



FOR SMALL BUSINESS

2016 Standard Benefits  
Covered California for Small Business

Key Benefits	Platinum (90%)				
	Platinum 90 Coinsurance Plans: •Health Net Platinum 90 PPO •Health Net Platinum 90 PPO + INF •Sharp Platinum 90 Network 2	Platinum 90 Coinsurance (Out of Network) •Health Net Platinum 90 PPO Out of Network	Platinum 90 Copay Plans: •Blue Shield Platinum 90 HMO •CCHP Platinum 90 HMO •Sharp Platinum 90 HMO Network 1 •Western Health Advantage Platinum 90 HMO		•Kaiser Platinum 90 HMO Alternate •Kaiser Platinum 90 HMO
	Benefits in blue are subject to deductibles		Copays in the yellow sections are not subject to any deductible and count towards the Annual Out-of-Pocket Maximum		
Individual Deductible (if any)	\$0	\$0	\$0	\$0	\$0
Family Deductible (if any)	\$0	\$0	\$0	\$0	\$0
Preventative Care Copay	No Charge	100%	No Charge	No Charge	No Charge
Primary Care Visit Copay	\$20	50%	\$20	\$15	\$20
Specialty Care Visit Copay	\$40	50%	\$40	\$15	\$40
Prenatal Care and Preconception Visit	No Charge	50%	No Charge	No Charge	No Charge
Urgent Care Visit Copay	\$40	50%	\$40	\$15	\$20
Lab Testing Copay	\$20	50%	\$20	\$20	\$20
X-Ray Copay	\$40	50%	\$40	\$40	\$40
Emergency Room Copay (waived if admitted)	\$150	\$150	\$150	\$150	\$150
Outpatient Hospital Facility Fee	10%	50%	\$250 per day (up to 5 days)	\$250	\$290
Inpatient Physician/Surgeon Fee	10%	50%	\$40	No Charge	\$40 per day (up to 5 days)
Inpatient Hospital Stay Facility Fee	10%	50%	\$250 per day (up to 5 days)	\$250	\$250 per day (up to 5 days)
Durable Medical Equipment	10%	100%	10%	10%	10%
Imaging (MRI, CT, PED Scans)	10%	50%	\$150	\$100	\$150
Tier 1 (Generic Drugs)	\$5	100%	\$5	\$5	\$5
Tier 2 (Preferred Brand Drugs)	\$15	100%	\$15	\$15	\$15
Tier 3 (Nonpreferred Brand Drugs)	\$25	100%	\$25	\$15	\$15
Tier 4 (Specialty Drugs)	10% (up to \$250 per script)	100%	10% (up to \$250 per script)	10% (up to \$250 per script)	10% (up to \$250 per script)
Mental/Behavior Health Outpatient Services	\$20	50%	\$20	\$15	\$20
Mental/Behavior Health Inpatient Services	10%	50%	\$250 per day (up to 5 days)	\$250	\$290 per day (up to 5 days)
Substance Use Disorder Outpatient Services	\$20	50%	\$20	\$15	\$20
Substance Use Disorder Inpatient Services	10%	50%	\$250 per day (up to 5 days)	\$250	\$290 per day (up to 5 days)
Embedded Pediatric Dental	Health Net: Not Embedded	Not Embedded	Pediatric Dental Embedded	Not Embedded	Not Embedded
	Sharp: Pediatric Dental Embedded				
<b>MAXIMUM OUT-OF-POCKET FOR ONE</b>	\$4,000	\$8,000	\$4,000	\$2,500	\$4,000
<b>MAXIMUM OUT-OF-POCKET FOR FAMILY</b>	\$8,000	\$16,000	\$8,000	\$5,000	\$8,000

Please note: this document is a high level benefit overview and is not intended as a substitution for the Summary of Benefits and Coverage (SBC) which can be viewed online at [www.coveredca.com](http://www.coveredca.com) or requested from the Covered California for Small Business Customer Service Center at 877-453-9198.

