

Date: April	l 17, 2014					
Summary of	Benefits and Coverage					
	Share amounts describe the Enrollee's out of	Platinu		Platinu		
pocket costs.		Coinsurance Plan 88.10%		Copay P		
Actuariai value	e - AV Calculator		/o	88.009	/0	
	rall deductible	\$0		\$0		
Other Individua	al deductibles for specific services Medical	\$0		\$0		
	Brand Drugs	\$0		\$0		
	Dental	\$0	0	\$0 \$4,00	2	
Individual Out-	-of-pocket maximum	\$4,00	0	\$4,00	J	
Common		Member Cost		Member Cost		
Medical Event	Service Type	Share	Deductible Applies	Share	Deductible Applies	
Health care	Primary care visit or non-specialist practitioner	\$20		\$20		
provider's	visit to treat an injury or illness	ΨΖΟ		ψ20		
office or	Specialist visit	¢40		£40		
clinic visit		\$40		\$40		
	Preventive care/ screening/ immunization	No cost share		No cost share		
Teete	Laboratory Tests	\$20		\$20		
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	\$40 10%		\$40 \$150		
	Generic drugs	\$5		\$150		
Drugs to treat	Preferred brand drugs	\$15		\$15		
illness or condition	Non-preferred brand drugs	\$25		\$25		
condition	Specialty drugs	10%		10%		
Outpatient	Facility fee (e.g., ASC)	10%		\$250		
surgery	Physician/surgeon fees	10%				
	Emergency room services (waived if admitted)	\$150		\$150		
Need	Emergency medical transportation	\$150		\$150		
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 outpatient services	\$20		\$20		
Mental health, behavioral	Maatal/Daharianal haalth innatiant as nissa	4.007		\$250 per day up		
health, or	Mental/Behavioral health inpatient services	10%		to 5 days		
substance						
abuse needs	Substance use disorder outpatient services	\$20		\$20		
		Ψ20		Ψ20		
				•••••		
	Substance use disorder inpatient services	10%		\$250 per day up to 5 days		
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share		
grandy	Delivery and all inpatient Hospital	10%		\$250 per day up		
	services Professional Home health care	<u> </u>		to 5 days \$20		
	Outpatient Rehabilitation services	10% \$20		\$20	_	
Help	Outpatient Habilitation services	\$20		\$20		
recovering or				\$150 per day up		
other special	Skilled nursing care	10%		to 5 days		
health needs	Durable medical equipment	10%		10%		
	Hospice service	No cost share		No cost share		
Child	Eye exam	No cost share		No cost share		
Child eye care	1 pair of glasses per year (or contact lenses in lieu	No cost share		No cost share		
Suro	of glasses)			NO COST SIIGLE		
Child Dental	Oral Exam Preventive - Cleaning					
Diagnostic	Preventive - Cleaning Preventive - X-ray					
and	Sealants per Tooth	Not Covered		Not Covered		
Preventive	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental						
Basic	Amalgam Fill - 1 Surface	Not Covered		Not Covered		
Services						
Child Dental	Root Canal- Molar Gingiyoctomy per Quad			Not Covered		
Major	Gingivectomy per Quad Extraction- Single Tooth Exposed Root or	Not Coverd		Not Covered Not Covered		
Services	Extraction- Complete Bony			Not Covered		
	Porcelain with Metal Crown			Not Covered		
Child	Madianthana					
Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered		

### Summary of Benefits and Coverage

 Member Cost Share amounts describe the Enrollee's out of pocket costs.
 Gold
 Gold

