

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

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

7/18/2013

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

| 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) | \$20   |                    | \$20   |                    |
|   | Specialist visit  | \$40   |                    | \$40   |                    |
|   | Other practitioner office visit                                 | \$20   |                    | \$20   |                    |
|   | Preventive care/ screening/ immunization                        | No cost share                                  |                    | No cost share                                  |                    |
| <b>Tests</b>  | Laboratory Tests  | \$20   |                    | \$20   |                    |
|   | X-rays and Diagnostic Imaging                                   | \$40   |                    | \$40   |                    |
|   | Imaging (CT/PET scans, MRIs)                                    | 10%  |                    | \$150  |                    |
| <b>Drugs to treat illness or condition</b>                        | Generic drugs   | \$5  |                    | \$5  |                    |
|   | Preferred brand drugs   | \$15   |                    | \$15   |                    |
|   | Non-preferred brand drugs                                       | \$25   |                    | \$25   |                    |
|   | Specialty drugs   | 10%  |                    | 10%  |                    |
| <b>Outpatient surgery</b>   | Facility fee (e.g., ASC)  | 10%  |                    | \$250  |                    |
|   | Physician/surgeon fees  | 10%  |                    |  |                    |
| <b>Need immediate attention</b>                                   | Emergency room services (waived if admitted)                    | \$150  |                    | \$150  |                    |
|   | Emergency medical transportation                                | \$150  |                    | \$150  |                    |
|   | Urgent care   | \$40   |                    | \$40   |                    |
| <b>Hospital stay</b>  | Facility fee (e.g., hospital room)                              | 10%  |                    | \$250 per day up to 5 days                     |                    |
|   | Physician/surgeon fee   | 10%  |                    |  |                    |
| <b>Mental health, behavioral health, or substance abuse needs</b> | 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                     |                    |
| <b>Pregnancy</b>  | Prenatal care and preconception visits                          | No cost share                                  |                    | No cost share                                  |                    |
|   | Delivery and all inpatient services                             | Hospital                                       | 10%                | \$250 per day up to 5 days                     |                    |
|   |   | Professional                                   | 10%                |  |                    |
| <b>Help recovering or other special health needs</b>              | 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%  |                    |
|   | Hospice service   | No cost share                                  |                    | No cost share                                  |                    |
| <b>Child needs dental or eye care</b>                             | Eye exam (deductible waived)                                    | 0%   |                    | 0%   |                    |
|   | Glasses   | 1 pair per year                                |                    | 1 pair per year                                |                    |
|   | Dental check-up - Preventive and Diagnostic                     | Pediatric Dental Standard Plan Design attached |                    | Pediatric Dental Standard Plan Design attached |                    |
|   | 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. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.
- 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 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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|  | Gold Coinsurance Plan | Gold Copay Plan |
|--|-----------------------|-----------------|
| <b>Overall deductible</b>                      | \$0                   | \$0             |
| <b>Other deductibles for specific services</b> |                       |                 |
| <b>Medical</b>                                 | \$0                   | \$0             |
| <b>Brand Drugs</b>                             | \$0                   | \$0             |
| <b>Dental</b>                                  | See attachment        | See attachment  |
| <b>Out-of-pocket limit on expenses</b>         | \$6,350               | \$6,350         |

