7/18/2013		COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		Platinum Coinsurance Plan		Platinum Copay Plan	
Overall deductible			\$0		\$0		
Other deductibles	for specific services		\$0		\$0		
	Medical Brand Drugs		\$0 \$0		\$0		
	Dental		See attach	nment	See attach	nment	
Out-of-pocket lim			\$4,00		\$4,00		
Common Medical			Member Cost	Deductible	Member Cost	Deductible	
Event	Service Type	e	Share	Applies	Share	Applies	
	Primary care visit to treat an inju	ırv or illness (see					
Visit to a health	footnote)	, 6	\$20		\$20		
care provider's	,						
office or clinic	Specialist visit		\$40		\$40		
	Other practitioner office visit		\$20		\$20		
	Preventive care/ screening/ imm	nunization	No cost share		No cost share		
	Laboratory Tests		\$20		\$20		
Tests	X-rays and Diagnostic Imaging		\$40		\$40		
	Imaging (CT/PET scans, MRIs)		10%		\$150		
Duvers to treat	Generic drugs		\$5		\$5		
Drugs to treat	Preferred brand drugs		\$15		\$15		
illness or	Non-preferred brand drugs		\$25		\$25		
condition	Specialty drugs		10%		10%		
Outpatient	Facility fee (e.g., ASC)		10%		¢250		
surgery	Physician/surgeon fees		10%		\$250		
	Emergency room services (waiv	ed if admitted)	\$150		\$150		
	Emergency medical transportation	on	\$150		\$150		
Need immediate attention	Urgent care		\$40		\$40		
	Facility fee (e.g., hospital room)		10%		\$250 per day up		
Hospital stay	Physician/surgeon fee		10%		to 5 days		
	Mental/Behavioral health outpat	ient services	\$20		\$20		
Mental health, behavioral health,	Mental/Behavioral health inpatie	ent services	10%		\$250 per day up		
or substance abuse needs	Substance use disorder outpatient services		\$20		to 5 days		
	Substance use disorder inpatier	nt services	10%		\$250 per day up to 5 days		
	Prenatal care and preconception	n visits	No cost share		No cost share		
Pregnancy	Delivery and all inpatient	Hospital	10%		\$250 per day up		
	services	Professional	10%		to 5 days		
	Home health care		10%		\$20		
	Rehabilitation services		\$20		\$20		
Help recovering	Habilitation services		\$20		\$20		
or other special health needs	Skilled nursing care		10%		\$150 per day up to 5 days		
	Durable medical equipment		10%		10%		
	Hospice service		No cost share		No cost share		
	Eye exam (deductible waived)		0%		0%		
	Glasses		1 pair per year		1 pair per year		
Child needs dental or eye care	Dental check-up - Preventive an Dental Basic Services Dental Restorative and Orthodo	•	Pediatric Denta Plan Design		Pediatric Denta Plan Design		

- 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.

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.

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		Gold Coinsurance Plan		Gold Copay Plan		
7/18/2013						
7710/2010						
Overall deductible			\$0		\$0	
	for specific services		ΨΟ		ΨΟ	
Other deddetables	Medical		\$0		\$0	
	Brand Drugs		\$0		\$0	
	Dental		See attach	nment	See attach	ment
Out-of-pocket lim	it on expenses		\$6,35	0	\$6,350)
Common Medical			Member Cost	Deductible	Member Cost	Deductible
Event	Service Typ	е	Share	Applies	Share	Applies
	Primary care visit to treat an inju	ıry or illness (see	\$30		\$30	
Visit to a health care provider's	footnote)		φου		φου	
office or clinic	Specialist visit		\$50		\$50	
	Other practitioner office visit		\$30		\$30	
	Preventive care/ screening/ imm	nunization	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		\$19		\$19	
illness or	Preferred brand drugs		\$50		\$50	
condition	Non-preferred brand drugs		\$70		\$70	
Outpotions	Specialty drugs		20%		20%	
Outpatient	Facility fee (e.g., ASC) Physician/surgeon fees		20%		\$600	
surgery	Emergency room services (waived if admitted)		20% \$250		\$250	
	Emergency medical transportation		\$250		\$250	
Need immediate attention	Urgent care		\$60		\$60	
	Facility fee (e.g., hospital room)		20%		\$600 per day up	
Hospital stay	Physician/surgeon fee	cian/surgeon fee			to 5 days	
	Mental/Behavioral health outpat	ient services	\$30		\$30	
Mental health, behavioral health,	Mental/Behavioral health inpation	Mental/Behavioral health inpatient services			\$600 per day up to 5 days	
or substance abuse needs	Substance use disorder outpatient services		\$30		\$30	
	Substance use disorder inpatier	nt services	20%		\$600 per day up to 5 days	
	Prenatal care and preconceptio		No cost share		No cost share	
Pregnancy	Delivery and all inpatient	Hospital	20%		\$600 per day up	
	services	Professional	20%		to 5 days	
	Home health care		20%		\$30	
Holp reserver!	Rehabilitation services		\$30		\$30	
Help recovering	Habilitation services		\$30		\$30	
or other special health needs	Skilled nursing care		20%		\$300 per day up to 5 days	
nealth ficeus	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
	Eye exam (deductible waived)		0%		0%	
01.11	Glasses		1 pair per year		1 pair per year	
Child needs	Dental check-up - Preventive ar	d Diagnostic		d Otalia da		l Otar day
dental or eye care	Dental Basic Services		Pediatric Denta		Pediatric Denta	
	Dental Restorative and Orthodo	ntia Services	Plan Design	allached	Plan Design a	allached

- Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
- 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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Covered California Standard Benefit Plan Designs - FINAL

Summary of Benefits and Coverage

ENROLLEE'S	OUT OF POCKET COSTS	Coinsurand	ce Plan	Copay Plan	
7/18/2013					
Overall deductible		N/A		N/A	
	for specific services			1 471.	
	Medical	\$2,00	0	\$2,00	0
	Brand Drugs	\$250		\$250	
	Dental	See attach		See attacl	
Out-of-pocket lim		\$6,35		\$6,35	
Common Medical		Member Cost	Deductible	Member Cost	Deductibl
Event	Service Type	Share	Applies	Share	Applies
/isit to a health care provider's	Primary care visit to treat an injury or illness (see footnote)	\$45		\$45	
office or clinic	Specialist visit	\$65		\$65	
	Other practitioner office visit	\$45		\$45	
	Preventive care/ screening/ immunization	No cost share		No cost share	
	Laboratory Tests	\$45		\$45	
ests	X-rays and Diagnostic Imaging	\$65		\$65	
	Imaging (CT/PET scans, MRIs)	20%	X	\$250	
ruge to troot	Generic drugs	\$19		\$19	
rugs to treat Iness or	Preferred brand drugs	\$50	Х	\$50	Х
	Non-preferred brand drugs	\$70	X	\$70	Х
ondition	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
	Emergency medical transportation	\$250	Х	\$250	Х
leed immediate attention	Urgent care	\$90		\$90	
	Facility fee (e.g., hospital room)	20%	Х	/	.,
lospital stay	Physician/surgeon fee	20%		20%	Х
	Mental/Behavioral health outpatient services	\$45		\$45	
Mental health, behavioral health,	Mental/Behavioral health inpatient services	20%	Х	20%	Х
or substance abuse needs	Substance use disorder outpatient services	\$45		\$45	
	Substance use disorder inpatient services	20%	Х	20%	Х
	Prenatal care and preconception visits	No cost share		No cost share	
Pregnancy	Delivery and all inpatient Hospital	20%	Х		V
	services Professional	20%		20%	Х
	Home health care	20%		\$45	
	Rehabilitation services	\$45		\$45	
lelp recovering	Habilitation services	\$45		\$45	
r other special ealth needs	Skilled nursing care	20%	Х	20%	Х
eaini ileeus	Durable medical equipment	200/		20%	
	Durable medical equipment Hospice service	20%			
		No cost share		No cost share	
	Eye exam (deductible waived) Glasses	0%		0%	
Child needs		1 pair per year		1 pair per year	
lental or eye care	Dental check-up - Preventive and Diagnostic Dental Basic Services	Pediatric Dental Standard Plan Design attached		Pediatric Dental Standard Plan Design attached	

Individual

Individual

- 2) Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
- 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.

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.

