



Summary of Benefits and Coverage

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

	Platinum Coinsurance Plan	Platinum Copay Plan
Actuarial Value - AV Calculator	88.10%	88.00%
Overall deductible	\$0	\$0
Other deductibles for specific services		
Medical	\$0	\$0
Brand Drugs	\$0	\$0
Dental	\$0	\$0
Out-of-pocket maximum	\$4,000	\$4,000

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner 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		\$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% Professional 10%		\$250 per day up to 5 days	
Help recovering or other special health needs	Home health care	10%		\$20	
	Outpatient Rehabilitation services	\$20		\$20	
	Outpatient 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 eye care	Eye exam	No cost share		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam				
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth	No cost share		No cost share	
	Topical Fluoride Application				
Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface	20%		\$25	
Child Dental Major Services	Root Canal- Molar			\$300	
	Gingivectomy per Quad			\$150	
	Extraction- Single Tooth Exposed Root or	50%		\$65	
	Extraction- Complete Bony			\$160	
Porcelain with Metal Crown			\$300		
Orthodontics	Medically necessary orthodontics	50%		\$1,000	

2015 Standard Benefit Plan Designs
3/20/2014 DRAFT - 10.0 EHB

Summary of Benefits and Coverage

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

	Gold Coinsurance Plan	Gold Copay Plan
Actuarial Value - AV Calculator	78.80%	78.60%
Overall deductible	\$0	\$0
Other deductibles for specific services		
Medical	\$0	\$0
Brand Drugs	\$0	\$0
Dental	\$0	\$0
Out-of-pocket maximum	\$6,250	\$6,250

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner 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		\$15	
	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% Professional 20%		\$600 per day up to 5 days	
Help recovering or other special health needs	Home health care	20%		\$30	
	Outpatient Rehabilitation services	\$30		\$30	
	Outpatient 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 eye care	Eye exam	No cost share		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam				
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth	No cost share		No cost share	
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Amalgam Fill - 1 Surface	20%		\$25	
Child Dental Major Services	Root Canal- Molar			\$300	
	Gingivectomy per Quad			\$150	
	Extraction- Single Tooth Exposed Root or	50%		\$65	
	Extraction- Complete Bony			\$160	
	Porcelain with Metal Crown			\$300	
Orthodontics	Medically necessary orthodontics	50%		\$1,000	

2015 Standard Benefit Plan Designs
3/20/2014 DRAFT - 10.0 EHB

Summary of Benefits and Coverage

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

	Individual Silver Coinsurance Plan	Individual Silver Copay Plan
Actuarial Value - AV Calculator	70.30%	69.90%
Overall deductible	N/A	N/A
Other deductibles for specific services		
Medical	\$2,000	\$2,000
Brand Drugs	\$250	\$250
Dental	\$0	\$0
Out-of-pocket maximum	\$6,250	\$6,250

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner 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		\$15	
	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%		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% Professional	X	20%	X
Help recovering or other special health needs	Home health care	20%		\$45	
	Outpatient Rehabilitation services	\$45		\$45	
	Outpatient Habilitation services	\$45		\$45	
	Skilled nursing care	20%	X	20%	X
	Durable medical equipment	20%		20%	
Child eye care	Hospice service	No cost share		No cost share	
	Eye exam	No cost share		No cost share	
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share		No cost share	
	Oral Exam				
	Preventive - Cleaning				
	Preventive - X-ray	No cost share		No cost share	
	Sealants per Tooth				
Child Dental Basic Services	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Major Services	Amalgam Fill - 1 Surface	20%		\$25	
	Root Canal- Molar			\$300	
	Gingivectomy per Quad			\$150	
	Extraction- Single Tooth Exposed Root or	50%		\$65	
	Extraction- Complete Bony			\$160	
Orthodontics	Porcelain with Metal Crown			\$300	
	Medically necessary orthodontics	50%		\$1,000	

2015 Standard Benefit Plan Designs
3/20/2014 DRAFT - 10.0 EHB

Summary of Benefits and Coverage

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

	SHOP	SHOP
	Silver Coinsurance Plan	Silver Copay Plan
Actuarial Value - AV Calculator	71.50%	71.00%
Overall deductible	N/A	N/A
Other deductibles for specific services		
Medical	\$1,500	\$1,500
Brand Drugs	\$500	\$500
Dental	\$0	\$0
Out-of-pocket maximum	\$6,250	\$6,250