| 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) | \$30   |                    | \$30   |                    |
|   | Specialist visit  | \$50   |                    | \$50   |                    |
|   | Other practitioner office visit                                 | \$30   |                    | \$30   |                    |
|   | Preventive care/ screening/ immunization                        | No cost share                                  |                    | No cost share                                  |                    |
| <b>Tests</b>  | Laboratory Tests  | \$30   |                    | \$30   |                    |
|   | X-rays and Diagnostic Imaging                                   | \$50   |                    | \$50   |                    |
|   | Imaging (CT/PET scans, MRIs)                                    | 20%  |                    | \$250  |                    |
| <b>Drugs to treat illness or condition</b>                        | Generic drugs   | \$19   |                    | \$19   |                    |
|   | Preferred brand drugs   | \$50   |                    | \$50   |                    |
|   | Non-preferred brand drugs                                       | \$70   |                    | \$70   |                    |
|   | Specialty drugs   | 20%  |                    | 20%  |                    |
| <b>Outpatient surgery</b>   | Facility fee (e.g., ASC)  | 20%  |                    | \$600  |                    |
|   | Physician/surgeon fees  | 20%  |                    |  |                    |
| <b>Need immediate attention</b>                                   | Emergency room services (waived if admitted)                    | \$250  |                    | \$250  |                    |
|   | Emergency medical transportation                                | \$250  |                    | \$250  |                    |
|   | Urgent care   | \$60   |                    | \$60   |                    |
| <b>Hospital stay</b>  | Facility fee (e.g., hospital room)                              | 20%  |                    | \$600 per day up to 5 days                     |                    |
|   | Physician/surgeon fee   | 20%  |                    |  |                    |
| <b>Mental health, behavioral health, or substance abuse needs</b> | 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                     |                    |
| <b>Pregnancy</b>  | Prenatal care and preconception visits                          | No cost share                                  |                    | No cost share                                  |                    |
|   | Delivery and all inpatient services                             | Hospital                                       | 20%                | \$600 per day up to 5 days                     |                    |
|   |   | Professional                                   | 20%                |  |                    |
| <b>Help recovering or other special health needs</b>              | 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                                  |                    |
| <b>Child needs dental or eye care</b>                             | Eye exam (deductible waived)                                    | 0%   |                    | 0%   |                    |
|   | Glasses   | 1 pair per year                                |                    | 1 pair per year                                |                    |
|   | Dental check-up - Preventive and Diagnostic                     | Pediatric Dental Standard Plan Design attached |                    | Pediatric Dental Standard Plan Design attached |                    |
|   | 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. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.
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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 outpatient Mental Health/Substance Abuse visits.
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|   | Individual              | Individual        |
|---|-------------------------|-------------------|
|   | Silver Coinsurance Plan | Silver Copay Plan |
| Overall deductible                      | N/A                     | N/A               |
| Other deductibles for specific services |                         |                   |
| Medical                                 | \$2,000                 | \$2,000           |
| Brand Drugs                             | \$250                   | \$250             |
| Dental                                  | See attachment          | See attachment    |
| Out-of-pocket limit on expenses         | \$6,350                 | \$6,350           |

| 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) | \$45   |                    | \$45   |                    |   |
|  | Specialist visit  | \$65   |                    | \$65   |                    |   |
|  | Other practitioner office visit                                 | \$45   |                    | \$45   |                    |   |
|  | Preventive care/ screening/ immunization                        | No cost share                                  |                    | No cost share                                  |                    |   |
| Tests  | Laboratory Tests  | \$45   |                    | \$45   |                    |   |
|  | X-rays and Diagnostic Imaging                                   | \$65   |                    | \$65   |                    |   |
|  | Imaging (CT/PET scans, MRIs)                                    | 20%  | X                  | \$250  |                    |   |
| Drugs to treat illness or condition                        | Generic drugs   | \$19   |                    | \$19   |                    |   |
|  | Preferred brand drugs   | \$50   | X                  | \$50   | X                  |   |
|  | Non-preferred brand drugs                                       | \$70   | X                  | \$70   | X                  |   |
|  | Specialty drugs   | 20%  | X                  | 20%  | X                  |   |
| Outpatient surgery   | Facility fee (e.g., ASC)  | 20%  |                    | 20%  |                    |   |
|  | Physician/surgeon fees  | 20%  |                    | 20%  |                    |   |
| Need immediate attention                                   | Emergency room services (waived if admitted)                    | \$250  | X                  | \$250  | X                  |   |
|  | Emergency medical transportation                                | \$250  | X                  | \$250  | X                  |   |
|  | Urgent care   | \$90   |                    | \$90   |                    |   |
| Hospital stay  | Facility fee (e.g., hospital room)                              | 20%  | X                  | 20%  | X                  |   |
|  | Physician/surgeon fee   | 20%  |                    |  |                    |   |
| Mental health, behavioral health, or substance abuse needs | 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                  |   |
| Pregnancy  | Prenatal care and preconception visits                          | No cost share                                  |                    | No cost share                                  |                    |   |
|  | Delivery and all inpatient services                             | Hospital                                       | 20%                | X  | 20%                | X |
|  |   | Professional                                   | 20%                |  |                    |   |
| Help recovering or other special health needs              | 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%  |                    |   |
|  | 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                     | Pediatric Dental Standard Plan Design attached |                    | Pediatric Dental Standard Plan Design attached |                    |   |
|  | 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. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.
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- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.
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7/18/2013

