COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Platinum Coinsurance Plan	Platinum Copay Plan
2/12/2013		
Actuarial Value SUBJECT TO FINAL FEDERAL RULES	89.1%	89.1%
Overall deductible	\$0	\$0
Other deductibles for specific services		
Medical	\$0	\$0
Brand Drugs	\$0	\$0
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$4,000	\$4,000

Common Medical			Member Cost	Deductible	Member Cost	Deductible	
Event	Service Typ	e	Share	Applies	Share	Applies	
LVOIR		~	Onaro	Аррисо	onaro	Аррисс	
	Primary care visit to treat an in	iury or illness (see	•				
Visit to a health	footnote)	, , , , , , , , , , , , , , , , , , ,	\$25		\$25		
care provider's	,						
office or clinic	Specialist visit		\$50		\$50		
	Other practitioner office visit		\$25		\$25		
	Preventive care/ screening/ im	munization	No cost share		No cost share		
	Laboratory Tests		\$25		\$25		
Tests	X-rays and Diagnostic Imaging		\$40		\$40		
	Imaging (CT/PET scans, MRIs)	10%		\$150		
Drugo to troot	Generic drugs		\$5		\$5		
Drugs to treat	Preferred brand drugs		\$15		\$15		
illness or condition	Non-preferred brand drugs		\$25		\$25		
condition	Specialty drugs		10%		10%		
Outpatient	Facility fee (e.g., ASC)		10%		\$250		
surgery	Physician/surgeon fees		10%		φ∠ου		
	Emergency room services (wai	ved if admitted)	\$150		\$150		
	Emergency medical transporta	tion	\$150		\$150		
Need immediate							
attention	Urgent care		\$50		\$50		
	orgeni care		\$ 50		φου		
Hospital stay	Facility fee (e.g., hospital room)	10%		\$250 per day up		
nospital stay	Physician/surgeon fee		10%		to 5 days		
	Mental/Behavioral health outpa	itient services	\$25		\$25		
Mental health,	Mental/Behavioral health inpati	ent services	10%		\$250 per day up		
behavioral health,			1078		to 5 days		
or substance	Substance use disorder outpat	ient services	\$25		\$25		
abuse needs	Substance use disorder inpatie	nt services	10%		\$250 per day up		
			1070		to 5 days		
	Prenatal and postnatal care		\$25		\$25		
Pregnancy			ΨZO		φΖΟ		
riognanoy							
	Delivery and all inpatient	Hospital	10%		\$250 per day up		
	services	Professional	10%		to 5 days		
	Home health care		10%		\$25		
	Rehabilitation services		\$25		\$25		
Help recovering	Habilitation services		\$25		\$25		
or other special	Skilled nursing care		10%		\$150 per day up		
health needs	<u> </u>				to 5 days		
	Durable medical equipment		10%		10%		
	Hospice service		No cost share		No cost share		
	Eye exam (deductible waived)		0%		0%		
Child needs	Glasses		1 pair per year		1 pair per year		
dental or eye care	Dental check-up - Preventive a	nd Diagnostic			• • • •		
	Dental Basic Services		See attac	nment	See attach	nment	
	Dental Restorative and Orthod	ontia Services					

Notes:

1) Actuarial values will be determined using the federal actuarial value calculator when it is released. To fit within allowable actuarial values, the cost sharing amounts in the standardized plans may be adjusted.

2) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense.

4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges.

5) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or

outpatient Mental Health/Substance Abuse visits.

specified in another benefit category.

7) Glasses benefit limited to \$100 per year.

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Gold Coinsurance Plan	Gold Copay Plan
2/12/2013		
Actuarial Value SUBJECT TO FINAL FEDERAL RULES	79.2%	79.0%
Overall deductible	\$0	\$0
Other deductibles for specific services		
Medical	\$0	\$0
Brand Drugs	\$0	\$0
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$6,400	\$6,400

