COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		Platinum Coinsurance Plan		Platinum Copay Plan		
2/25/2013						
<b>Actuarial Value - F</b>	inal AV Calculator		88.1%		88.0%	
Overall deductible			\$0		\$0	
	for specific services		ΨΟ		ΨΟ	
Other deddetholes	Medical		\$0		\$0	
	Brand Drugs		\$0		\$0	
	Dental		See attach	nment	See attach	nment
Out-of-pocket lim	it on expenses		\$4,00	0	\$4,00	0
Common Medical Event	Service Typ	е	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's	Primary care visit to treat an inj	ury or illness (see	\$20		\$20	
office or clinic	Specialist visit		\$40		\$40	
	Other practitioner office visit		\$20		\$20	
	Preventive care/ screening/ imr	nunization	No cost share		No cost share	
	Laboratory Tests		\$20		\$20	
Tests	X-rays and Diagnostic Imaging		\$40		\$40	
	Imaging (CT/PET scans, MRIs)		10%		\$150	
Drugs to treat	Generic drugs		\$5		\$5	
illness or	Preferred brand drugs Non-preferred brand drugs		\$15 \$25		\$15 \$25	
condition	Specialty drugs		\$25 10%		\$25 10%	
Outpatient	Facility fee (e.g., ASC)		10%			
surgery	Physician/surgeon fees		10%		\$250	
our gory	Emergency room services (wai	ved if admitted)	\$150		\$150	
	Emergency medical transportat		\$150		\$150	
Need immediate attention	Urgent care		\$40		\$40	
	Facility fee (e.g., hospital room)		10%		\$250 per day up	
Hospital stay	Physician/surgeon fee		10%		to 5 days	
	Mental/Behavioral health outpa	tient services	\$20		\$20	
Mental health, behavioral health,	Mental/Behavioral health inpation	ent services	10%		\$250 per day up to 5 days	
or substance	Substance use disorder outpatient services		\$20		\$20	
abuse needs	Substance use disorder inpatient services		10%		\$250 per day up to 5 days	
Pregnancy	Prenatal and postnatal care		\$20		\$20	
	Delivery and all inpatient	Hospital	10%		\$250 per day up	
	services	Professional	10%		to 5 days	
	Home health care		10%		\$20	
	Rehabilitation services		\$20		\$20	
Help recovering	Habilitation services		\$20		\$20	
or other special health needs	Skilled nursing care		10%		\$150 per day up to 5 days	
	Durable medical equipment		10%		10%	
	Hospice service		No cost share		No cost share	
	Eye exam (deductible waived)		0%		0%	
Child needs	Glasses		1 pair per year		1 pair per year	
dental or eye care	Dental Check-up - Preventive at Dental Basic Services Dental Restorative and Orthodo	<u> </u>	See attach	nment	See attach	nment
	Denial Residualive and Onnout	ATILIA OCTVICES				

