Summary or be	enerits and Coverage				
DESCRIBE THE E	NG AMOUNTS ENROLLEE'S OUT ET COSTS	Platinum- Coinsurance Plan	Platinum- Copay Plan	Gold- Coinsurance Plan	Gold-Copay Plan
12/12/2012					
Estimated Actuarial Value		91.8%	90.3%	81.7%	80.3%
Overall deductible		\$0	N/A	\$500	N/A
Other deductibles	for specific services	ΨΟ	IN/A	φουσ	IN/A
Other deductibles for specific services					
	Facility only (IP, ASC, and ER)		\$0		\$500
Brand Drugs		\$0	\$0	\$100	\$100
	Dental	TBD	TBD	TBD	TBD
Out-of-pocket lim	nit on expenses	\$3,000	\$3,000	\$4,500	\$4,500
•					
Common Medical		Member Cost	Member Cost	Member Cost	Member Cost
Event	Service Type	Share	Share	Share	Share
Visit to a health	Primary care visit to treat an injury or illness (deductible waived for first visit except Non-Par Providers or HSA planssee footnote)	\$25	\$25	\$35	\$35
care provider's office or clinic	Specialist visit	\$25	\$25	\$35	\$35
office of chillic	Other practitioner office visit	\$25	\$25	\$35	\$35
	Preventive care/ screening/ immunization	No cost share	No cost share	No cost share	No cost share
Tests	Diagnostic test (x-ray, blood work)	10%	\$25	20%	\$100
16313	Imaging (CT/PET scans, MRIs)	10%	\$150	20%	\$200
Drugs to treat	Generic drugs	\$5	\$5	\$10	\$10
illness or	Preferred brand drugs	\$15	\$15	\$20	\$20
condition	Non-preferred brand drugs	\$25	\$25	\$35	\$35
Condition	Specialty drugs	10%	10%	20%	20%
Outpatient	Facility fee (e.g., ASC)	10%	10%	20%	20%
surgery	Physician/surgeon fees	10%	\$150	20%	\$200
Need immediate	Emergency room services (waived if admitted)	\$150	\$150	\$200	\$200
attention	Emergency medical transportation	\$150	\$150	\$200	\$200
	Urgent care	\$40	\$40	\$50	\$50
Hospital stay	Facility fee (e.g., hospital room)	10%	\$300 per day,	20%	\$600 per day,
1103pital Stay	Physician/surgeon fee	10%	up to 3 days	20%	up to 3 days
Mental health,	Mental/Behavioral health outpatient services	\$25	\$25	\$35	\$35
behavioral health, or	Mental/Behavioral health inpatient services	10%	\$300 per day, up to 3 days	20%	\$600 per day, up to 3 days
substance abuse needs	Substance use disorder outpatient services	\$25	\$25	\$35	\$35
	Substance use disorder inpatient services	10%	\$300 per day, up to 3 days	20%	\$600 per day, up to 3 days
D	Prenatal and postnatal care	\$25	\$25	\$35	\$35
Pregnancy	Delivery and all Professional	10%	\$300 per day,	20%	\$600 per day,
	inpatient services Hospital	10%	up to 3 days	20%	up to 3 days
	Home health care	10%	\$25	20%	\$25
Holm receivering	Rehabilitation services	10%	\$25	20%	\$25
Help recovering	Habilitation services	10%	\$25	20%	\$25
or other special health needs	Skilled nursing care	10%	\$150 per day, up to 3 days	20%	\$200 per day, up to 3 days
	Durable medical equipment	10%	10%	20%	20%
	Hospice service	No cost share	No cost share	No cost share	No cost share
	Eye exam(deductible waived)	0%	0%	0%	0%
Obilel are and	Glasses	1 pair per year	1 pair per year	1 pair per year	1 pair per year
Child needs dental or eye	Dental check-up - Preventive and Diagnostic Services (ded waived)	0%	0%	0%	0%
care	Dental Basic Services	TBD	TBD	TBD	TBD
	Dental Restorative and Orthodontia Services	TBD	TBD	TBD	TBD
Notes:					

- 1) Actuarial values will be determined using the federal actuarial value calculator when it is released. To fit within allowable actuarial values, the cost sharing amounts in the standardized plans may be adjusted.
