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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 Value - AV Calculator	88.62%	88.41%
Overall deductible	$0	$0
Other deductibles for specific services		
Medical	$0	$0
Brand Drugs	$0	$0
Dental	Not Covered	Not Covered
Out–of–pocket limit	$4,000	$4,000

Common Medical Event	Service Type	Platinum Coinsurance Plan: Member Cost Share	Platinum Coinsurance Plan: Deductible Applies	Platinum Copay Plan: Member Cost Share	Platinum Copay Plan: Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20		$20	
	Specialist visit	$40		$40	
	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 or less		$5 or less	
	Preferred brand drugs	$15		$15	
	Non-preferred brand drugs	$25		$25	
	Specialty drugs[1]	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	
	Delivery and all inpatient services – 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 Services	Not Covered		Not Covered	
	Dental Basic Services				
	Dental Major Services				
	Orthodontics (medically necessary)				

Notes:

[1] Oral anti-cancer drugs are capped at $200 monthly maximum.

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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Gold Coinsurance Plan	Gold Copay Plan
2/20/2014		
Actuarial Value - AV Calculator	79.60%	79.22%
Overall deductible	$0	$0
Other deductibles for specific services		
Medical	$0	$0
Brand Drugs	$0	$0
Dental	Not Covered	Not Covered
Out–of–pocket limit	$6,350	$6,350

Common Medical Event	Service Type	Gold Coinsurance Plan: Member Cost Share	Gold Coinsurance Plan: Deductible Applies	Gold Copay Plan: Member Cost Share	Gold Copay Plan: Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30		$30	
	Specialist visit	$50		$50	
	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	$15 or less		$15 or less	
	Preferred brand drugs	$50		$50	
	Non-preferred brand drugs	$70		$70	
	Specialty drugs[1]	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	
	Delivery and all inpatient services — 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 Services	Not Covered		Not Covered	
	Dental Basic Services				
	Dental Major Services				
	Orthodontics (medically necessary)				

Notes:

[1] Oral anti-cancer drugs are capped at $200 monthly maximum.

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Summary of Benefits and Coverage

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

2/20/2014

	Individual Silver Coinsurance Plan	Individual Silver Copay Plan
Actuarial Value - AV Calculator	68.74%	68.49%
Overall deductible	N/A	N/A
Other deductibles for specific services		
Medical	$2,000	$2,000
Brand Drugs	$250	$250
Dental	Not Covered	Not Covered
Out–of–pocket limit	$6,350	$6,350

Common Medical Event	Service Type		Coinsurance Plan: Member Cost Share	Coinsurance Plan: Deductible Applies	Copay Plan: Member Cost Share	Copay Plan: Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness		$45		$45	
	Specialist visit		$65		$65	
	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		$15 or less		$15 or less	
	Preferred brand drugs		$50	X	$50	X
	Non-preferred brand drugs		$70	X	$70	X
	Specialty drugs[1]		20%	X	20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%		20%	
	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 Services		Not Covered		Not Covered	
	Dental Basic Services					
	Dental Major Services					
	Orthodontics (medically necessary)					

Notes:

[1] Oral anti-cancer drugs are capped at $200 monthly maximum.

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Summary of Benefits and Coverage

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

2/20/2014

	SHOP Silver Coinsurance Plan	SHOP Silver Copay Plan
Actuarial Value - AV Calculator	69.36%	69.07%
Overall deductible	N/A	N/A
Other deductibles for specific services		
Medical	$1,500	$1,500
Brand Drugs	$500	$500
Dental	Not Covered	Not Covered
Out–of–pocket limit	$6,350	$6,350

Common Medical Event	Service Type	Silver Coinsurance Plan: Member Cost Share	Silver Coinsurance Plan: Deductible Applies	Silver Copay Plan: Member Cost Share	Silver Copay Plan: Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness	$45		$45	
	Specialist visit	$65		$65	
	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	$15 or less		$15 or less	
	Preferred brand drugs	$50	X	$50	X
	Non-preferred brand drugs	$70	X	$70	X
	Specialty drugs[1]	20%	X	20%	X
Outpatient surgery	Facility fee (e.g., ASC)	20%		20%	
	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
	Delivery and all inpatient services — 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 Services	Not Covered		Not Covered	
	Dental Basic Services				
	Dental Major Services				
	Orthodontics (medically necessary)				

Notes:

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

2/20/2014

	SHOP Silver HSA Plan
Actuarial Value - AV Calculator	71.48%
Overall deductible	$1,500 integrated Med/Rx Ded
Other deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	Not Covered
Out–of–pocket limit	$6,350

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	20%	X
	Specialist 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[1]	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	
	Delivery and all inpatient services — Hospital	20%	X
	Delivery and all inpatient services — 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 Services	Not Covered	
	Dental Basic Services	Not Covered	
	Dental Major Services	Not Covered	
	Orthodontics (medically necessary)	Not Covered	

Notes:

