Date: April 17, 2014



Member Cost Share amounts describe the Enrollee's out of pocket costs.	Platinum Coinsurance Plan	Platinum Copay Plan
Actuarial Value - AV Calculator	88.10%	88.00%
Individual Overall deductible	\$0	\$0
Other individual deductibles for specific services		
Medical	\$0	\$0
Brand Drugs	\$0	\$0
Dental	\$0	\$0
Individual Out-of-pocket maximum	\$4,000	\$4,000

Medical		\$0		\$0	
	Brand Drugs	\$0		\$0 \$0	
Individual Out-	Dental -of-pocket maximum	\$0 \$4,000	0	\$0 \$4.000)
marviduai Out	-oi-pocket maximum	ψ4,000		ψ4,000	
Common		Member Cost	Deductible	Member Cost	Deductible
Medical Event	Service Type	Share	Applies	Share	Applies
	00.0001,70				
	Primary care visit or non-specialist practitioner	#00		#00	
Health care provider's	visit to treat an injury or illness	\$20		\$20	
office or					
clinic visit	Specialist visit	\$40		\$40	
	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)	10%		\$150	
Drugs to treat	Generic drugs	\$5		\$5	
illness or	Preferred brand drugs	\$15		\$15	
condition	Non-preferred brand drugs	\$25		\$25	
Outpatient	Specialty drugs Facility fee (e.g., ASC)	10% 10%		10%	
surgery	Physician/surgeon fees	10%		\$250	
ou.go.y	Emergency room services (waived if admitted)	\$150		\$150	
	Emergency medical transportation	\$150		\$150	
Need	3 7 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Ţ3		4 ,23	
immediate	December 1999	0.40		A 40	
attention	Urgent care	\$40		\$40	
Hospital stay	Facility fee (e.g. hospital room)	10%		\$250 per day up	
1103pitai Stay	Physician/surgeon fee	10%		to 5 days	
	Mental/Behavioral health outpatient services	\$20		\$20	
	morna, zonaviora, noam, carpanorii con noce	ΨΣΟ		ΨΣο	
Mental health,					
behavioral	Mental/Behavioral health inpatient services	10%		\$250 per day up	
health, or	The state of the s	.070		to 5 days	
substance					
abuse needs	Substance use disorder outpatient services	\$20		\$20	
				\$250 per day up	
	Substance use disorder inpatient services	10%		to 5 days	
	Prenatal care and preconception visits	No cost share		No cost share	
Pregnancy	Delivery and all inpatient Hospital	10%		\$250 per day up	
	services Professional	10%		to 5 days	
	Home health care	10%		\$20	
	Outpatient Rehabilitation services	\$20		\$20	
Help	Outpatient Habilitation services	\$20		\$20	
recovering or other special	Skilled nursing care	10%		\$150 per day up	
health needs	Durable medical equipment	10%		to 5 days	
	Hospice service	No cost share		No cost share	
Child eye	Eye exam	No cost share		No cost share	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share		No cost share	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic	Preventive - X-ray	No cost share		No cost share	
and	Sealants per Tooth				
Preventive	Topical Fluoride Application Space Maintainers - Fixed				
Child Destal	орасс машашего - г ксс				
Child Dental Basic	Amalgam Fill - 1 Surface	20%		\$25	
Services	s.gairr iii i Guiraoo	2070		ΨΖΟ	
30.1.000	Root Canal- Molar			\$300	
Child Dental	Gingivectomy per Quad			\$150	
Major	Extraction- Single Tooth Exposed Root or	50%		\$65	
Services	Extraction- Complete Bony			\$160	
	Porcelain with Metal Crown			\$300	
Child	Medically necessary orthodontics	50%		\$1,000	
Orthodontics	,,	0070		Ç1,000	