|   | SHOP                    | SHOP              |
|---|-------------------------|-------------------|
|   | Silver Coinsurance Plan | Silver Copay Plan |
| Overall deductible                      | N/A                     | N/A               |
| Other deductibles for specific services |                         |                   |
| Medical                                 | \$1,500                 | \$1,500           |
| Brand Drugs                             | \$500                   | \$500             |
| Dental                                  | See attachment          | See attachment    |
| Out-of-pocket limit on expenses         | \$6,350                 | \$6,350           |

| 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) | \$45   |                    | \$45   |                    |   |
|  | Specialist visit  | \$65   |                    | \$65   |                    |   |
|  | Other practitioner office visit                                 | \$45   |                    | \$45   |                    |   |
|  | Preventive care/ screening/ immunization                        | No cost share                                  |                    | No cost share                                  |                    |   |
| Tests  | Laboratory Tests  | \$45   |                    | \$45   |                    |   |
|  | X-rays and Diagnostic Imaging                                   | \$65   |                    | \$65   |                    |   |
|  | Imaging (CT/PET scans, MRIs)                                    | 20%  | X                  | \$250  |                    |   |
| Drugs to treat illness or condition                        | Generic drugs   | \$19   |                    | \$19   |                    |   |
|  | Preferred brand drugs   | \$50   | X                  | \$50   | X                  |   |
|  | Non-preferred brand drugs                                       | \$70   | X                  | \$70   | X                  |   |
|  | Specialty drugs   | 20%  | X                  | 20%  | X                  |   |
| Outpatient surgery   | Facility fee (e.g., ASC)  | 20%  |                    | 20%  |                    |   |
|  | Physician/surgeon fees  | 20%  |                    | 20%  |                    |   |
| Need immediate attention                                   | Emergency room services (waived if admitted)                    | \$250  | X                  | \$250  | X                  |   |
|  | Emergency medical transportation                                | \$250  | X                  | \$250  | X                  |   |
|  | Urgent care   | \$90   |                    | \$90   |                    |   |
| Hospital stay  | Facility fee (e.g., hospital room)                              | 20%  | X                  | 20%  | X                  |   |
|  | Physician/surgeon fee   | 20%  |                    |  |                    |   |
| Mental health, behavioral health, or substance abuse needs | 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                  |   |
| Pregnancy  | Prenatal care and preconception visits                          | No cost share                                  |                    | No cost share                                  |                    |   |
|  | Delivery and all inpatient services                             | Hospital                                       | 20%                | X  | 20%                | X |
|  |   | Professional                                   | 20%                |  |                    |   |
| Help recovering or other special health needs              | 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%  |                    |   |
|  | 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                     | Pediatric Dental Standard Plan Design attached |                    | Pediatric Dental Standard Plan Design attached |                    |   |
|  | 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. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.
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|  | Silver Coinsurance Plan<br>100%-150% FPL | Silver Coinsurance Plan<br>150%-200% FPL |
|--|--|--|
| <b>Overall deductible</b>                      | \$0                                      | N/A                                      |
| <b>Other deductibles for specific services</b> |  |  |
| <b>Medical</b>                                 | \$0                                      | \$500                                    |
| <b>Brand Drugs</b>                             | \$0                                      | \$50                                     |
| <b>Dental</b>                                  | See attachment                           | See attachment                           |
| <b>Out-of-pocket limit on expenses</b>         | \$2,250                                  | \$2,250                                  |