\* Deductible waived first three visits

\*\*Up to \$500 per script after pharmacy deductible

**Notes**

- 1) Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. In-network services include services provided by an out-of-network provider but are approved as in-network by the carrier.
- 2) For covered out of network services in a PPO plan, these Standard Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
- 3) Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
- 4) For plans except HDHPs linked to HSA plans, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the carrier pays all costs for covered services for all family members.
- 5) For HDHPs linked to HSAs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of the specified deductible amount for individual coverage or \$2600 for Plan Year 2016. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.



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Key Benefits	Gold (80%)					
	Gold 80 Coinsurance Plans: *Health Net Gold 80 PPO *Health Net Gold 80 PPO + INF *Sharp Gold 80 Network 2	Gold 80 Coinsurance Out of Network *Health Net Gold 80 Coinsurance Out of Network	*Blue Shield Gold 80 HMO *CCHP Gold 80 HMO *Sharp Gold 80 HMO Network 1 *Western Health Advantage Gold 80	Gold 80 Copay Plans: *Health Net Gold 80 EPO Alternate *Health Net Gold 80 EPO Alternate + INF	*Kaiser Gold 80 HMO Alternate	*Kaiser Gold 80 HMO
	Benefits in blue are subject to deductibles			Copays in the yellow sections are not subject to any deductible and count towards the Annual Out-of-Pocket Maximum		
Individual Deductible (if any)	\$0	\$0	\$0	\$1,000	\$500	\$0
Family Deductible (if any)	\$0	\$0	\$0	\$2,000	\$1,000	\$0
Preventative Care Copay	No Charge	100%	No Charge	No Charge	No Charge	No Charge
Primary Care Visit Copay	\$35	50%	\$35	\$20	\$30	\$35
Specialty Care Visit Copay	\$55	50%	\$55	\$30	\$30	\$55
Prenatal Care and Preconception Visit	No Charge	50%	No Charge	No Charge	No Charge	No Charge
Urgent Care Visit Copay	\$60	50%	\$60	\$60	\$30	\$35
Lab Testing Copay	\$35	50%	\$35	\$20 Copay after deductible	\$20	\$35
X-Ray Copay	\$50	50%	\$50	\$30 Copay after deductible	\$20	\$50
Emergency Room Copay (waived if admitted)	\$250	\$250	\$250	\$175	\$250 Copay after deductible	\$250
Outpatient Hospital Facility Fee	20%	50%	\$600 per day (up to 5 days)	20% Coinsurance after deductible	\$600 Copay after deductible	\$655
Inpatient Physician/Surgeon Fee	20%	50%	\$55	20% Coinsurance after deductible	No Charge	\$55
Inpatient Hospital Stay Facility Fee	20%	50%	\$600 per day (up to 5 days)	20% Coinsurance after deductible	\$600 per day (up to 5 days) after deductible	\$600 per day (up to 5 days)
Durable Medical Equipment	20%	100%	20%	20% Coinsurance after deductible	20%	20%
Imaging (MRI, CT, PED Scans)	20%	50%	\$250	20% Coinsurance after deductible	\$250	\$250
Tier 1 (Generic Drugs)	\$15	100%	\$15	\$5	\$15	\$15
Tier 2 (Preferred Brand Drugs)	\$50	100%	\$50	\$15	\$50	\$50
Tier 3 (Nonpreferred Brand Drugs)	\$70	100%	\$70	20% Coinsurance after deductible	\$50	\$50
Tier 4 (Specialty Drugs)	20% (up to \$250 per script)	100%	20% (up to \$250 per script)	20% Coinsurance after deductible	20% (up to \$250 per script)	20% (up to \$250 per script)
Mental/Behavior Health Outpatient Services	\$35	50%	\$35	\$20	\$30	\$35
Mental/Behavior Health Inpatient Services	20%	50%	\$600 per day (up to 5 days)	20% Coinsurance after deductible	\$600 per day (up to 5 days) after deductible	\$655 per day (up to 5 days)
Substance Use Disorder Outpatient Services	\$35	50%	\$35	\$20	\$30	\$35
Substance Use Disorder Inpatient Services	20%	50%	\$600 per day (up to 5 days)	20% Coinsurance after deductible	\$600 per day (up to 5 days) after deductible	\$655 per day (up to 5 days)
Embedded Pediatric Dental	Health Net: Not Embedded Sharp: Pediatric Dental Embedded	Not Embedded	Pediatric Dental Embedded	Not Embedded	Not Embedded	Not Embedded
<b>MAXIMUM OUT-OF-POCKET FOR ONE</b>	\$6,200	\$12,400	\$6,200	\$4,500	\$6,250	\$6,200
<b>MAXIMUM OUT-OF-POCKET FOR FAMILY</b>	\$12,400	\$24,800	\$12,400	\$9,000	\$12,500	\$12,400