Summar	v of	Benefits	and	Coverage
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-	Benefits and Coverage	a out of	Cold		Gold	
pocket costs.	Share amounts describe the Enrollee'	s out of	Gold Coinsurance		Copay P	
·	e - AV Calculator		78.809		78.609	
	rall deductible al deductibles for specific services	•	\$0		\$0	
Other marvida	Medical	•	\$0		\$0	
	Brand Drugs		\$0		\$0	
	Dental		\$0		\$0	
Individual 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	Primary care visit or non-specialist provisit to treat an injury or illness	oractitioner	\$30		\$30	
clinic visit	Specialist visit		\$50		\$50	
	Preventive care/ screening/ immuniz	zation	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		\$250 \$15	
Drugs to treat	Preferred brand drugs		\$15 \$50		\$50	
illness or	Non-preferred brand drugs		\$70		\$70	
condition	Specialty drugs		20%		20%	
Outpatient	Facility fee (e.g., ASC)		20%			
surgery	Physician/surgeon fees		20%		\$600	
	Emergency room services (waived i	f admitted)	\$250		\$250	
	Emergency medical transportation		\$250		\$250	
Need immediate attention	Urgent care		\$60		\$60	
	Facility fee (e.g. hospital room)		20%		\$600 per day up	
Hospital stay	Physician/surgeon fee		20%		to 5 days	
Mental health,	Mental/Behavioral health outpatient	services	\$30		\$30 \$600 per day up	
behavioral	Mental/Behavioral health inpatient s	ervices	20%		to 5 days	
health, or substance abuse needs	Substance use disorder outpatient s	services	\$30		\$30	
	Substance use disorder inpatient se	ervices	20%		\$600 per day up to 5 days	
Pregnancy	Prenatal care and preconception vis		No cost share		No cost share	
	Delivery and all inpatient Hosp services Profe		20%		\$600 per day up	
	Home health care	ssional	20%		to 5 days \$30	
	Outpatient Rehabilitation services		\$30		\$30 \$30	
Help	Outpatient Habilitation services		\$30		\$30	
recovering or					\$300 per day up	
other special	Skilled nursing care		20%		to 5 days	
health needs	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
Child eye	Eye exam		No cost share		No cost share	
care	pair of glasses per year (or contact of glasses) Oral Exam	ienses in lieu	No cost share		No cost share	
Child Dental	Preventive - Cleaning					
Diagnostic	Preventive - X-ray					
and	Sealants per Tooth		No cost share		No cost share	
Preventive	Topical Fluoride Application Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%		\$25	
	Root Canal- Molar				\$300	
Child Dental	Gingivectomy per Quad				\$150	
Major	Extraction- Single Tooth Exposed R	oot or	50%		\$65	
Services	Extraction- Complete Bony Porcelain with Metal Crown				\$160 \$300	
	1 OTOGIAITI WILLI WIGIAI OTOWIT				φουυ	
Child Orthodontics	Medically necessary orthodontics		50%		\$1,000	

-	Benefits and Coverage		Individ		Individu	
	hare amounts describe the E	nrollee's out of	Silver		Silver	
pocket costs.	AV Onlawfor		Coinsurance Plan 70.30%		Copay Plan 69.90%	
Actuariai value	e - AV Calculator			/o	69.90%	′ 0
Individual Over			N/A		N/A	
Other individua	al deductibles for specific s Medical	ervices	\$2,00	n	\$2,000	1
	Brand Drugs		\$250		\$250	
	Dental		\$0		\$0	
Individual Out-	-of-pocket maximum		\$6,25	0	\$6,250)
Common			Member Cost	Deductible	Member Cost	Deductible
Medical Event	Service Ty	pe	Share	Applies	Share	Applies
Health care provider's	Primary care visit or non-spe visit to treat an injury or illnes	•	\$45		\$45	
office or clinic visit	Specialist visit		\$65		\$65	
Cillic Visit	·	mmunization				
	Preventive care/ screening/ i	mmunization	No cost share		No cost share	
	Laboratory Tests		\$45		\$45	
Tests	X-rays and Diagnostic Imagir	-	\$65	V	\$65	
	Imaging (CT/PET scans, MR Generic drugs	is)	20% \$15	X	\$250 \$15	
Drugs to treat	Preferred brand drugs		\$50	Х	\$50	Х
illness or	Non-preferred brand drugs		\$70	X	\$70	X
condition	Specialty drugs		20%	X	20%	X
Outpatient	Facility fee (e.g., ASC)		20%	^_	20%	^
surgery	Physician/surgeon fees		20%		20%	
31	Emergency room services (w	aived if admitted)	\$250	X	\$250	X
	Emergency medical transpor		\$250	X	\$250	X
Need	- 3 - 1-7 baibai iranopor		+-00		\$200	
immediate attention	Urgent care		\$90		\$90	
Hospital stay	Facility fee (e.g. hospital roor	n)	20%	Х	20%	Х
noopha olay	Physician/surgeon fee		20%		20,0	
Mental health,	Mental/Behavioral health out	patient services	\$45		\$45	
behavioral	Mental/Behavioral health inp	atient services	20%	Х	20%	Х
health, or substance abuse needs	Substance use disorder outp	atient services	\$45		\$45	
	Substance use disorder inpa	tient services	20%	Х	20%	Х
	Prenatal care and preconcep	tion visits	No cost share		No cost share	
Pregnancy	Delivery and all inpatient	Hospital	20%	Х		
	services	Professional	20%		20%	Х
	Home health care		20%		\$45	
	Outpatient Rehabilitation ser	vices	\$45		\$45	
Help	Outpatient Habilitation service	es	\$45		\$45	
recovering or	Skilled nursing care		20%	Х	20%	Х
other special	ū			^		^
health needs	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
	Eye exam		No cost share		No cost share	
Child eye	1 pair of glasses per year (or	contact lenses in lieu				
care	of glasses) Oral Exam		No cost share		No cost share	
Child Dental	Preventive - Cleaning					
Diagnostic	Preventive - X-ray		No ocet ches		No ocet street	
and	Sealants per Tooth		No cost share		No cost share	
Preventive	Topical Fluoride Application					
Child Dental Basic	Space Maintainers - Fixed Amalgam Fill - 1 Surface		20%		\$25	
Services	D 10 111					
Object D	Root Canal- Molar				\$300	
Child Dental	Gingivectomy per Quad	and Deel er	F00/		\$150	
Major Sorvices	Extraction- Single Tooth Exp	osed Root or	50%		\$65 \$160	
Services	Extraction- Complete Bony Porcelain with Metal Crown				\$160 \$300	
	i Giogiani with Metal Ciowii				φουυ	
Child Orthodontics	Medically necessary orthodo	ntics	50%		\$1,000	

