

2015 Standard Benefit Plan Designs - Sample 10.0 EHB

Changes in benefits from 2014 to 2015 are displayed in orange

Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		Platinum Coinsurance Plan		Platinum Copay Plan	
2/20/2014					
Actuarial Valu	e - AV Calculator	88.62%		88.41%	
Overall deduc		\$0		\$0	
Other deductil	bles for specific services Medical	\$0		\$0	
	Brand Drugs	\$0		\$0	
	Dental	\$0		\$0	
Out-of-pocke	t limit (includes \$300 Pediatric Dental Out-of-pocket	\$4,000	0	\$4,00	0
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's	Primary care visit to treat an injury or illness	\$20		\$20	
office or	Specialist visit	\$40		\$40	
clinic	Preventive care/ screening/ immunization	No cost share		No cost share	
	Laboratory Tests	\$20		\$20	
Tests	X-rays and Diagnostic Imaging	\$40		\$40	
	Imaging (CT/PET scans, MRIs) Generic drugs	10% \$5 or less		\$150 \$5 or less	
Drugs to treat illness or	Preferred brand drugs	\$15		\$15	
condition	Non-preferred brand drugs	\$25		\$25	
Outpatient	Specialty drugs ² Facility fee (e.g., ASC)	10% 10%		10%	
surgery	Physician/surgeon fees	10%		\$250	
	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	
Hospital stay	Physician/surgeon fee	10%		up to 5 days	
Mental	Mental/Behavioral health outpatient services	\$20		\$20	
health, behavioral	Mental/Behavioral health inpatient services	10%		\$250 per day up to 5 days	
health, or substance abuse needs	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	
. Togridiloy	Delivery and all inpatient services Hospital Professional	10% 10%		\$250 per day up to 5 days	
	Home health care	10%		\$20	
	Rehabilitation services	\$20		\$20	
Help recovering or	Habilitation services	\$20		\$20 \$150 per day	
other special	Skilled nursing care	10%		up to 5 days	
health needs	Durable medical equipment	10%		10%	
	Hospice service	No cost share		No cost share	
	Eye exam (deductible waived) Glasses	0%		0%	
Child needs	Dental check-up - Preventive and Diagnostic Services	1 pair per year No cost share		1 pair per year No cost share	
dental or eye	Dental Basic Services ³	20%		see fee schedule	
50.0	Dental Major Services ³	50%		see fee schedule	
	Orthodontics (medically necessary)	50%		\$300	
				· · · · · · · · · · · · · · · · · · ·	

¹ For members 19 years of age or older, the Pediatric Dental Out-of-pocket limit does not apply.

² Oral anti-cancer drugs are capped at \$200 monthly maximum.

