

**Covered California**  
**Standard Benefit Plan Designs - FINAL**  
**Summary of Benefits and Coverage**

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

2/25/2013

Actuarial Value - Final AV Calculator

	Platinum Coinsurance Plan	Platinum Copay Plan
Overall deductible	\$0	\$0
Other deductibles for specific services		
Medical	\$0	\$0
Brand Drugs	\$0	\$0
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$4,000	\$4,000

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	\$20		\$20	
	Specialist visit	\$40		\$40	
	Other practitioner office visit	\$20		\$20	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	\$20		\$20	
	X-rays and Diagnostic Imaging	\$40		\$40	
	Imaging (CT/PET scans, MRIs)	10%		\$150	
Drugs to treat illness or condition	Generic drugs	\$5		\$5	
	Preferred brand drugs	\$15		\$15	
	Non-preferred brand drugs	\$25		\$25	
	Specialty drugs	10%		10%	
Outpatient surgery	Facility fee (e.g., ASC)	10%		\$250	
	Physician/surgeon fees	10%			
Need immediate attention	Emergency room services (waived if admitted)	\$150		\$150	
	Emergency medical transportation	\$150		\$150	
	Urgent care	\$40		\$40	
Hospital stay	Facility fee (e.g., hospital room)	10%		\$250 per day up to 5 days	
	Physician/surgeon fee	10%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20		\$20	
	Mental/Behavioral health inpatient services	10%		\$250 per day up to 5 days	
	Substance use disorder outpatient services	\$20		\$20	
	Substance use disorder inpatient services	10%		\$250 per day up to 5 days	
Pregnancy	Prenatal and postnatal care	\$20		\$20	
	Delivery and all inpatient services	Hospital	10%	\$250 per day up to 5 days	
		Professional	10%		
Help recovering or other special health needs	Home health care	10%		\$20	
	Rehabilitation services	\$20		\$20	
	Habilitation services	\$20		\$20	
	Skilled nursing care	10%		\$150 per day up to 5 days	
	Durable medical equipment	10%		10%	
Child needs dental or eye care	Hospice service	No cost share		No cost share	
	Eye exam (deductible waived)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic Dental Basic Services Dental Restorative and Orthodontia Services	See attachment		See attachment	

- Notes:**
- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
  - 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
  - 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
  - 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or outpatient Mental Health/Substance Abuse visits.
  - 5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
  - 6) Glasses benefit limited to \$100 per year.
  - 7) Dental benefits are described on separate attachment. For pediatric oral care, the high option dental benefits are paired with the Platinum and Gold medical metal tier plans and the low option benefits are paired with the Silver and Bronze tier plans.

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	Gold Coinsurance Plan	Gold Copay Plan
Overall deductible	\$0	\$0
Other deductibles for specific services		
Medical	\$0	\$0
Brand Drugs	\$0	\$0
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$6,400	\$6,400

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	\$30		\$30	
	Specialist visit	\$50		\$50	
	Other practitioner office visit	\$30		\$30	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	\$30		\$30	
	X-rays and Diagnostic Imaging	\$50		\$50	
	Imaging (CT/PET scans, MRIs)	20%		\$250	
Drugs to treat illness or condition	Generic drugs	\$20		\$20	
	Preferred brand drugs	\$50		\$50	
	Non-preferred brand drugs	\$70		\$70	
	Specialty drugs	20%		20%	
Outpatient surgery	Facility fee (e.g., ASC)	20%		\$600	
	Physician/surgeon fees	20%			
Need immediate attention	Emergency room services (waived if admitted)	\$250		\$250	
	Emergency medical transportation	\$250		\$250	
	Urgent care	\$60		\$60	
Hospital stay	Facility fee (e.g., hospital room)	20%		\$600 per day up to 5 days	
	Physician/surgeon fee	20%			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$30		\$30	
	Mental/Behavioral health inpatient services	20%		\$600 per day up to 5 days	
	Substance use disorder outpatient services	\$30		\$30	
	Substance use disorder inpatient services	20%		\$600 per day up to 5 days	
Pregnancy	Prenatal and postnatal care	\$30		\$30	
	Delivery and all inpatient services	Hospital	20%	\$600 per day up to 5 days	
		Professional	20%		
Help recovering or other special health needs	Home health care	20%		\$30	
	Rehabilitation services	\$30		\$30	
	Habilitation services	\$30		\$30	
	Skilled nursing care	20%		\$300 per day up to 5 days	
	Durable medical equipment	20%		20%	
	Hospice service	No cost share		No cost share	
Child needs dental or eye care	Eye exam (deductible waived)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic	See attachment		See attachment	
	Dental Basic Services				
Dental Restorative and Orthodontia Services					

