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Standard Benefit Plan Designs - FINAL

Summary of Benefits and Coverage

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

3/15/2013

	Individual & SHOP	Individual & SHOP
	Platinum Coinsurance Plan	**Platinum Copay Plan**
Actuarial Value - Final AV Calculator	88.1%	88.0%
Overall deductible	$0	$0
Other deductibles for specific services		
Medical	$0	$0
Brand Drugs	$0	$0
Dental	See attachment	See attachment
Out–of–pocket limit on expenses	$4,000	$4,000

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*)		$20		$20	
	Specialist visit		$40		$40	
	Other practitioner office visit		$20		$20	
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		$20		$20	
	X-rays and Diagnostic Imaging		$40		$40	
	Imaging (CT/PET scans, MRIs)		10%		$150	
Drugs to treat illness or condition	Generic drugs		$5		$5	
	Preferred brand drugs		$15		$15	
	Non-preferred brand drugs		$25		$25	
	Specialty drugs		10%		10%	
Outpatient surgery	Facility fee (e.g., ASC)		10%		$250	
	Physician/surgeon fees		10%			
Need immediate attention	Emergency room services (waived if admitted)		$150		$150	
	Emergency medical transportation		$150		$150	
	Urgent care		$40		$40	
Hospital stay	Facility fee (e.g., hospital room)		10%		$250 per day up to 5 days	
	Physician/surgeon fee		10%			
Mental health, behavioral health, or substance abuse needs	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	
Pregnancy	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%			
Help recovering or other special health needs	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	
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		See Pediatric Dental Standard Plan Design, Note 6 Below		See Pediatric Dental Standard Plan Design, Note 6 Below	
	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.

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 postnatal visits or outpatient Mental Health/Substance Abuse visits.

5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

6) Pediatric Dental Standard Plan Design may be accessed at:
http://www.healthexchange.ca.gov/Documents/Ped%20Dental%20Standard%20Plan%20Design.pdf

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

3/15/2013

	Individual & SHOP	Individual & SHOP
	Gold Coinsurance Plan	**Gold Copay Plan**
Actuarial Value - Final AV Calculator	78.2%	78.0%
Overall deductible	$0	$0
Other deductibles for specific services		
Medical	$0	$0
Brand Drugs	$0	$0
Dental	See attachment	See attachment
Out–of–pocket limit on expenses	$6,400	$6,400

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*)		$30		$30	
	Specialist visit		$50		$50	
	Other practitioner office visit		$30		$30	
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		$30		$30	
	X-rays and Diagnostic Imaging		$50		$50	
	Imaging (CT/PET scans, MRIs)		20%		$250	
Drugs to treat illness or condition	Generic drugs		$20		$20	
	Preferred brand drugs		$50		$50	
	Non-preferred brand drugs		$70		$70	
	Specialty drugs		20%		20%	
Outpatient surgery	Facility fee (e.g., ASC)		20%		$600	
	Physician/surgeon fees		20%			
Need immediate attention	Emergency room services (waived if admitted)		$250		$250	
	Emergency medical transportation		$250		$250	
	Urgent care		$60		$60	
Hospital stay	Facility fee (e.g., hospital room)		20%		$600 per day up to 5 days	
	Physician/surgeon fee		20%			
Mental health, behavioral health, or substance abuse needs	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	
Pregnancy	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%			
Help recovering or other special health needs	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	
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		See Pediatric Dental Standard Plan Design, Note 6 Below		See Pediatric Dental Standard Plan Design, Note 6 Below	
	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.

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 postnatal visits or outpatient Mental Health/Substance Abuse visits.

5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

6) Pediatric Dental Standard Plan Design may be accessed at:
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Summary of Benefits and Coverage

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

3/15/2013

	Individual	Individual
	Silver Coinsurance Plan	**Silver Copay Plan**
Actuarial Value - Final AV Calculator	68.7%	68.3%
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	$6,400	$6,400

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		$25		$25	
	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%	X	20%	X
	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		See Pediatric Dental Standard Plan Design, Note 6 Below		See Pediatric Dental Standard Plan Design, Note 6 Below	
	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.

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 postnatal visits or outpatient Mental Health/Substance Abuse visits.

5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

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

3/15/2013

	SHOP	SHOP
	Silver Coinsurance Plan	**Silver Copay Plan**
Actuarial Value - Final AV Calculator	69.8%	69.3%
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	$6,400	$6,400

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		$25		$25	
	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%	X	20%	X
	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		See Pediatric Dental Standard Plan Design, Note 6 Below		See Pediatric Dental Standard Plan Design, Note 6 Below	
	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.

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 postnatal visits or outpatient Mental Health/Substance Abuse visits.