³ See Dental Standard Benefit Plan Designs



2015 Standard Benefit Plan Designs - Sample 10.0 EHB

Changes in benefits from 2014 to 2015 are displayed in orange

Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		Gold Coinsurance Plan		Gold Copay Plan		
2/20/2014						
	e - AV Calculator		79.60%		79.22%	
Overall deduct	tible		\$0		\$0	
	bles for specific services		Ψ0		Ţ,	
	Medical		\$0		\$0	
	Brand Drugs Dental		\$0 \$0		\$0 \$0	
Out-of-pocke	t limit (includes \$300 Pediatric Dental	Out-of-pocket		_		_
limit) ¹			\$6,350	J	\$6,35	0
Common Medical Event	Service Type		Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's	Primary care visit to treat an injury or i	llness	\$30		\$30	
office or	Specialist visit		\$50		\$50	
clinic	Preventive care/ screening/ immuniza	tion	No cost share		No cost share	
	Laboratory Tests		\$30		\$30	
Tests	X-rays and Diagnostic Imaging		\$50		\$50	
	Imaging (CT/PET scans, MRIs) Generic drugs		20% \$15 or less		\$250 \$15 or less	
Drugs to treat	Preferred brand drugs		\$50		\$50	
illness or	Non-preferred brand drugs		\$70		\$70	
condition	Specialty drugs ²		20%		20%	
Outpatient	Facility fee (e.g., ASC)		20%		\$600	
surgery	Physician/surgeon fees		20%			
	Emergency room services (waived if a	dmitted)	\$250		\$250	
Need	Emergency medical transportation		\$250		\$250	
immediate attention	Urgent care		\$60		\$60	
Hospital stay	Facility fee (e.g., hospital room)		20%		\$600 per day	
Hospital stay	Physician/surgeon fee		20%		up to 5 days	
Mental	Mental/Behavioral health outpatient services		\$30		\$30	
health, behavioral	Mental/Behavioral health inpatient services		20%		\$600 per day up to 5 days	
health, or substance abuse needs	Substance use disorder outpatient ser	vices	\$30		\$30	
	Substance use disorder inpatient serv	ices	20%		\$600 per day up to 5 days	
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
. Togridiloy	Delivery and all inpatient services	Hospital Professional	20%		\$600 per day up to 5 days	
	Home health care		20%		\$30	
	Rehabilitation services		\$30		\$30	
Help	Habilitation services		\$30		\$30	
recovering or other special health needs	Skilled nursing care		20%		\$300 per day up to 5 days	
	Durable medical equipment		20%		20%	
	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 check-up - Preventive and Diag	gnostic Services	No cost share		No cost share	
dental or eye care	Dental Basic Services ³		20%		see fee schedule	
	Dental Major Services ³		50%		see fee schedule	
	Orthodontics (medically necessary)		50%		\$300	

 $^{^{\}rm 1}$ For members 19 years of age or older, the Pediatric Dental Out-of-pocket limit does not ap $^{\rm 2}$ Oral anti-cancer drugs are capped at \$200 monthly maximum.

³ See Dental Standard Benefit Plan Designs



2015 Standard Benefit Plan Designs - Sample 10.0 EHB

Changes in benefits from 2014 to 2015 are displayed in orange		
Summary of Benefits and Coverage	Individual	Individual
COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver Coinsurance Plan	Silver Copay Plan
2/20/2014		
Actuarial Value - AV Calculator	68.74%	68.49%
Overall deductible	N/A	N/A

Overall deduc	tible		N/A		N/A	
	bles for specific services					
	Medical		\$2,00	0	\$2,00	00
	Brand Drugs		\$250)	\$250	0
	Dental Coop Paris in Paris III	0	\$0		\$0	
limit) ¹	t limit (includes \$300 Pediatric Dental	Out-or-pocket	\$6,35	0	\$6,35	50
Common						
Medical			Member Cost	Deductible	Member Cost	Deductible
Event	Service Type		Share	Applies	Share	Applies
Visit to a health care provider's	Primary care visit to treat an injury or	illness	\$45		\$45	
office or	Specialist visit		\$65		\$65	
clinic	Preventive care/ screening/ immuniza	ation	No cost share		No cost share	
	Laboratory Tests		\$45		\$45	
Tests	X-rays and Diagnostic Imaging		\$65		\$65	
	Imaging (CT/PET scans, MRIs)		20%	Х	\$250	
Drugs to treat	Generic drugs		\$15 or less		\$15 or less	
illness or	Preferred brand drugs		\$50	X	\$50	X
condition	Non-preferred brand drugs		\$70	X	\$70	X
Outpotions	Specialty drugs ² Facility fee (e.g., ASC)		20%	X	20%	X
Outpatient surgery	Physician/surgeon fees		20%		20%	
Surgery						
	Emergency room services (waived if	admitted)	\$250	Х	\$250	Х
Need	Emergency medical transportation		\$250	X	\$250	X
immediate attention	Urgent care		\$90		\$90	
Heavital stay	Facility fee (e.g., hospital room)		20%	X	20%	X
Hospital stay	Physician/surgeon fee		20%	^	20%	^
Mental	Mental/Behavioral health outpatient s	ervices	\$45		\$45	
health, behavioral	Mental/Behavioral health inpatient se	rvices	20%	Х	20%	Х
health, or substance abuse needs	Substance use disorder outpatient se	rvices	\$45		\$45	
	Substance use disorder inpatient serv	vices	20%	Х	20%	Х
Duama	Prenatal care and preconception visit	S	No cost share		No cost share	
Pregnancy	Delivery and all inpatient services	Hospital Professional	20% 20%	Х	20%	Х
	Home health care	,	20%		\$45	
	Rehabilitation services		\$45		\$45	
Help	Habilitation services		\$45		\$45	
recovering or other special health needs	Skilled nursing care		20%	Х	20%	Х
	Durable medical equipment		20%		20%	
	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 check-up - Preventive and Dia	gnostic Services	No cost share		No cost share	
dental or eye care	Dental Basic Services ³		20%		see fee schedule	
	Dental Major Services ³		50%		see fee schedule	
	Orthodontics (medically necessary)		50%		\$200	