Covered California Standard Benefit Plan Designs - FINAL

Summary of Benefits and Coverage

ENROLLEE'S OUT OF POCKET COSTS		Coinsurance Plan		Copay Plan	
7/18/2013					
Overall deductible		N/A		N/A	
	for specific services	IN/A		IN/A	
	Medical	\$1,50	10	\$1,50	0
	Brand Drugs	\$500		\$500	
	Dental	See attacl		See attacl	
Out-of-pocket limi	it on expenses	\$6,35		\$6,35	
Common Medical		Member Cost	Deductible	Member Cost	Deductibl
Event	Service Type	Share	Applies	Share	Applies
/isit to a health	Primary care visit to treat an injury or illness (see footnote)	\$45		\$45	
office or clinic	Specialist visit	\$65		\$65	
	Other practitioner office visit	\$45		\$45	
	Preventive care/ screening/ immunization	No cost share		No cost share	
	Laboratory Tests	\$45		\$45	
ests	X-rays and Diagnostic Imaging	\$65		\$65	
	Imaging (CT/PET scans, MRIs)	20%	X	\$250	
Orugs to treat	Generic drugs	\$19		\$19	
lness or	Preferred brand drugs	\$50	Х	\$50	Х
ondition	Non-preferred brand drugs	\$70	X	\$70	Х
	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) Emergency medical transportation	\$250 \$250	X	\$250 \$250	X
leed immediate attention	Urgent care	\$90	· ·	\$90	
	Facility fee (e.g., hospital room)	20%	Х		
lospital stay	Physician/surgeon fee	20%	7.	20%	Х
	Mental/Behavioral health outpatient services	\$45		\$45	
Mental health, behavioral health,	Mental/Behavioral health inpatient services	20%	Х	20%	Х
or substance	Substance use disorder outpatient services	\$45		\$45	
	Substance use disorder inpatient services	20%	Х	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	
	Rehabilitation services	\$45		\$45	
	Habilitation services	\$45		\$45	
r other special ealth needs	Skilled nursing care	20%	Х	20%	Х
leaith needs	Durable readical aminorant	000/		000/	
	Durable medical equipment	20%		20%	
	Hospice service Evo exam (doductible waived)	No cost share		No cost share	
	Eye exam (deductible waived) Glasses	0%		0%	
Child needs	Dental check-up - Preventive and Diagnostic	1 pair per year		1 pair per year	
	Dental Basic Services Dental Restorative and Orthodontia Services	Pediatric Denta Plan Design		Pediatric Denta Plan Design	

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SHOP

- 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.

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.

Covered California Standard Benefit Plan Designs - FINAL

Summary of Benefits and Coverage

Summary of Be	3000					
COST SHARING	AMOUNTS DESCRIBE THE		Silve	r		
ENROLLEE'S	OUT OF POCKET COSTS		HSA PI	HSA Plan		
7/18/2013						
Overall deductible			¢4 500 into grat	ad Mad/Dv		
	for specific services		\$1,500 integrat	ea iviea/kx		
Other deductibles	Medical		N/A			
	Brand Drugs		N/A			
	Dental		See attach	nment		
Out-of-pocket lim	it on expenses		\$6,35	0		
Common Medical			Member Cost	Deductible		
Event	Service Typ	е	Share	Applies		
VC 24 1 141	Primary care visit to treat an inju	ıry or illness (see	20%	Х		
Visit to a health	footnote)					
care provider's office or clinic	Specialist visit		20%	X		
Office of Chillic	Other practitioner office visit		20%	X		
	Preventive care/ screening/ imm	nunization	No cost share			
	Laboratory Tests		20%	Х		
Tests	X-rays and Diagnostic Imaging		20%	Х		
	Imaging (CT/PET scans, MRIs)		20%	Х		
Drugs to treat	Generic drugs		20%	X		
illness or	Preferred brand drugs		20%	X		
condition	Non-preferred brand drugs Specialty drugs		20%	X		
Outpatient	Facility fee (e.g., ASC)		20%	X		
surgery	Physician/surgeon fees		20%	X		
ou.go.y	Emergency room services (waiv	ed if admitted)	20%	X		
	Emergency medical transportation		20%	Х		
Need immediate attention	Urgent care	20%	Х			
	Facility fee (e.g., hospital room)		20%	Х		
Hospital stay	Physician/surgeon fee		20%	Х		
	Mental/Behavioral health outpat	20%	Х			
Mental health, behavioral health,	Mental/Behavioral health inpatie	20%	Х			
or substance						
abuse needs	Substance use disorder outpatie	20%	Х			
	Substance use disorder inpatient services		20%	Х		
B	Prenatal care and preconception		No cost share			
Pregnancy	Delivery and all inpatient services	Hospital Professional	20% 20%	X		
	Home health care	Professional	20%	X		
	Rehabilitation services		20%	X		
Help recovering	Habilitation services		20%	X		
or other special health needs	Skilled nursing care		20%	Х		
	Durable medical equipment		20%	Χ		
	Hospice service		No cost share	Х		
	Eye exam (deductible waived)		0%			
Child needs	Glasses	d Diographia	1 pair per year			
dental or eye care	Dental check-up - Preventive an Dental Basic Services	u Diagnostic	Pediatric Denta	l Standard		
	Dental Restorative and Orthodo	ntia Services	Plan Design	attached		
	2 3 Mai 1 13010 I alivo alia Oltilodo					