**Notes:**

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
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- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or outpatient Mental Health/Substance Abuse visits.
- 5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
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2/25/2013

Actuarial Value - Final AV Calculator

	Individual	Individual
	Silver Coinsurance Plan	Silver Copay Plan
	68.7%	68.3%
	N/A	N/A
<b>Overall deductible</b>		
<b>Other deductibles for specific services</b>		
<b>Medical</b>	\$2,000	\$2,000
<b>Brand Drugs</b>	\$250	\$250
<b>Dental</b>	See attachment	See attachment
<b>Out-of-pocket limit on expenses</b>	\$6,400	\$6,400

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
<b>Visit to a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness (see footnote)	\$45		\$45		
	Specialist visit	\$65		\$65		
	Other practitioner office visit	\$45		\$45		
	Preventive care/ screening/ immunization	No cost share		No cost share		
<b>Tests</b>	Laboratory Tests	\$45		\$45		
	X-rays and Diagnostic Imaging	\$65		\$65		
	Imaging (CT/PET scans, MRIs)	20%	X	\$250		
<b>Drugs to treat illness or condition</b>	Generic drugs	\$25		\$25		
	Preferred brand drugs	\$50	X	\$50	X	
	Non-preferred brand drugs	\$70	X	\$70	X	
	Specialty drugs	20%	X	20%	X	
<b>Outpatient surgery</b>	Facility fee (e.g., ASC)	20%	X	20%	X	
	Physician/surgeon fees	20%				
<b>Need immediate attention</b>	Emergency room services (waived if admitted)	\$250	X	\$250	X	
	Emergency medical transportation	\$250	X	\$250	X	
	Urgent care	\$90		\$90		
<b>Hospital stay</b>	Facility fee (e.g., hospital room)	20%	X	20%	X	
	Physician/surgeon fee	20%				
<b>Mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$45		\$45		
	Mental/Behavioral health inpatient services	20%	X	20%	X	
	Substance use disorder outpatient services	\$45		\$45		
	Substance use disorder inpatient services	20%	X	20%	X	
<b>Pregnancy</b>	Prenatal and postnatal care	\$45		\$45		
	Delivery and all inpatient services	Hospital	20%	X	20%	X
		Professional	20%			
<b>Help recovering or other special health needs</b>	Home health care	20%		\$45		
	Rehabilitation services	\$45		\$45		
	Habilitation services	\$45		\$45		
	Skilled nursing care	20%	X	20%	X	
	Durable medical equipment	20%		20%		
<b>Child needs dental or eye care</b>	Hospice service	No cost share		No cost share		
	Eye exam (deductible waived)	0%		0%		
	Glasses	1 pair per year		1 pair per year		
	Dental check-up - Preventive and Diagnostic Dental Basic Services Dental Restorative and Orthodontia Services	See attachment		See attachment		

**Notes:**

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
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Actuarial Value - Final AV Calculator

	SHOP	SHOP
	Silver Coinsurance Plan	Silver Copay Plan
	69.8%	69.3%
	N/A	N/A
<b>Overall deductible</b>		
<b>Other deductibles for specific services</b>		
<b>Medical</b>	\$1,500	\$1,500
<b>Brand Drugs</b>	\$500	\$500
<b>Dental</b>	See attachment	See attachment
<b>Out-of-pocket limit on expenses</b>	\$6,400	\$6,400