Orthodontics (medically necessary) 50% \$300

 $^{^{\}rm 1}$ For members 19 years of age or older, the Pediatric Dental Out-of-pocket limit does not ap $^{\rm 2}$ Oral anti-cancer drugs are capped at \$200 monthly maximum.

³ See Dental Standard Benefit Plan Designs



2015 Standard Benefit Plan Designs - Sample 10.0 EHB

Changes in benefits from 2014 to 2015 are displayed in orange

_	enefits from 2014 to 2015 are displayed in orange f Benefits and Coverage	SHO	P	SH	IOP
_	OST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF		Silver Coinsurance Plan		ver y Plan
2/20/2014					
	e - AV Calculator	69.369	%	69.0	07%
Overall deduc		N/A		N	/A
	bles for specific services	14/71			<i>,</i>
	Medical	\$1,50			500
	Brand Drugs Dental	\$500 \$0			500 50
Out-of-pocke limit) ¹	t limit (includes \$300 Pediatric Dental Out-of-pocket	\$6,35	0		350
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's	Primary care visit to treat an injury or illness	\$45		\$45	
office or	Specialist visit	\$65		\$65	
clinic	Preventive care/ screening/ immunization	No cost share		No cost share	
	Laboratory Tests	\$45		\$45	
Tests	X-rays and Diagnostic Imaging	\$65		\$65	
	Imaging (CT/PET scans, MRIs) Generic drugs	20% \$15 or less	X	\$250 \$15 or less	
Drugs to treat illness or	Preferred brand drugs	\$15 of less \$50	X	\$15 or less \$50	X
condition	Non-preferred brand drugs	\$70	Х	\$70	Х
	Specialty drugs ² Facility fee (e.g., ASC)	20%	X	20%	X
Outpatient surgery	Physician/surgeon fees	20%		20%	
<u> </u>	Emergency room services (waived if admitted)	\$250	X	\$250	Х
Need	Emergency medical transportation	\$250	X	\$250	X
immediate attention	Urgent care	\$90	^	\$90	^
Hospital stay	Facility fee (e.g., hospital room)	20%	X	200/	Х
nospital stay	Physician/surgeon fee	20%	^	20%	^
Mental	Mental/Behavioral health outpatient services	\$45		\$45	
health, behavioral	Mental/Behavioral health inpatient services	20%	Х	20%	Х
health, or substance abuse needs	Substance use disorder outpatient services	\$45		\$45	
	Substance use disorder inpatient services	20%	Х	20%	Х
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services Hospital Professional	20%	X	20%	Х
	Home health care	20%		\$45	
Help	Rehabilitation services Habilitation services	\$45 \$45		\$45 \$45	
recovering or	Skilled nursing care	20%	Х	20%	X
other special			^		^
health needs	Durable medical equipment	20%		20%	
	Hospice service	No cost share		No cost share	
	Eye exam (deductible waived) Glasses	0% 1 pair per year		0% 1 pair per year	
Child needs	Dental check-up - Preventive and Diagnostic Services	No cost share		No cost share	
dental or eye care	Dental Basic Services ³	20%		see fee schedule	
	Dental Major Services ³	50%		see fee schedule	
	Orthodontics (medically necessary)	50%		\$300	

¹ For members 19 years of age or older, the Pediatric Dental Out-of-pocket limit does not ap

² Oral anti-cancer drugs are capped at \$200 monthly maximum.