- 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		Gold Coinsurance Plan		Gold Copay Plan		
2/25/2013						
Actuarial Value - Final AV Calculator			78.2%	6	78.0%	,
• " • • • • • • • • • • • • • • • • • •						
Overall deductible			\$0		\$0	
Other deductibles	for specific services  Medical		\$0		\$0	
	Brand Drugs		\$0		\$0	
	Dental		See attach	nment	See attach	ment
Out-of-pocket lim	it on expenses		\$6,40		\$6,40	
Common Medical			Member Cost	Deductible	Member Cost	Deductible
Event	Service Typ	е	Share	Applies	Share	Applies
	Defendance and a fait to the at an incident					
Visit to a health	Primary care visit to treat an inj footnote)	ury or lliness (see	\$30		\$30	
care provider's	iodinole)					
office or clinic	Specialist visit		\$50		\$50	
	Other practitioner office visit		\$30		\$30	
	Preventive care/ screening/ imr	munization	No cost share		No cost share	
	Laboratory Tests		\$30		\$30	
Tests	X-rays and Diagnostic Imaging		\$50		\$50	
	Imaging (CT/PET scans, MRIs)		20%		\$250	
Drugs to treat	Generic drugs		\$20		\$20	
illness or	Preferred brand drugs		\$50		\$50	
condition	Non-preferred brand drugs		\$70		\$70	
Outpotiont	Specialty drugs Facility fee (e.g., ASC)		20% 20%		20%	
Outpatient	Physician/surgeon fees		20%		\$600	
surgery	Emergency room services (wai	ved if admitted)	\$250		\$250	
	Emergency medical transportat		\$250		\$250	
Need immediate						
attention	Urgent care		\$60		\$60	
Hospital stay	Facility fee (e.g., hospital room				\$600 per day up	
1103pital Stay	Physician/surgeon fee		20%		to 5 days	
Mandal basks	Mental/Behavioral health outpa	tient services	\$30		\$30	
Mental health, behavioral health,	Mental/Behavioral health inpatient services		20%		\$600 per day up to 5 days	
or substance	Substance use disorder outpatient services		\$30		\$30	
abuse needs	· ·				\$600 per day up	
	Substance use disorder inpatie	nt services	20%		to 5 days	
	Proposal and postnotal save		<b>MOD</b>		<b>ው</b> ስር	
Pregnancy	Prenatal and postnatal care		\$30		\$30	
	Delbara and Hill of a	111 22 1	222/		Ф000	
	Delivery and all inpatient	Hospital	20%		\$600 per day up	
	services Home health care	Professional	20% 20%		to 5 days \$30	
	Rehabilitation services		\$30		\$30	
Help recovering	Habilitation services		\$30		\$30	
or other special					\$300 per day up	
health needs	Skilled nursing care		20%		to 5 days	
	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
	Eye exam (deductible waived)		0%		0%	
Child needs	Glasses	nd Diagrantin	1 pair per year		1 pair per year	
dental or eye care	Dental check-up - Preventive a Dental Basic Services	na Diagnostic	See attach	nmen <del>t</del>	See attach	ment
	Dental Restorative and Orthodo	ontia Services	See allact	miichit	See allact	IIIIGIII
	20. Ital 1.00torative and Orthod	on the Convious				

- 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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## Covered California Standard Benefit Plan Designs - FINAL

**Summary of Benefits and Coverage** 

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		Silver Coinsurance Plan		Silver Copay Plan	
0/05/0040					
2/25/2013 Actuarial Value - F	inal AV Calculator	68.7%	<b>%</b>	68.3%	
Overall deductible	for specific services	N/A		N/A	
Other deductibles	Medical	\$2,00	0	\$2,00	0
	Brand Drugs	\$250		\$250	
	Dental	See attack		See attach	
Out-of-pocket lim	it on expenses	\$6,40	0	\$6,40	0
Common Medical		Member Cost	Deductible	Member Cost	Deductible
Event	Service Type	Share	Applies	Share	Applies
Visit to a health care provider's	Primary care visit to treat an injury or illness (see footnote)	\$45		\$45	
office or clinic	Specialist visit	\$65		\$65	
	Other practitioner office visit	\$45		\$45	
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tanta	Laboratory Tests	\$45		\$45	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	\$65 20%	X	\$65 \$250	
	Generic drugs	\$25	^	\$250	
Drugs to treat	Preferred brand drugs	\$50	X	\$50	Х
illness or	Non-preferred brand drugs	\$70	X	\$70	X
condition	Specialty drugs	20%	Х	20%	Х
Outpatient	Facility fee (e.g., ASC)	20%	X	20%	Х
surgery	Physician/surgeon fees	20%			
	Emergency room services (waived if admitted)	\$250	X	\$250	X
Need immediate attention	Emergency medical transportation  Urgent care	\$250 \$90	^	\$250 \$90	^
Haanital atau	Facility fee (e.g., hospital room)	20%	X	200/	V
Hospital stay	Physician/surgeon fee	20%		20%	Х
	Mental/Behavioral health outpatient services	\$45		\$45	
Mental health, behavioral health,	Mental/Behavioral health inpatient services	20%	Х	20%	Х
or substance	Substance use disorder outpatient services	\$45		\$45	
abuse needs	Substance use disorder inpatient services	20%	Χ	20%	Х
Pregnancy	Prenatal and postnatal care	\$45		\$45	
	Delivery and all inpatient Hospital	20%	X	20%	Х
	services Professional	20%			^
	Home health care	20%		\$45	
Help recovering	Rehabilitation services Habilitation services	\$45 \$45		\$45 \$45	
Help recovering or other special health needs	Skilled nursing care	20%	Х	20%	Х
neath needs	Durable medical equipment	20%		20%	
	Hospice service	No cost share		No cost share	
	Eye exam (deductible waived)	0%		0%	
Child needs	Glasses	1 pair per year		1 pair per year	
dental or eye care	Dental check-up - Preventive and Diagnostic  Dental Basic Services  Dental Restorative and Orthodontia Services	See attacl	nment	See attach	nment