Summary of	Benefits and Coverage	S	НОР	SHO)P
Member Cost S	share amounts describe the Enrollee's out of	s	ilver	Silv	er
oocket costs.			rance Plan	Copay	
Actuarial Value	e - AV Calculator	71	.50%	71.00	0%
	rall deductible		N/A	N/A	4
Other individua	al deductibles for specific services	¢.	1,500	\$1,5	00
	Medical Brand Drugs		6500	\$1,5	
	Dental		\$0	\$0	
ndividual Out-	of-pocket maximum	\$6	6,250	\$6,2	50
Common		Member Cost		Member Cost	Deductible
Medical Event	Service Type	Share	Deductible Applies	Share	Applies
Health care provider's office or	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$45		\$45	
clinic visit	Specialist visit	\$65		\$65	
	Preventive care/ screening/ immunization	No cost share		No cost share	
	-				
Tests	Laboratory Tests X-rays and Diagnostic Imaging	\$45 \$65		\$45 \$65	
16313	Imaging (CT/PET scans, MRIs)	20%	Х	\$250	
	Generic drugs	\$15		\$15	
Drugs to treat	Preferred brand drugs	\$50	Х	\$50	Х
condition	Non-preferred brand drugs	\$70	Х	\$70	X
	Specialty drugs	20%	X	20%	Х
Outpatient	Facility fee (e.g., ASC)	20%		20%	
surgery	Physician/surgeon fees Emergency room services (waived if admitted)	20% \$250	X	20% \$250	X
	Emergency medical transportation	\$250 \$250	X	\$250	X
Need immediate attention	Urgent care	\$90	X	\$90	X
	Facility fee (e.g. hospital room)	20%	X		.,
Hospital stay	Physician/surgeon fee	20%		20%	Х
Mental health,	Mental/Behavioral health outpatient services	\$45		\$45	
pehavioral	Mental/Behavioral health inpatient services	20%	Х	20%	Х
nealth, 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 Delivery and all inpatient Hospital	No cost share 20%	X	No cost share	
	services Professional	20%	^	20%	X
	Home health care	20%		\$45	
	Outpatient Rehabilitation services	\$45		\$45	
Help	Outpatient Habilitation services	\$45		\$45	
recovering or other special	Skilled nursing care	20%	Х	20%	Χ
health needs	Durable medical equipment	20%		20%	
	Hospice service	No cost share		No cost share	
Child eye	Eye exam	No cost share		No cost share	
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share		No cost share	
Child Daw	Oral Exam				
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray				
and	Sealants per Tooth	No cost share		No cost share	
Preventive	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Basic	Amalgam Fill - 1 Surface	20%		\$25	
Services					
	Root Canal- Molar			\$300	
Child Dental	Gingivectomy per Quad	50%		\$150	
		50%			