 Coinsurance Plan
 Copay Plan

Member Cost Share amounts describe the Enrollee's out of pocket costs.		Gold Coinsurance Plan		Gold Copay Plan		
-	e - AV Calculator		78.80%		78.60%	
Individual Ove	rall deductible		\$0		\$0	
	al deductibles for specific servic	es	ψυ		φ0	
	Medical		\$0		\$0	
	Brand Drugs Dental		\$0 \$0		\$0 \$0	
Individual Out-	–of–pocket maximum		\$6,250	0	\$6,250	)
Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or	Primary care visit or non-specialis visit to treat an injury or illness	t practitioner	\$30		\$30	
clinic visit	Specialist visit		\$50		\$50	
	Preventive care/ screening/ immu	nization	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		\$15		\$15	
illness or	Preferred brand drugs		\$50		\$50	
condition	Non-preferred brand drugs		\$70		\$70	
	Specialty drugs		20%		20%	
Outpatient	Facility fee (e.g., ASC)		20%		\$600	
surgery	Physician/surgeon fees	d if admitted)	20%		<b>*</b> 250	
	Emergency room services (waived Emergency medical transportation	,	\$250 \$250		\$250 \$250	
Need immediate attention	Urgent care		\$60		\$60	
	Facility fee (e.g. hospital room)		200/		¢600 per dev up	
Hospital stay	Physician/surgeon fee		20% 20%		\$600 per day up to 5 days	
Mental health, behavioral	Mental/Behavioral health outpatien		\$30		\$30 \$600 per day up	
health, or substance abuse needs	Substance use disorder outpatien	t services	\$30		to 5 days \$30	
	Substance use disorder inpatient	services	20%		\$600 per day up to 5 days	
Pregnancy	Prenatal care and preconception v Delivery and all inpatient Hos	visits	No cost share		No cost share \$600 per day up	
		fessional	20%		to 5 days	
	Home health care		20%		\$30	
	Outpatient Rehabilitation services		\$30		\$30	
Help	Outpatient Habilitation services		\$30		\$30	
recovering or	Skilled nursing care		20%		\$300 per day up	
other special					to 5 days	
health needs	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
Child ove	Eye exam		No cost share		No cost share	
Child eye care	1 pair of glasses per year (or conta of glasses)	ct lenses in lieu	No cost share		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam Preventive - Cleaning Preventive - X-ray Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed		Not Covered		Not Covered	
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
	Root Canal- Molar				Not Covered	
Child Dental	Gingivectomy per Quad				Not Covered	
Major	Extraction- Single Tooth Exposed	Root or	Not Coverd		Not Covered	
Services	Extraction- Complete Bony				Not Covered	
	Porcelain with Metal Crown				Not Covered	
Child Orthodontics	Medically necessary orthodontics		Not Covered		Not Covered	

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Date: April 17, 2014

Summarv of	Benefits and Coverag	е	Individ	ual	Individ	ual
	hare amounts describe the E		Silve		Silve	
oocket costs.			Coinsurand	e Plan	Copay Plan	
Actuarial Value	- AV Calculator		70.30%		69.90%	
ndividual Over	all deductible		N/A		N/A	
	al deductibles for specific s	services				
	Medical		\$2,00	0	\$2,00	0
	Brand Drugs		\$250	)	\$250	
	Dental -of–pocket maximum		\$0 \$6,25	0	\$0 \$6,25	0
			ψ0,23	0	ψ0,23	0
Common			Member Cost	Deductible	Member Cost	Deductible
Medical Event	Service Ty	/pe	Share	Applies	Share	Deductible Applies
lealth care	Primary care visit or non-spe	ecialist practitioner	\$45		\$45	
provider's	visit to treat an injury or illne	SS	φ <del>4</del> 0		φ <del>4</del> 5	
office or						
linic visit	Specialist visit		\$65		\$65	
	Preventive care/ screening/	immunization	No cost share		No cost share	
	Laboratory Tests		\$45		\$45	
	X-rays and Diagnostic Imagi	ing	\$65		\$65	
	Imaging (CT/PET scans, MF	RIs)	20%	Х	\$250	
Irugs to treat	Generic drugs		\$15		\$15	
liness or	Preferred brand drugs		\$50	Х	\$50	X
ondition	Non-preferred brand drugs		\$70	X	\$70	Х
	Specialty drugs		20%	<u> </u>	20%	X
	Facility fee (e.g., ASC)		20%		20%	
	Physician/surgeon fees	vaived if admitted	20%	X	20%	X
	Emergency room services (v Emergency medical transpo	,	\$250 \$250	X	\$250 \$250	X
Veed	Emergency medical transpo	Itation	φ230	~	\$250	
mmediate						
attention	Urgent care		\$90		\$90	
	Facility fee (e.g. hospital roc	om)	20%	Х		V
Hospital stav	Physician/surgeon fee	,	20%		20%	Х
	Mental/Behavioral health ou	tpatient services	\$45		\$45	
Mental health,						
pehavioral nealth, or	Mental/Behavioral health inp	batient services	20%	Х	20%	Х
substance						
abuse needs	Substance use disorder out	actiont convicos	\$45		\$45	
	Substance use disorder out	Salient Services	<b>Φ4</b> Ο		<b>Φ4</b> Ο	
	Substance use disorder inpa	atient services	20%	х	20%	х
	·					
	Prenatal care and preconce	ption visits	No cost share		No cost share	
Pregnancy	Delivery and all inpatient	Hospital	20%	Х	200/	v
	services	Professional	20%		20%	Х
	Home health care		20%		\$45	
	Outpatient Rehabilitation se		\$45		\$45	
•	Outpatient Habilitation servi	ces	\$45		\$45	
ecovering or	Skilled nursing care		20%	х	20%	х
other special nealth needs	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
Child eye	Eye exam		No cost share		No cost share	
are	1 pair of glasses per year (o	r contact lenses in lieu	No cost share		No cost share	
	of glasses) Oral Exam					
	Preventive - Cleaning					
Diagnostic	Preventive - X-ray		Net Orac		Net Oracial	
-	Sealants per Tooth		Not Covered		Not Covered	
	Topical Fluoride Application					
	Space Maintainers - Fixed					
Child Dental						
	Amalgam Fill - 1 Surface		Not Covered		Not Covered	
Services	Deat Occur Mail					
Child Dental	Root Canal- Molar				Not Covered	
	Gingivectomy per Quad Extraction- Single Tooth Exp	oosed Root or	Not Coverd		Not Covered Not Covered	
	Extraction- Complete Bony				Not Covered	
Services	Porcelain with Metal Crown				Not Covered	
Services					Not Covered	