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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.

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) &}quot;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.

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		Silver Coinsur 100%-1509		Silver Coinsurance Plan 150%-200% FPL		
7/18/2013						
Overall deductible			\$0		N/A	
	for specific services		ΨΟ		IN/A	
other addadabled	Medical		\$0		\$500	
	Brand Drugs		\$0		\$50	
	Dental		See attach	nment	See attach	nment
Out-of-pocket lim			\$2,25		\$2,25	
Common Medical			Member Cost	Deductible	Member Cost	Deductible
Event	Service Type	9	Share	Applies	Share	Applies
	Primary care visit to treat an inju	ry or illness (see	\$3		\$15	
/isit to a health	footnote)		ψΟ		φισ	
are provider's						
office or clinic	Specialist visit		\$5		\$20	
	Other practitioner office visit		\$3		\$15	
	Preventive care/ screening/ imm	unization	No cost share		No cost share	
	Laboratory Tests		\$3		\$15	
Tests Tests	X-rays and Diagnostic Imaging		\$5		\$20	
	Imaging (CT/PET scans, MRIs)		10%		15%	Х
Orugs to treat	Generic drugs		\$3		\$5	
liness or	Preferred brand drugs		\$5		\$15	Х
	Non-preferred brand drugs		\$10		\$25	Χ
ondition	Specialty drugs		10%		15%	Х
Outpatient	Facility fee (e.g., ASC)		10%		15%	
urgery	Physician/surgeon fees		10%		15%	
	Emergency room services (waive	ed if admitted)	\$25		\$75	Х
	Emergency medical transportation	on	\$25		\$75	Х
leed immediate attention	Urgent care		\$6		\$30	
	Facility fee (e.g., hospital room)		10%		15%	X
lospital stay	Physician/surgeon fee		10%		15%	
	Mental/Behavioral health outpati	ent services	\$3		\$15	
Mental health, behavioral health,	Mental/Behavioral health inpatie	nt services	10%		15%	Х
or substance abuse needs	Substance use disorder outpatient services		\$3		\$15	
	Substance use disorder inpatien	t services	10%		15%	Х
	Prenatal care and preconception	visits	No cost share		No cost share	
Pregnancy		Hospital	10%		15%	Х
		Professional	10%		15%	
	Home health care		10%		15%	
	Rehabilitation services		\$3		\$15	
lelp recovering	Habilitation services		\$3		\$15	
or other special nealth needs	Skilled nursing care		10%		15%	Х
.cam noods	Durable medical equipment		10%		15%	
	Hospice service		No cost share		No cost share	
	Eye exam (deductible waived)		0%		0%	
			1 pair per year		1 pair per year	
	Glasses Dental check-up - Preventive and Diagnostic		u pali pel veal		i paii poi yeal	
Child needs lental or eye care	Dental check-up - Preventive an Dental Basic Services	d Diagnostic	Pediatric Denta	l Standard	Pediatric Denta	I Standard

- 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.

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.