Common Medical			Member Cost	Member Cost Deductible		Deductible
Event		^	Share	Applies	Member Cost Share	Applies
Event	Service Typ	е	Share	Applies	Share	Applies
	Primary care visit to treat an in	iury or illness (see				
Visit to a health	footnote)		\$45		\$45	
care provider's						
office or clinic	Specialist visit		\$65		\$65	
	Other practitioner office visit		\$45		\$45	
	Preventive care/ screening/ imi	munization	No cost share		No cost share	
	Laboratory Tests		\$45		\$45	
Tests	X-rays and Diagnostic Imaging		\$65		\$65	
	Imaging (CT/PET scans, MRIs		20%		\$250	
	Generic drugs	,	\$25		\$25	
Drugs to treat	Preferred brand drugs		\$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 if admitted)		\$250		\$250	
	Emergency medical transporta		\$250		\$250	
Need immediate						
attention	Urgent care		A aa		\$90	
			\$90			
Heapital stay	Facility fee (e.g., hospital room)		20%		\$600 per day up	
Hospital stay	Physician/surgeon fee		20%		to 5 days	
	Mental/Behavioral health outpa	itient services	\$45		\$45	
Mental health,	Montal/Rabayiaral baalth innat	ant convisco	2007		\$600 per day up	
behavioral health,	Mental/Behavioral health inpati	ent services	20%		to 5 days	
or substance	Substance use disorder outpat	ient services	\$45		\$45	
abuse needs	Substance use disorder inpatie	nt convicos	20%		\$600 per day up	
	Substance use disorder inpatie		20%		to 5 days	
	Prenatal and postnatal care		\$45		\$45	
Pregnancy			φ 4 0		φ40	
riegnancy						
	Delivery and all inpatient	Hospital	20%		\$600 per day up	
	services	Professional	20%		to 5 days	
	Home health care		20%		\$45	
	Rehabilitation services		\$45		\$45	
Help recovering	Habilitation services		\$45		\$45	
or other special	Skilled nursing care		20%		\$300 per day up	
health needs					to 5 days	
	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
	Eye exam (deductible waived)		0%		0%	
Child needs	Glasses		1 pair per year		1 pair per year	
dental or eye care	Dental check-up - Preventive a	nd Diagnostic				
dental of eye cale	Dental Basic Services		See attac	hment	See attack	nment
	Dental Restorative and Orthodontia Services					

Notes:

1) Actuarial values will be determined using the federal actuarial value calculator when it is released. To fit within allowable actuarial values, the cost sharing amounts in the standardized plans may be adjusted.

2) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense.

4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges.

5) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or

outpatient Mental Health/Substance Abuse visits.

specified in another benefit category.

7) Glasses benefit limited to \$100 per year.

Summary of Benefits and Coverage	Individual	Individual
COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver Coinsurance Plan	Silver Copay Plan
2/12/2013		
Actuarial Value SUBJECT TO FINAL FEDERAL RULES	70.2%	69.8%
Overall deductible	N/A	N/A
Other deductibles for specific services		
Medical	\$2,000	\$2,000
Brand Drugs	\$500	\$500
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$6,400	\$6,400

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Common Medical			Mombon Cost		Mombor Cost	
			Member Cost Share	Deductible	Member Cost	Deductible
Event	Service Typ	e	Snare	Applies	Share	Applies
	Primary care visit to treat an inj	iury or illness (see				
Visit to a health	footnote)		\$45		\$45	
care provider's						
office or clinic	Specialist visit		\$65		\$65	
	Other practitioner office visit		\$45		\$45	
	Preventive care/ screening/ imi	munization	No cost share		No cost share	
	Laboratory Tests		\$45		\$45	
Tests	X-rays and Diagnostic Imaging		\$65		\$65	
	Imaging (CT/PET scans, MRIs		20%	Х	\$250	
D	Generic drugs	,	\$25		\$25	
Drugs to treat	Preferred brand drugs		\$50	Х	\$50	Х
illness or	Non-preferred brand drugs		\$70	Х	\$70	Х
condition	Specialty drugs		20%	Х	20%	Х
Outpatient	Facility fee (e.g., ASC)		20%	Х		V
surgery	Physician/surgeon fees		20%		20%	Х
	Emergency room services (wai	ved if admitted)	\$250	Х	\$250	Х
	Emergency medical transporta		\$250	Х	\$250	Х
Need immediate						
attention	Linnand anna		\$90		#0 0	
	Urgent care	orgeni care			\$90	
Heenitel stay	Facility fee (e.g., hospital room)		20%	Х	20%	Х
Hospital stay	Physician/surgeon fee	hysician/surgeon fee			20%	~
	Mental/Behavioral health outpa	itient services	\$45		\$45	
Mental health,	Mental/Behavioral health inpatient services		20%	Х	20%	х
behavioral health,	Mental/Denavioral health inpatient services		2076	^	2070	^
or substance	Substance use disorder outpat	ient services	\$45		\$45	
abuse needs	Substance use disorder inpatie	nt services	20%	Х	20%	х
			2070	Λ	2070	~
	Prenatal and postnatal care		\$45		\$45	
Pregnancy			ψτο		Φ 45	
riognarioy						
	Delivery and all inpatient	Hospital	20%	X	20%	Х
	services	Professional	20%			~
	Home health care		20%		\$45	
	Rehabilitation services		\$45		\$45	
Help recovering	Habilitation services		\$45		\$45	
or other special	Skilled nursing care		20%	х	20%	Х
health needs	-					
	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
	Eye exam (deductible waived)		0%		0%	
Child needs	Glasses		1 pair per year		1 pair per year	
dental or eye care	Dental check-up - Preventive a	nd Diagnostic			•	
, je calo	Dental Basic Services		See attachment See attachm		nment	
	Dental Restorative and Orthodontia Services					

