

Senate Bill 91 (2011) Standard Plan - EHB and Cost Share Matrix - Updated for 2016

*****NOT INTENDED AS A STATEMENT OF COVERAGE*****

Benefit as listed on the SB 91 Exhibit document	Gold	Silver	Bronze	Day/visit limits	EHB Category as listed on the Plan and Benefits Template
Deductible	Medical: \$1,250; Rx: \$0	Medical: \$2,500; Rx: \$0	Integrated Medical/Rx: \$5,000		
Maximum OOP	Combined Medical and Drug: \$6,350	Combined Medical and Drug: \$6,350	Combined Medical and Drug: \$6,350		
Family Multiplier	2x Individual	2x Individual	2x Individual		
Primary Care Office Visit to Treat an Injury or Illness	\$20	\$35	\$60 After Deductible		Primary Care Visit to Treat an Injury or Illness
Specialist Office Visit	\$40	\$70	\$100 After Deductible		Specialist Visit
Other Practitioner Office Visit (Nurse, Physician Assistant)	\$20	\$35	\$60 After Deductible		Other Practitioner Office Visit (Nurse, Physician Assistant)
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	10% After Deductible	30% After Deductible	50% After Deductible		Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
Outpatient Surgery Physician/Surgical Services	10% After Deductible	30% After Deductible	50% After Deductible		Outpatient Surgery Physician/Surgical Services
Hospice Services	10% After Deductible	30% After Deductible	50% After Deductible	Respite care - max of 5 consecutive days; lifetime max of 30 days	Hospice Services
Not covered in standard plan					Non-Emergency Care When Traveling Outside the U.S.
Not covered in standard plan					Routine Dental Services (Adult)
Not covered in standard plan					Infertility Treatment
Not covered in standard plan					Long-Term/Custodial Nursing

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<i>Not covered in standard plan</i>					Private-Duty Nursing
<i>Not covered in standard plan</i>					Routine Eye Exam (Adult)
Urgent Care Centers or Facilities	\$60	\$90	\$120 After Deductible		Urgent Care Centers or Facilities
Home Health Care Services	10% After Deductible	30% After Deductible	50% After Deductible		Home Health Care Services
Emergency Room Services	10% After Deductible	30% After Deductible	50% After Deductible		Emergency Room Services
Emergency Transportation/ Ambulance	10% After Deductible	30% After Deductible	50% After Deductible		Emergency Transportation/ Ambulance
Inpatient Hospital Services (e.g., Hospital Stay)	10% After Deductible	30% After Deductible	50% After Deductible		Inpatient Hospital Services (e.g., Hospital Stay)
Inpatient Physician and Surgical Services	10% After Deductible	30% After Deductible	50% After Deductible		Inpatient Physician and Surgical Services
<i>Not covered in standard plan</i>					Bariatric Surgery
Cosmetic Surgery	10% After Deductible	30% After Deductible	50% After Deductible		Cosmetic Surgery
Skilled Nursing Facility	10% After Deductible	30% After Deductible	50% After Deductible	60 days per year	Skilled Nursing Facility
Prenatal and Postnatal Care	10% After Deductible	30% After Deductible	50% After Deductible		Prenatal and Postnatal Care
Delivery and All Inpatient Services for Maternity Care	10% After Deductible	30% After Deductible	50% After Deductible		Delivery and All Inpatient Services for Maternity Care
*Mental/Behavioral Health Outpatient Services	Varies based on type/place of service. Please see the applicable service category.	Varies based on type/place of service. Please see the applicable service category.	Varies based on type/place of service. Please see the applicable service category.		Mental/Behavioral Health Outpatient Services

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*Mental/Behavioral Health Inpatient Services	10% After Deductible	30% After Deductible	50% After Deductible		Mental/Behavioral Health Inpatient Services
Substance Abuse Disorder Outpatient Services	Varies based on type/place of service. Please see the applicable service category.	Varies based on type/place of service. Please see the applicable service category.	Varies based on type/place of service. Please see the applicable service category.		Substance Abuse Disorder Outpatient Services
Substance Abuse Disorder Inpatient Services	10% After Deductible	30% After Deductible	50% After Deductible		Substance Abuse Disorder Inpatient Services
Generic Drugs	\$10	\$15	\$20 After Deductible		Generic Drugs
Preferred Brand Drugs	\$30	\$50	\$80 After Deductible		Preferred Brand Drugs
Non-Preferred Brand Drugs	50%	50%	50% After Deductible		Non-Preferred Brand Drugs
Specialty Drugs	50%	50%	50% After Deductible		Specialty Drugs
*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.	\$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.	\$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 (to 60) visits per year	Outpatient Rehabilitation Services
*Inpatient Habilitation Services	10% After Deductible	30% After Deductible	50% After Deductible	30 days per year	Habilitation Services
<i>Not covered in standard plan. Carriers must comply with federal Provider Non-discrimination provisions found in PHSA Section 2706(a).</i>					⁺Chiropractic Care
Durable Medical Equipment	10% After Deductible	30% After Deductible	50% After Deductible		Durable Medical Equipment