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\* Deductible waived first three visits  
\*\*Up to \$500 per script after pharmacy deductible

**Notes**

- Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. In-network services include services provided by an out-of-network provider but are approved as in-network by the carrier.
- For covered out of network services in a PPO plan, these Standard Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
- Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
- For plans except HDHPs linked to HSA plans, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the carrier pays all costs for covered services for all family members.
- For HDHPs linked to HSAs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of the specified deductible amount for individual coverage or \$2600 for Plan Year 2016. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.



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Key Benefits	Silver (70%)						
	Silver 70 Coinsurance Plans: •Health Net Silver 70 PPO •Health Net Silver 70 PPO + INF •Sharp Silver 70 HMO Network 2	Silver 70 Coinsurance Out of Network •Health Net Silver 70 PPO Out of Network	•Blue Shield Silver 70 HMO •CCHP Silver 70 HMO •Sharp Silver 70 HMO Network 1 •Western Health Advantage Silver 70 HMO	Silver 70 Copay Plans: •Kaiser Silver 70 HMO	•Kaiser Silver 70 HMO Alternate	Silver 70 HSA Plans: •Sharp Silver 70 HSA HMO Network 1 •Western Health Advantage Silver 70 HSA HMO	Silver 70 EPO Plans: •Health Net Silver 70 EPO Alternative •Health Net Silver 70 EPO + INF Alternative
	Benefits in blue are subject to deductibles			Copays in the yellow sections are not subject to any deductible and count towards the Annual Out-of-Pocket Maximum			
Deductible (if any)	\$1,500 Medical/ \$250 Pharmacy/ \$0 Dental	\$3,000	\$1,500 Medical/ \$250 Pharmacy/ \$0 Dental	\$1,500 Medical/ \$250 Pharmacy	\$1,000	\$2,000 Integrated	\$1,800
Family Deductible (if any)	\$3,000 Medical/ \$500 Pharmacy/ \$0 Dental	\$6,000	\$3,000 Medical/ \$500 Pharmacy/ \$0 Dental	\$3,000 Medical/ \$500 Pharmacy	\$2,000	\$4,000 Integrated	\$3,600
Preventative Care Copay	No Charge	100%	No Charge	No Charge	No Charge	No Charge	No Charge
Primary Care Visit Copay	\$45	50% Coinsurance after deductible	\$45	\$45	\$50	20% Coinsurance after deductible	\$30
Specialty Care Visit Copay	\$70	50% Coinsurance after deductible	\$70	\$70	\$50	20% Coinsurance after deductible	\$50
Prenatal Care and Preconception Visit	No Charge	50% Coinsurance after deductible	No Charge	No Charge	No Charge	No Charge	No Charge
Urgent Care Visit Copay	\$90	50% Coinsurance after deductible	\$90	\$45	\$50	20% Coinsurance after deductible	\$100