Summary of	Benefits and Coverage	S	НОР	SHO	P	
	share amounts describe the Enrollee's out of		ilver	Silver		
oocket costs.			rance Plan	Copay Plan		
ctuarial Value	e - AV Calculator	71.50%		71.00%		
	rall deductible		N/A	N/A	l l	
other individua	al deductibles for specific services Medical	\$	1,500	\$1,50	חר	
	Brand Drugs		500	\$50		
	Dental		\$0	\$0		
ndividual Out-	-of–pocket maximum	\$6	6,250	\$6,25	50	
Common Medical Event	Convice Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies	
	Service Type	Onare	Deddetible Applies	Onare	Applies	
lealth care provider's office or	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$45		\$45		
linic visit	Specialist visit	\$65		\$65		
	Preventive care/ screening/ immunization	No cost share		No cost share		
ests	Laboratory Tests X-rays and Diagnostic Imaging	\$45 \$65		\$45 \$65		
0313	Imaging (CT/PET scans, MRIs)	305 20%	Х	\$250		
	Generic drugs	\$15		\$15		
Prugs to treat	Preferred brand drugs	\$50	X	\$50	Х	
Iness or ondition	Non-preferred brand drugs	\$70	Х	\$70	Х	
onunion	Specialty drugs	20%	Х	20%	Х	
Outpatient	Facility fee (e.g., ASC)	20%		20%		
urgery	Physician/surgeon fees	20%		20%		
	Emergency room services (waived if admitted)	\$250	X	\$250	Х	
leed	Emergency medical transportation	\$250	X	\$250	Х	
nmediate ttention	Urgent care	\$90		\$90		
	Facility fee (e.g. hospital room)	20%	X	200/	х	
lospital stay	Physician/surgeon fee	20%		20%	Χ.	
lental health,	Mental/Behavioral health outpatient services	\$45		\$45		
ehavioral	Mental/Behavioral health inpatient services	20%	Х	20%	Х	
nealth, or substance abuse needs	Substance use disorder outpatient services	\$45		\$45		
	Substance use disorder inpatient services	20%	x	20%	х	
	Prenatal care and preconception visits	No cost share		No cost share		
Pregnancy	Delivery and all inpatient Hospital	20%	X	20%	х	
	services Professional	20%			^	
	Home health care	20%		\$45		
lala	Outpatient Rehabilitation services Outpatient Habilitation services	\$45 \$45		\$45 \$45		
lelp ecovering or		\$45		\$45		
ther special	Skilled nursing care	20%	Х	20%	Х	
ealth needs	Durable medical equipment	20%		20%		
	Hospice service	No cost share		No cost share		
	Eye exam	No cost share		No cost share		
child eye are	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share		No cost share		
	Oral Exam					
Child Dental	Preventive - Cleaning					
)iagnostic nd	Preventive - X-ray Sealants per Tooth	Not Covered		Not Covered		
reventive	Topical Fluoride Application					
	Space Maintainers - Fixed					
child Dental asic services	- Amalgam Fill - 1 Surface	Not Covered		Not Covered		
	Root Canal- Molar			Not Covered		
Child Dental	Gingivectomy per Quad			Not Covered		
	Extraction- Single Tooth Exposed Root or	Not Coverd		Not Covered		
-				Net Courses		
-	Extraction- Complete Bony			Not Covered		
Major Services Child	Extraction- Complete Bony Porcelain with Metal Crown			Not Covered		