5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

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

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	Individual & SHOP
	Silver HSA Plan
Actuarial Value - Final AV Calculator	71.5%
Overall deductible	$1500 integrated Med/Rx Ded
Other deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	See attachment
Out–of–pocket limit on expenses	$6,400

Common Medical Event	Service Type		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*)		20%	X
	Specialist visit		20%	X
	Other practitioner office visit		20%	X
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		20%	X
	X-rays and Diagnostic Imaging		20%	X
	Imaging (CT/PET scans, MRIs)		20%	X
Drugs to treat illness or condition	Generic drugs		20%	X
	Preferred brand drugs		20%	X
	Non-preferred brand drugs		20%	X
	Specialty drugs		20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%	X
	Physician/surgeon fees		20%	X
Need immediate attention	Emergency room services (waived if admitted)		20%	X
	Emergency medical transportation		20%	X
	Urgent care		20%	X
Hospital stay	Facility fee (e.g., hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		20%	X
	Mental/Behavioral health inpatient services		20%	X
	Substance use disorder outpatient services		20%	X
	Substance use disorder inpatient services		20%	X
Pregnancy	Prenatal care and preconception visits		No cost share	X
	Delivery and all inpatient services	Hospital	20%	X
		Professional	20%	X
Help recovering or other special health needs	Home health care		20%	X
	Rehabilitation services		20%	X
	Habilitation services		20%	X
	Skilled nursing care		20%	X
	Durable medical equipment		20%	X
	Hospice service		No cost share	X
Child needs dental or eye care	Eye exam (*deductible waived*)		0%	
	Glasses		1 pair per year	
	Dental check-up - Preventive and Diagnostic		See Pediatric Dental Standard Plan Design, Note 6 Below	
	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.

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 postnatal visits or outpatient Mental Health/Substance Abuse visits.

5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

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

3/15/2013

	Individual & SHOP	Individual & SHOP
	Bronze Plan	**Bronze HSA Plan**
Actuarial Value - Final AV Calculator	60.4%	59.0%
Overall deductible	$5000 integrated Med/Rx Ded	$4500 integrated Med/Rx Ded
Other deductibles for specific services		
Medical	N/A	N/A
Brand Drugs	N/A	N/A
Dental	See attachment	See attachment
Out–of–pocket limit on expenses	$6,400	$6,400

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*)		$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	
Tests	Laboratory Tests		30%	X	40%	X
	X-rays and Diagnostic Imaging		30%	X	40%	X
	Imaging (CT/PET scans, MRIs)		30%	X	40%	X
Drugs to treat illness or condition	Generic drugs		$25	X	40%	X
	Preferred brand drugs		$50	X	40%	X
	Non-preferred brand drugs		$75	X	40%	X
	Specialty drugs		30%	X	40%	X
Outpatient surgery	Facility fee (e.g., ASC)		30%	X	40%	X
	Physician/surgeon fees		30%	X	40%	X
Need immediate attention	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
Hospital stay	Facility fee (e.g., hospital room)		30%	X	40%	X
	Physician/surgeon fee		30%	X	40%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$60	X	40%	X
	Mental/Behavioral health inpatient services		30%	X	40%	X
	Substance use disorder outpatient services		$60	X	40%	X
	Substance use disorder inpatient services		30%	X	40%	X
Pregnancy	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
Help recovering or other special health needs	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
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		See Pediatric Dental Standard Plan Design, Note 6 Below		See Pediatric Dental Standard Plan Design, Note 6 Below	
	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.

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 postnatal visits or outpatient Mental Health/Substance Abuse visits.

5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

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

3/15/2013

	Individual
	Catastrophic Plan
Actuarial Value - Final AV Calculator	60.4%
Overall deductible	$6400 integrated Med/Rx Ded
Other deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	See attachment
Out–of–pocket limit on expenses	$6,400

Common Medical Event	Service Type		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*)		0%	After 1st 3 non-preventive visits
	Specialist visit		0%	X
	Other practitioner office visit		0%	X
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		0%	X
	X-rays and Diagnostic Imaging		0%	X
	Imaging (CT/PET scans, MRIs)		0%	X
Drugs to treat illness or condition	Generic drugs		0%	X
	Preferred brand drugs		0%	X
	Non-preferred brand drugs		0%	X
	Specialty drugs		0%	X
Outpatient surgery	Facility fee (e.g., ASC)		0%	X
	Physician/surgeon fees		0%	X
Need immediate attention	Emergency room services (waived if admitted)		0%	X
	Emergency medical transportation		0%	X
	Urgent care		0%	After 1st 3 non-preventive visits
Hospital stay	Facility fee (e.g., hospital room)		0%	X
	Physician/surgeon fee		0%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		0%	X
	Mental/Behavioral health inpatient services		0%	X
	Substance use disorder outpatient services		0%	X
	Substance use disorder inpatient services		0%	X
Pregnancy	Prenatal care and preconception visits		No cost share	
	Delivery and all inpatient services	Hospital	0%	X
		Professional	0%	X
Help recovering or other special health needs	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
Child needs dental or eye care	Eye exam (*deductible waived*)		0%	
	Glasses		1 pair per year	
	Dental check-up - Preventive and Diagnostic		See Pediatric Dental Standard Plan Design, Note 6 Below	
	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.

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 postnatal visits or outpatient Mental Health/Substance Abuse visits.

5) "Other Practitioner Office Visits" includes Therapy Visits, other office visits not provided by either Primary Care or Specialty Physicians or not specified in another benefit category.

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