- 2) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values
- 3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense
- 4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges
- 5) For all Coinsurance plans other than Catastrophic, deductible is waived for one office visit, including prenatal/postnatal visits or outpatient Mental Health/Substance Abuse visits. Deductible is waived for the first 3 office visits under the Catastrophic plan.
- 6) "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:
- 7) Total pregnancy-related prenatal and postnatal visit copayments are limited to a total of \$250
- 8) Glasses benefit limited to \$100 per year
- 9) It is anticipated that high and low dental benefit options will be developed (cost sharing to be determined) and paired with the medical metal tier plans for pediatric oral care.
- 10) Orthodontia coverage is limited to medically necessary services

ouninary or De	chenis and Coverage				
COST SHARING AMOUNTS		Silver-	Silver Coins	Silver Coins	Silver Coins
		Coinsurance	Plan-100%-	Plan-150%-	Plan-200%-
DESCRIBE THE ENROLLEE'S OUT					
OF POCKET COSTS		Plan	150% FPL	200% FPL	250% FPL
12/12/2012					
Estimated Actuarial Value		71.9%	94.8%	87.9%	76.9%
Estimated Actualial Value		111070	0.1070	011070	
Overall deductible					
		\$1,200	\$0	\$400	\$1,200
Other deductibles	for specific services	Ψ1,200	ΨΟ	Ψ100	Ψ1,200
Other deductibles	for specific services				
	Facility only (IP, ASC, and ER)				
Brand Drugs		\$200	\$0	\$25	\$200
	Dental	TBD	TBD	TBD	TBD
Out-of-pocket lim	nit on expenses	\$6,400	\$2,133	\$2,133	\$3,200
out or poonet in	in on expenses	φο, του	ΨΣ,100	φ2,100	ψ0,200
		Manshau Caat	Mamban Coot	Manchau Coat	Manshau Caat
Common Medical		Member Cost	Member Cost	Member Cost	Member Cost
Event	Service Type	Share	Share	Share	Share
	Primary care visit to treat an injury or				
	illness (deductible waived for first visit	Ф 4 Г	ሰ ብ	# 00	Ф 4Е
Vielt to a la la	except Non-Par Providers or HSA	\$45	\$3	\$20	\$45
Visit to a health	planssee footnote)				
care provider's	Specialist visit	\$45	\$3	\$20	\$45
office or clinic	Other practitioner office visit				
	· ·	\$45	\$3	\$20	\$45
	Preventive care/ screening/	No cost share	No cost share	No cost share	No cost share
	immunization				
Tests	Diagnostic test (x-ray, blood work)	30%	10%	15%	30%
16212	Imaging (CT/PET scans, MRIs)	30%	10%	15%	30%
	Generic drugs	\$20	\$3	\$8	\$20
Drugs to treat	Preferred brand drugs	\$30	\$5	\$18	\$30
illness or	Non-preferred brand drugs	\$50	\$8	\$27	\$50
condition			·		
	Specialty drugs	30%	10%	15%	30%
Outpatient	Facility fee (e.g., ASC)	30%	10%	15%	30%
surgery	Physician/surgeon fees	30%	10%	15%	30%
	Emergency room services (waived if		Ф О.Г	Ф 7Г	#050
Need immediate	admitted)	\$250	\$25	\$75	\$250
attention	Emergency medical transportation	\$250	\$25	\$75	\$250
	Urgent care	\$60	\$8	\$30	\$60
	Facility fee (e.g., hospital room)	30%	10%	15%	30%
Hospital stay					
	Physician/surgeon fee	30%	10%	15%	30%
	Mental/Behavioral health outpatient	\$45	\$3	\$20	\$45
Mental health,	services	Ψίο	ΨΟ	ΨΖΟ	Ψιο
behavioral	Mental/Behavioral health inpatient	200/	100/	150/	200/
	services	30%	10%	15%	30%
health, or	Substance use disorder outpatient	A	4:		
substance abuse	services	\$45	\$3	\$20	\$45
needs	Substance use disorder inpatient				30%