| 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)   | \$3  |                    | \$15   |                    |
|   | Specialist visit  | \$5  |                    | \$20   |                    |
|   | Other practitioner office visit   | \$3  |                    | \$15   |                    |
|   | Preventive care/ screening/ immunization  | No cost share                                  |                    | No cost share                                  |                    |
| <b>Tests</b>  | Laboratory Tests  | \$3  |                    | \$15   |                    |
|   | X-rays and Diagnostic Imaging   | \$5  |                    | \$20   |                    |
|   | Imaging (CT/PET scans, MRIs)  | 10%  |                    | 15%  | X                  |
| <b>Drugs to treat illness or condition</b>                        | Generic drugs   | \$3  |                    | \$5  |                    |
|   | Preferred brand drugs   | \$5  |                    | \$15   | X                  |
|   | Non-preferred brand drugs   | \$10   |                    | \$25   | X                  |
|   | Specialty drugs   | 10%  |                    | 15%  | X                  |
| <b>Outpatient surgery</b>   | Facility fee (e.g., ASC)  | 10%  |                    | 15%  |                    |
|   | Physician/surgeon fees  | 10%  |                    | 15%  |                    |
| <b>Need immediate attention</b>                                   | Emergency room services (waived if admitted)  | \$25   |                    | \$75   | X                  |
|   | Emergency medical transportation  | \$25   |                    | \$75   | X                  |
|   | Urgent care   | \$6  |                    | \$30   |                    |
| <b>Hospital stay</b>  | Facility fee (e.g., hospital room)  | 10%  |                    | 15%  | X                  |
|   | Physician/surgeon fee   | 10%  |                    | 15%  |                    |
| <b>Mental health, behavioral health, or substance abuse needs</b> | 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                  |
| <b>Pregnancy</b>  | Prenatal care and preconception visits  | No cost share                                  |                    | No cost share                                  |                    |
|   | Delivery and all inpatient services   | Hospital                                       | 10%                | 15%  | X                  |
|   |   | Professional                                   | 10%                |  | 15%                |
| <b>Help recovering or other special health needs</b>              | Home health care  | 10%  |                    | 15%  |                    |
|   | Rehabilitation services   | \$3  |                    | \$15   |                    |
|   | Habilitation services   | \$3  |                    | \$15   |                    |
|   | Skilled nursing care  | 10%  |                    | 15%  | X                  |
|   | Durable medical equipment   | 10%  |                    | 15%  |                    |
| <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<br>Dental Basic Services<br>Dental Restorative and Orthodontia Services | Pediatric Dental Standard Plan Design attached |                    | Pediatric Dental Standard Plan Design attached |                    |

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- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.
- 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
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- 4) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including 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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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

7/18/2013

**Silver Coinsurance Plan**  
**200%-250% FPL**

|  |                |
|--|----------------|
| <b>Overall deductible</b>                      | N/A            |
| <b>Other deductibles for specific services</b> |                |
| <b>Medical</b>                                 | \$1,500        |
| <b>Brand Drugs</b>                             | \$250          |
| <b>Dental</b>                                  | See attachment |
| <b>Out-of-pocket limit on expenses</b>         | \$5,200        |