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Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver Coinsurance Plan 100%-150% FPL	Silver Coinsurance Plan 150%-200% FPL
2/20/2014		
Actuarial Value - AV Calculator	94.38%	87.44%
Overall deductible	$0	N/A
Other deductibles for specific services		
Medical	$0	$500
Brand Drugs	$0	$50
Dental	Not Covered	Not Covered
Out–of–pocket limit	$2,250	$2,250

Common Medical Event	Service Type		100%-150% FPL Member Cost Share	100%-150% FPL Deductible Applies	150%-200% FPL Member Cost Share	150%-200% FPL Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness		$3		$15	
	Specialist visit		$5		$20	
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		$3		$15	
	X-rays and Diagnostic Imaging		$5		$20	
	Imaging (CT/PET scans, MRIs)		10%		15%	X
Drugs to treat illness or condition	Generic drugs		$3 or less		$5 or less	
	Preferred brand drugs		$5		$15	X
	Non-preferred brand drugs		$10		$25	X
	Specialty drugs[1]		10%		15%	X
Outpatient surgery	Facility fee (e.g., ASC)		10%		15%	
	Physician/surgeon fees		10%		15%	
Need immediate attention	Emergency room services (waived if admitted)		$25		$75	X
	Emergency medical transportation		$25		$75	X
	Urgent care		$6		$30	
Hospital stay	Facility fee (e.g., hospital room)		10%		15%	X
	Physician/surgeon fee		10%		15%	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$3		$15	
	Mental/Behavioral health inpatient services		10%		15%	X
	Substance use disorder outpatient services		$3		$15	
	Substance use disorder inpatient services		10%		15%	X
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	10%		15%	X
		Professional	10%		15%	
Help recovering or other special health needs	Home health care		10%		15%	
	Rehabilitation services		$3		$15	
	Habilitation services		$3		$15	
	Skilled nursing care		10%		15%	X
	Durable medical equipment		10%		15%	
	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 Services		Not Covered		Not Covered	
	Dental Basic Services					
	Dental Major Services					
	Orthodontics (medically necessary)					

Notes:

[1] Oral anti-cancer drugs are capped at $200 monthly maximum.

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Summary of Benefits and Coverage

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver Coinsurance Plan 200%-250% FPL
2/20/2014	
Actuarial Value - AV Calculator	73.47%
Overall deductible	N/A
Other deductibles for specific services	
Medical	$1,500
Brand Drugs	$250
Dental	Not Covered
Out–of–pocket limit	$5,200

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	$40	
	Specialist visit	$50	
	Preventive care/ screening/ immunization	No cost share	
Tests	Laboratory Tests	$40	
	X-rays and Diagnostic Imaging	$50	
	Imaging (CT/PET scans, MRIs)	20%	X
Drugs to treat illness or condition	Generic drugs	$15 or less	
	Preferred brand drugs	$30	X
	Non-preferred brand drugs	$50	X
	Specialty drugs[1]	20%	X
Outpatient surgery	Facility fee (e.g., ASC)	20%	
	Physician/surgeon fees	20%	
Need immediate attention	Emergency room services (waived if admitted)	$250	X
	Emergency medical transportation	$250	X
	Urgent care	$80	
Hospital stay	Facility fee (e.g., hospital room)	20%	X
	Physician/surgeon fee	20%	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40	
	Mental/Behavioral health inpatient services	20%	X
	Substance use disorder outpatient services	$40	
	Substance use disorder inpatient services	20%	X
Pregnancy	Prenatal care and preconception visits	No cost share	
	Delivery and all inpatient services – Hospital	20%	X
	Delivery and all inpatient services – Professional	20%	
Help recovering or other special health needs	Home health care	20%	
	Rehabilitation services	$40	
	Habilitation services	$40	
	Skilled nursing care	20%	X
	Durable medical equipment	20%	
	Hospice service	No cost share	
Child needs dental or eye care	Eye exam (*deductible waived*)	0%	
	Glasses	1 pair per	
	Dental check-up - Preventive and Diagnostic Services	Not Covered	
	Dental Basic Services		
	Dental Major Services		
	Orthodontics (medically necessary)		

Notes:

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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 Value - AV Calculator	94.42%	87.40%
Overall deductible	$0	N/A
Other deductibles for specific services		
Medical	$0	$500
Brand Drugs	$0	$50
Dental	Not Covered	Not Covered
Out–of–pocket limit	$2,250	$2,250