Individual

Individual

- 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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## Covered California Standard Benefit Plan Designs - FINAL

**Summary of Benefits and Coverage** 

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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		Silver Coinsurance Plan		Silver Copay Plan	
2/25/2013					
Actuarial Value - F	inal AV Calculator	69.8%		69.3%	
					0
Overall deductible		N/A		N/A	
Other deductibles	for specific services				
	Medical	\$1,50		\$1,50	
	Brand Drugs	\$500		\$500	
	Dental	See attacl		See attach	
Out-of-pocket lim	it on expenses	\$6,40	0	\$6,40	0
Common Medical		Mambar Cast		Manahan Caat	
Event		Member Cost Share	Deductible	Member Cost Share	Deductible
Event	Service Type	Silare	Applies	Share	Applies
Visit to a health care provider's	Primary care visit to treat an injury or illness (see footnote)	\$45		\$45	
office or clinic	Specialist visit	\$65		\$65	
	Other practitioner office visit	\$45		\$45	
	Preventive care/ screening/ immunization	No cost share		No cost share	
	Laboratory Tests	\$45		\$45	
Tests	X-rays and Diagnostic Imaging	\$65		\$65	
	Imaging (CT/PET scans, MRIs)	20%	X	\$250	
Drugs to treat	Generic drugs	\$25		\$25	
illness or	Preferred brand drugs	\$50	X	\$50	X
condition	Non-preferred brand drugs	\$70	X	\$70	X
	Specialty drugs	20%	Х	20%	X
Outpatient	Facility fee (e.g., ASC)	20%	X	20%	Х
surgery	Physician/surgeon fees	20%			
	Emergency room services (waived if admitted)	\$250	X	\$250	X
Need immediate attention	Emergency medical transportation	\$250	Х	\$250	X
	Urgent care	\$90		\$90	
	Facility fee (e.g., hospital room)	20%	Х	200/	V
Hospital stay	Physician/surgeon fee	20%		20%	Х
	Mental/Behavioral health outpatient services	\$45		\$45	
Mental health, behavioral health,	Mental/Behavioral health inpatient services	20%	Х	20%	Х
or substance	Substance use disorder outpatient services	\$45		\$45	
abuse needs	Substance use disorder inpatient services	20%	Х	20%	Х
Pregnancy	Prenatal and postnatal care	\$45		\$45	
	Delivery and all inpatient Hospital	20%	X	20%	Х
	services Professional	20%		∠0%	Λ
	Home health care	20%		\$45	
	Rehabilitation services	\$45		\$45	
Help recovering	Habilitation services	\$45		\$45	
or other special health needs	Skilled nursing care	20%	Х	20%	Х
	Durable medical equipment	20%		20%	
	Hospice service	No cost share		No cost share	
	Eye exam (deductible waived)	0%		0%	
Child needs	Glasses	1 pair per year		1 pair per year	
dental or eye care	Dental Check-up - Preventive and Diagnostic  Dental Basic Services	See attacl	nment	See attach	nment
	Dental Restorative and Orthodontia Services				