Lab Testing Copay	\$35	50% Coinsurance after deductible	\$35	\$35	\$40	20% Coinsurance after deductible	\$50 Copay after deductible
X-Ray Copay	\$65	50% Coinsurance after deductible	\$65	\$65	\$40	20% Coinsurance after deductible	\$60 Copay after deductible
Emergency Room Copay (waived if admitted)	\$250	\$250 Copay after deductible	\$250	\$300 Copay after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	\$300
Outpatient Hospital Facility Fee	20%	50% Coinsurance after deductible	20%	20%	30% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Inpatient Physician/Surgeon Fee	20%	50% Coinsurance after deductible	20%	20%	30% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Inpatient Hospital Stay Facility Fee	20%	50% Coinsurance after deductible	20%	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Durable Medical Equipment	20%	100%	20%	20%	30%	20% Coinsurance after deductible	50% Coinsurance after deductible
Imaging (MRI, CT, PED Scans)	20%	50% Coinsurance after deductible	\$250	\$250	30% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Tier 1 (Generic Drugs)	\$15	100%	\$15	\$15	\$25	20% Coinsurance after deductible	\$10
Tier 2 (Preferred Brand Drugs)	\$55	100%	\$55	\$55 after pharmacy deductible	\$50	20% Coinsurance after deductible	\$55
Tier 3 (Nonpreferred Brand Drugs)	\$75	100%	\$75	\$55 after pharmacy deductible	\$50	20% Coinsurance after deductible	50% Coinsurance after deductible
Tier 4 (Specialty Drugs)	20% (up to \$250 per script)	100%	20% (up to \$250 per script)	20% (up to \$250 per script) after pharmacy deductible	20% (up to \$250 per script)	20% Coinsurance after deductible	50% Coinsurance after deductible
Mental/Behavior Health Outpatient Services	\$45	50% Coinsurance after deductible	\$45	\$45	\$50	20% Coinsurance after deductible	\$30
Mental/Behavior Health Inpatient Services	20% Coinsurance after deductible	50% Coinsurance after deductible	20%	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Substance Use Disorder Outpatient Services	\$45	50% Coinsurance after deductible	\$45	\$45	\$50	20% Coinsurance after deductible	\$30
Substance Use Disorder Inpatient Services	20% Coinsurance after deductible	50% Coinsurance after deductible	20%	20% Coinsurance after deductible	30% Coinsurance after deductible	20% Coinsurance after deductible	50% Coinsurance after deductible
Embedded Pediatric Dental	Health Net: Not Embedded	Not Embedded	Pediatric Dental Embedded	Not Embedded	Not Embedded	Pediatric Dental Embedded	Not Embedded
	Sharp: Pediatric Dental Embedded						
MAXIMUM OUT-OF-POCKET FOR ONE	\$6,500	\$13,000	\$6,500	\$6,500	\$6,500	\$6,250	\$6,500
MAXIMUM OUT-OF-POCKET FOR FAMILY	\$13,000	\$26,000	\$13,000	\$13,000	\$13,000	\$12,500	\$13,000