Common Medical Event	Service Type		Member Cost Share (100%-150% FPL)	Deductible Applies (100%-150% FPL)	Member Cost Share (150%-200% FPL)	Deductible Applies (150%-200% FPL)
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness		$3		$15	
	Specialist visit		$5		$20	
	Preventive care/ screening/ immunization		No cost share		No cost share	
Tests	Laboratory Tests		$3		$15	
	X-rays and Diagnostic Imaging		$5		$20	
	Imaging (CT/PET scans, MRIs)		$50		$100	
Drugs to treat illness or condition	Generic drugs		$3 or less		$5 or less	
	Preferred brand drugs		$5		$15	X
	Non-preferred brand drugs		$10		$25	X
	Specialty drugs[1]		10%		15%	X
Outpatient surgery	Facility fee (e.g., ASC)		10%		15%	
	Physician/surgeon fees		10%		15%	
Need immediate attention	Emergency room services (waived if admitted)		$25		$75	X
	Emergency medical transportation		$25		$75	X
	Urgent care		$6		$30	
Hospital stay	Facility fee (e.g., hospital room)		10%		15%	X
	Physician/surgeon fee					
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$3		$15	
	Mental/Behavioral health inpatient services		10%		15%	X
	Substance use disorder outpatient services		$3		$15	
	Substance use disorder inpatient services		10%		15%	X
Pregnancy	Prenatal care and preconception visits		No cost share		No cost share	
	Delivery and all inpatient services	Hospital	10%		15%	X
		Professional				
Help recovering or other special health needs	Home health care		$3		$15	
	Rehabilitation services		$3		$15	
	Habilitation services		$3		$15	
	Skilled nursing care		10%		15%	X
	Durable medical equipment		10%		15%	
	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 Services		Not Covered		Not Covered	
	Dental Basic Services					
	Dental Major Services					
	Orthodontics (medically necessary)					

Notes:

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COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver Copay Plan 200%-250% FPL
2/20/2014	
Actuarial Value - AV Calculator	73.18%
Overall deductible	N/A
Other deductibles for specific services	
Medical	$1,500
Brand Drugs	$250
Dental	Not Covered
Out–of–pocket limit	$5,200

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		$40	
	Specialist visit		$50	
	Preventive care/ screening/ immunization		No cost share	
Tests	Laboratory Tests		$40	
	X-rays and Diagnostic Imaging		$50	
	Imaging (CT/PET scans, MRIs)		$250	
Drugs to treat illness or condition	Generic drugs		$15 or less	
	Preferred brand drugs		$30	X
	Non-preferred brand drugs		$50	X
	Specialty drugs[1]		20%	X
Outpatient surgery	Facility fee (e.g., ASC)		20%	
	Physician/surgeon fees		20%	
Need immediate attention	Emergency room services (waived if admitted)		$250	X
	Emergency medical transportation		$250	X
	Urgent care		$80	
Hospital stay	Facility fee (e.g., hospital room)		20%	X
	Physician/surgeon fee			
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services		$40	
	Mental/Behavioral health inpatient services		20%	X
	Substance use disorder outpatient services		$40	
	Substance use disorder inpatient services		20%	X
Pregnancy	Prenatal care and preconception visits		No cost share	
	Delivery and all inpatient services	Hospital	20%	X
		Professional		
Help recovering or other special health needs	Home health care		$40	
	Rehabilitation services		$40	
	Habilitation services		$40	
	Skilled nursing care		20%	X
	Durable medical equipment		20%	
	Hospice service		No cost share	
Child needs dental or eye care	Eye exam (*deductible waived*)		0%	
	Glasses		1 pair per year	
	Dental check-up - Preventive and Diagnostic Services		Not Covered	
	Dental Basic Services			
	Dental Major Services			
	Orthodontics (medically necessary)			

Notes:

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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 Value - AV Calculator	60.87%	58.95%
Overall deductible	$5,000 integrated Med/Rx Ded	$4,500 integrated Med/Rx
Other deductibles for specific services		
Medical	N/A	N/A
Brand Drugs	N/A	N/A
Dental	Not Covered	Not Covered
Out–of–pocket limit	$6,350	$6,350

Common Medical Event	Service Type		Bronze Plan Member Cost Share	Bronze Plan Deductible Applies	Bronze HSA Plan Member Cost Share	Bronze HSA Plan Deductible Applies
Visit to a health care provider's office or clinic	Primary care visit to treat an injury or illness		$60	After 1st 3 non-preventive visits	40%	X
	Specialist visit		$70	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		$15 or less	X	40%	X
	Preferred brand drugs		$50	X	40%	X
	Non-preferred brand drugs		$75	X	40%	X
	Specialty drugs[1]		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	After 1st 3 non-preventive visits	40%	X
	Mental/Behavioral health inpatient services		30%	X	40%	X
	Substance use disorder outpatient services		$60	After 1st 3 non-preventive visits	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 Services		Not Covered		Not Covered	
	Dental Basic Services					
	Dental Major Services					
	Orthodontics (medically necessary)					

Notes:

[1] Oral anti-cancer drugs are capped at $200 monthly maximum.

DRAFT

2015 Standard Benefit Plan Designs - Sample 9.5 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

2/20/2014

	Catastrophic Plan
Actuarial Value - AV Calculator	60.56%
Overall deductible	$6,350 integrated Med/Rx
Other deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	Not Covered
Out–of–pocket limit	$6,350

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		0%	After 1st 3 non-preventive visits
	Specialist 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[1]		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%	After 1st 3 non-preventive visits
	Mental/Behavioral health inpatient services		0%	X
	Substance use disorder outpatient services		0%	After 1st 3 non-preventive visits
	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 Services		Not Covered	
	Dental Basic Services			
	Dental Major Services			
	Orthodontics (medically necessary)			

Notes:

[1] Oral anti-cancer drugs are capped at $200 monthly maximum.