SHOP

**SHOP** 

- 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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## **Covered California** Standard Benefit Plan Designs - FINAL

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Summary of Benefits and Coverage	Individual & SHOP
COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver HSA Plan
2/25/2013	
Actuarial Value - Final AV Calculator	71.5%
Overall deductible	\$1500 integrated Med/Rx Ded
Other deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
<b>Dental</b>	See attachment
Out-of-pocket limit on expenses	\$6,400

Common Medical		Member Cost	Deductible		
Event	Service Type	9	Share	Applies	
Visit to a health care provider's	Primary care visit to treat an injufootnote)	ury or illness (see	20%	Х	
office or clinic	Specialist visit		20%	X	
	Other practitioner office visit		20%	X	
	Preventive care/ screening/ imm	nunization	No cost share		
	Laboratory Tests		20%	X	
Tests	X-rays and Diagnostic Imaging		20%	X	
	Imaging (CT/PET scans, MRIs)		20%	X	
Drugs to treat	Generic drugs		20%	X	
illness or	Preferred brand drugs		20%	X	
condition	Non-preferred brand drugs		20%	X	
<b>.</b>	Specialty drugs		20%	X	
Outpatient	Facility fee (e.g., ASC)		20%	X	
surgery	Physician/surgeon fees		20%	X	
	Emergency room services (waiv Emergency medical transportati		20% 20%	X	
Need immediate attention	Urgent care		20%	X	
Hospital stay	Facility fee (e.g., hospital room)	20%	Х		
1105pital Stay	Physician/surgeon fee	20%	X		
	Mental/Behavioral health outpat	20%	X		
Mental health, behavioral health,	Mental/Behavioral health inpation	20%	Х		
or substance	Substance use disorder outpatie	20%	X		
abuse needs	Substance use disorder inpatier	20%	Х		
Pregnancy	Prenatal and postnatal care		20%	X	
	Delivery and all inpatient	Hospital	20%	X	
	services	Professional	20%	X	
	Home health care		20%	X	
	Rehabilitation services		20%	X	
Help recovering	Habilitation services		20%	X	
or other special health needs	Skilled nursing care		20%	Х	
	Durable medical equipment		20%	X	
	Hospice service		No cost share	X	
	Eye exam (deductible waived)		0%		
Child needs	Glasses		1 pair per year		
dental or eye care	Dental check-up - Preventive ar	nd Diagnostic			
dental of eye care	Dental Basic Services		See attach	nment	
	Dental Restorative and Orthodo	ntia Services			