	services	30%	10%	15%	
		MAE	ФО.	# 00	Ф 4 Г
	Prenatal and postnatal care	\$45	\$3	\$20	\$45
Pregnancy	Delivery and all Professional	30%	10%	15%	30%
	inpatient services Hospital	30%	10%	15%	30%
	Home health care	30%	10%	15%	30%
	Rehabilitation services	30%	10%	15%	30%
Help recovering	Habilitation services	30%	10%	15%	30%
or other special		30 /0			
health needs	Skilled nursing care	30%	10%	15%	30%
nealli needs	Durable medical aminar and	2007	400/	450/	200/
	Durable medical equipment	30%	10%	15%	30%
	Hospice service	No cost share	No cost share	No cost share	No cost share
	Eye exam(deductible waived)	0%	0%	0%	0%
	Glasses	1 pair per year			
Child needs	Dental check-up - Preventive and		00/		00/
dental or eye	Diagnostic Services (ded waived)	0%	0%	0%	0%
care	Dental Basic Services	TBD	TBD	TBD	TBD
	Dental Restorative and Orthodontia	100	TOO	100	100
		TBD	TBD	TBD	TBD
D V 30 NO 30 M	Services				
Notes:					

- 1) Actuarial values will be determined using the federal actuarial value calculator when it is released. To fit within allowable actuarial values, the cost sharing amounts in the standardized plans may be adjusted.
- 2) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values
- 3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense
- 4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges
- 5) For all Coinsurance plans other than Catastrophic, deductible is waived for one office visit, including prenatal/postnatal visits or outpatient Mental Health/Substance Abuse visits. Deductible is waived for the first 3 office visits under the Catastrophic plan.
- 6) "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:
- 7) Total pregnancy-related prenatal and postnatal visit copayments are limited to a total of \$250
- 8) Glasses benefit limited to \$100 per year
- 9) It is anticipated that high and low dental benefit options will be developed (cost sharing to be determined) and paired with the medical metal tier plans for pediatric oral care.
- 10) Orthodontia coverage is limited to medically necessary services

Cummary or Do	chenis and Coverage				
COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		Silver-Copay Plan	Silver Copay Plan 100%- 150% FPL	Silver Copay Plan 150%- 200% FPL	Silver Copay Plan 200%- 250% FPL
12/12/2012					
Estimated Actuarial Value		71.7%	94.9%	87.8%	78.1%
	·				
Overall deductible		N/A	NI/A	NI/A	NI/A
		IN/A	N/A	N/A	N/A
Other deductibles	for specific services				
Facility only (IP, ASC, and ER)		\$1,400	\$0	\$400	\$1,400
	Brand Drugs	\$250	\$0	\$25	\$250
	Dental	TBD	TBD	TBD	TBD
Out-of-pocket lim	nit on expenses	\$6,400	\$2,133	\$2,133	\$3,200
•					
Common Medical		Member Cost	Member Cost	Member Cost	Member Cost
Event	Service Type	Share	Share	Share	Share
Lvent	Primary care visit to treat an injury or	Share	Silare	Silare	Share
	illness (deductible waived for first visit	\$45	\$3	\$20	\$45
Visit to a health	except Non-Par Providers or HSA		·	·	4.5
care provider's	planssee footnote)				
office or clinic	Specialist visit	\$45	\$3	\$20	\$45
Cities of Cities	Other practitioner office visit	\$45	\$3	\$20	\$45
	Preventive care/ screening/	No cost share	No cost share	No cost share	No cost share
	immunization Diagnostic test (v. rov. blood work)	\$150	\$25	\$50	\$150
Tests	Diagnostic test (x-ray, blood work)				