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
<b>Visit to a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness (see footnote)	\$45		\$45		
	Specialist visit	\$65		\$65		
	Other practitioner office visit	\$45		\$45		
	Preventive care/ screening/ immunization	No cost share		No cost share		
<b>Tests</b>	Laboratory Tests	\$45		\$45		
	X-rays and Diagnostic Imaging	\$65		\$65		
	Imaging (CT/PET scans, MRIs)	20%	X	\$250		
<b>Drugs to treat illness or condition</b>	Generic drugs	\$25		\$25		
	Preferred brand drugs	\$50	X	\$50	X	
	Non-preferred brand drugs	\$70	X	\$70	X	
	Specialty drugs	20%	X	20%	X	
<b>Outpatient surgery</b>	Facility fee (e.g., ASC)	20%	X	20%	X	
	Physician/surgeon fees	20%				
<b>Need immediate attention</b>	Emergency room services (waived if admitted)	\$250	X	\$250	X	
	Emergency medical transportation	\$250	X	\$250	X	
	Urgent care	\$90		\$90		
<b>Hospital stay</b>	Facility fee (e.g., hospital room)	20%	X	20%	X	
	Physician/surgeon fee	20%				
<b>Mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$45		\$45		
	Mental/Behavioral health inpatient services	20%	X	20%	X	
	Substance use disorder outpatient services	\$45		\$45		
	Substance use disorder inpatient services	20%	X	20%	X	
<b>Pregnancy</b>	Prenatal and postnatal care	\$45		\$45		
	Delivery and all inpatient services	Hospital	20%	X	20%	X
		Professional	20%			
<b>Help recovering or other special health needs</b>	Home health care	20%		\$45		
	Rehabilitation services	\$45		\$45		
	Habilitation services	\$45		\$45		
	Skilled nursing care	20%	X	20%	X	
	Durable medical equipment	20%		20%		
<b>Child needs dental or eye care</b>	Hospice service	No cost share		No cost share		
	Eye exam ( <i>deductible waived</i> )	0%		0%		
	Glasses	1 pair per year		1 pair per year		
	Dental check-up - Preventive and Diagnostic Dental Basic Services Dental Restorative and Orthodontia Services	See attachment		See attachment		

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2/25/2013

Actuarial Value - Final AV Calculator

**Individual & SHOP**

**Silver HSA Plan**

71.5%

<b>Overall deductible</b>	\$1500 integrated Med/Rx Ded
<b>Other deductibles for specific services</b>	
<b>Medical</b>	N/A
<b>Brand Drugs</b>	N/A
<b>Dental</b>	See attachment
<b>Out-of-pocket limit on expenses</b>	\$6,400

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
<b>Visit to a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness (see footnote)	20%	X	
	Specialist visit	20%	X	
	Other practitioner office visit	20%	X	
	Preventive care/ screening/ immunization	No cost share		
<b>Tests</b>	Laboratory Tests	20%	X	
	X-rays and Diagnostic Imaging	20%	X	
	Imaging (CT/PET scans, MRIs)	20%	X	
<b>Drugs to treat illness or condition</b>	Generic drugs	20%	X	
	Preferred brand drugs	20%	X	
	Non-preferred brand drugs	20%	X	
	Specialty drugs	20%	X	
<b>Outpatient surgery</b>	Facility fee (e.g., ASC)	20%	X	
	Physician/surgeon fees	20%	X	
<b>Need immediate attention</b>	Emergency room services (waived if admitted)	20%	X	
	Emergency medical transportation	20%	X	
	Urgent care	20%	X	
<b>Hospital stay</b>	Facility fee (e.g., hospital room)	20%	X	
	Physician/surgeon fee	20%	X	
<b>Mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	20%	X	
	Mental/Behavioral health inpatient services	20%	X	
	Substance use disorder outpatient services	20%	X	
	Substance use disorder inpatient services	20%	X	
<b>Pregnancy</b>	Prenatal and postnatal care	20%	X	
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
<b>Help recovering or other special health needs</b>	Home health care	20%	X	
	Rehabilitation services	20%	X	
	Habilitation services	20%	X	
	Skilled nursing care	20%	X	
	Durable medical equipment	20%	X	
<b>Child needs dental or eye care</b>	Hospice service	No cost share	X	
	Eye exam ( <i>deductible waived</i> )	0%		
	Glasses	1 pair per year		
	Dental check-up - Preventive and Diagnostic Dental Basic Services Dental Restorative and Orthodontia Services	See attachment		

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Actuarial Value - Final AV Calculator

	Silver Coinsurance Plan 100%-150% FPL	Silver Coinsurance Plan 150%-200% FPL
Overall deductible	\$0	N/A
Other deductibles for specific services		
Medical	\$0	\$500
Brand Drugs	\$0	\$50
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$2,250	\$2,250