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner 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		\$15	
	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%		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	20%	X	20%	X
	Professional	20%			
Help recovering or other special health needs	Home health care	20%		\$45	
	Outpatient Rehabilitation services	\$45		\$45	
	Outpatient Habilitation services	\$45		\$45	
	Skilled nursing care	20%	X	20%	X
	Durable medical equipment	20%		20%	
Child eye care	Hospice service	No cost share		No cost share	
	Eye exam	No cost share		No cost share	
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share		No cost share	
	Oral Exam				
Child Dental Basic Services	Preventive - Cleaning	No cost share		No cost share	
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Major Services	Amalgam Fill - 1 Surface	20%		\$25	
	Root Canal- Molar	50%		\$300	
	Gingivectomy per Quad			\$150	
	Extraction- Single Tooth Exposed Root or			\$65	
	Extraction- Complete Bony			\$160	
Porcelain with Metal Crown	\$300				
Orthodontics	Medically necessary orthodontics	50%		\$1,000	

2015 Standard Benefit Plan Designs
3/20/2014 DRAFT - 10.0 EHB

Summary of Benefits and Coverage

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

	SHOP
	Silver HSA Plan
Actuarial Value - AV Calculator	71.60%
Overall deductible	\$1,500 integrated Med/Rx Ded
Other deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	N/A
Out-of-pocket maximum	\$6,250

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner 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	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% Professional 20%	X X
	Home health care	20%	X
Help recovering or other special health needs	Outpatient Rehabilitation services	20%	X
	Outpatient Habilitation services	20%	X
	Skilled nursing care	20%	X
	Durable medical equipment	20%	X
	Hospice service	No cost share	X
Child eye care	Eye exam	No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share	
Child Dental Diagnostic and Preventive	Oral Exam		
	Preventive - Cleaning		
	Preventive - X-ray		
	Sealants per Tooth		
	Topical Fluoride Application		
Child Dental Basic Services	Space Maintainers - Fixed		
	Amalgam Fill - 1 Surface	20%	
Child Dental Major Services	Root Canal- Molar		
	Gingivectomy per Quad		
	Extraction- Single Tooth Exposed Root or		
	Extraction- Complete Bony	50%	
Orthodontics	Porcelain with Metal Crown		
	Medically necessary orthodontics	50%	

2015 Standard Benefit Plan Designs
3/20/2014 DRAFT - 10.0 EHB

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
Actuarial Value - AV Calculator	94.80%	88.00%
Overall deductible	\$0	N/A
Other deductibles for specific services		
Medical	\$0	\$500
Brand Drugs	\$0	\$50
Dental	\$0	\$0
Out-of-pocket maximum	\$2,250	\$2,250

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner 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		\$5	
	Preferred brand drugs	\$5		\$15	X
	Non-preferred brand drugs	\$10		\$25	X
	Specialty drugs	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% Professional 10%		15% 15%	X
Help recovering or other special health needs	Home health care	10%		15%	
	Outpatient Rehabilitation services	\$3		\$15	
	Outpatient Habilitation services	\$3		\$15	
	Skilled nursing care	10%		15%	X
	Durable medical equipment	10%		15%	
Child eye care	Hospice service	No cost share		No cost share	
	Eye exam	No cost share		No cost share	
Child eye care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share		No cost share	
	Oral Exam				
Child Dental Diagnostic and Preventive	Preventive - Cleaning	No cost share		No cost share	
	Preventive - X-ray				
	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic Services	Amalgam Fill - 1 Surface	20%		20%	
Child Dental Major Services	Root Canal- Molar	50%		50%	
	Gingivectomy per Quad				
	Extraction- Single Tooth Exposed Root or				
	Extraction- Complete Bony Porcelain with Metal Crown				
Orthodontics	Medically necessary orthodontics	50%		50%	

2015 Standard Benefit Plan Designs
3/20/2014 DRAFT - 10.0 EHB

Summary of Benefits and Coverage

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

Silver Coinsurance Plan
200%-250% FPL

Actuarial Value - AV Calculator	73.50%
Overall deductible	N/A
Other deductibles for specific services	
Medical	\$1,500
Brand Drugs	\$250
Dental	\$0
Out-of-pocket maximum	\$5,200