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\*\*Up to \$500 per script after pharmacy deductible

**Notes**

- Any and all cost-sharing payments for in-network covered services apply to the out-of-pocket maximum. If a deductible applies to the service, cost sharing payments for all in-network services accumulate toward the deductible. In-network services include services provided by an out-of-network provider but are approved as in-network by the carrier.
- For covered out of network services in a PPO plan, these Standard Benefit Plan Designs do not determine cost sharing, deductible, or maximum out-of-pocket amounts. See the applicable PPO's Evidence of Coverage or Policy.
- Cost-sharing payments for drugs that are not on-formulary but are approved as exceptions accumulate toward the Plan's in-network out-of-pocket maximum.
- For plans except HDHPs linked to HSA plans, in coverage other than self-only coverage, an individual's payment toward a deductible, if required, is limited to the individual annual deductible amount. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum. After a family satisfies the family out-of-pocket maximum, the carrier pays all costs for covered services for all family members.
- For HDHPs linked to HSAs, in other than self-only coverage, an individual's payment toward a deductible, if required, must be the higher of the specified deductible amount for individual coverage or \$2600 for Plan Year 2016. In coverage other than self-only coverage, an individual's out of pocket contribution is limited to the individual's annual out of pocket maximum.



**2016 Standard Benefits  
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Key Benefits	Bronze 60 Coinsurance Plans:	Bronze 60 Out of Network Plans:	Bronze (60%)		
	•Health Net Bronze 60 PPO •Health Net Bronze 60 PPO + INF •Blue Shield Bronze 60 PPO •Blue Shield Bronze 60 PPO + INF •CCHP Bronze HMO •Sharp Bronze 60 HMO Network 2 •Western Health Advantage Bronze 60 HMO	•Health Net Bronze 60 PPO Out of Network •Blue Shield Bronze 60 PPO Out of Network	Bronze 60 Copay Plans: •Kaiser Bronze HMO	Bronze 60 HSA Plans: •Kaiser Bronze 60 HSA HMO •Sharp Bronze 60 HSA HMO Network 1 •Western Health Advantage Bronze 60 HSA HMO 4500/40	•Western Health Advantage Bronze 60 HSA HMO 6000/0
	Benefits in blue are subject to deductibles		Copays in the yellow sections are not subject to any deductible and count towards the Annual Out-of-Pocket Maximum		
Individual Deductible (if any)	\$6,000 Medical/ \$500 Pharmacy/ \$0 Dental	\$12,000	\$6,000 Medical/ \$500 Pharmacy	\$4,500 Integrated	\$6,000
Family Deductible (if any)	\$12,000 Medical/ \$1,000 Pharmacy/ \$0 Dental	\$24,000	\$12,000 Medical/ \$1,000 Pharmacy	\$9,000 Integrated	\$12,000
Preventative Care Copay	No Charge	100%	No Charge	No Charge	No Charge
Primary Care Visit Copay	\$70*	50% Coinsurance after deductible	\$70* Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible
Specialty Care Visit Copay	\$90*	50% Coinsurance after deductible	\$90* Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible
Prenatal Care and Preconception Visit	No Charge	50% Coinsurance after deductible	No Charge	No Charge	No Charge
Urgent Care Visit Copay	\$120*	50% Coinsurance after deductible	\$70* Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible
Lab Testing Copay	\$40	50% Coinsurance after deductible	\$40	40% Coinsurance after deductible	0% Coinsurance after deductible
X-Ray Copay	100%	100% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible
Emergency Room Copay (waived if admitted)	100%	100% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible
Outpatient Hospital Facility Fee	100%	100% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible
Inpatient Physician/Surgeon Fee	100%	100% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible
Inpatient Hospital Stay Facility Fee	100%	100% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible
Durable Medical Equipment	100%	100%	100% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible
Imaging (MRI, CT, PED Scans)	100%	100% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible
Tier 1 (Generic Drugs)	100%**	100%	100% Coinsurance after deductible**	40% Coinsurance after deductible	0% Coinsurance after deductible
Tier 2 (Preferred Brand Drugs)	100%**	100%	100% Coinsurance after deductible**	40% Coinsurance after deductible	0% Coinsurance after deductible
Tier 3 (Nonpreferred Brand Drugs)	100%**	100%	100% Coinsurance after deductible**	40% Coinsurance after deductible	0% Coinsurance after deductible
Tier 4 (Specialty Drugs)	100%**	100%	100% Coinsurance after deductible**	40% Coinsurance after deductible	0% Coinsurance after deductible
Mental/Behavior Health Outpatient Services	\$70*	50% Coinsurance after deductible	\$70 Copay after deductible*	40% Coinsurance after deductible	0% Coinsurance after deductible
Mental/Behavior Health Inpatient Services	100%	100% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible
Substance Use Disorder Outpatient Services	\$70*	50% Coinsurance after deductible	\$70 Copay after deductible*	40% Coinsurance after deductible	0% Coinsurance after deductible
Substance Use Disorder Inpatient Services	100%	100% Coinsurance after deductible	100% Coinsurance after deductible	40% Coinsurance after deductible	0% Coinsurance after deductible
Embedded Pediatric Dental	Health Net: Not Embedded	Not Embedded	Not Embedded	Kaiser: Not Embedded	Pediatric Dental Embedded
	Blue Shield, CCHP, Sharp, Western Health: Pediatric Dental Embedded			Sharp & Western Health: Pediatric Dental Embedded	
MAXIMUM OUT-OF-POCKET FOR ONE	\$6,500	\$13,000	\$6,500	\$6,500	\$6,000
MAXIMUM OUT-OF-POCKET FOR FAMILY	\$13,000	\$26,000	\$13,000	\$13,000	\$12,000

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