| 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) | \$40   |                    |   |
|   | Specialist visit  | \$50   |                    |   |
|   | Other practitioner office visit                                 | \$40   |                    |   |
|   | Preventive care/ screening/ immunization                        | No cost share                                  |                    |   |
| <b>Tests</b>  | Laboratory Tests  | \$40   |                    |   |
|   | X-rays and Diagnostic Imaging                                   | \$50   |                    |   |
|   | Imaging (CT/PET scans, MRIs)                                    | 20%  | X                  |   |
| <b>Drugs to treat illness or condition</b>                        | Generic drugs   | \$19   |                    |   |
|   | Preferred brand drugs   | \$30   | X                  |   |
|   | Non-preferred brand drugs                                       | \$50   | X                  |   |
|   | Specialty drugs   | 20%  | X                  |   |
| <b>Outpatient surgery</b>   | Facility fee (e.g., ASC)  | 20%  |                    |   |
|   | Physician/surgeon fees  | 20%  |                    |   |
| <b>Need immediate attention</b>                                   | Emergency room services (waived if admitted)                    | \$250  | X                  |   |
|   | Emergency medical transportation                                | \$250  | X                  |   |
|   | Urgent care   | \$80   |                    |   |
| <b>Hospital stay</b>  | Facility fee (e.g., hospital room)                              | 20%  | X                  |   |
|   | Physician/surgeon fee   | 20%  |                    |   |
| <b>Mental health, behavioral health, or substance abuse needs</b> | 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                  |   |
| <b>Pregnancy</b>  | Prenatal care and preconception visits                          | No cost share                                  |                    |   |
|   | Delivery and all inpatient services                             | Hospital                                       | 20%                | X |
|   |   | Professional                                   | 20%                |   |
| <b>Help recovering or other special health needs</b>              | Home health care  | 20%  |                    |   |
|   | Rehabilitation services   | \$40   |                    |   |
|   | Habilitation services   | \$40   |                    |   |
|   | Skilled nursing care  | 20%  | X                  |   |
|   | Durable medical equipment                                       | 20%  |                    |   |
|   | Hospice service   | No cost share                                  |                    |   |
| <b>Child needs dental or eye care</b>                             | Eye exam ( <i>deductible waived</i> )                           | 0%   |                    |   |
|   | Glasses   | 1 pair per year                                |                    |   |
|   | Dental check-up - Preventive and Diagnostic                     | Pediatric Dental Standard Plan Design attached |                    |   |
|   | 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. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.
- 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 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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|  | Silver Copay Plan<br>100%-150% FPL | Silver Copay Plan<br>150%-200% FPL |
|--|------------------------------------|------------------------------------|
| <b>Overall deductible</b>                      | \$0                                | N/A                                |
| <b>Other deductibles for specific services</b> |                                    |                                    |
| <b>Medical</b>                                 | \$0                                | \$500                              |
| <b>Brand Drugs</b>                             | \$0                                | \$50                               |
| <b>Dental</b>                                  | See attachment                     | See attachment                     |
| <b>Out-of-pocket limit on expenses</b>         | \$2,250                            | \$2,250                            |

| 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) | \$3  |                       | \$15   |                    |
|   | Specialist visit  | \$5  |                       | \$20   |                    |
|   | Other practitioner office visit                                 | \$3  |                       | \$15   |                    |
|   | Preventive care/ screening/ immunization                        | No cost share                                  |                       | No cost share                                  |                    |
| <b>Tests</b>  | Laboratory Tests  | \$3  |                       | \$15   |                    |
|   | X-rays and Diagnostic Imaging                                   | \$5  |                       | \$20   |                    |
|   | Imaging (CT/PET scans, MRIs)                                    | \$50   |                       | \$100  |                    |
| <b>Drugs to treat illness or condition</b>                        | Generic drugs   | \$3  |                       | \$5  |                    |
|   | Preferred brand drugs   | \$5  |                       | \$15   | X                  |
|   | Non-preferred brand drugs                                       | \$10   |                       | \$25   | X                  |
|   | Specialty drugs   | 10%  |                       | 15%  | X                  |
| <b>Outpatient surgery</b>   | Facility fee (e.g., ASC)  | 10%  |                       | 15%  |                    |
|   | Physician/surgeon fees  | 10%  |                       | 15%  |                    |
| <b>Need immediate attention</b>                                   | Emergency room services (waived if admitted)                    | \$25   |                       | \$75   | X                  |
|   | Emergency medical transportation                                | \$25   |                       | \$75   | X                  |
|   | Urgent care   | \$6  |                       | \$30   |                    |
| <b>Hospital stay</b>  | Facility fee (e.g., hospital room)                              | 10%  |                       | 15%  | X                  |
|   | Physician/surgeon fee   |  |                       |  |                    |
| <b>Mental health, behavioral health, or substance abuse needs</b> | 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                  |
| <b>Pregnancy</b>  | Prenatal care and preconception visits                          | No cost share                                  |                       | No cost share                                  |                    |
|   | Delivery and all inpatient services                             | 10%  | Hospital Professional | 15%  | X                  |
| <b>Help recovering or other special health needs</b>              | Home health care  |  | \$3                   |  | \$15               |
|   | Rehabilitation services   | \$3  |                       | \$15   |                    |
|   | Habilitation services   | \$3  |                       | \$15   |                    |
|   | Skilled nursing care  | 10%  |                       | 15%  | X                  |
|   | Durable medical equipment                                       | 10%  |                       | 15%  |                    |
|   | Hospice service   | No cost share                                  |                       | No cost share                                  |                    |
| <b>Child needs dental or eye care</b>                             | Eye exam (deductible waived)                                    | 0%   |                       | 0%   |                    |
|   | Glasses   | 1 pair per year                                |                       | 1 pair per year                                |                    |
|   | Dental check-up - Preventive and Diagnostic                     | Pediatric Dental Standard Plan Design attached |                       | Pediatric Dental Standard Plan Design attached |                    |
|   | 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. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.
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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