Notes:

1) Actuarial values will be determined using the federal actuarial value calculator when it is released. To fit within allowable actuarial values, the cost sharing amounts in the standardized plans may be adjusted.

2) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense.

4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges.

5) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or

outpatient Mental Health/Substance Abuse visits.

specified in another benefit category.

7) Glasses benefit limited to \$100 per year.

Summary of Benefits and Coverage	SHOP	SHOP
COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver Coinsurance Plan	Silver Copay Plan
2/12/2013		
Actuarial Value SUBJECT TO FINAL FEDERAL RULES	71.2%	71.0%
Overall deductible	N/A	N/A
Other deductibles for specific services		107
Medical	\$1,500	\$1,500
Brand Drugs	\$500	\$500
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$6,400	\$6,400

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Common Medical			Member Cost	Deductible	Member Cost	Deductible
Event	Service Typ	e	Share	Applies	Share	Applies
Visit to a health care provider's	Primary care visit to treat an inj footnote)	ury or illness (see	\$45		\$45	
office or clinic	Specialist visit		\$65		\$65	
	Other practitioner office visit		\$45		\$45	
	Preventive care/ screening/ imi	munization	No cost share		No cost share	
	Laboratory Tests		\$45		\$45	
Tests	X-rays and Diagnostic Imaging		\$65		\$65	
	Imaging (CT/PET scans, MRIs		20%	Х	\$250	
_	Generic drugs	/	\$25		\$25	
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%	X		
surgery	Physician/surgeon fees		20%		20%	Х
Surgery	Emergency room services (wai	ved if admitted)	\$250	Х	\$250	Х
	Emergency medical transporta		\$250	X	\$250	X
Need immediate attention	Urgent care		\$90	~~~	\$90	
	Facility fee (e.g., hospital room)		20%	Х	00%/	X
Hospital stay	Physician/surgeon fee		20%		20%	Х
	Mental/Behavioral health outpa	tient services	\$45		\$45	
Mental health, behavioral health,	Mental/Behavioral health innatient services		20%	х	20%	х
or substance	Substance use disorder outpat	ent services	\$45		\$45	
abuse needs	Substance use disorder inpatie		20%	х	20%	х
Pregnancy	Prenatal and postnatal care		\$45		\$45	
	Delivery and all inpatient	Hospital	20%	X	20%	Х
	services	Professional	20%			
	Home health care		20%		\$45	
	Rehabilitation services		\$45		\$45	
Help recovering	Habilitation services		\$45		\$45	
or other special health needs	Skilled nursing care		20%	х	20%	х
	Durable medical equipment		20%		20%	
	Hospice service		No cost share		No cost share	
	Eye exam (deductible waived)		0%		0%	
Child poods	Glasses		1 pair per year		1 pair per year	
Child needs dental or eye care	Dental check-up - Preventive a Dental Basic Services		See attack	hment	See attac	hment
	Dental Restorative and Orthodontia Services					

Notes:

1) Actuarial values will be determined using the federal actuarial value calculator when it is released. To fit within allowable actuarial values, the cost sharing amounts in the standardized plans may be adjusted.

2) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense.

4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges.

5) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or

outpatient Mental Health/Substance Abuse visits.

specified in another benefit category.

7) Glasses benefit limited to \$100 per year.

Covered Califo Standard Bene	rnia fit Plan Designs				
Summary of Be	enefits and Coverage		Individual & SHOP		
	AMOUNTS DESCRIBE THE OUT OF POCKET COSTS		Silver HS/	A Plan	
2/12/2013					
Actuarial Value SL	IBJECT TO FINAL FEDERAL RU	JLES	71.6%	6	
Overall deductible			\$1500 integrated	Med/Rx Ded	
Other deductibles	for specific services				
	Medical		N/A		
	Brand Drugs		N/A		
Out of modest lim	Dental		See attack		
Out-of-pocket lim	it on expenses		\$6,40	0	
Common Medical			Member Cost	Deductible	
Event	Service Type		Share	Applies	
Visit to a health care provider's	Primary care visit to treat an injur footnote)	20%	х		
office or clinic	Specialist visit	20%	Х		
	Other practitioner office visit	20%	Х		
	Preventive care/ screening/ immu	unization	No cost share	X	
Tasta	Laboratory Tests		20%	X	
Tests	X-rays and Diagnostic Imaging		20%	X X	
	Imaging (CT/PET scans, MRIs) Generic drugs		20% 20%	Х	
Drugs to treat	Preferred brand drugs		20%	X	
illness or	Non-preferred brand drugs		20%	X	
condition	Specialty drugs		20%	X	
Outpatient	Facility fee (e.g., ASC)		20%	Х	
surgery	Physician/surgeon fees		20%	Х	
	Emergency room services (waive		20%	Х	
Need immediate attention	Emergency medical transportatio	n	20% 20%	x	
Hospital stay	Facility fee (e.g., hospital room)		20%	Х	
nospital stay	Physician/surgeon fee		20%	Х	
	Mental/Behavioral health outpatie	ent services	20%	Х	
Mental health, behavioral health,	Mental/Behavioral health inpatier		20%	X	
or substance	Substance use disorder outpatier	nt services	20%	X	
abuse needs	Substance use disorder inpatient	20%	Х		
Pregnancy	Prenatal and postnatal care		20%	x	
		Hospital	20%	Х	
		Professional	20%	X	
	Home health care		20%	X	
	Rehabilitation services		20%	X	
Help recovering	Habilitation services		20%	Х	

dental or eye care Dental check-up - Preventive and Diagnostic Dental Basic Services Dental Restorative and Orthodontia Services

Skilled nursing care

Hospice service

Glasses

Durable medical equipment

Eye exam (deductible waived)

1) Actuarial values will be determined using the federal actuarial value calculator when it is released. To fit within allowable actuarial values, the cost sharing amounts in the standardized plans may be adjusted.

20%

20%

No cost share

0%

1 pair per year

See attachment

Х

Х

Х

Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense.

Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges.

5) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or

outpatient Mental Health/Substance Abuse visits.

specified in another benefit category.

or other special

health needs

Child needs

7) Glasses benefit limited to \$100 per year.

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver Coinsurance Plan 100%-150% FPL	Silver Coinsurance Plan 150%-200% FPL
2/12/2013		
Actuarial Value SUBJECT TO FINAL FEDERAL RULES	94.5%	87.5%
Overall deductible	\$0	N/A
Other deductibles for specific services	ψŪ	
Medical	\$0	\$500
Brand Drugs	\$0	\$50
Dental	See attachment	See attachment
Out-of-pocket limit on expenses	\$2,250	\$2,250

