered	Not Covered

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		Bronze Standard	Bronze A	Bronze B	Bronze C	Bronze D	Bronze E
		ACA	Non-ACA	Non-ACA	ACA	ACA	ACA
Outpatient	Nutritional Counseling	50% After Deductible	Not in the summary	Not in the summary	\$50	\$50	50% After Deductible
Cosmetic Surgery	Reconstructive Surgery	50% After Deductible	Not in the summary	Not in the summary	30% After Deductible	30% After Deductible	50% After Deductible
Oregon Mandates (ORS 743 and 743A)	Clinical Trials	50% After Deductible	Not in the summary	Not in the summary	\$0	\$0	50% After Deductible
	Inherited Metabolic Disorder - PKU	50% After Deductible	Not in the summary	Not in the summary	\$0	\$0	50% After Deductible
Specialty Drugs	Off Label Prescription Drugs	50% After Deductible	Not in the summary	Not in the summary	50% After Deductible	50% After Deductible	50% After Deductible
Specialty Drugs	Prescription Drugs Other	50% After Deductible	Not in the summary	Not in the summary	50% After Deductible	50% After Deductible	50% After Deductible
Breast Reconstruction	Mastectomy-Related Coverage	50% After Deductible	Not in the summary	Not in the summary	30% After Deductible	30% After Deductible	Not in the summary
*Outpatient Rehabilitation Services	Brain Injury	\$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.	Not in the summary	Not in the summary	30% After Deductible	30% After Deductible	50% After Deductible
Biofeedback	Covered with same cost shares as Non-Specialist Visit	\$60 After Deductible	\$35	\$35	\$50	\$50	50% After Deductible
Cardiac Rehabilitation	Covered with the same cost shares as Rehabilitation	\$60 After Deductible	30% After Deductible	20%	\$60 After Deductible	\$60 After Deductible	50% After Deductible
Hospitalization for Dental Procedures	Covered with the same cost shares and visit limits of Inpatient and Outpatient Hospital Services	50% After Deductible	30% After Deductible	20%	30% After Deductible	30% After Deductible	50% After Deductible
*Inpatient Rehabilitation Services	Covered with the same cost shares and visit limits of Inpatient Habilitation Services	50% After Deductible	30% After Deductible	20%	30% After Deductible	30% After Deductible	50% After Deductible
*Outpatient Habilitation Services	Covered with the same cost shares and visit limits as Outpatient Rehabilitation Services	\$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.	30% After Deductible	20%	\$60 After Deductible	\$60 After Deductible	50% After Deductible
Sleep Studies	Covered with the same cost shares as Outpatient Services	50% After Deductible	30% After Deductible	20%	30% After Deductible	30% After Deductible	50% After Deductible
Vasectomy	Covered with the same cost shares as under Outpatient Surgery	50% After Deductible	30% After Deductible	20%	30% After Deductible	30% After Deductible	50% After Deductible