50%

\$1,000

Medically necessary orthodontics

•	Benefits and Coverage thare amounts describe the Enro	llee's out of	SHO Silve HSA P	er
Actuarial Value	e - AV Calculator		71.60	1%
Individual Ove	rall deductible		\$1,500 integrated	d Med/Rx Ded
Other individua	al deductibles for specific serv	rices		
	Medical Brand Drugs		N/A N/A	
	Dental		N/A	
Individual Out-	-of-pocket maximum		\$6,25	
Common				
Medical Event	Service Type		Member Cost Share	Deductible Applie
Health care provider's office or	Primary care visit or non-specia visit to treat an injury or illness	list practitioner	20%	Х
clinic visit	Specialist visit		20%	Х
	Preventive care/ screening/ imn	nunization	No cost share	
	Laboratory Toota		200/	
Tests	Laboratory Tests X-rays and Diagnostic Imaging		20% 20%	X
	Imaging (CT/PET scans, MRIs)		20%	X
Drugo to troot	Generic drugs		20%	X
Drugs to treat	Preferred brand drugs		20%	Х
condition	Non-preferred brand drugs		20%	X
	Specialty drugs		20%	X
Outpatient	Facility fee (e.g., ASC)		20%	X
surgery	Physician/surgeon fees Emergency room services (waived if admitted)		20%	X
			20% 20%	X
Need immediate attention	Emergency medical transportation Urgent care		20%	X
Hospital stay	Facility fee (e.g. hospital room)		20%	X
	Physician/surgeon fee		20%	X
Mental health,	Mental/Behavioral health outpat	ient services	20%	х
behavioral	Mental/Behavioral health inpatie	ent services	20%	Х
health, or substance abuse needs	Substance use disorder outpation	ent services	20%	х
	Substance use disorder inpatier	nt services	20%	Х
	Prenatal care and preconception	n visits	No cost share	
Pregnancy	Delivery and all inpatient	lospital	20%	X
	, ,	rofessional	20%	X
	Home health care		20%	X
	Outpatient Rehabilitation service	es	20%	X
Help	Outpatient Habilitation services		20%	X
recovering or other special	Skilled nursing care		20%	Х
health needs	Durable medical equipment		20%	Х
	Hospice service		No cost share	X
Child eye	Eye exam		No cost share	
care	1 pair of glasses per year (or corof glasses) Oral Exam	ntact lenses in lieu	No cost share	
Child Dental	Preventive - Cleaning			
Diagnostic	Preventive - X-ray		No cost share	
and	Sealants per Tooth		No cost share	
Preventive	Topical Fluoride Application			
Child Dental Basic Services	Space Maintainers - Fixed Amalgam Fill - 1 Surface		20%	
231 11003	Root Canal- Molar			
Child Dental	Gingivectomy per Quad			
Major	Extraction- Single Tooth Expose	ed Root or	50%	
Services	Extraction- Complete Bony			
	Porcelain with Metal Crown			
Child	Medically necessary orthodontic	·c	50%	

Member Cost Share 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%		%	
Individual Overall deductible	\$0	\$0 N/A		
Other individual deductibles for specific services				
Medical	\$0		\$500	
Brand Drugs	\$0		\$50	
Dental	\$0		\$0	
Individual Out-of-pocket maximum	\$2,250		\$2,250	
Common	Member Cost	Deductible	Member Cost	Deductible

Individual Out-	Dental -of-pocket maximum	\$0 \$2,250		\$0 \$2,250	
- Industrial		Ψ2,20		Ψ2,20	
Common Medical Event	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$3		\$15	
clinic visit	Specialist visit	\$5		\$20	
	Preventive care/ screening/ immunization	No cost share		No cost share	
	Laboratory Tests	\$3		\$15	
Tests	X-rays and Diagnostic Imaging	\$5		\$20	
	Imaging (CT/PET scans, MRIs)	10%		15%	X
Drugs to treat	Generic drugs Preferred brand drugs	\$3 \$5		\$5 \$15	Х
illness or	Non-preferred brand drugs	\$10		\$25	X
condition	Specialty drugs	10%		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
	Emergency medical transportation	\$25		\$75	Х
Need immediate attention	Urgent care	\$6		\$30	
	Facility fee (e.g. hospital room)	10%		15%	X
Hospital stay	Physician/surgeon fee	10%		15%	
Mental health,	Mental/Behavioral health outpatient services	\$3		\$15	
behavioral health, or	Mental/Behavioral health inpatient services	10%		15%	Х
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	
.5,	Delivery and all inpatient Hospital	10%		15%	Х
	Services Professional Home health care	10% 10%		15% 15%	
	Outpatient Rehabilitation services	\$3		\$15	
Help	Outpatient Habilitation services	\$3		\$15	
recovering or	·	·			.,
other special	Skilled nursing care	10%		15%	Х
health needs	Durable medical equipment	10%		15%	
	Hospice service	No cost share		No cost share	
	Eye exam	No cost share		No cost share	
Child eye	1 pair of glasses per year (or contact lenses in lieu				
care	of glasses)	No cost share		No cost share	
	Oral Exam				
Child Dental	Preventive - Cleaning				
Diagnostic and	Preventive - X-ray	No cost share		No cost share	
Preventive	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 Gingivectomy per Quad Extraction- Single Tooth Exposed Root or Extraction- Complete Bony Porcelain with Metal Crown	50%		50%	
Child Orthodontics	Medically necessary orthodontics	50%		50%	