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	\$3		\$15	
	Specialist visit	\$5		\$20	
	Other practitioner office visit	\$3		\$15	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	\$3		\$15	
	X-rays and Diagnostic Imaging	\$5		\$20	
	Imaging (CT/PET scans, MRIs)	10%		15%	X
Drugs to treat illness or condition	Generic drugs	\$3		\$5	
	Preferred brand drugs	\$5		\$15	X
	Non-preferred brand drugs	\$10		\$25	X
	Specialty drugs	10%		15%	X
Outpatient surgery	Facility fee (e.g., ASC)	10%		15%	X
	Physician/surgeon fees	10%		15%	X
Need immediate attention	Emergency room services (waived if admitted)	\$25		\$75	X
	Emergency medical transportation	\$25		\$75	X
	Urgent care	\$6		\$30	
Hospital stay	Facility fee (e.g., hospital room)	10%		15%	X
	Physician/surgeon fee	10%		15%	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$3		\$15	
	Mental/Behavioral health inpatient services	10%		15%	X
	Substance use disorder outpatient services	\$3		\$15	
	Substance use disorder inpatient services	10%		15%	X
Pregnancy	Prenatal and postnatal care	\$3		\$15	
	Delivery and all inpatient services	Hospital	10%	15%	X
		Professional	10%		15%
Help recovering or other special health needs	Home health care	10%		15%	
	Rehabilitation services	\$3		\$15	
	Habilitation services	\$3		\$15	
	Skilled nursing care	10%		15%	X
	Durable medical equipment	10%		15%	
Child needs dental or eye care	Hospice service	No cost share		No cost share	
	Eye exam (deductible waived)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic Dental Basic Services Dental Restorative and Orthodontia Services	See attachment		See attachment	

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	Silver Coinsurance Plan 200%-250% FPL
Actuarial Value - Final AV Calculator	73.7%
Overall deductible	N/A
Other deductibles for specific services	
Medical	\$1,500
Brand Drugs	\$250
Dental	See attachment
Out-of-pocket limit on expenses	\$5,200

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	\$40		
	Specialist visit	\$50		
	Other practitioner office visit	\$40		
	Preventive care/ screening/ immunization	No cost share		
Tests	Laboratory Tests	\$40		
	X-rays and Diagnostic Imaging	\$50		
	Imaging (CT/PET scans, MRIs)	20%	X	
Drugs to treat illness or condition	Generic drugs	\$20		
	Preferred brand drugs	\$30	X	
	Non-preferred brand drugs	\$50	X	
	Specialty drugs	20%	X	
Outpatient surgery	Facility fee (e.g., ASC)	20%	X	
	Physician/surgeon fees	20%		
Need immediate attention	Emergency room services (waived if admitted)	\$250	X	
	Emergency medical transportation	\$250	X	
	Urgent care	\$80		
Hospital stay	Facility fee (e.g., hospital room)	20%	X	
	Physician/surgeon fee	20%		
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$40		
	Mental/Behavioral health inpatient services	20%	X	
	Substance use disorder outpatient services	\$40		
	Substance use disorder inpatient services	20%	X	
Pregnancy	Prenatal and postnatal care	\$40		
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	
Help recovering or other special health needs	Home health care	20%		
	Rehabilitation services	\$40		
	Habilitation services	\$40		
	Skilled nursing care	20%	X	
	Durable medical equipment	20%		
Child needs dental or eye care	Hospice service	No cost share		
	Eye exam (deductible waived)	0%		
	Glasses	1 pair per year		
	Dental check-up - Preventive and Diagnostic Dental Basic Services Dental Restorative and Orthodontia Services	See attachment		

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2/25/2013

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	Silver Copay Plan 100%-150% FPL	Silver Copay Plan 150%-200% FPL
Overall deductible	\$0	N/A
Other deductibles for specific services		
Medical	\$0	\$500
Brand Drugs	\$0	\$50
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$2,250	\$2,250

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	\$3		\$15	
	Specialist visit	\$5		\$20	
	Other practitioner office visit	\$3		\$15	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	\$3		\$15	
	X-rays and Diagnostic Imaging	\$5		\$20	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
Drugs to treat illness or condition	Generic drugs	\$3		\$5	
	Preferred brand drugs	\$5		\$15	X
	Non-preferred brand drugs	\$10		\$25	X
	Specialty drugs	10%		15%	X
Outpatient surgery	Facility fee (e.g., ASC)	10%		15%	X
	Physician/surgeon fees				
Need immediate attention	Emergency room services (waived if admitted)	\$25		\$75	X
	Emergency medical transportation	\$25		\$75	X
	Urgent care	\$6		\$30	
Hospital stay	Facility fee (e.g., hospital room)	10%		15%	X
	Physician/surgeon fee				
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$3		\$15	
	Mental/Behavioral health inpatient services	10%		15%	X
	Substance use disorder outpatient services	\$3		\$15	
	Substance use disorder inpatient services	10%		15%	X
Pregnancy	Prenatal and postnatal care	\$3		\$15	
	Delivery and all inpatient services	10%	Hospital Professional	15%	X
Help recovering or other special health needs	Home health care	\$3		\$15	
	Rehabilitation services	\$3		\$15	
	Habilitation services	\$3		\$15	
	Skilled nursing care	10%		15%	X
	Durable medical equipment	10%		15%	
Child needs dental or eye care	Hospice service	No cost share		No cost share	
	Eye exam (deductible waived)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
	Dental check-up - Preventive and Diagnostic Dental Basic Services Dental Restorative and Orthodontia Services	See attachment		See attachment	