- 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		Silver Coinsurance Plan 100%-150% FPL		Silver Coinsurance Plan 150%-200% FPL		
2/25/2013						
Actuarial Value - Final AV Calculator			94.8%	6	87.89	<del></del>
Overall deductible			\$0		N/A	
Other deductibles	for specific services  Medical		\$0		\$500	1
	Brand Drugs		\$0		\$50	
	Dental		See attach	nment	See attach	nment
Out-of-pocket lim	it on expenses		\$2,25		\$2,25	
Common Medical			Member Cost	Deductible	Member Cost	Deductible
Event	Service Typ	е	Share	Applies	Share	Applies
	Defendance and a fait to the at an incident					
Visit to a health	Primary care visit to treat an inj footnote)	ury or lliness (see	\$3		\$15	
care provider's	iootriote)					
office or clinic	Specialist visit		\$5		\$20	
	Other practitioner office visit		\$3		\$15	
	Preventive care/ screening/ imr	nunization	No cost share		No cost share	
	Laboratory Tests		\$3		\$15	
Tests	X-rays and Diagnostic Imaging		\$5		\$20	
	Imaging (CT/PET scans, MRIs)		10%		15%	X
Drugs to treat	Generic drugs		\$3		\$5	
illness or	Preferred brand drugs		\$5		\$15	X
condition	Non-preferred brand drugs		\$10		\$25	X
	Specialty drugs		10%		15%	X
Outpatient	Facility fee (e.g., ASC)		10%		15%	X
surgery	Physician/surgeon fees Emergency room services (wai	und if admitted)	10%		15%	X
	Emergency medical transportation		\$25 \$25		\$75 \$75	X
Need immediate	Linergency medical transportal	IIOH	φΖΟ		φισ	^
attention	Urgent care		\$6		\$30	
Hospital stay	Facility fee (e.g., hospital room)		10%		15%	X
1103pital Stay	Physician/surgeon fee		10%		15%	
M	Mental/Behavioral health outpa	tient services	\$3		\$15	
Mental health, behavioral health,	Mental/Behavioral health inpatient services		10%		15%	Х
or substance	Substance use disorder outpati	ient services	\$3		\$15	
abuse needs	Substance use disorder inpatie	nt services	10%		15%	Х
Pregnancy	Prenatal and postnatal care		\$3		\$15	
	Delivery and all inpatient	Hospital	10%		15%	Х
	services	Professional	10%		15%	
	Home health care		10%		15%	
	Rehabilitation services		\$3		\$15	
Help recovering	Habilitation services		\$3		\$15	
or other special health needs	Skilled nursing care		10%		15%	Х
nealth needs	Durable medical equipment		10%		15%	
	Hospice service		No cost share		No cost share	
	Eye exam (deductible waived)		0%		0%	
Child needs	Glasses		1 pair per year		1 pair per year	
Child needs dental or eye care	Dental check-up - Preventive a	nd Diagnostic				
demai or eye care	Dental Basic Services Dental Restorative and Orthodo	ontia Services	See attach	nment	See attachment	

- 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 ENROLLEE'S	• • • • • • • • • • • • • • • • • • •	Silver Coinsurance Plan 200%-250% FPL		
2/25/2013				
<b>Actuarial Value - F</b>	inal AV Calculator		73.7%	
<b>Overall deductible</b>			N/A	
Other deductibles	for specific services			
	Medical		\$1,50	
	Brand Drugs		\$250	
Out of poolset lim	Dental		See attach \$5,20	
Out-of-pocket lim	it on expenses		Φ5,20	U .
Common Medical			Member Cost	Deductible
Event	Service Type	е	Share	Applies
Visit to a health care provider's	Primary care visit to treat an injufootnote)		\$40	
office or clinic	Specialist visit		\$50	
	Other practitioner office visit		\$40	
	Preventive care/ screening/ imn	nunization	No cost share	
T4-	Laboratory Tests		\$40	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)		\$50 20%	X
_	Generic drugs		\$20	^
Drugs to treat	Preferred brand drugs		\$30	X
illness or	Non-preferred brand drugs	\$50	X	
condition	Specialty drugs		20%	Х
Outpatient	Facility fee (e.g., ASC)		20%	Х
surgery	Physician/surgeon fees		20%	
	Emergency room services (waix Emergency medical transportat	\$250 \$250	X	
Need immediate attention	Urgent care	\$80	^	
	Facility fee (e.g., hospital room)	20%	X	
Hospital stay	Physician/surgeon fee		20%	
	Mental/Behavioral health outpa	tient services	\$40	
Mental health, behavioral health,	Mental/Behavioral health inpation	20%	X	
or substance	Substance use disorder outpati	ent services	\$40	
abuse needs	Substance use disorder inpatie	nt services	20%	Х
Pregnancy	Prenatal and postnatal care		\$40	
	Delivery and all inpatient	Hospital	20%	Х
	services	Professional	20%	
	Home health care Rehabilitation services		20%	
Help recovering	Habilitation services		\$40 \$40	
or other special health needs	Skilled nursing care		20%	Х
	Durable medical equipment		20%	
	Hospice service		No cost share	
	Eye exam (deductible waived)		0%	
Child needs	Glasses		1 pair per year	
dental or eye care	Dental check-up - Preventive ar Dental Basic Services	-	See attach	nment
	Dental Restorative and Orthodo			

- 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.