Date: April 17, 2014

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Coinsurance Plan 200%-250% FPL
Actuarial Value - AV Calculator	rounded up to 74.0%
Individual Overall deductible	N/A
Other individual deductibles for specific services	
Medical	\$1,600
Brand Drugs	\$250
Dental	\$0
Individual Out-of-pocket maximum	\$5,200

	Dental Drugs		\$0	
Individual Out-	-of-pocket maximum		\$5,20	0
Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or	Primary care visit or non-specialist pr visit to treat an injury or illness	actitioner	\$40	
clinic visit	Specialist visit		\$50	
	Preventive care/ screening/ immuniza	ation	No cost share	
	Laboratory Tests		\$40	
Tests	X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)		\$50 20%	Х
D	Generic drugs		\$15	
Drugs to treat illness or	Preferred brand drugs		\$35	Х
condition	Non-preferred brand drugs		\$60	Х
Outpotions	Specialty drugs Facility fee (e.g., ASC)		20%	X
Outpatient surgery	Physician/surgeon fees		20% 20%	
Surgery	Emergency room services (waived if	admitted)	\$250	Х
	Emergency medical transportation		\$250	X
Need immediate attention	Urgent care		\$80	
	Facility fee (e.g. hospital room)		20%	Х
Hospital stay	Physician/surgeon fee		20%	
Mental health,	Mental/Behavioral health outpatient s	\$40		
behavioral health, or	Mental/Behavioral health inpatient se	rvices	20%	Х
substance abuse needs	Substance use disorder outpatient services		\$40	
	Substance use disorder inpatient ser	/ices	20%	Х
Pregnancy	Prenatal care and preconception visit		No cost share	V
, i	Delivery and all inpatient Hospital Services Profes	al sional	20%	Х
	Home health care	Siuriai	20%	
	Outpatient Rehabilitation services		\$40	
Help	Outpatient Habilitation services		\$40	
recovering or	Skilled nursing care		20%	Х
other special health needs	Durable medical equipment		20%	
noun noodo	Hospice service		No cost share	
Child aug	Eye exam		No cost share	
Child eye care	1 pair of glasses per year (or contact le of glasses)	enses in lieu	No cost share	
OLUL D	Oral Exam			
Child Dental Diagnostic	Preventive - Cleaning Preventive - X-ray			
and	Sealants per Tooth		No cost share	
Preventive	Topical Fluoride Application Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface		20%	
Child Dental Major Services	Root Canal- Molar Gingivectomy per Quad Extraction- Single Tooth Exposed Ro Extraction- Complete Bony Porcelain with Metal Crown	ot or	50%	
Child Orthodontics	Medically necessary orthodontics		50%	