7/18/2013

**Silver Copay Plan**  
**200%-250% FPL**

|  |                |
|--|----------------|
| <b>Overall deductible</b>                      | N/A            |
| <b>Other deductibles for specific services</b> |                |
| <b>Medical</b>                                 | \$1,500        |
| <b>Brand Drugs</b>                             | \$250          |
| <b>Dental</b>                                  | See attachment |
| <b>Out-of-pocket limit on expenses</b>         | \$5,200        |

| 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) | \$40   |                    |
|   | Specialist visit  | \$50   |                    |
|   | Other practitioner office visit                                 | \$40   |                    |
|   | Preventive care/ screening/ immunization                        | No cost share                                  |                    |
| <b>Tests</b>  | Laboratory Tests  | \$40   |                    |
|   | X-rays and Diagnostic Imaging                                   | \$50   |                    |
|   | Imaging (CT/PET scans, MRIs)                                    | \$250  |                    |
| <b>Drugs to treat illness or condition</b>                        | Generic drugs   | \$19   |                    |
|   | Preferred brand drugs   | \$30   | X                  |
|   | Non-preferred brand drugs                                       | \$50   | X                  |
|   | Specialty drugs   | 20%  | X                  |
| <b>Outpatient surgery</b>   | Facility fee (e.g., ASC)  | 20%  |                    |
|   | Physician/surgeon fees  | 20%  |                    |
| <b>Need immediate attention</b>                                   | Emergency room services (waived if admitted)                    | \$250  | X                  |
|   | Emergency medical transportation                                | \$250  | X                  |
|   | Urgent care   | \$80   |                    |
| <b>Hospital stay</b>  | Facility fee (e.g., hospital room)                              | 20%  | X                  |
|   | Physician/surgeon fee   |  |                    |
| <b>Mental health, behavioral health, or substance abuse needs</b> | 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                  |
| <b>Pregnancy</b>  | Prenatal care and preconception visits                          | No cost share                                  |                    |
|   | Delivery and all inpatient services                             | Hospital<br>Professional                       | 20%                |
| <b>Help recovering or other special health needs</b>              | Home health care  | \$40   |                    |
|   | Rehabilitation services   | \$40   |                    |
|   | Habilitation services   | \$40   |                    |
|   | Skilled nursing care  | 20%  | X                  |
|   | Durable medical equipment                                       | 20%  |                    |
|   | Hospice service   | No cost share                                  |                    |
| <b>Child needs dental or eye care</b>                             | Eye exam ( <i>deductible waived</i> )                           | 0%   |                    |
|   | Glasses   | 1 pair per year                                |                    |
|   | Dental check-up - Preventive and Diagnostic                     | Pediatric Dental Standard Plan Design attached |                    |
|   | 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. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.
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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

7/18/2013

|  | Bronze Plan               | Bronze HSA Plan           |
|--|---------------------------|---------------------------|
| <b>Overall deductible</b>                      | \$5,000 integrated Med/Rx | \$4,500 integrated Med/Rx |
| <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>         | \$6,350                   | \$6,350                   |

| 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   | \$19   | 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   | After 1st 3 non-preventive visits | 40%  | X                  |   |
|   | Mental/Behavioral health inpatient services                     | 30%  | X                                 | 40%  | X                  |   |
|   | Substance use disorder outpatient services                      | \$60   | After 1st 3 non-preventive visits | 40%  | X                  |   |
|   | Substance use disorder inpatient services                       | 30%  | X                                 | 40%  | X                  |   |
| <b>Pregnancy</b>  | Prenatal care and preconception visits                          | No cost share                                  |                                   | No cost share                                  |                    |   |
|   | 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                  |   |
|   | Hospice service   | No cost share                                  | X                                 | No cost share                                  | X                  |   |
| <b>Child needs dental or eye care</b>                             | Eye exam (deductible waived)                                    | 0%   |                                   | 0%   |                    |   |
|   | Glasses   | 1 pair per year                                |                                   | 1 pair per year                                |                    |   |
|   | Dental check-up - Preventive and Diagnostic                     | Pediatric Dental Standard Plan Design attached |                                   | Pediatric Dental Standard Plan Design attached |                    |   |
|   | 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. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.
- 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 outpatient Mental Health/Substance Abuse visits.
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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS

7/18/2013

**Catastrophic Plan**

|  |                           |
|--|---------------------------|
| <b>Overall deductible</b>                      | \$6,350 integrated Med/Rx |
| <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>         | \$6,350                   |

| 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) | 0%   | After 1st 3 non-preventive visits |   |
|   | Specialist visit  | 0%   | X                                 |   |
|   | Other practitioner office visit                                 | 0%   | X                                 |   |
|   | Preventive care/ screening/ immunization                        | No cost share                                  |                                   |   |
| <b>Tests</b>  | Laboratory Tests  | 0%   | X                                 |   |
|   | X-rays and Diagnostic Imaging                                   | 0%   | X                                 |   |
|   | Imaging (CT/PET scans, MRIs)                                    | 0%   | X                                 |   |
| <b>Drugs to treat illness or condition</b>                        | Generic drugs   | 0%   | X                                 |   |
|   | Preferred brand drugs   | 0%   | X                                 |   |
|   | Non-preferred brand drugs                                       | 0%   | X                                 |   |
|   | Specialty drugs   | 0%   | X                                 |   |
| <b>Outpatient surgery</b>   | Facility fee (e.g., ASC)  | 0%   | X                                 |   |
|   | Physician/surgeon fees  | 0%   | X                                 |   |
| <b>Need immediate attention</b>                                   | Emergency room services (waived if admitted)                    | 0%   | X                                 |   |
|   | Emergency medical transportation                                | 0%   | X                                 |   |
|   | Urgent care   | 0%   | After 1st 3 non-preventive visits |   |
| <b>Hospital stay</b>  | Facility fee (e.g., hospital room)                              | 0%   | X                                 |   |
|   | Physician/surgeon fee   | 0%   | X                                 |   |
| <b>Mental health, behavioral health, or substance abuse needs</b> | Mental/Behavioral health outpatient services                    | 0%   | After 1st 3 non-preventive visits |   |
|   | Mental/Behavioral health inpatient services                     | 0%   | X                                 |   |
|   | Substance use disorder outpatient services                      | 0%   | After 1st 3 non-preventive visits |   |
|   | Substance use disorder inpatient services                       | 0%   | X                                 |   |
| <b>Pregnancy</b>  | Prenatal care and preconception visits                          | No cost share                                  |                                   |   |
|   | Delivery and all inpatient services                             | Hospital                                       | 0%                                | X |
|   |   | Professional                                   | 0%                                | X |
| <b>Help recovering or other special health needs</b>              | Home health care  | 0%   | X                                 |   |
|   | Rehabilitation services   | 0%   | X                                 |   |
|   | Habilitation services   | 0%   | X                                 |   |
|   | Skilled nursing care  | 0%   | X                                 |   |
|   | Durable medical equipment                                       | 0%   | X                                 |   |
|   | Hospice service   | No cost share                                  | X                                 |   |
| <b>Child needs dental or eye care</b>                             | Eye exam ( <i>deductible waived</i> )                           | 0%   |                                   |   |
|   | Glasses   | 1 pair per year                                |                                   |   |
|   | Dental check-up - Preventive and Diagnostic                     | Pediatric Dental Standard Plan Design attached |                                   |   |
|   | 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. Except for high deductible health plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the single out-of-pocket deductible and a single out of pocket maximum amount. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out of pocket maximum. Once the family deductible amount is satisfied by any combination of individual deductible payments, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members. Under HDHP plans, the family deductible must be satisfied before the plan pays anything for services for any individual in the family, and the family out-of-pocket maximum must be satisfied before any individual's cost sharing responsibility ends.
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