  2/22/201

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		Silver Copay Plan 100%-150% FPL		Silver Copay Plan 150%-200% FPL		
2/25/2013						
<b>Actuarial Value - F</b>	inal AV Calculator		94.9%		87.7%	
Overall deductible			\$0		N/A	
	for specific services		ΨΟ		14/74	
	Medical		\$0		\$500	)
	Brand Drugs		\$0		\$50	
	Dental		See attach		See attach	
Out-of-pocket lim	it on expenses		\$2,25	0	\$2,25	0
Common Medical			Member Cost	Deductible	Member Cost	Deductible
Event	Service Type		Share	Applies	Share	Applies
Visit to a health care provider's	Primary care visit to treat an injufootnote)	ry or illness (see	\$3		\$15	
office or clinic	Specialist visit		\$5		\$20	
	Other practitioner office visit		\$3		\$15	
	Preventive care/ screening/ imm	unization	No cost share		No cost share	
	Laboratory Tests		\$3		\$15	
Tests	X-rays and Diagnostic Imaging		\$5		\$20	
	Imaging (CT/PET scans, MRIs)		\$50		\$100	
Drugs to treat	Generic drugs		\$3 \$5		\$5 \$4.5	V
illness or	Preferred brand drugs Non-preferred brand drugs		\$5 \$10		\$15 \$25	X
condition	Specialty drugs		10%		15%	X
Outpatient	Facility fee (e.g., ASC)					
surgery	Physician/surgeon fees		10%		15%	Х
J ,	Emergency room services (waiv	ed if admitted)	\$25		\$75	X
	Emergency medical transportation		\$25		\$75	X
Need immediate attention	Urgent care		\$6		\$30	
	Facility fee (e.g., hospital room)		400/		450/	V
Hospital stay	Physician/surgeon fee		10%		15%	Х
	Mental/Behavioral health outpatient services		\$3		\$15	
Mental health, behavioral health,	Mental/Behavioral health inpatient services		10%		15%	X
or substance	Substance use disorder outpatie	ent services	\$3		\$15	
abuse needs	Substance use disorder inpatier	nt services	10%		15%	Х
Pregnancy	Prenatal and postnatal care		\$3		\$15	
	Delivery and all inpatient	Hospital	10%		15%	Х
	services	Professional			15%	^
	Home health care		\$3		\$15	
	Rehabilitation services		\$3		\$15	
Help recovering	Habilitation services		\$3		\$15	
or other special health needs	Skilled nursing care		10%		15%	Χ
neatti necus	Durable medical equipment		10%		15%	
	Hospice service		No cost share		No cost share	
	Eye exam (deductible waived)		0%		0%	
Child needs	Glasses		1 pair per year		1 pair per year	
dental or eye care	Dental check-up - Preventive an	d Diagnostic				
acinal of tye cale	Dental Basic Services		See attach	nment	See attach	nment
	Dental Restorative and Orthodo	ntia Services				

- 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.