# 2015 Standard Benefit Plan Designs 9.5 EHB

Date: April 17, 2014

-	Benefits and Coverage hare amounts describe the Enrollee's out of	SHC	
pocket costs.		HSA P	
	e - AV Calculator	71.60	
ndividual Over	rall deductible al deductibles for specific services	\$1,500 integrated	d Med/Rx Ded
	Medical	N/A	١
	Brand Drugs	N/A	
ndividual Out-	Dental -of–pocket maximum	N/A \$6,2	
	- -		
Common			
Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or	Primary care visit or non-specialist practitioner visit to treat an injury or illness	20%	х
clinic visit	Specialist visit	20%	Х
	Preventive care/ screening/ immunization	No cost share	
	Laboratory Tests	20%	Х
Tests	X-rays and Diagnostic Imaging	20%	X
	Imaging (CT/PET scans, MRIs) Generic drugs	20%	<u> </u>
Drugs to treat	Preferred brand drugs	20%	X
Ilness or condition	Non-preferred brand drugs	20%	X
	Specialty drugs	20%	X
Outpatient	Facility fee (e.g., ASC)	20%	X
surgery	Physician/surgeon fees Emergency room services (waived if admitted)	20%	× ×
	Emergency medical transportation	20%	X
Need Immediate attention	Urgent care	20%	х
Hospital stay	Facility fee (e.g. hospital room)	20%	Х
nospital stay	Physician/surgeon fee	20%	X
Mental health,	Mental/Behavioral health outpatient services	20%	х
behavioral	Mental/Behavioral health inpatient services	20%	х
nealth, or substance abuse needs	Substance use disorder outpatient services	20%	x
	Substance use disorder inpatient services	20%	х
	Prenatal care and preconception visits	No cost share	
Pregnancy	Delivery and all inpatient Hospital	20%	X
	services Professional	20%	<u> </u>
	Home health care Outpatient Rehabilitation services	20% 20%	X X
Help	Outpatient Renabilitation services	20%	X
recovering or	Skilled nursing care	20%	х
other special health needs			×
icalar neeus	Durable medical equipment	20%	
	Hospice service	No cost share	X
Child eye	Eye exam 1 pair of glasses per year (or contact lenses in lie	No cost share	
care	of glasses)	No cost share	
Child Dental	Oral Exam Proventive - Cleaning		
Diagnostic	Preventive - Cleaning Preventive - X-ray		
and	Sealants per Tooth	Not Covered	
Preventive	Topical Fluoride Application		
Child Dental Basic Services	Space Maintainers - Fixed Amalgam Fill - 1 Surface	Not Covered	
	Root Canal- Molar		
Child Dental	Gingivectomy per Quad		
Major Services	Extraction- Single Tooth Exposed Root or Extraction- Complete Bony	Not Coverd	
	Porcelain with Metal Crown		
Child			

#### Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of Silver Coinsurance Plan Silver Coinsurance Plan pocket costs. 100%-150% FPL 150%-200% FPL Actuarial Value - AV Calculator 94.80% 88.00% Individual Overall deductible Other individual deductibles for specific services \$0 N/A Medical \$0 \$500 Brand Drugs \$0 \$50 Dental \$0 \$0 Individual Out-of-pocket maximum \$2,250 \$2,250 Member Cost Deductible Member Cost Deductible Medical Event Service Type Share Share Primary care visit or non-specialist practitioner Health care \$3 \$15 visit to treat an injury or illness provider's office or Specialist visit \$5 \$20 clinic visit Preventive care/ screening/ immunization No cost share No cost share Laboratory Tests \$3 \$15 X-rays and Diagnostic Imaging Tests \$5 \$20 Imaging (CT/PET scans, MRIs) 10% 15% Х Generic drugs \$3 \$5 Drugs to treat Preferred brand drugs \$15 \$5 Х illness or Non-preferred brand drugs \$10 \$25 Х condition Specialty drugs Facility fee (e.g., ASC) 15% 10% Х Outpatient 10% 15% Physician/surgeon fees surgery 10% 15% Emergency room services (waived if admitted) \$25 \$75 Х Emergency medical transportation \$25 \$75 Х Need immediate attention Urgent care \$6 \$30 Facility fee (e.g. hospital room) 10% 15% Х Hospital stay Physician/surgeon fee 10% 15% Mental/Behavioral health outpatient services \$3 \$15 Mental health, behavioral Mental/Behavioral health inpatient services 10% 15% Х health, or substance abuse needs Substance use disorder outpatient services \$3 \$15 Substance use disorder inpatient services 10% 15% Х Prenatal care and preconception visits No cost share No cost share Pregnancy Delivery and all inpatient Hospital 15% 10% Х services Professional 10% 15% Home health care 10% 15% Outpatient Rehabilitation services \$3 \$15 Outpatient Habilitation services Help \$3 \$15 recovering or Skilled nursing care 10% 15% Х other special health needs Durable medical equipment 10% 15% Hospice service No cost share No cost share Eye exam No cost share No cost share Child eye 1 pair of glasses per year (or contact lenses in lieu care No cost share No cost share of glasses) Oral Exam Child Dental Preventive - Cleaning Diagnostic Preventive - X-ray Not Covered Not Covered and Sealants per Tooth Topical Fluoride Application Preventive Space Maintainers - Fixed **Child Dental** Amalgam Fill - 1 Surface Not Covered Not Covered Basic Services Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Child Dental Not Coverd Not Coverd Major Services Extraction- Complete Bony Porcelain with Metal Crown Child Medically necessary orthodontics Not Covered Not Covered Orthodontics

## Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs. Silver Coinsurance Plan 200%-250% FPL

Member Cost S pocket costs.	hare amounts describe the Enrollee's out of	Silver Coinsur 200%-250	
•	e - AV Calculator	rounded up t	
Individual Ove	rall deductible	N/A	
	al deductibles for specific services		
	Medical	\$1,60	0
	Brand Drugs	\$250	)
Individual Out	Dental -of-pocket maximum	\$0 \$5,20	0
individual Out		\$3,20	0
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$40	
clinic visit	Specialist visit	\$50	
	Preventive care/ screening/ immunization	No cost share	
	Laboratory Tests	\$40	
Tests	X-rays and Diagnostic Imaging	\$50	
	Imaging (CT/PET scans, MRIs)	20%	Х
Drugs to troat	Generic drugs	\$15	
Drugs to treat illness or	Preferred brand drugs	\$35	Х
condition	Non-preferred brand drugs	\$60	X
Outrationt	Specialty drugs	20%	X
Outpatient surgery	Facility fee (e.g., ASC) Physician/surgeon fees	20% 20%	
Surgery	Emergency room services (waived if admitted)	\$250	X
	Emergency medical transportation	\$250	X
Need immediate attention	Urgent care	\$80	
I I a construction of	Facility fee (e.g. hospital room)	20%	Х
Hospital stay	Physician/surgeon fee	20%	
Mental health,	Mental/Behavioral health outpatient services	\$40	
behavioral health, or	Mental/Behavioral health inpatient services	20%	Х
substance abuse needs	Substance use disorder outpatient services	\$40	
	Substance use disorder inpatient services	20%	х
Pregnancy	Prenatal care and preconception visits	No cost share	V
	Delivery and all inpatient Hospital services Professional	20% 20%	X
	Home health care	20%	
	Outpatient Rehabilitation services	\$40	
Help	Outpatient Habilitation services	\$40	
recovering or	Skilled nursing care	20%	х
other special health needs	Durable medical equipment	20%	
nearth neeus			
	Hospice service	No cost share	
Child eye	Eye exam	No cost share	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share	
	Oral Exam		
Child Dental	Preventive - Cleaning		
and	iagnostic Preventive - X-ray nd Sealants per Tooth		
Preventive	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic Services	Amalgam Fill - 1 Surface	Not Covered	
	Root Canal- Molar		
Child Dental	Gingivectomy per Quad	Net Orect	
Major Services	Extraction- Single Tooth Exposed Root or Extraction- Complete Bony	Not Coverd	
	Porcelain with Metal Crown		
Child Orthodontics	Medically necessary orthodontics	Not Covered	

# 2015 Standard Benefit Plan Designs 9.5 EHB

Date: April 17, 2014

### Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of 5ilver Copay Plan 5ilver Copay Plan 5ilver Copay Plan 50%-200% FPL 150%-200% FPL