³ See Dental Standard Benefit Plan Designs



2015 Standard Benefit Plan Designs - Sample 10.0 EHB

_	nefits from 2014 to 2015 are display Benefits and Coverage	ed in orange	SHO	Р	
COST SHARIN POCKET COS ⁻	G AMOUNTS DESCRIBE THE ENRO IS	LLEE'S OUT OF	Silver HSA Plan		
2/20/2014 Actuarial Value	e - AV Calculator		71.48	%	
Overall deduct	tible		\$1,500 integrated	I Med/Rx Ded	
	oles for specific services		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
	Medical		N/A		
	Brand Drugs Dental		N/A \$0		
Out-of-pocke [,] imit) ¹	t limit (includes \$300 Pediatric Dental	Out-of-pocket	\$6,35	60	
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	20%	Х	
office or	Specialist visit		20%	X	
clinic	Preventive care/ screening/ immuniza	tion	No cost share		
	Laboratory Tests		20%	Х	
Tests	X-rays and Diagnostic Imaging		20%	X	
	Imaging (CT/PET scans, MRIs)		20%	X	
Drugs to treat	Generic drugs Preferred brand drugs		20% 20%	X	
liness or	Non-preferred brand drugs		20%	X	
condition	Specialty drugs ²		20%	X	
Outpatient	Facility fee (e.g., ASC)		20%	X	
surgery	Physician/surgeon fees		20%	Х	
	Emergency room services (waived if admitted)		20%	Х	
Need	Emergency medical transportation		20%	Х	
mmediate attention	Urgent care		20%	Х	
Hospital stay	Facility fee (e.g., hospital room)		20%	Х	
nospital stay	Physician/surgeon fee		20%	Х	
Mental	Mental/Behavioral health outpatient services		20%	Х	
health, behavioral	Mental/Behavioral health inpatient ser	vices	20%	Х	
health, or substance abuse needs	Substance use disorder outpatient services		20%	Х	
	Substance use disorder inpatient serv	rices	20%	Х	
Pregnancy	Prenatal care and preconception visits		No cost share		
. og.iuiioy	Delivery and all inpatient services	Hospital Professional	20%	X	
	Home health care	i iuicssiuiidi	20%	X	
	Rehabilitation services		20%	Х	
Help	Habilitation services		20%	X	
recovering or other special health needs	Skilled nursing care		20%	Х	
	Durable medical equipment		20%	X	
	Hospice service		No cost share	Х	
	Eye exam (deductible waived) Glasses		0%		
Child needs	Dental check-up - Preventive and Dia	gnostic Services	1 pair per year No cost share		
dental or eye	Dental Basic Services ³		20%		
	Dental Major Services ³		50%		

Notes:

50%

Orthodontics (medically necessary)

¹ For members 19 years of age or older, the Pediatric Dental Out-of-pocket limit does not ap ² Oral anti-cancer drugs are capped at \$200 monthly maximum.