Date: April 17, 2014

	Share amounts describe the Enrollee's out of	Silver Cop	•	Silver Cop		
pocket costs. Actuarial Value - AV Calculator		100%-150% FPL		150%-200% FPL		
		94.90%		88.00%		
	rall deductible	\$0		N/A	١	
Otner individu	al deductibles for specific services Medical	\$0		\$50	0	
	Brand Drugs	\$0		\$50		
	Dental	\$0		\$0		
Individual Out	of-pocket maximum	\$2,25	50	\$2,2	50	
Common		Member Cost	Deductible	Member Cost	Deductible	
Medical Event	Service Type	Share	Applies	Share	Applies	
Health care provider's	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$3		\$15		
office or clinic visit	Specialist visit	\$5		\$20		
Cillic Visit	Preventive care/ screening/ immunization	No cost share		No cost share		
	-					
	Laboratory Tests	\$3		\$15		
Tests	X-rays and Diagnostic Imaging	\$5 \$50		\$20 \$100		
	Imaging (CT/PET scans, MRIs) Generic drugs	\$50 \$3		\$100 \$5		
Drugs to treat	Preferred brand drugs	\$5		\$15	Х	
illness or	Non-preferred brand drugs	\$10		\$25	X	
condition	Specialty drugs	10%		15%	X	
Outpatient	Facility fee (e.g., ASC)	10%		15%		
surgery	Physician/surgeon fees	10%		15%		
	Emergency room services (waived if admitted)	\$25		\$75	X	
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 health,	Mental/Behavioral health outpatient services	\$3		\$15		
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 Hospital services Professional	10%		15%	Х	
	Home health care	\$3		\$15		
	Outpatient Rehabilitation services	\$3		\$15		
Help	Outpatient Habilitation services	\$3		\$15		
recovering or	Skilled nursing care	10%		15%	Х	
other special health needs	Durable medical equipment	10%		15%		
nealth needs						
	Hospice service	No cost share		No cost share		
Child eye	Eye exam	No cost share		No cost share		
care	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share		No cost share		
	Oral Exam					
Child Dental	Preventive - Cleaning					
Diagnostic	Preventive - X-ray	No cost share		No cost share		
and	Sealants per Tooth	. 10 0001 311016		.10 0001 311016		
Preventive	Topical Fluoride Application Space Maintainers - Fixed					
Child Dental Basic Services	Amalgam Fill - 1 Surface	\$25		\$25		
Child Davidal	Root Canal- Molar	\$300		\$300		
Child Dental	Gingivectomy per Quad Extraction- Single Tooth Exposed Root or	\$150		\$150		
Major Services	Extraction- Single Tooth Exposed Root or Extraction- Complete Bony	\$65 \$160		\$65 \$160		
3	Porcelain with Metal Crown	\$300		\$300		
Child Orthodontics	Medically necessary orthodontics	\$1,000		\$1,000		

Date: April 17, 2014

Member Cost Share amounts describe the Enrollee's out of pocket costs.	Silver Copay Plan 200%-250% FPL		
Actuarial Value - AV Calculator	73.50%		
Individual Overall deductible	N/A		
Other individual deductibles for specific services			
Medical	\$1,600		
Brand Drugs	\$250		
Dental	\$0		
Individual Out-of-pocket maximum	\$5,200		

	Dental	\$250 \$0		
Individual Out	Dental -of-pocket maximum	\$0 \$5,200		
muividuai Out-	-oi-pocket maximum	\$5,200		
Common Medical Event	Service Type		Member Cost Share	Deductible Applies
Health care provider's office or	Primary care visit or non-specia visit to treat an injury or illness	alist practitioner	\$40	
clinic visit	Specialist visit Preventive care/ screening/ imr	munization	\$50 No cost share	
	Laboratory Tests	Tidilization	\$40	
Tests	X-rays and Diagnostic Imaging		\$50	
During to treat	Imaging (CT/PET scans, MRIs) Generic drugs	<u> </u>	\$250 \$15	
Drugs to treat illness or	Preferred brand drugs		\$35	Х
condition	Non-preferred brand drugs		\$60	Χ
Condition	Specialty drugs		20%	Х
Outpatient	Facility fee (e.g., ASC)		20%	
surgery	Physician/surgeon fees		20%	
	Emergency room services (wair		\$250	Х
News	Emergency medical transportat	tion	\$250	Х
Need immediate attention	Urgent care	\$80		
Hospital stay	Facility fee (e.g. hospital room) Physician/surgeon fee		20%	Х
Mental health.	Mental/Behavioral health outpa	\$40		
behavioral health, or	Mental/Behavioral health inpatient services		20%	Х
substance abuse needs	Substance use disorder outpatient services		\$40	
	Substance use disorder inpatient services		20%	Х
Pregnancy	Prenatal care and preconception		No cost share	
		Hospital Professional	20%	Χ
	Home health care	TOTOGOTOTIAL	\$40	
	Outpatient Rehabilitation service	ces	\$40	
Help	Outpatient Habilitation services		\$40	
recovering or	·			v
other special health needs	Skilled nursing care		20%	Х
nearth needs	Durable medical equipment Hospice service	20% No cost share		
	·			
Child eye	1 pair of glasses per year (or co	intoot longes in lie	No cost share	
care	1 pair of glasses per year (or co of glasses)	madi letises iti ileü	No cost share	
	Oral Exam			
Child Dental	Preventive - Cleaning			
Diagnostic	Preventive - X-ray	No cost share		
and Preventive	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface	\$25		
OLUL D	Root Canal- Molar		\$300	
Child Dental	Gingivectomy per Quad	ad Doct ar	\$150	
Major	Extraction- Single Tooth Expos	ed KOOI OF	\$65 \$160	
Services	Extraction- Complete Bony Porcelain with Metal Crown		\$160 \$300	
Child Orthodontics	Medically necessary orthodonti	cs	\$1,000	
Orthodontics				