COST SHARING ENROLLEE'S	Silver Coinsurance Plan 200%-250% FPL		
7/18/2013			
1710/2010			
Overall deductible		N/A	
	for specific services	IN/A	
	Medical	\$1,50	0
	Brand Drugs	\$250	
	Dental	See attach	
Out-of-pocket lim	iit on expenses	\$5,20	0
Common Medical		Member Cost	Deductible
Event	Service Type	Share	Applies
Visit to a health care provider's	Primary care visit to treat an injury or illness (see footnote)	\$40	
office or clinic	Specialist visit	\$50	
	Other practitioner office visit	\$40	
	Preventive care/ screening/ immunization Laboratory Tests	No cost share \$40	
Tests	X-rays and Diagnostic Imaging	\$50	
	Imaging (CT/PET scans, MRIs)	20%	X
Drugs to troot	Generic drugs	\$19	
Drugs to treat illness or	Preferred brand drugs	\$30	X
condition	Non-preferred brand drugs	\$50	Х
	Specialty drugs	20%	Х
Outpatient	Facility fee (e.g., ASC)	20%	
surgery	Physician/surgeon fees Emergency room services (waived if admitted)	20% \$250	X
	Emergency medical transportation	\$250	X
Need immediate attention	Urgent care	\$80	
	Facility fee (e.g., hospital room)	20%	Х
Hospital stay	Physician/surgeon fee	20%	
	Mental/Behavioral health outpatient services	\$40	
Mental health, behavioral health,	Mental/Behavioral health inpatient services	20%	Х
or substance abuse needs	Substance use disorder outpatient services	\$40	
	Substance use disorder inpatient services	20%	X
	Prenatal care and preconception visits	No cost share	
Pregnancy	Delivery and all inpatient Hospital	20%	Х
	Services Professional Home health care	20%	
	Rehabilitation services	\$40	
Help recovering	Habilitation services	\$40	
or other special health needs	Skilled nursing care	20%	Х
	Durable medical equipment	20%	
	Hospice service Eye exam (deductible waived)	No cost share 0%	
	Glasses	1 pair per year	
Child needs dental or eye care	Dental check-up - Preventive and Diagnostic Dental Basic Services	Pediatric Denta	
	Dental Restorative and Orthodontia Services	. ian booigii	a.i.aorioa

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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) &}quot;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.

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		Silver Copay Plan 100%-150% FPL		Silver Copay Plan 150%-200% FPL	
7/18/2013					
1710/2010					
• " " "		Ф.		N1/A	
Overall deductible	for specific services	\$0		N/A	
Other deductibles	Medical	\$0		\$500	1
	Brand Drugs	\$0		\$50	
	Dental	See attach	hment	See attach	nment
Out-of-pocket lim	it on expenses	\$2,25	0	\$2,25	0
Common Medical		Member Cost	Deductible	Member Cost	Deductible
Event	Service Type	Share	Applies	Share	Applies
		onar o	пррпос	Onaro	пррисс
	Primary care visit to treat an injury or illness (see	¢ο		04 5	
Visit to a health	footnote)	\$3		\$15	
care provider's					
office or clinic	Specialist visit	\$5		\$20	
	Other practitioner office visit	\$3		\$15	
	Preventive care/ screening/ immunization	No cost share		No cost share	
	Laboratory Tests	\$3		\$15	
Tests	X-rays and Diagnostic Imaging	\$5		\$20	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
Drugs to treat	Generic drugs Preferred brand drugs	\$3 \$5		\$5 \$15	X
illness or	Non-preferred brand drugs	\$10		\$25	X
condition	Specialty drugs	10%		15%	X
Outpatient	Facility fee (e.g., ASC)	10%		15%	Λ
surgery	Physician/surgeon fees	10%		15%	
July 30. 7	Emergency room services (waived if admitted)	\$25		\$75	Х
	Emergency medical transportation	\$25		\$75	X
Need immediate attention	Urgent care	\$6		\$30	
Heavital star	Facility fee (e.g., hospital room)	400/		450/	V
Hospital stay	Physician/surgeon fee	10%		15%	Х
	Mental/Behavioral health outpatient services	\$3		\$15	
Mental health, behavioral health,	Mental/Behavioral health inpatient services	10%		15%	Х
or substance abuse needs	Substance use disorder outpatient services	\$3		\$15	
	Substance use disorder inpatient services	10%		15%	X
	Prenatal care and preconception visits	No cost share		No cost share	
Pregnancy	Delivery and all inpatient Hospital Professional	10%		15%	X
	Home health care	\$3		\$15	
	Rehabilitation services	\$3		\$15	
Help recovering	Habilitation services	\$3		\$15	
or other special	Skilled nursing care	10%		15%	Х
health needs					
	Durable medical equipment Hospice service	10% No cost share		15% No cost share	
	Eye exam (deductible waived)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
Child needs	Dental check-up - Preventive and Diagnostic				
dental or eye care	Dental Basic Services	Pediatric Denta		Pediatric Denta	
	Dental Restorative and Orthodontia Services	Plan Design	attached	Plan Design	attached
	Dental Restorative and Orthodontia Services	. iaii booigii		, idil boolgii	

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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.