³ See Dental Standard Benefit Plan Designs



2015 Standard Benefit Plan Designs - Sample 10.0 EHB

Changes in benefits from 2014 to 2015 are displayed in orange

Summary of Benefits and Coverage

COST SHARIN	IG AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF	Silver Coinsur 100%-150		Silver Coinsur 150%-200	
2/20/2014					
	e - AV Calculator	94.38	%	87.44	%
Overall deduc		\$0		N/A	
Other deducti	bles for specific services			# 500	
	Medical Brand Drugs	\$0 \$0		\$500 \$50	
	Dental	\$0		\$0	
Out-of-pocke limit) ¹	t limit (includes \$300 Pediatric Dental Out-of-pocket	\$2,25	0	\$2,25	0
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care provider's	Primary care visit to treat an injury or illness	\$3		\$15	
office or	Specialist visit	\$5		\$20	
clinic	Preventive care/ screening/ immunization	No cost share		No cost share	
	Laboratory Tests	\$3		\$15	
Tests	X-rays and Diagnostic Imaging	\$5		\$20	V
	Imaging (CT/PET scans, MRIs) Generic drugs	10% \$3 or less		15% \$5 or less	X
Drugs to treat	Preferred brand drugs	\$3 or less \$5		\$5 or less \$15	X
illness or condition	Non-preferred brand drugs	\$10		\$25	X
	Specialty drugs ²	10%		15%	X
Outpatient	Facility fee (e.g., ASC) Physician/surgeon fees	10% 10%		15% 15%	
surgery					.,
	Emergency room services (waived if admitted)	\$25		\$75	X
Need immediate	Emergency medical transportation	\$25		\$75	X
attention	Urgent care	\$6		\$30	
Hospital stay	Facility fee (e.g., hospital room)	10%		15%	Х
	Physician/surgeon fee	10%		15%	
Mental	Mental/Behavioral health outpatient services	\$3		\$15	
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
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services Hospital Professional	10% 10%		15% 15%	X
	Home health care	10%		15%	
	Rehabilitation services	\$3		\$15	
Help	Habilitation services	\$3		\$15	
recovering or other special health needs	Skilled nursing care	10%		15%	X
	Durable medical equipment	10%		15%	
	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 check-up - Preventive and Diagnostic Services	No cost share		No cost share	
dental or eye care	Dental Basic Services ³	20%		20%	
	Dental Major Services ³	50%		50%	
	Orthodontics (medically necessary)	50%		50%	

 $^{^{\}rm 1}$ For members 19 years of age or older, the Pediatric Dental Out-of-pocket limit does not ap $^{\rm 2}$ Oral anti-cancer drugs are capped at \$200 monthly maximum.

³ See Dental Standard Benefit Plan Designs



2015 Standard Benefit Plan Designs - Sample 10.0 EHB

COST SHARIN POCKET COS	G AMOUNTS DESCRIBE THE ENROLLE TS	EE'S OUT OF	Silver Coinsur 200%-250	
2/20/2014				
Actuarial Valu	e - AV Calculator		73.47	%
Overall deduc			N/A	
Other deducti	oles for specific services Medical		\$1,50	ın
	Brand Drugs		\$250	
0	Dental Coop Paris in Paris III		\$0	
Out–ot–pocke limit) ¹	t limit (includes \$300 Pediatric Dental Ou	т-от-роскет	\$5,20	0
Common			Mambar Cost	
Medical Event	Service Type		Member Cost Share	Deductik Applies
Vicit to a				
Visit to a health care	Primary care visit to treat an injury or illne	ess	\$40	
provider's				
office or clinic	Specialist visit		\$50	
CIIIIC	Preventive care/ screening/ immunization	1	No cost share	
	Laboratory Tests		\$40	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)		\$50 20%	Х
Drugs to treat	Generic drugs		\$15 or less	
illness or	Preferred brand drugs		\$30	X
condition	Non-preferred brand drugs Specialty drugs ²		\$50 20%	X
Outpatient	Facility fee (e.g., ASC)		20%	
surgery	Physician/surgeon fees		20%	
	Emergency room services (waived if adm	\$250	Х	
Need	Emergency medical transportation	\$250	Х	
immediate attention	Urgent care		\$80	
Hospital stay	Facility fee (e.g., hospital room)		20%	X
i iospitai stay	Physician/surgeon fee		20%	^
Mental	Mental/Behavioral health outpatient servi	\$40		
health, behavioral	Mental/Behavioral health inpatient servic	20%	Х	
health, or substance abuse needs	Substance use disorder outpatient service	\$40		
	Substance use disorder inpatient service	s	20%	Х
Duamer	Prenatal care and preconception visits		No cost share	
Pregnancy		ospital ofessional	20% 20%	Х
	Home health care		20%	
Help	Rehabilitation services Habilitation services		\$40 \$40	
recovering or other special				V
	Skilled nursing care		20%	Х
health needs	Durable medical equipment		20%	
	Hospice service		No cost share	
	Eye exam (deductible waived) Glasses		0% ı pali pel	
Child needs	Dental check-up - Preventive and Diagno	ostic Services	No cost share	
dental or eye	Dental Basic Services ³		20%	
care				