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner 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)	30%	X
Drugs to treat illness or condition	Generic drugs	\$15	
	Preferred brand drugs	\$30	X
	Non-preferred brand drugs	\$50	X
	Specialty drugs	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% Professional 20%	X
Help recovering or other special health needs	Home health care	20%	
	Outpatient Rehabilitation services	\$40	
	Outpatient Habilitation services	\$40	
	Skilled nursing care	20%	X
	Durable medical equipment	20%	
Child eye care	Hospice service	No cost share	
	Eye exam	No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share	
Child Dental Diagnostic and Preventive	Oral Exam		
	Preventive - Cleaning		
	Preventive - X-ray	No cost share	
	Sealants per Tooth		
	Topical Fluoride Application		
Child Dental Basic Services	Space Maintainers - Fixed		
	Amalgam Fill - 1 Surface	20%	
Child Dental Major Services	Root Canal- Molar		
	Gingivectomy per Quad		
	Extraction- Single Tooth Exposed Root or	50%	
	Extraction- Complete Bony		
Orthodontics	Porcelain with Metal Crown		
	Medically necessary orthodontics	50%	

2015 Standard Benefit Plan Designs
3/20/2014 DRAFT - 10.0 EHB

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
Actuarial Value - AV Calculator	94.90%	88.00%
Overall deductible	\$0	N/A
Other deductibles for specific services		
Medical	\$0	\$500
Brand Drugs	\$0	\$50
Dental	\$0	\$0
Out-of-pocket maximum	\$2,250	\$2,250

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner 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		\$5	
	Preferred brand drugs	\$5		\$15	X
	Non-preferred brand drugs	\$10		\$25	X
	Specialty drugs	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 Professional	10%	15%	X
Help recovering or other special health needs	Home health care	\$3		\$15	
	Outpatient Rehabilitation services	\$3		\$15	
	Outpatient Habilitation services	\$3		\$15	
	Skilled nursing care	10%		15%	X
	Durable medical equipment	10%		15%	
Child eye care	Hospice service	No cost share		No cost share	
	Eye exam	No cost share		No cost share	
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share		No cost share	
	Oral Exam	No cost share		No cost share	
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth				
Topical Fluoride Application					
Child Dental Basic Services	Space Maintainers - Fixed				
	Amalgam Fill - 1 Surface	\$25		\$25	
Child Dental Major Services	Root Canal- Molar	\$300		\$300	
	Gingivectomy per Quad	\$150		\$150	
	Extraction- Single Tooth Exposed Root or	\$65		\$65	
	Extraction- Complete Bony	\$160		\$160	
Orthodontics	Porcelain with Metal Crown	\$300		\$300	
	Medically necessary orthodontics	\$1,000		\$1,000	

2015 Standard Benefit Plan Designs
3/20/2014 DRAFT - 10.0 EHB

Summary of Benefits and Coverage

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

	Silver Copay Plan 200%-250% FPL
Actuarial Value - AV Calculator	74.00%
Overall deductible	N/A
Other deductibles for specific services	
Medical	\$1,600
Brand Drugs	\$250
Dental	\$0
Out-of-pocket maximum	\$5,200

Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner 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	
	Preferred brand drugs	\$30	X
	Non-preferred brand drugs	\$50	X
	Specialty drugs	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 Professional	20% X
Help recovering or other special health needs	Home health care	\$40	
	Outpatient Rehabilitation services	\$40	
	Outpatient Habilitation services	\$40	
	Skilled nursing care	20%	X
	Durable medical equipment	20%	
Child eye care	Hospice service	No cost share	
	Eye exam	No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share	
Child Dental Diagnostic and Preventive	Oral Exam	No cost share	
	Preventive - Cleaning		
	Preventive - X-ray		
	Sealants per Tooth		
	Topical Fluoride Application		
Child Dental Basic Services	Space Maintainers - Fixed		
	Amalgam Fill - 1 Surface	\$25	
Child Dental Major Services	Root Canal- Molar	\$300	
	Gingivectomy per Quad	\$150	
	Extraction- Single Tooth Exposed Root or	\$65	
	Extraction- Complete Bony	\$160	
Orthodontics	Porcelain with Metal Crown	\$300	
	Medically necessary orthodontics	\$1,000	