Summary	/ of	Renefits	and	Coverage
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-	f Benefits and Coverage Share amounts describe the E		Prone	n Plan	Bronz	ze
pocket costs.			Bronze Plan		HSA Plan	
Actuarial Value - AV Calculator			60.60%		59.40%	
	rall deductible		\$5,000 integrate	ed Med/Rx Ded	\$4,500 integrat	ed Med/Rx
Other individu	al deductibles for specific s	ervices	NI	ΙΔ.	NI/A	
	Medical Brand Drugs		N/ N/		N/A N/A	
	Dental		\$(N/A	
Individual Out	of-pocket maximum		\$6,2	250	\$6,25	0
Common Medical Event	Service Ty	pe	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Health care provider's office or	Primary care visit or non-spe visit to treat an injury or illnes	•	\$60	After 1st three non-preventive visits	40%	Х
clinic visit	Specialist visit		\$70	Х	40%	Х
	Preventive care/ screening/ i	mmunization	No cost share		No cost share	
	Laboratory Tests		30%	X	40%	X
Tests	X-rays and Diagnostic Imagir		30%	X	40%	X
	Imaging (CT/PET scans, MR	IS)	30%	X	40%	X
Drugs to treat	Generic drugs Preferred brand drugs		\$15 \$50	X	40%	X
illness or	Non-preferred brand drugs		\$50 \$75	X	40%	X
condition	Specialty drugs		30%	X	40%	X
Outpatient	Facility fee (e.g., ASC)		30%	X	40%	X
surgery	Physician/surgeon fees		30%	X	40%	X
	Emergency room services (w	aived if admitted)	\$300	X	40%	X
	Emergency medical transpor	· · · · · · · · · · · · · · · · · · ·	\$300	X	40%	X
Need immediate attention	Urgent care	\$120	After 1st three non-preventive visits	40%	×	
	Facility fee (e.g. hospital rooi	m)	30%	Х	40%	X
Hospital stay	Physician/surgeon fee	,	30%	Х	40%	Х
Mental/Behavioral health outpatient service		patient services	\$60	After 1st three non- preventive visits	40%	Х
behavioral health, or	Mental/Behavioral health inp	30%	Х	40%	Х	
substance abuse needs	Substance use disorder outpatient services		\$60	After 1st three non- preventive visits	40%	Х
	Substance use disorder inpa	tient services	30%	Х	40%	Х
Pregnancy	Prenatal care and preconcep		No cost share	, ,	No cost share	V
	Delivery and all inpatient	Hospital	30%	X	40%	X
	services Home health care	Professional	30%	X	40%	X
	Outpatient Rehabilitation ser	vices	\$60	X	40%	X
Help	Outpatient Habilitation service		\$60	X	40%	X
recovering or	Skilled nursing care		30%	X	40%	X
other special health needs	Durable medical equipment		30%	X	40%	X
	Hospice service		No cost share	Х	No cost share	Х
Child eye	Eye exam		No cost share		No cost share	
care	1 pair of glasses per year (or of glasses)	contact lenses in lieu	No cost share		No cost share	
Child Dental	Oral Exam Preventive - Cleaning					
Diagnostic	Preventive - X-ray					
and	Sealants per Tooth	No cost share		No cost share		
Preventive	Topical Fluoride Application					
Child Dental Basic Services	Space Maintainers - Fixed Amalgam Fill - 1 Surface		20%		20%	
	Root Canal- Molar					
Child Dental	Gingivectomy per Quad					
Major	Extraction- Single Tooth Exp	osed Root or	50%		50%	
Services	Extraction- Complete Bony Porcelain with Metal Crown					
Child Orthodontics	Medically necessary orthodo	ntics	50%		50%	

Summar	v of	Benefits	and	Coverage
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Member Cost Share amounts describe the Enrollee's out of pocket costs.	Catastrophic Plan		
Actuarial Value - AV Calculator			
Individual Overall deductible	\$6,600 integrated Med/Rx		
Other individual deductibles for specific services			
Medical	N/A		
Brand Drugs	N/A		
Dental	N/A		
Individual Out-of-pocket maximum	\$6,600		