  2/22/201:

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS			Silver Copay Plan 200%-250% FPL		
2/25/2013					
Actuarial Value - F	Actuarial Value - Final AV Calculator				
Overall deductible			N/A		
	for specific services		14/71		
	\$1,500				
	Brand Drugs		\$250		
	Dental		See attach	nment	
Out-of-pocket lim	it on expenses		\$5,20	0	
Common Medical Event	1		Member Cost Share	Deductible	
Event	Service Typ	е	Share	Applies	
Visit to a health care provider's	Primary care visit to treat an injufootnote)	ury or illness (see	\$40		
office or clinic	Specialist visit		\$50		
	Other practitioner office visit		\$40		
	Preventive care/ screening/ imm	nunization	No cost share		
Tests	Laboratory Tests X-rays and Diagnostic Imaging		\$40 \$50		
Tesis	Imaging (CT/PET scans, MRIs)		\$250		
	Generic drugs		\$20		
Drugs to treat	Preferred brand drugs	\$30	X		
illness or condition	Non-preferred brand drugs	\$50	X		
Condition	Specialty drugs		20%	X	
Outpatient	Facility fee (e.g., ASC)		20%	Х	
surgery	Physician/surgeon fees	'f  '((  \)	0050		
	Emergency room services (waived if admitted) Emergency medical transportation		\$250 \$250	X	
Need immediate attention	Urgent care		\$80		
Hannital atau	Facility fee (e.g., hospital room)	)	200/	V	
Hospital stay	Physician/surgeon fee		20%	Х	
	Mental/Behavioral health outpa	tient services	\$40		
Mental health, behavioral health,	Mental/Behavioral health inpation	ent services	20%	Х	
or substance	Substance use disorder outpati	ent services	\$40		
abuse needs	Substance use disorder inpatie	nt services	20%	Х	
Pregnancy	Prenatal and postnatal care		\$40		
	Delivery and all inpatient services	Hospital Professional	20%	Х	
	Home health care	. 101000101101	\$40		
	Rehabilitation services		\$40		
Help recovering	Habilitation services		\$40		
or other special health needs	Skilled nursing care		20%	Х	
	Durable medical equipment		20%		
	Hospice service		No cost share		
	Eye exam (deductible waived)		0%		
Child needs	Glasses Dental check-up - Preventive ar	nd Diagnostic	1 pair per year		
dental or eye care	Dental Basic Services Dental Restorative and Orthodo		See attach	nment	

- 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		Bronze Plan		Bronze HSA Plan			
2/25/2013 Actuarial Value - Final AV Calculator		60.4%	/	FO 00	/		
Actuariai value - F	inal AV Calculator		60.47	⁄o	59.0%		
<b>Overall deductible</b>			\$5000 integrated	Med/Rx Ded	\$4500 integrated	Med/Rx Ded	
Other deductibles	for specific services						
	Medical		N/A		N/A		
	Brand Drugs		N/A		N/A		
	Dental		See attack		See attach		
Out-of-pocket lim	it on expenses		\$6,40	0	\$6,40	0	
Common Medical Event	Service Typ	e	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
	Colvide Typ		Orialo	After 1st 3	Onaro	Пррпос	
Visit to a health care provider's	Primary care visit to treat an inj footnote)	ury or illness (see	\$60	non- preventive visits	40%	х	
office or clinic	Specialist visit		\$70	X	40%	Χ	
	Other practitioner office visit		\$60	X	40%	X	
	Preventive care/ screening/ imr	nunization	No cost share		No cost share		
	Laboratory Tests		30%	X	40%	X	
Tests	X-rays and Diagnostic Imaging		30%	X	40%	X	
	Imaging (CT/PET scans, MRIs)		30%	X	40%	X	
Drugs to treat	Generic drugs		\$25	Х	40%	X	
illness or	Preferred brand drugs		\$50	X	40%	X	
condition	Non-preferred brand drugs		\$75	X	40%	X	
Condition	Specialty drugs		30%	X	40%	X	
Outpatient	Facility fee (e.g., ASC)		30%	X	40%	X	
surgery	Physician/surgeon fees		30%	Х	40%	X	
	Emergency room services (wai	ved if admitted)	\$300	X	40%	X	
	Emergency medical transportat	ion	\$300	X	40%	X	
Need immediate attention	Urgent care		\$120	After 1st 3 non- preventive visits	40%	Х	
	Facility fee (e.g., hospital room)		30%	X	40%	Х	
Hospital stay	Physician/surgeon fee		30%	X	40%	X	
	Mental/Behavioral health outpatient services		\$60	X	40%	X	
Mental health, behavioral health,	Mental/Behavioral health inpatient services		30%	X	40%	Х	
or substance	Substance use disorder outpatient services		\$60	X	40%	X	
abuse needs	Substance use disorder inpatie	nt services	30%	Х	40%	Х	
Pregnancy	Prenatal and postnatal care		\$60	After 1st 3 non- preventive visits	40%	х	
	Delivery and all inpatient	Hospital	30%	X	40%	X	
	services	Professional	30%	X	40%	X	
	Home health care		30%	X	40%	Х	
	Rehabilitation services		30%	X	40%	X	
Help recovering	Habilitation services		30%	X	40%	X	
or other special health needs	Skilled nursing care		30%	X	40%	Х	
	Durable medical equipment		30%	Х	40%	X	
	Hospice service		No cost share	Х	No cost share	X	
	Eye exam (deductible waived)		0%		0%		
Child needs	Glasses		1 pair per year		1 pair per year		
dental or eye care	Dental check-up - Preventive a Dental Basic Services		See attacl	nment	See attachment		
	Dental Restorative and Orthodo	Dental Restorative and Orthodontia Services					