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^{5) &}quot;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.

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS			Silver Copay Plan 200%-250% FPL		
7/18/2013					
Overall deductible			N/A		
	for specific services		IN/A		
	Medical		\$1,50	0	
	Brand Drugs		\$250		
	Dental		See attach	nment	
Out-of-pocket lim	it on expenses		\$5,20	0	
Common Medical			Member Cost	Deductible	
Event	Service Type	е	Share	Applies	
	,				
Visit to a health care provider's	Primary care visit to treat an injufootnote)	ıry or illness (<i>see</i>	\$40		
office or clinic	Specialist visit		\$50		
	Other practitioner office visit		\$40		
	Preventive care/ screening/ imm	nunization	No cost share		
	Laboratory Tests		\$40		
Tests	X-rays and Diagnostic Imaging		\$50		
	Imaging (CT/PET scans, MRIs)		\$250		
Drugs to treat	Generic drugs Preferred brand drugs		\$19 \$30	X	
illness or	Non-preferred brand drugs		\$50 \$50	X	
condition	Specialty drugs		20%	X	
Outpatient	Facility fee (e.g., ASC)		20%	Α	
surgery	Physician/surgeon fees	20%			
	Emergency room services (waived if admitted)		\$250	Х	
	Emergency medical transportation		\$250	Х	
Need immediate attention	Urgent care	\$80			
	Facility fee (e.g., hospital room)		000/	V	
Hospital stay	Physician/surgeon fee		20%	Х	
	Mental/Behavioral health outpat	\$40			
Mental health,	Mental/Behavioral health inpatie	ent services	20%	Χ	
behavioral health, or substance abuse needs	Substance use disorder outpatie	\$40			
	Substance use disorder inpatier		20%	Х	
	Prenatal care and preconception		No cost share		
Pregnancy	Delivery and all inpatient	Hospital	20%	Χ	
	Services	Professional	C 40		
	Home health care Rehabilitation services		\$40 \$40		
Help recovering	Habilitation services		\$40		
or other special health needs	Skilled nursing care		20%	Х	
	Durable medical equipment		20%		
	Hospice service		No cost share		
	Eye exam (deductible waived)		0%		
Child needs dental or eye care	Glasses Dental check-up - Preventive an	d Diagnostic	1 pair per year Pediatric Denta	I Standard	
	Dental Basic Services Dental Restorative and Orthodo	ntia Services	Plan Design		

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		Bronze l	Plan	Bronze HSA Plan		
7/18/2013						
Overall deductible	<u> </u>		\$5,000 integrat	ed Med/Rx	\$4,500 integrat	ed Med/Rx
	for specific services		φο,σσο iiiiσgiαi		ψ 1,000 integrat	00 11100/1101
	Medical		N/A		N/A	
	Brand Drugs		N/A		N/A	
	Dental		See attach	hment	See attach	nment
Out-of-pocket lim	nit on expenses		\$6,35	0	\$6,35	0
Common Medical	1		Member Cost	Deductible	Member Cost	Deductible
Event	Service Type		Share	Applies After 1st 3	Share	Applies
Visit to a health care provider's	Primary care visit to treat an injur footnote)	y or illness (see	\$60	non- preventive visits	40%	Х
office or clinic	Specialist visit		\$70	Х	40%	Х
	Other practitioner office visit		\$60	X	40%	X
	Preventive care/ screening/ immu	ınization	No cost share		No cost share	
	Laboratory Tests		30%	X	40%	X
Tests	X-rays and Diagnostic Imaging		30%	X	40%	Х
	Imaging (CT/PET scans, MRIs)		30%	Х	40%	Х
Drugo to troot	Generic drugs		\$19	X	40%	Х
Drugs to treat illness or	Preferred brand drugs		\$50	X	40%	Х
	Non-preferred brand drugs		\$75	X	40%	X
condition	Specialty drugs		30%	X	40%	Х
Outpatient	Facility fee (e.g., ASC)		30%	X	40%	Х
surgery	Physician/surgeon fees		30%	Х	40%	Х
	Emergency room services (waive	ed if admitted)	\$300	Х	40%	Х
Emergency medical transportation			\$300	Х	40%	Х
Need immediate attention	Urgent care		\$120	After 1st 3 non- preventive visits	40%	Х
Heenitel etev	Facility fee (e.g., hospital room)		30%	X	40%	Х
Hospital stay	Physician/surgeon fee		30%	Х	40%	Х
	Mental/Behavioral health outpation	ent services	\$60	After 1st 3 non- preventive visits	40%	Х
Mental health, behavioral health,	Mental/Behavioral health inpatier	nt services	30%	Х	40%	Х
or substance abuse needs	Substance use disorder outpatier	nt services	\$60	After 1st 3 non- preventive visits	40%	Х
	Substance use disorder inpatient	services	30%	Х	40%	Х
	Prenatal care and preconception	visits	No cost share		No cost share	
Pregnancy		Hospital	30%	X	40%	X
		Professional	30%	Х	40%	Х
	Home health care		30%	Х	40%	X
	Rehabilitation services		30%	X	40%	Х
Help recovering	Habilitation services		30%	Х	40%	Х
or other special health needs	Skilled nursing care		30%	Х	40%	Х
	Durable medical equipment		30%	Х	40%	Х
	Hospice service		No cost share	X	No cost share	X
	Eye exam (deductible waived)		0%		0%	
	Glasses		1 pair per year			
	Dental check-up - Preventive and Diagnostic		1 pair per year Pediatric Dental Standard		1 pair per year Pediatric Dental Standard	
Child needs dental or eye care	Dental check-up - Preventive and Dental Basic Services	l Diagnostic	Pediatric Denta Plan Design		Pediatric Denta Plan Design	