	Imaging (CT/PET scans, MRIs)	\$250	\$50	\$100	\$250
Drugs to treat	Generic drugs	\$20	\$3	\$8	\$20
illness or	Preferred brand drugs	\$30	\$5	\$20	\$30
condition	Non-preferred brand drugs	\$50	\$8	\$35	\$50
Condition	Specialty drugs	30%	10%	15%	30%
Outpatient	Facility fee (e.g., ASC)	30%	10%	15%	30%
surgery	Physician/surgeon fees	\$250	\$50	\$100	\$250
	Emergency room services (waived if	# 050	фол	075	0050
Need immediate	admitted)	\$250	\$25	\$75	\$250
attention	Emergency medical transportation	\$250	\$25	\$75	\$250
	Urgent care	\$60	\$18	\$35	\$60
	Facility fee (e.g., hospital room)	30%	\$300 per day,	\$600 per day,	30%
Hospital stay	Physician/surgeon fee	0%	up to 3 days	up to 3 days	0%
	Mental/Behavioral health outpatient				
	services	\$45	\$3	\$20	\$45
Mental health,	Mental/Behavioral health inpatient		\$300 per day,	\$600 per day,	
behavioral	services	30%	up to 3 days	up to 3 days	30%
health, or	Substance use disorder outpatient		up to 5 days	up to 3 days	
substance abuse	services	\$45	\$3	\$20	\$45
needs	Substance use disorder inpatient		\$300 per day,	\$600 per day,	
	services	30%	up to 3 days	up to 3 days	30%
	Prenatal and postnatal care	\$45	\$3	\$20	\$45
Pregnancy	Delivery and all Professional	0%	\$300 per day,	\$600 per day,	0%
	inpatient services Hospital	30%	up to 3 days	up to 3 days	30%
	Home health care	\$25	\$25	\$25	\$25
	Rehabilitation services	\$25	\$25	\$25	\$25
Help recovering	Habilitation services	\$25	\$25	\$25	\$25
or other special	Habilitation 361VIC63	φ∠υ			⊅ ∠5
health needs	Skilled nursing care	30%	\$300 per day, up to 3 days	\$600 per day, up to 3 days	30%
111111111111111111111111111111111111111	Durable medical equipment	30%	10%	15%	30%
	Hospice service	No cost share	No cost share	No cost share	No cost share
	Eye exam(deductible waived)	0%	0%	0%	0%
	Glasses	1 pair per year	1 pair per year	1 pair per year	1 pair per year
Child needs	Dental check-up - Preventive and	ı paii pei yedi	i paii pei yedi	i paii pei yedi	i paii pei yeal
	Diagnostic Services (ded waived)	0%	0%	0%	0%
dental or eye care	Dental Basic Services (ded warved)	TBD	TBD	TBD	TBD
cai c	Dental Restorative and Orthodontia	וסט	ו סט	וסט	עסו
	Services	TBD	TBD	TBD	TBD
Notes:	00171000				

- 1) Actuarial values will be determined using the federal actuarial value calculator when it is released. To fit within allowable actuarial values, the cost sharing amounts in the standardized plans may be adjusted.
- 2) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values
- 3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense
- 4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges
- 5) For all Coinsurance plans other than Catastrophic, deductible is waived for one office visit, including prenatal/postnatal visits or outpatient Mental Health/Substance Abuse visits. Deductible is waived for the first 3 office visits under the Catastrophic plan.
- 6) "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:
- 7) Total pregnancy-related prenatal and postnatal visit copayments are limited to a total of \$250
- 8) Glasses benefit limited to \$100 per year
- 9) It is anticipated that high and low dental benefit options will be developed (cost sharing to be determined) and paired with the medical metal tier plans for pediatric oral care.