2015 Standard Benefit Plan Designs
3/20/2014 DRAFT - 10.0 EHB

Summary of Benefits and Coverage

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

	Bronze Plan	Bronze HSA Plan
Actuarial Value - AV Calculator	60.60%	59.40%
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	\$0	N/A
Out-of-pocket maximum	\$6,250	\$6,250

Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$60	See Note 4	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	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	See Note 4	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	See Note 4	40%	X
	Mental/Behavioral health inpatient services	30%	X	40%	X
	Substance use disorder outpatient services	\$60	See Note 4	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		X	40%	X
Help recovering or other special health needs	Home health care	30%	X	40%	X
	Outpatient Rehabilitation services	\$60	X	40%	X
	Outpatient Habilitation services	\$60	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 eye care	Eye exam	No cost share		No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share		No cost share	
Child Dental Diagnostic and Preventive	Oral Exam				
	Preventive - Cleaning				
	Preventive - X-ray				
	Sealants per Tooth	No cost share		No cost share	
	Topical Fluoride Application				
Child Dental Basic Services	Space Maintainers - Fixed				
	Amalgam Fill - 1 Surface	20%		20%	
Child Dental Major Services	Root Canal- Molar				
	Gingivectomy per Quad				
	Extraction- Single Tooth Exposed Root or	50%		50%	
	Extraction- Complete Bony				
Orthodontics	Porcelain with Metal Crown				
	Medically necessary orthodontics	50%		50%	

2015 Standard Benefit Plan Designs
3/20/2014 DRAFT - 10.0 EHB

Summary of Benefits and Coverage

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

		Catastrophic Plan	
Actuarial Value - AV Calculator			
Overall deductible		\$6,600 integrated Med/Rx	
Other deductibles for specific services			
Medical		N/A	
Brand Drugs		N/A	
Dental		N/A	
Out-of-pocket maximum		\$6,600	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies
Health care provider's office or clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	0%	After 1st 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	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 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 non-preventive visits
	Mental/Behavioral health inpatient services	0%	X
	Substance use disorder outpatient services	0%	After 1st 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% Professional 0%	X X
Help recovering or other special health needs	Home health care	0%	X
	Outpatient Rehabilitation services	0%	X
	Outpatient Habilitation services	0%	X
	Skilled nursing care	0%	X
	Durable medical equipment	0%	X
	Hospice service	No cost share	X
Child eye care	Eye exam	No cost share	
	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share	x
Child Dental Diagnostic and Preventive	Oral Exam		
	Preventive - Cleaning		
	Preventive - X-ray	No cost share	
	Sealants per Tooth		
	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Basic Services	Amalgam Fill - 1 Surface	20%	X
Child Dental Major Services	Root Canal- Molar		X
	Gingivectomy per Quad		X
	Extraction- Single Tooth Exposed Root or	50%	X
	Extraction- Complete Bony		X
	Porcelain with Metal Crown		X
Orthodontics	Medically necessary orthodontics	50%	X

End Notes:

- 1) The family deductible and out-of-pocket maximum are equal to 2 times the individual values. In a family plan, an individual is responsible only for the individual deductible and the individual out-of-pocket maximum. Deductibles and other cost sharing payments made by each individual in a family contribute to the family deductible or out-of-pocket maximum. Once the family deductible is satisfied, plan copays or coinsurance apply until the family out of pocket maximum is reached, after which the plan pays all costs for covered services for all family members.
- 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 Bronze and Catastrophic plans, the deductible is waived for three office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.
- 5) Member cost-share for oral anti-cancer drugs shall not exceed \$200 per month.
- 6) The in-patient stay for Platinum and Gold Copay Plans has no additional cost share after 5 days.
- 7) For drugs to treat an illness or condition, the copay applies to the term of prescription.
- 8) The member cost share for a generic drug is the copay specified or the retail cost of the generic drug, whichever is less.
- 9) There is no requirement for the pediatric dental benefit design to match the non-dental benefit design. It is permissible to combine a coinsurance benefit design with a copay pediatric dental benefit design or a copay benefit design with a coinsurance pediatric dental benefit design.