	Dental	N/A N/A		
Individual Out	of-pocket maximum	\$6,600		
	or pocket maximum	φ0,00	0	
Common			Member Cost	Deductible
Medical Event	Service Typ	е	Share	Applies
Health care provider's office or	Primary care visit or non-specialist practitioner visit to treat an injury or illness		0%	After 1st three non- preventive visits
clinic visit	Specialist visit		0%	X
Cimilo Viole	Preventive care/ screening/ in	nmunization	No cost share	
	Laboratory Tests		0%	Х
Tests	X-rays and Diagnostic Imaging		0%	Х
	Imaging (CT/PET scans, MRIs	s)	0%	Х
Drugs to treat	Generic drugs		0%	X
illness or	Preferred brand drugs Non-preferred brand drugs		0%	X
condition			0%	X
Outpotions	Specialty drugs Facility fee (e.g., ASC)		0% 0%	X
Outpatient surgery	Physician/surgeon fees		0%	X
surgery	Emergency room services (wa	aived if admitted)		X
	Emergency medical transporta		0% 0%	X
Need immediate attention	Urgent care		0%	After 1st three non- preventive visits
	Facility fee (e.g. hospital room	1)	0%	Х
Hospital stay	Physician/surgeon fee		0%	Х
Mental health.	Mental/Behavioral health outpatient services		0%	After 1st three non- preventive visits
behavioral health, or	Mental/Behavioral health inpatient services		0%	Х
substance abuse needs	Substance use disorder outpatient services		0%	After 1st three non- preventive visits
	Substance use disorder inpati	ent services	0%	Х
Pregnancy	Prenatal care and preconcept		No cost share	
rognancy	Delivery and all inpatient	Hospital	0%	Х
	services	Professional	0%	X
	Home health care	:	0%	X
Holp	Outpatient Rehabilitation serv Outpatient Habilitation service		0% 0%	X
Help recovering or	Outpatient Habilitation Service		U70	^
other special	Skilled nursing care	0%	Х	
health needs	Durable medical equipment	0%	Х	
	Hospice service	No cost share	Х	
Child eye	Eye exam		No cost share	
care	1 pair of glasses per year (or of glasses)	contact lenses in lieu	No cost share	х
OLUL D	Oral Exam			
Child Dental	Preventive - Cleaning			
Diagnostic and	Preventive - X-ray		No cost share	
Preventive Preventive	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed			
Child Dental Basic Services	Amalgam Fill - 1 Surface	20%	Х	
Child Daniel	Root Canal- Molar			X
Child Dental	Gingivectomy per Quad Extraction- Single Tooth Expo	sed Root or	50%	X
Major Services	Extraction- Single Tooth Expo	Seu NOULUI	JU 70	X
50, 11003	Porcelain with Metal Crown			X
Child Orthodontics	Medically necessary orthodon	50%	X	

Endnotes:

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for High Deductible Health Plans (HDHPs) linked to Health Savings Accounts (HSAs), in a family plan, an individual is responsible only for the individual deductible and the individual out-of-pocket maximum amount. Cost sharing payments (deductibles, copayments and coinsurance, but not yet premiums) made by each individual in a family contribute to the family deductible and out-of-pocket maximums. The family deductible may be satisfied by any combination of individual deductible payments, after which member copays or coinsurance apply until the family out of pocket maximum is reached. Once the family out-of-pocket maximum is reached, the plan pays all costs for covered services for all family members.
- 2) For HDHPs linked to HSAs, an individual in a self-only coverage plan must meet a deductible of not less than the amount designated by the IRS for self-only coverage. In a family plan, each individual in the family must meet the deductible of not less than the amount designated by the IRS for family coverage, until the family deductible is met. The cost-sharing payments cannot exceed the out of pocket limits set for self-only coverage and family coverage.
- Cost sharing payments for all in-network services accumulate toward the deductible, if deductible applies to that service, and the out-of-pocket maximum.
- 4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed amount (the maximum amount on which payment is based for covered health care services).
- 5) For the Bronze and Catastrophic plans, deductible is waived for the first three non-preventive office or urgent care visits, including outpatient Mental Health/Substance Abuse visits.
- 6) Member cost-share for oral anti-cancer drugs shall not exceed \$200 per month.
- 7) In the Platinum and Gold Copay Plans, hospital, in-patient and skilled nursing facility stays have no additional cost share after 5 days.
- 8) For drugs to treat an illness or condition the supply of drugs for which the copay or coinsurance applies is for the prescription term. Nothing in this note precludes a carrier from offering discounts that vary with the term of the prescription.
- 9) For the child dental portion of the benefit design, a carrier may choose the copay or coinsurance child dental benefit design, regardless of whether the carrier selects the copay or the coinsurance design for the non-child dental portion of the benefit design.