2017 Platinum Mirror Plan Summary of Benefits and Coverage Effective 1/1/2017

Individual/Family Overall Annual Deductible	$0
Individual/Family Out–of–Pocket Maximum	$4,000/$8,000

Common Medical Event	Service Type	Member Cost Share
Health Care Provider's Office or Clinic Visit	Office Visits – PCP or Primary Care (including Mental Health)	$15 per visit
	Office Visits – Specialist	$40 per visit
	Office Visits - Other Healthcare Practitioners	$15 per visit
	Preventive Care/Screening/Immunization	No Copay
Tests	Laboratory Tests	$20 per visit
	X-rays and Diagnostic Imaging	$40 per visit
	Imaging – (CT/Pet Scans, MRIs)	$150 per visit
Outpatient Prescription Drug Coverage to treat illness or condition	Tier 1	$5 per drug
	Tier 2	$15 per drug
	Tier 3	$25 per drug
	Tier 4	10%, up to $250 per script
Outpatient Services	Surgery Facility Fee	$250 per visit
	Physician/Surgeon Fees	$40
	Outpatient visit	10%
Need Immediate Attention	Emergency Room Facility Fee (waived if admitted)	$150
	Emergency Room Physician Fees (waived if admitted)	No Copay
	Ambulance Services or emergency medical transportation	$150
	Urgent Care in Mexico	$15 per visit
	Urgent Care outside of Mexico	$15 per visit
Hospital Stays	Inpatient Hospital Facility Fees	$250 per day, up to 5 days
	Inpatient Physician/Surgeon Fees	$40
Mental Health, Behavioral Health, or Substance Abuse Needs	Mental/Behavioral health outpatient office visits	$15 per visit
	Mental/Behavioral health other outpatient items and services	$15
	Mental/Behavioral health inpatient services (hospital room)	$250 per day, up to 5 days
	Mental/Behavioral health inpatient physician/surgeon fee	$40
	Substance use disorder outpatient office visits	$15 per visit
	Substance use disorder other outpatient items and services	$15
	Substance use disorder inpatient facility fee (hospital room)	$250 per day, up to 5 days
	Substance use disorder inpatient physician/surgeon fee	$40
Pregnancy	Prenatal care and preconception visits	No Copay
	Delivery and all inpatient services – Hospital	$250 per day, up to 5 days
	Delivery and all inpatient services – Professional	$40
Help Recovering or other Special Health Needs	Home health care	$20 per visit
	Outpatient Rehabilitation/Habilitation Therapy Services	$15 per visit
	Skilled Nursing Care	$150 per day, up to 5 days
	Durable Medical Equipment (including Diabetic Equipment)	10%
	Prosthetics/Orthotics	10%
	Hospice Services	No Copay
Child Eye Care	Eye exam	No Copay
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No Copay
Child Dental Diagnostic and Preventive	Oral Exam	No Copay
	Preventive – Cleaning & Xray	No Copay
	Sealants per Tooth	No Copay
	Topical Fluoride Application	No Copay
	Space Maintainers – Fixed	No Copay
Child Dental Basic Services	Amalgam Fill - 1 Surface	$25
Child Dental Major Services	Root Canal- Molar	$300
	Gingivectomy per Quad	$150
	Extraction- Single Tooth Exposed Root or Erupted	$65
	Extraction- Complete Bony	$160
	Porcelain with Metal Crown	$300
Child Orthodontics	Medically necessary orthodontics	$350

See Endnotes

Endnotes:

1) Family out-of-pocket maximums are equal to 2 times the individual values. Cost sharing payments (copayments and coinsurance, but not yet premiums) made by each individual in a family contribute to the family out-of-pocket maximums. Once the family out-of-pocket maximum is reached, the plan pays all costs for covered services for all family members. In a family plan, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.
2) The cost-sharing payments cannot exceed the out of pocket limits set for self-only coverage and family coverage.
3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount (the maximum amount on which payment is based for covered health care services).
4) In the Platinum and Gold Copay Plans, hospital, in-patient and skilled nursing facility stays have no additional cost share after 5 days.
5) For drugs to treat an illness or condition the supply of drugs for which the copay or coinsurance applies is for the prescription term, not to exceed 30 days.
6) Preventive Care Includes checkups; periodic screenings; Well-baby visits up to age 2; Well-woman visits; Pap and HPV tests; Maternity/prenatal care; Immunizations for children; Vision and hearing exams; health education classes.
7) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's out-of-pocket maximum.
8) Copayments may never exceed the Plan's actual cost of the service. For example, if laboratory tests cost less than the $20 copayment, the lesser amount is the Member's applicable cost-sharing amount.
9) Member's cost-sharing amount for oral anti-cancer drugs shall not exceed $200 per month per state law.
10) The Outpatient Visit line item within the Outpatient Services category includes but is not limited to the following types of outpatient visits: outpatient chemotherapy, outpatient radiation, outpatient infusion therapy and outpatient dialysis and similar outpatient services.
11) Cost-sharing for services subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA) may be less than those listed in these standard benefit plan designs if necessary for compliance with MHPAEA.
12) Drug tiers are defined as follows:

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