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Hearing Aids	10% After Deductible	30% After Deductible	50% After Deductible		Hearing Aids
Imaging (CT/PET Scans, MRIs)	10% After Deductible	30% After Deductible	50% After Deductible		Imaging (CT/PET Scans, MRIs)
ACA Preventive Services	\$0	\$0	\$0		Preventive Care/ Screening/Immunization
Routine Foot Care	10% After Deductible	30% After Deductible	50% After Deductible		Routine Foot Care
Not covered in standard plan					Acupuncture
Not covered in standard plan					Weight Loss Programs
Pediatric Vision Services	Exams at \$0 for these codes: 92002/92004, 92012/92014, S0620/S0621; for other codes cost shares may apply.				Routine Eye Exam 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.				Eye Glasses for Children
Not covered in standard plan					Dental Check-Up for Children
*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.	\$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.	\$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 (to 60) visits per year	Rehabilitative Speech Therapy
					Rehabilitative Occupational and Rehabilitative Physical Therapy

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ACA Preventive Services	\$0	\$0	\$0		Well Baby Visits and Care
Diagnostic Test (X-Ray and Lab Work)	10% After Deductible	30% After Deductible	50% After Deductible		Laboratory Outpatient and Professional Services
	10% After Deductible	30% After Deductible	50% After Deductible		X-rays and Diagnostic Imaging
<i>Not covered in standard plan</i>					Basic Dental Care - Child
<i>Not covered in standard plan</i>					Orthodontia - Child
<i>Not covered in standard plan</i>					Major Dental Care - Child
<i>Not covered in standard plan</i>					Basic Dental Care - Adult
<i>Not covered in standard plan</i>					Orthodontia - Adult
<i>Not covered in standard plan</i>					Major Dental Care - Adult
<i>Outpatient</i>	10% After Deductible	30% After Deductible	50% After Deductible		Abortion for Which Public Funding is Prohibited
Organ Transplants	10% After Deductible	30% After Deductible	50% After Deductible		Transplant
<i>Emergency Room Services</i>	10% After Deductible	30% After Deductible	50% After Deductible		Accidental Dental
<i>Outpatient</i>	10% After Deductible	30% After Deductible	50% After Deductible		Dialysis
Allergy Injections	10% After Deductible	30% After Deductible	50% After Deductible		Allergy Testing

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<i>Outpatient</i>	10% After Deductible	30% After Deductible	50% After Deductible		Chemotherapy
	10% After Deductible	30% After Deductible	50% After Deductible		Radiation
	10% After Deductible	30% After Deductible	50% After Deductible		Diabetes Education
Oregon Mandates (ORS 743 and 743A)	10% After Deductible	30% After Deductible	50% After Deductible		Prosthetic Devices
<i>Outpatient</i>	10% After Deductible	30% After Deductible	50% After Deductible		Infusion Therapy
<i>Not covered in standard plan</i>					<i>Treatment for Temporomandibular Joint Disorders</i>
<i>Outpatient</i>	10% After Deductible	30% After Deductible	50% After Deductible		Nutritional Counseling
Cosmetic Surgery	10% After Deductible	30% After Deductible	50% After Deductible		Reconstructive Surgery
Oregon Mandates (ORS 743 and 743A)	10% After Deductible	30% After Deductible	50% After Deductible		Clinical Trials
	10% After Deductible	30% After Deductible	50% After Deductible		Inherited Metabolic Disorder - PKU
<i>Specialty Drugs</i>	50%	50%	50% After Deductible		Off Label Prescription Drugs
<i>Specialty Drugs</i>	50%	50%	50% After Deductible		Prescription Drugs Other

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Breast Reconstruction	10% After Deductible	30% After Deductible	50% After Deductible		Mastectomy-Related Coverage
*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.	\$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.	\$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 (to 60) visits per year	Brain Injury
Biofeedback	\$20	\$35	\$60 After Deductible	10 treatments per lifetime	<i>Covered with same cost shares as Non-Specialist Visit</i>
Cardiac Rehabilitation	\$20	\$35	\$60 After Deductible	36 sessions of cardiac rehabilitation exercise	<i>Covered with the same cost shares as Rehabilitation</i>
Hospitalization for Dental Procedures	10% After Deductible	30% After Deductible	50% After Deductible		<i>Covered with the same cost shares and visit limits of Inpatient and Outpatient Hospital Services</i>
*Inpatient Rehabilitation Services	10% After Deductible	30% After Deductible	50% After Deductible	30 days per year	<i>Covered with the same cost shares and visit limits of Inpatient Habilitation Services</i>
*Outpatient Habilitation 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.	\$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.	\$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 (to 60) visits per year	<i>Covered with the same cost shares and visit limits as Outpatient Rehabilitation Services</i>

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Sleep Studies	10% After Deductible	30% After Deductible	50% After Deductible		<i>Covered with the same cost shares as Outpatient Services</i>
Vasectomy	10% After Deductible	30% After Deductible	50% After Deductible		<i>Covered with the same cost shares as under Outpatient Surgery</i>
<p>*Mental Health Services covered under Habilitation and Rehabilitation must comply with state and federal rules on Mental Health Parity. Carriers should review state and federal laws regarding mental health parity for benefits and limitations, including visit limitations, in relation to requirements outlined in http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf. If carriers apply benefit limitations to mental health services the carrier will be required to prove compliance with state and federal law.</p>					
<p>[†]Chiropractic Care: Benefits otherwise covered by the plan must be covered if provided by a doctor of chiropractic acting within the scope of their license. (PHSA 2706(a))</p>					
<p>Most cost shares apply to in-network benefits only. Out-of-network benefits, if available, are defined by the insurer. Emergency Services must be covered at the same cost share for both in and out-of-network, however, different maximum out-of-pocket costs and balance billing may apply. Provider contracting varies between insurers.</p>					