**Notes:**

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or outpatient Mental Health/Substance Abuse visits.
- 5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
- 6) Glasses benefit limited to \$100 per year.
- 7) Dental benefits are described on separate attachment. For pediatric oral care, the high option dental benefits are paired with the Platinum and Gold medical metal tier plans and the low option benefits are paired with the Silver and Bronze tier plans.



**Covered California**  
**Standard Benefit Plan Designs - FINAL**  
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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

2/25/2013

	Silver Copay Plan 200%-250% FPL
Actuarial Value - Final AV Calculator	73.3%
Overall deductible	N/A
Other deductibles for specific services	
Medical	\$1,500
Brand Drugs	\$250
Dental	See attachment
Out-of-pocket limit on expenses	\$5,200

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	\$40	
	Specialist visit	\$50	
	Other practitioner office visit	\$40	
	Preventive care/ screening/ immunization	No cost share	
Tests	Laboratory Tests	\$40	
	X-rays and Diagnostic Imaging	\$50	
	Imaging (CT/PET scans, MRIs)	\$250	
Drugs to treat illness or condition	Generic drugs	\$20	
	Preferred brand drugs	\$30	X
	Non-preferred brand drugs	\$50	X
	Specialty drugs	20%	X
Outpatient surgery	Facility fee (e.g., ASC)	20%	X
	Physician/surgeon fees		
Need immediate attention	Emergency room services (waived if admitted)	\$250	X
	Emergency medical transportation	\$250	X
	Urgent care	\$80	
Hospital stay	Facility fee (e.g., hospital room)	20%	X
	Physician/surgeon fee		
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$40	
	Mental/Behavioral health inpatient services	20%	X
	Substance use disorder outpatient services	\$40	
	Substance use disorder inpatient services	20%	X
Pregnancy	Prenatal and postnatal care	\$40	
	Delivery and all inpatient services	Hospital Professional	20%
Help recovering or other special health needs	Home health care	\$40	
	Rehabilitation services	\$40	
	Habilitation services	\$40	
	Skilled nursing care	20%	X
	Durable medical equipment	20%	
Child needs dental or eye care	Hospice service	No cost share	
	Eye exam (deductible waived)	0%	
	Glasses	1 pair per year	
	Dental check-up - Preventive and Diagnostic Dental Basic Services Dental Restorative and Orthodontia Services	See attachment	

**Notes:**

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
- 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
- 3) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or outpatient Mental Health/Substance Abuse visits.
- 5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
- 6) Glasses benefit limited to \$100 per year.
- 7) Dental benefits are described on separate attachment. For pediatric oral care, the high option dental benefits are paired with the Platinum and Gold medical metal tier plans and the low option benefits are paired with the Silver and Bronze tier plans.

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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

2/25/2013

Actuarial Value - Final AV Calculator

	Bronze Plan	Bronze HSA Plan
	60.4%	59.0%
<b>Overall deductible</b>	\$5000 integrated Med/Rx Ded	\$4500 integrated Med/Rx Ded
<b>Other deductibles for specific services</b>		
<b>Medical</b>	N/A	N/A
<b>Brand Drugs</b>	N/A	N/A
<b>Dental</b>	See attachment	See attachment
<b>Out-of-pocket limit on expenses</b>	\$6,400	\$6,400