Member Cost Share amounts describe the Enrollee's out of pocket costs.		Silver Copay Plan 100%-150% FPL		Silver Copay Plan 150%-200% FPL		
•	e - AV Calculator	_	94.90		88.00%	
Individual Ove	rall deductible		\$0		N/A	
	al deductibles for specific services	5	÷.			
	Medical		\$0		\$500	
	Brand Drugs Dental		\$0 \$0		\$50 \$0	
Individual Out-	-of-pocket maximum		\$2,25	50	\$2,25	
Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or	Primary care visit or non-specialist p visit to treat an injury or illness Specialist visit	practitioner	\$3		\$15 \$20	
clinic visit		ation .				
	Preventive care/ screening/ immuniz	ation	No cost share		No cost share	
	Laboratory Tests		\$3		\$15	
Tests	X-rays and Diagnostic Imaging		\$5 \$5		\$20	
	Imaging (CT/PET scans, MRIs) Generic drugs		\$50 \$3		\$100 \$5	
Drugs to treat	Preferred brand drugs		\$3 \$5		\$5 \$15	Х
illness or	Non-preferred brand drugs		\$10		\$25	X
condition	Specialty drugs		10%		15%	X
Outpatient	Facility fee (e.g., ASC)		10%		15%	
surgery	Physician/surgeon fees		10%		15%	
	Emergency room services (waived if	f admitted)	\$25		\$75	Х
	Emergency medical transportation		\$25		\$75	Х
Need immediate attention	Urgent care		\$6		\$30	
Hospital stay	Facility fee (e.g. hospital room) Physician/surgeon fee		10%		15%	х
Mental health,	Mental/Behavioral health outpatient	services	\$3		\$15	
behavioral health, or	Mental/Behavioral health inpatient se	ervices	10%		15%	Х
substance abuse needs	Substance use disorder outpatient s	ervices	\$3		\$15	
	Substance use disorder inpatient se	rvices	10%		15%	х
Pregnancy	Prenatal care and preconception vis	its	No cost share		No cost share	
regnancy	Delivery and all inpatient Hospi services Profes	ital ssional	10%		15%	Х
	Home health care		\$3		\$15	
	Outpatient Rehabilitation services		\$3		\$15	
Help	Outpatient Habilitation services		\$3		\$15	
recovering or	Skilled nursing care		10%		15%	х
other special health needs	Durable medical equipment		10%		15%	
illuarin neeus	Hospice service		No cost share			
					No cost share	
Child eye	Eye exam 1 pair of glasses per year (or contact	lenses in liou	No cost share		No cost share	
care	of glasses) Oral Exam	ioniaca III ileu	No cost share		No cost share	
Child Dental	Preventive - Cleaning					
Diagnostic	Preventive - X-ray		Net Care		Net Carry	
and	Sealants per Tooth		Not Covered		Not Covered	
Preventive	Topical Fluoride Application					
Child Dental Basic Services	Space Maintainers - Fixed Amalgam Fill - 1 Surface		Not Covered		Not Covered	
	Root Canal- Molar		Not Covered		Not Covered	
Child Dental	Gingivectomy per Quad		Not Covered		Not Covered	
Major	Extraction- Single Tooth Exposed Ro	oot or	Not Covered		Not Covered	
Services	Extraction- Complete Bony		Not Covered		Not Covered	
	Porcelain with Metal Crown		Not Covered		Not Covered	
Child	Medically necessary orthodontics		Not Covered		Not Covered	

Summary of Benefits and Coverage

-	Benefits and Coverage	ut of	Silver Con	ny Dian	
pocket costs.	hare amounts describe the Enrollee's c	out of	Silver Copa 200%-2509	% FPL	
Actuarial Value	e - AV Calculator		73.50	%	
Individual Ove	rall deductible		N/A		
Other individu	al deductibles for specific services				
	Medical		\$1,60	0	
	Brand Drugs		\$250		
	Dental		\$0		
Individual Out	-of-pocket maximum		\$5,20	0	
Common			Member Cost	Deductible	
Medical Event	Service Type		Share	Applies	
Health care provider's office or	Primary care visit or non-specialist pra visit to treat an injury or illness	ctitioner	\$40		
clinic visit	Specialist visit		\$50		
	Preventive care/ screening/ immunizat	ion	No cost share		
	Laboratory Tests		\$40		
Tests	X-rays and Diagnostic Imaging		\$50		
	Imaging (CT/PET scans, MRIs)		\$250		
Drugs to treat	Generic drugs		\$15		
illness or	Preferred brand drugs		\$35	X	
condition	Non-preferred brand drugs		\$60	Х	
	Specialty drugs		20%	Χ	
Outpatient	Facility fee (e.g., ASC)		20%		
surgery	Physician/surgeon fees		20%		
	Emergency room services (waived if a	dmitted)	\$250	Х	
	Emergency medical transportation		\$250	Х	
Need immediate attention	Urgent care	\$80			
	Facility fee (e.g. hospital room)		200/	v	
Hospital stay	Physician/surgeon fee		20%	Х	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services Mental/Behavioral health inpatient services Substance use disorder outpatient services		\$40 20% \$40	X	
	Substance use disorder inpatient servi	ces	20%	x	
	Prenatal care and preconception visits		No cost share		
Pregnancy	· · · ·				
	Delivery and all inpatient Hospital services Professi		20%	Х	
	1101000	onal	<b>.</b>		
	Home health care		\$40		
Holp	Outpatient Rehabilitation services Outpatient Habilitation services		\$40		
Help recovering or	Carpanent nabilitation services		\$40		
other special	Skilled nursing care		20%	Х	
health needs	Durable medical equipment		20%		
			No cost share		
	Hospice service				
Child eye	Eye exam		No cost share		
care	1 pair of glasses per year (or contact ler of glasses)	ises in lieu	No cost share		
Child Dental	Oral Exam Preventive - Cleaning				
Diagnostic	Preventive - X-ray				
and	Sealants per Tooth		Not Covered		
Preventive	e calane per recur				
	Space Maintainers - Fixed				
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		
	Root Canal- Molar		Not Covered		
Child Dental	Gingivectomy per Quad		Not Covered		
Major	Extraction- Single Tooth Exposed Roo	t or	Not Covered		
Services	Extraction- Complete Bony		Not Covered		
	Porcelain with Metal Crown		Not Covered		
Child	Medically necessary orthodontics		Not Covered		
Orthodontics					

### Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs. Bronze Plan HSA Plan

Member Cost Share amounts describe the Enrollee's out of pocket costs.		Bro	Bronze Plan		Bronze HSA Plan	
Actuarial Value	e - AV Calculator	6	0.60%	59.40%		
	rall deductible	\$5,000 integr	ated Med/Rx Ded	\$4,500 integra	ted Med/R	
Other individu	al deductibles for specific services		N1/A			
	Medical Brand Drugs		N/A N/A	N/A N/A		
	Dental		\$0	N/A		
ndividual Out-	-of–pocket maximum	\$	\$6,250		50	
Common Medical Event	Service Type	Member Co Share	st Deductible Applies	Member Cost Share	Deductibl Applies	
Health care provider's office or	Primary care visit or non-specialist practition visit to treat an injury or illness	er \$60	After 1st three non- preventive visits	40%	x	
clinic visit	Specialist visit	\$70	X	40%	X	
	Preventive care/ screening/ immunization	No cost shar	е	No cost share		
	Laboratory Tests	30%	X	40%	Х	
lests	X-rays and Diagnostic Imaging	30%	Х	40%	Х	
	Imaging (CT/PET scans, MRIs)	30%	Х	40%	Х	
Drugs to treat	Generic drugs	\$15	Х	40%	Х	
illness or	Preferred brand drugs	\$50	Х	40%	Х	
condition	Non-preferred brand drugs	\$75	Х	40%	Х	
	Specialty drugs	30%	<u> </u>	40%	<u>X</u>	
Outpatient	Facility fee (e.g., ASC)	30%	X	40%	X	
surgery	Physician/surgeon fees	30%	X	40%	X	
	Emergency room services (waived if admitte	· ·	X	40%	X	
Need Immediate attention	Emergency medical transportation	\$300	After 1st three non- preventive visits	40% 40%	x	
	Facility fee (e.g. hospital room)	30%	X	40%	X	
Hospital stay	Physician/surgeon fee	30%	X	40%	X	
Mental health.	Mental/Behavioral health outpatient services	\$60	After 1st three non- preventive visits	40%	x	
behavioral health, or	Mental/Behavioral health inpatient services	30%	х	40%	x	
substance abuse needs	Substance use disorder outpatient services	\$60	After 1st three non- preventive visits	40%	х	
	Substance use disorder inpatient services	30%	х	40%	х	
Pregnancy	Prenatal care and preconception visits	No cost shar	e	No cost share		
regnariey	Delivery and all inpatient Hospital	30%	X	40%	X	
	services Professional	30%	X	40%	X	
	Home health care	30%	Х	40%	Х	
	Outpatient Rehabilitation services	\$60	X	40%	X	
Help	Outpatient Habilitation services	\$60	X	40%	Х	
ecovering or other special	Skilled nursing care	30%	х	40%	х	
nealth needs	Durable medical equipment	30%	X	40%	Х	
	Hospice service	No cost sha	re X	No cost share	х	
	Eye exam	No cost cho	<u> </u>	No cost charo		
Child eye care	1 pair of glasses per year (or contact lenses in of glasses)	lieu No cost shai		No cost share No cost share		
	Oral Exam					
Child Dental	Preventive - Cleaning					
Diagnostic	Preventive - X-ray	Not Covere		Not Covered		
and	Sealants per Tooth		-			
Preventive	Topical Fluoride Application					
Child Dental Basic Services	Space Maintainers - Fixed Amalgam Fill - 1 Surface	Not Covered		Not Covered		
	Root Canal- Molar					
Child Dental Major Services	Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Extraction- Complete Bony Porcelain with Metal Crown	Not Covered	te	Not Covered		
Child Orthodontics	Medically necessary orthodontics	Not Covered	t	Not Covered		