Notes:

Orthodontics (medically necessary)

50%

50%

Dental Major Services³

 $^{^{\}rm 1}$ For members 19 years of age or older, the Pediatric Dental Out-of-pocket limit does not ap $^{\rm 2}$ Oral anti-cancer drugs are capped at \$200 monthly maximum.

³ See Dental Standard Benefit Plan Designs



2015 Standard Benefit Plan Designs - Sample 10.0 EHB

Changes in benefits from 2014 to 2015 are displayed in orange

Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		Silver Copay Plan 100%-150% FPL		Silver Copay Plan 150%-200% FPL	
2/20/2014					
Actuarial Valu	e - AV Calculator	94.42	%	87.40	1%
Overall deduc		\$0		N/A	1
Other deductil	bles for specific services	\$0		\$50	<u> </u>
	Medical Brand Drugs	\$0 \$0		\$50	
	Dental	\$0		\$0	
Out-of-pocke limit) ¹	t limit (includes \$300 Pediatric Dental Out-of-pocket	\$2,25	50	\$2,25	50
Common					
Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care	Primary care visit to treat an injury or illness	\$3		\$15	
provider's office or	Specialist visit	\$5		\$20	
clinic	Preventive care/ screening/ immunization	No cost share		No cost share	
	Laboratory Tests				
Tests	X-rays and Diagnostic Imaging	\$3 \$5		\$15 \$20	
	Imaging (CT/PET scans, MRIs)	\$50		\$100	
Drugs to treat	Generic drugs	\$3 or less		\$5 or less	
illness or	Preferred brand drugs	\$5		\$15	X
condition	Non-preferred brand drugs Specialty drugs ²	\$10 10%		\$25 15%	X
Outpatient	Facility fee (e.g., ASC)	10%		15%	^
surgery	Physician/surgeon fees	10%		15%	
	Emergency room services (waived if admitted)	\$25		\$75	Х
Need	Emergency medical transportation	\$25		\$75	Х
immediate attention	Urgent care	\$6		\$30	
Hospital stay	Facility fee (e.g., hospital room) Physician/surgeon fee	10%		15%	Х
Mental	Mental/Behavioral health outpatient services	\$3		\$15	
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
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services Hospital Professional	10%		15%	Х
	Home health care Rehabilitation services	\$3 \$3		\$15 \$15	
Help	Habilitation services	\$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 (deductible waived)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
Child needs	Dental check-up - Preventive and Diagnostic Services	No cost share		No cost share	
dental or eye care	Dental Basic Services ³	see fee schedule		see fee schedule	
	Dental Major Services ³	see fee schedule		see fee schedule	
	Orthodontics (medically necessary)	\$300		\$300	

¹ For members 19 years of age or older, the Pediatric Dental Out-of-pocket limit does not ap

² Oral anti-cancer drugs are capped at \$200 monthly maximum.