- Cost sharing amounts for all in-network services accumulate toward the maximum out-of-pocket expense.
- Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount.
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COST SHARING ENROLLEE'S	Catastrophic Plan			
7/18/2013				
1710/2010				
Overall deductible Other deductibles	for specific services		\$6,350 integrated Med/Rx	
	Medical		N/A	
	Brand Drugs		N/A	
	Dental		See attack	
Out-of-pocket lim	it on expenses		\$6,35	0
Common Medical Event			Member Cost Share	Deductible
Event	Service Typ	e	Share	Applies After 1st 3
Visit to a health care provider's	Primary care visit to treat an injufootnote)	ury or illness (see	0%	non- preventive visits
office or clinic	Specialist visit		0%	X
	Other practitioner office visit	iti	0%	Х
	Preventive care/ screening/ imn Laboratory Tests	nunization	No cost share 0%	X
Tests	X-rays and Diagnostic Imaging		0%	X
	Imaging (CT/PET scans, MRIs)		0%	X
Drugs to troot	Generic drugs		0%	Х
Drugs to treat illness or	Preferred brand drugs		0%	X
condition	Non-preferred brand drugs		0%	X
	Specialty drugs		0%	X
Outpatient surgery	Facility fee (e.g., ASC) Physician/surgeon fees		0% 0%	X
Surgery	Emergency room services (waix	0%	X	
	Emergency medical transportati		0%	X
Need immediate attention	Urgent care	0%	After 1st 3 non- preventive visits	
Hospital stay	Facility fee (e.g., hospital room)		0%	Х
1103pital Stay	Physician/surgeon fee		0%	X
	Mental/Behavioral health outpar	0%	After 1st 3 non- preventive visits	
Mental health, behavioral health,	Mental/Behavioral health inpation	ent services	0%	Х
or substance abuse needs	Substance use disorder outpation	0%	After 1st 3 non- preventive visits	
	Substance use disorder inpatie		0%	Х
Pregnancy	Prenatal care and preconception Delivery and all inpatient		No cost share	V
Pregnancy	services	Hospital Professional	0% 0%	X
	Home health care	. rereceional	0%	X
	Rehabilitation services		0%	X
Help recovering	Habilitation services		0%	X
or other special	Skilled nursing care		0%	Х
health needs	Durable medical equipment		00/	V
	Durable medical equipment Hospice service		0% No cost share	X
	Eye exam (deductible waived)		0%	Α
Child poods	Glasses		1 pair per year	
Child needs dental or eye care	Dental check-up - Preventive ar	nd Diagnostic	Pediatric Denta	l Standard
Jona or Gyo Gare	Dental Basic Services	ti O i	Plan Design	
	Dental Restorative and Orthodo	entia Services	3	

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