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
<b>Visit to a health care provider's office or clinic</b>	Primary care visit to treat an injury or illness (see footnote)	\$60	After 1st 3 non-preventive visits	40%	X	
	Specialist visit	\$70	X	40%	X	
	Other practitioner office visit	\$60	X	40%	X	
	Preventive care/ screening/ immunization	No cost share		No cost share		
<b>Tests</b>	Laboratory Tests	30%	X	40%	X	
	X-rays and Diagnostic Imaging	30%	X	40%	X	
	Imaging (CT/PET scans, MRIs)	30%	X	40%	X	
<b>Drugs to treat illness or condition</b>	Generic drugs	\$25	X	40%	X	
	Preferred brand drugs	\$50	X	40%	X	
	Non-preferred brand drugs	\$75	X	40%	X	
	Specialty drugs	30%	X	40%	X	
<b>Outpatient surgery</b>	Facility fee (e.g., ASC)	30%	X	40%	X	
	Physician/surgeon fees	30%	X	40%	X	
<b>Need immediate attention</b>	Emergency room services (waived if admitted)	\$300	X	40%	X	
	Emergency medical transportation	\$300	X	40%	X	
	Urgent care	\$120	After 1st 3 non-preventive visits	40%	X	
<b>Hospital stay</b>	Facility fee (e.g., hospital room)	30%	X	40%	X	
	Physician/surgeon fee	30%	X	40%	X	
<b>Mental health, behavioral health, or substance abuse needs</b>	Mental/Behavioral health outpatient services	\$60	X	40%	X	
	Mental/Behavioral health inpatient services	30%	X	40%	X	
	Substance use disorder outpatient services	\$60	X	40%	X	
	Substance use disorder inpatient services	30%	X	40%	X	
<b>Pregnancy</b>	Prenatal and postnatal care	\$60	After 1st 3 non-preventive visits	40%	X	
	Delivery and all inpatient services	Hospital	30%	X	40%	X
		Professional	30%	X	40%	X
<b>Help recovering or other special health needs</b>	Home health care	30%	X	40%	X	
	Rehabilitation services	30%	X	40%	X	
	Habilitation services	30%	X	40%	X	
	Skilled nursing care	30%	X	40%	X	
	Durable medical equipment	30%	X	40%	X	
<b>Child needs dental or eye care</b>	Hospice service	No cost share	X	No cost share	X	
	Eye exam ( <i>deductible waived</i> )	0%		0%		
	Glasses	1 pair per year		1 pair per year		
	Dental check-up - Preventive and Diagnostic Dental Basic Services Dental Restorative and Orthodontia Services	See attachment		See attachment		

**Notes:**

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- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or outpatient Mental Health/Substance Abuse visits.
- 5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.
- 6) Glasses benefit limited to \$100 per year.
- 7) Dental benefits are described on separate attachment. For pediatric oral care, the high option dental benefits are paired with the Platinum and Gold medical metal tier plans and the low option benefits are paired with the Silver and Bronze tier plans.

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**Standard Benefit Plan Designs - FINAL**  
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2/25/2013

Catastrophic Plan	
Actuarial Value - Final AV Calculator	60.4%
Overall deductible	\$6400 integrated Med/Rx Ded
Other deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	See attachment
Out-of-pocket limit on expenses	\$6,400

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness (see footnote)	0%	After 1st 3 non-preventive visits	
	Specialist visit	0%	X	
	Other practitioner office visit	0%	X	
	Preventive care/ screening/ immunization	No cost share		
Tests	Laboratory Tests	0%	X	
	X-rays and Diagnostic Imaging	0%	X	
	Imaging (CT/PET scans, MRIs)	0%	X	
Drugs to treat illness or condition	Generic drugs	0%	X	
	Preferred brand drugs	0%	X	
	Non-preferred brand drugs	0%	X	
	Specialty drugs	0%	X	
Outpatient surgery	Facility fee (e.g., ASC)	0%	X	
	Physician/surgeon fees	0%	X	
Need immediate attention	Emergency room services (waived if admitted)	0%	X	
	Emergency medical transportation	0%	X	
	Urgent care	0%	After 1st 3 non-preventive visits	
Hospital stay	Facility fee (e.g., hospital room)	0%	X	
	Physician/surgeon fee	0%	X	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	0%	X	
	Mental/Behavioral health inpatient services	0%	X	
	Substance use disorder outpatient services	0%	X	
	Substance use disorder inpatient services	0%	X	
Pregnancy	Prenatal and postnatal care	0%	After 1st 3 non-preventive visits	
	Delivery and all inpatient services	Hospital	0%	X
		Professional	0%	X
Help recovering or other special health needs	Home health care	0%	X	
	Rehabilitation services	0%	X	
	Habilitation services	0%	X	
	Skilled nursing care	0%	X	
	Durable medical equipment	0%	X	
Child needs dental or eye care	Hospice service	No cost share	X	
	Eye exam (deductible waived)	0%		
	Glasses	1 pair per year		
	Dental check-up - Preventive and Diagnostic Dental Basic Services Dental Restorative and Orthodontia Services	See attachment		

**Notes:**

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