³ See Dental Standard Benefit Plan Designs



2015 Standard Benefit Plan Designs - Sample 10.0 EHB

Changes in benefits from 2014 to 2015 are displayed in orange

Summary of Benefits and Coverage

COST SHARIN	IG AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF	Silver Copa 200%-250°	-
2/20/2014			
	e - AV Calculator	73.18	%
Overall deduc	tible	N/A	
Other deductil	bles for specific services		
	Medical	\$1,50	
	Brand Drugs Dental	\$250 \$0	
Out-of-pocke limit) ¹	t limit (includes \$300 Pediatric Dental Out-of-pocket	\$5,20	0
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Visit to a health care provider's	Primary care visit to treat an injury or illness	\$40	
office or	Specialist visit	\$50	
clinic	Preventive care/ screening/ immunization	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	\$15 or less	V
illness or	Non-preferred brand drugs	\$30 \$50	X
condition	Specialty drugs ²	20%	X
Outpatient	Facility fee (e.g., ASC)	20%	
surgery	Physician/surgeon fees	20%	
	Emergency room services (waived if admitted)	\$250	Х
Need	Emergency medical transportation	\$250	Х
immediate attention	Urgent care	\$80	
	Facility fee (e.g., hospital room)	2001	
Hospital stay	Physician/surgeon fee	20%	Х
Mental	Mental/Behavioral health outpatient services	\$40	
health, behavioral	Mental/Behavioral health inpatient services	20%	Х
health, or 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	
	Delivery and all inpatient services Hospital Professional	20%	Х
	Home health care Rehabilitation services	\$40 \$40	
Help	Habilitation services	\$40	
recovering or	Skilled nursing care	20%	Х
other special health needs	Durable medical equipment	20%	
	Hospice service	No cost share	
	·		
	Eye exam (deductible waived) Glasses	0% 1 pair per year	
Child needs	Dental check-up - Preventive and Diagnostic Services	No cost share	
dental or eye care	Dental Basic Services ³	see fee schedule	
	Dental Major Services ³	see fee	
	Orthodontics (medically necessary)	schedule \$300	
	J Jack in the second of t	ψοσο	

 $^{^{\}rm 1}$ For members 19 years of age or older, the Pediatric Dental Out-of-pocket limit does not ap $^{\rm 2}$ Oral anti-cancer drugs are capped at \$200 monthly maximum.

³ See Dental Standard Benefit Plan Designs



2015 Standard Benefit Plan Designs - Sample 10.0 EHB

Changes in benefits from 2014 to 2015 are displayed in orange

Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS		Bronze Plan		Bronze HSA Plan	
2/20/2014					
Actuarial Valu	e - AV Calculator	60.87%		58.95%	
		\$5,000 integrate	d Med/Rx Ded	\$4,500 integrat	ed Med/Rx
Other deductil	bles for specific services Medical	N/A	Δ	N/A	
	Brand Drugs	N/A		N/A	
	Dental	\$0)	\$0	
Out-of-pocke	t limit (includes \$300 Pediatric Dental Out-of-pocket	\$6,3	50	\$6,35	50
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Visit to a health care	Primary care visit to treat an injury or illness	\$60	After 1st 3 non- preventive	40%	х
provider's office or	Specialist visit	¢70	visits X	40%	X
clinic	Specialist visit	\$70	٨		
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests X-rays and Diagnostic Imaging	30%	X	40% 40%	X
rests	Imaging (CT/PET scans, MRIs)	30%	X	40%	X
Drugs to troot	Generic drugs	\$15 or less	X	40%	X
Drugs to treat illness or	Preferred brand drugs	\$50	X	40%	Х
condition	Non-preferred brand drugs	\$75	X	40%	X
Outpatient	Specialty drugs ² Facility fee (e.g., ASC)	30%	X	40% 40%	X X
surgery	Physician/surgeon fees	30%	X	40%	X
	Emergency room services (waived if admitted)	\$300	Х	40%	Х
Need	Emergency medical transportation	\$300	Х	40%	Х
immediate attention	Urgent care	\$120	After 1st 3 non- preventive visits	40%	Х
Hospital stay	Facility fee (e.g., hospital room)	30%	X	40%	X
nospital stay	Physician/surgeon fee	30%	Х	40%	X
Mental	Mental/Behavioral health outpatient services	\$60	After 1st 3 non- preventive visits	40%	Х
health, behavioral	Mental/Behavioral health inpatient services	30%	Х	40%	Х
health, or substance abuse needs	Substance use disorder outpatient services	\$60	After 1st 3 non- preventive visits	40%	Х
	Substance use disorder inpatient services	30%	Х	40%	X
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services Hospital Professional	30%	X	40%	X
	Professional Home health care	30%	X	40% 40%	X X
	Rehabilitation services	30%	X	40%	Х
Help .	Habilitation services	30%	Х	40%	X
recovering or other special	Skilled nursing care	30%	Х	40%	Х
health needs	Durable medical equipment	30%	Х	40%	Х
	Hospice service	No cost share	Х	No cost share	Х
	Eye exam (deductible waived)	0%		0%	
	Glasses	1 pair per year		1 pair per year	
Child needs	Dental check-up - Preventive and Diagnostic Services	No cost share		No cost share	
dental or eye care	Dental Basic Services ³	see fee schedule		20%	
	Dental Major Services ³	see fee schedule		50%	
	Orthodontics (medically necessary)	\$300		50%	