- 10) Orthodontia coverage is limited to medically necessary services

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		Silver-HSA Plan	Bronze- Coinsurance Plan	Bronze-Copay Plan	Bronze-HSA Plan	Catastrophic Plan
12/12/2012						
Estimated Actuari	al Value	71.6%	62.0%	64.8%	61.6%	57.9%
Overall deductible		\$1500 integrated Med/Rx Ded	\$3500 integrated Med/Rx Ded		\$3500 integrated Med/Rx Ded	\$6400 integrated Med/Rx Ded
Other deductibles	for specific services					
Facility only (IP, ASC, and ER)				\$4500 integrated Med/Rx Ded		
	Brand Drugs					
	Dental	TBD	TBD	TBD	TBD	TBD
Out-of-pocket lim	nit on expenses	\$6,400	\$6,400	\$6,400	\$6,400	\$6,400
Common Medical	1	Member Cost				
Event	Service Type	Share	Share	Share	Share	Share
Visit to a health	Primary care visit to treat an injury illness (deductible waived for first except Non-Par Providers or HSA planssee footnote)	visit 20%	\$60	\$80	30%	0%
care provider's	Specialist visit	20%	\$60	\$80	30%	0%
office or clinic	Other practitioner office visit	20%	\$60	\$80	30%	0%
	Preventive care/ screening/ immunization	No cost share				
_	Diagnostic test (x-ray, blood work) 20%	40%	\$200	30%	0%
Tests	Imaging (CT/PET scans, MRIs)	20%	40%	\$350	30%	0%
	Generic drugs	20%	\$25	\$25	30%	0%
Drugs to treat	Preferred brand drugs	20%	\$50	\$50	30%	0%
illness or	Non-preferred brand drugs	20%	\$75	\$75	30%	0%
condition			40%			0%
Outpations	Specialty drugs	20%		40%	30%	
Outpatient	Facility fee (e.g., ASC)	20%	40%	40%	30%	0%
surgery	Physician/surgeon fees	20%	40%	\$350	30%	0%
Need immediate	Emergency room services (waive admitted)	20%	\$300	\$300	30%	0%
attention	Emergency medical transportation	າ 20%	\$300	\$300	30%	0%
	Urgent care	20%	\$75	\$95	30%	0%
Hospital stay	Facility fee (e.g., hospital room)	20%	40%	40%	30%	0%
nospital stay	Physician/surgeon fee	20%	40%	0%	30%	0%
Mental health, behavioral health, or	Mental/Behavioral health outpatie services	nt 20%	\$60	\$80	30%	0%
	Mental/Behavioral health inpatien services	t 20%	40%	40%	30%	0%
substance abuse	Substance use disorder outpatien services	t 20%	\$60	\$80	30%	0%
	Substance use disorder inpatient services	20%	40%	40%	30%	0%
	Prenatal and postnatal care	20%	\$60	\$80	30%	0%
Pregnancy	Delivery and all Professional	20%	40%	0%	30%	0%
	inpatient services Hospital	20%	40%	40%	30%	0%
	Home health care	20%	40%	\$25	30%	0%
	Rehabilitation services	20%	40%	\$25	30%	0%
Help recovering	Habilitation services	20%	40%	\$25	30%	0%
or other special health needs	Skilled nursing care	20%	40%	40%	30%	0%
	Durable medical equipment	20%	40%	40%	30%	0%
	Hospice service	No cost share				
	Eye exam(deductible waived)	0%	0%	0%	0%	0%
	Glasses	1 pair per year				
Child needs	Dental check-up - Preventive and					
dental or eye care	Diagnostic Services (ded waived) Dental Basic Services		0% TBD	0% TBD	0% TBD	0% TBD
	Dental Restorative and Orthodont	ia				
Notes:	Services	TBD	TBD	TBD	TBD	TBD

- 1) Actuarial values will be determined using the federal actuarial value calculator when it is released. To fit within allowable actuarial values, the cost sharing amounts in the standardized plans may be adjusted.
- 2) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values
- 3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense
- 4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges
- 5) For all Coinsurance plans other than Catastrophic, deductible is waived for one office visit, including prenatal/postnatal visits or outpatient Mental Health/Substance Abuse visits. Deductible is waived for the first 3 office visits under the Catastrophic plan.
- 6) "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:
- 7) Total pregnancy-related prenatal and postnatal visit copayments are limited to a total of \$250
- 8) Glasses benefit limited to \$100 per year
- 9) It is anticipated that high and low dental benefit options will be developed (cost sharing to be determined) and paired with the medical metal tier plans for pediatric oral care.
- 10) Orthodontia coverage is limited to medically necessary services