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
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- 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			Catastrophic Plan	
2/25/2013				
<b>Actuarial Value - F</b>	60.4%			
<b>Overall deductible</b>			\$6400 integrated	Med/Rx Ded
Other deductibles	for specific services			
	Medical		N/A	
	Brand Drugs		N/A	
Out of modest lim	Dental		See attacl	
Out-of-pocket lim	it on expenses		\$6,40	0
Common Medical			Member Cost	Deductible
Event	Service Typ	е	Share	Applies
				After 1st 3
Visit to a health care provider's	Primary care visit to treat an inj footnote)	ury or illness (see	0%	non- preventive visits
office or clinic	Specialist visit		0%	Х
	Other practitioner office visit		0%	Х
	Preventive care/ screening/ imr	munization	No cost share	
	Laboratory Tests		0%	Х
Tests	X-rays and Diagnostic Imaging		0%	Х
	Imaging (CT/PET scans, MRIs)		0%	Х
Drugs to treat	Generic drugs		0%	X
illness or	Preferred brand drugs	0%	X	
condition	Non-preferred brand drugs	0%	X	
Outpatiant	Specialty drugs		0%	X
Outpatient	Facility fee (e.g., ASC) Physician/surgeon fees		0% 0%	X
surgery	Emergency room services (wai	ved if admitted)	0%	X
	Emergency medical transportat	,	0%	X
Need immediate	Emergency medical transportation	070	After 1st 3	
attention	Urgent care	0%	non- preventive visits	
Hospital stay	Facility fee (e.g., hospital room)	0%	Х	
nospital stay	Physician/surgeon fee	0%	Х	
	Mental/Behavioral health outpa	tient services	0%	Х
Mental health, behavioral health,	Mental/Behavioral health inpati	0%	Х	
or substance	Substance use disorder outpati	ient services	0%	X
abuse needs	Substance use disorder inpatie	nt services	0%	Х
Pregnancy	Prenatal and postnatal care		0%	After 1st 3 non- preventive visits
	Delivery and all inpatient	Hospital	0%	X
	services	Professional	0%	Х
	Home health care		0%	X
Holp recovering	Rehabilitation services Habilitation services		0%	X
Help recovering or other special	Habilitation services		0%	Х
health needs	Skilled nursing care		0%	Х
nealth needs	Durable medical equipment		0%	Х
	Hospice service		No cost share	X
	Eye exam (deductible waived)		0%	
Child needs	Glasses		1 pair per year	
Child needs dental or eye care	Dental check-up - Preventive at Dental Basic Services Dental Restorative and Orthodo	-	See attacl	nment

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.
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