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.			Catastrophic Plan		
·	e - AV Calculator				
Individual Ove	rall deductible		\$6,600 integrat	ed Med/Rx	
Other individua	al deductibles for specific serv	/ices			
	Medical Brand Drugs		N/A		
	Brand Drugs Dental		N/A N/A		
Individual Out-	-of–pocket maximum		\$6,60		
Common Medical Event	Service Type	Member Cost Share	Deductible Applies		
Health care provider's office or	er's or Contract an injury or liness			After 1st three non- preventive visits	
clinic visit	Specialist visit		0%	Х	
	Preventive care/ screening/ imn	nunization	No cost share		
	Laboratory Tests		0%	Х	
Tests	X-rays and Diagnostic Imaging		0%	Х	
	Imaging (CT/PET scans, MRIs)		0% 0%	Х	
Drugs to treat	Generic drugs			X	
illness or	Preferred brand drugs		0%	X	
condition	Non-preferred brand drugs Specialty drugs		0%	X	
Outpatient	Facility fee (e.g., ASC)		0% 0%	X X	
surgery	Physician/surgeon fees		0%	X	
	Emergency room services (waiv	ved if admitted)	0%	X	
	Emergency medical transportati		0%	X	
Need immediate attention	Urgent care	0%	After 1st three non- preventive visits		
Hospital stay	Facility fee (e.g. hospital room) Physician/surgeon fee		0% 0%	X	
Mental health.	Mental/Behavioral health outpat	0%	After 1st three non- preventive visits		
behavioral health, or	Mental/Behavioral health inpatie	0%	х		
substance abuse needs	Substance use disorder outpation	ent services	0%	After 1st three non- preventive visits	
	Substance use disorder inpatier	nt services	0%	х	
Pregnancy	Prenatal care and preconceptio	n visits	No cost share		
regnancy		lospital	0%	X	
	services F Home health care	Professional	0%	X X	
	Home health care Outpatient Rehabilitation service	es	0% 0%	X	
Help	Outpatient Habilitation services	~~	0%	X	
recovering or					
other special	Skilled nursing care		0%	X	
health needs	Durable medical equipment		0%	Х	
	Hospice service		No cost share	х	
	Eye exam		No cost share		
Child eye care	1 pair of glasses per year (or con	ntact lenses in lieu	No cost share	v	
care	of glasses)		THU CUSI SHALE	x	
Child Dental	Oral Exam Preventive - Cleaning				
Diagnostic	Preventive - Cleaning Preventive - X-ray				
and	Sealants per Tooth		No cost share		
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Amalgam Fill - 1 Surface		Not Covered		
	Root Canal- Molar				
Child Dental	Gingivectomy per Quad	d Deat an	Net Orac		
Major Services	Extraction- Single Tooth Expose Extraction- Complete Bony	ea Root or	Not Covered		
Ser nees	Porcelain with Metal Crown				
Child	Medically necessary orthodontic	26	Not Covered		
Orthodontics			Not Covered		

# 2015 Standard Benefit Plan Designs 9.5 EHB

# Endnotes:

- 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 individual deductible and the individual out-of-pocket maximum amount. Cost sharing payments (deductibles, copayments and coinsurance, but not yet premiums) made by each individual in a family contribute to the family deductible and out-of-pocket maximums. The family deductible may be satisfied by any combination of individual deductible payments, after which member copays or coinsurance apply until the family out of pocket maximum is reached. Once the family out-of-pocket maximum is reached, the plan pays all costs for covered services for all family members.
- 2) For HDHPs linked to HSAs, an individual in a self-only coverage plan must meet a deductible of not less than the amount designated by the IRS for self-only coverage. In a family plan, each individual in the family must meet the deductible of not less than the amount designated by the IRS for family coverage, until the family deductible is met. The cost-sharing payments cannot exceed the out of pocket limits set for self-only coverage and family coverage.
- 3) Cost sharing payments for all in-network services accumulate toward the deductible, if deductible applies to that service, and the out-of-pocket maximum.
- Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount (the maximum amount on which payment is based for covered health care services).
- 5) For the Bronze and Catastrophic plans, deductible is waived for the first three non-preventive office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.
- 6) Member cost-share for oral anti-cancer drugs shall not exceed \$200 per month.
- 7) In the Platinum and Gold Copay Plans, hospital, in-patient and skilled nursing facility stays have no additional cost share after 5 days.
- 8) For drugs to treat an illness or condition the supply of drugs for which the copay or coinsurance applies is for the prescription term. Nothing in this note precludes a carrier from offering discounts that vary with the term of the prescription.