 $^{^{\}rm 1}$ For members 19 years of age or older, the Pediatric Dental Out-of-pocket limit does not ap

² Oral anti-cancer drugs are capped at \$200 monthly maximum.

³ See Dental Standard Benefit Plan Designs



2015 Standard Benefit Plan Designs - Sample 10.0 EHB

Changes in benefits from 2014 to 2015 are displayed in orange

Summary of Benefits and Coverage

ouriniary or	Delicints and Goverage			
COST SHARIN POCKET COS ⁻	G AMOUNTS DESCRIBE THE ENRO IS	LLEE'S OUT OF	Catastroph	ic Plan
2/20/2014				
Actuarial Value	e - AV Calculator		60.56	%
Overall deduc	ible		\$6,350 integrat	ed Med/Rx
	oles for specific services		φο,σσο integrat	.00 11100/110
	Medical		N/A	
	Brand Drugs		N/A	
	Dental		\$0	
Out–of–pocke limit) ¹	t limit (includes \$300 Pediatric Dental	Out-of-pocket	\$6,35	60
Common				
Medical			Member Cost	Deductibl
Event	Service Type		Share	Applies
Visit to a health care provider's	Primary care visit to treat an injury or i	illness	0%	After 1st non- preventiv visits
office or	Specialist visit		0%	Х
clinic	Preventive care/ screening/ immuniza	tion	No cost share	
	Laboratory Tests		0%	Х
Tests	X-rays and Diagnostic Imaging		0%	Х
	Imaging (CT/PET scans, MRIs)		0%	Х
Drugs to treat	Generic drugs		0%	Х
liness or	Preferred brand drugs		0%	Х
condition	Non-preferred brand drugs		0%	Х
	Specialty drugs ²		0%	X
Outpatient	Facility fee (e.g., ASC)		0%	Х
surgery	Physician/surgeon fees		0%	X
	Emergency room services (waived if a	admitted)	0%	Х
Need	Emergency medical transportation		0%	Х
mmediate attention	Urgent care		0%	After 1st non- preventiv visits
	Facility fee (e.g., hospital room)		0%	X
Hospital stay	Physician/surgeon fee		0%	X
Mental	Mental/Behavioral health outpatient services		0%	After 1st non- preventiv visits
health, behavioral	Mental/Behavioral health inpatient ser	vices	0%	Х
health, or substance abuse needs	Substance use disorder outpatient services		0%	After 1st non- preventiv visits
	Substance use disorder inpatient serv	rices	0%	Х
	Prenatal care and preconception visits	3	No cost share	
Pregnancy	Delivery and all inpatient services	Hospital Professional	0% 0%	X
	Home health care	i iuicosiuiidi	0%	X
	Rehabilitation services		0%	X
Help	Habilitation services		0%	X
ecovering or				
other special	Skilled nursing care		0%	X
health needs	Durable medical equipment		0%	Х

0%

No cost share

1 pair per year

No cost share

20%

50%

50%

Χ

Χ

Notes:

care

health needs

Child needs dental or eye

Orthodontics (medically necessary)

Dental check-up - Preventive and Diagnostic Services

Dental Basic Services³

Dental Major Services³

Durable medical equipment

Eye exam (deductible waived)

Hospice service

¹ For members 19 years of age or older, the Pediatric Dental Out-of-pocket limit does not ap

² Oral anti-cancer drugs are capped at \$200 monthly maximum.

³ See Dental Standard Benefit Plan Designs