Common Medical			Member Cost	Deductible	Member Cost	Deductible
Event	Service Type	ž	Share	Applies	Share	Applies
Visit to a health care provider's	Primary care visit to treat an inju footnote)		\$4		\$20	
office or clinic	Specialist visit		\$6		\$25	
	ce or clinic Specialist visit Other practitioner office visit		\$3		\$20	
	Preventive care/ screening/ imm	nunization	No cost share		No cost share	
	Laboratory Tests		\$6		\$20	
Tests	X-rays and Diagnostic Imaging		\$10		\$25	
	Imaging (CT/PET scans, MRIs)		10%		15%	Х
	Generic drugs		\$4		\$8	
Drugs to treat	Preferred brand drugs		\$7		\$18	Х
illness or	Non-preferred brand drugs		\$10		\$27	X
condition	Specialty drugs		10%		15%	X
Outpatient	Facility fee (e.g., ASC)		10%		15%	X
surgery	Physician/surgeon fees		10%		15%	
	Emergency room services (wai	ved if admitted)	\$25		\$75	Х
	Emergency medical transportat		\$25		\$75	Х
Need immediate attention	Urgent care		\$8		\$40	
	Facility fee (e.g., hospital room)		10%		15%	Х
Hospital stay	Physician/surgeon fee		10%		15%	
	Mental/Behavioral health outpat	tient services	\$4		\$20	
Mental health, behavioral health,	Mental/Behavioral health innatient services		10%		15%	х
or substance	Substance use disorder outpati	ent services	\$4		\$20	
abuse needs	Substance use disorder inpatier		10%		15%	х
Pregnancy	Prenatal and postnatal care		\$4		\$20	
	Delivery and all inpatient	Hospital	10%		15%	Х
	services	Professional	10%		15%	
	Home health care		10%		15%	
	Rehabilitation services		\$4		\$20	
Help recovering	Habilitation services		\$4		\$20	
or other special health needs	Skilled nursing care		10%		15%	х
	Durable medical equipment		10%		15%	
	Hospice service		No cost share		No cost share	
	Eye exam (<i>deductible waived</i>)		0%		0%	
	Glasses		1 pair per year		1 pair per year	
Child needs	Dental check-up - Preventive a	nd Diagnostic				
dental or eye care	Dental Basic Services		See attac	hment	See attack	nment
	Dental Restorative and Orthodo	ontia Services				

Notes:

1) Actuarial values will be determined using the federal actuarial value calculator when it is released. To fit within allowable actuarial values, the cost sharing amounts in the standardized plans may be adjusted.

2) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense.

4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges.

5) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or

outpatient Mental Health/Substance Abuse visits.

specified in another benefit category.

7) Glasses benefit limited to \$100 per year.

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver Coinsurance Plan 200%-250% FPL
2/12/2013	
Actuarial Value SUBJECT TO FINAL FEDERAL RULES	73.9%
Overall deductible	N/A
Other deductibles for specific services	
Medical	\$1,500
Brand Drugs	\$500
Dental	See attachment
Out-of-pocket limit on expenses	\$5,200

Common Medical		Member Cost	Deductible	
Event	Service Type	9	Share	Applies
Visit to a health care provider's	Primary care visit to treat an injury or illness (<i>see footnote</i>)		\$45	
office or clinic	Specialist visit		\$55	
	Other practitioner office visit		\$45	
	Preventive care/ screening/ immunization		No cost share	
	Laboratory Tests		\$45	
Tests	X-rays and Diagnostic Imaging		\$55	
	Imaging (CT/PET scans, MRIs)		20%	Х
Drugs to treat	Generic drugs		\$20	
illness or	Preferred brand drugs		\$30	Х
condition	Non-preferred brand drugs		\$50	Х
condition	Specialty drugs		20%	Х
Outpatient	Facility fee (e.g., ASC)		20%	Х
surgery	Physician/surgeon fees		20%	
	Emergency room services (wai	ved if admitted)	\$250	Х
	Emergency medical transportat	ion	\$250	Х
Need immediate attention	Urgent care		\$90	
	Facility fee (e.g., hospital room)		20%	Х
Hospital stay	Physician/surgeon fee		20%	
	Mental/Behavioral health outpatient services		\$45	
Mental health, behavioral health,	Mental/Behavioral health inpatient services		20%	х
or substance	Substance use disorder outpatient services		\$45	
abuse needs	Substance use disorder inpatient services		20%	х
Pregnancy	Prenatal and postnatal care		\$45	
	Delivery and all inpatient	Hospital	20%	X
	services	Professional	20%	
	Home health care		20%	
	Rehabilitation services		\$45	
Help recovering	Habilitation services		\$45	
or other special health needs	Skilled nursing care		20%	х
	Durable medical equipment		20%	
	Hospice service		No cost share	
	Eye exam (deductible waived)		0%	
Child needs	Glasses		1 pair per year	
dental or eye care	Dental check-up - Preventive and Diagnostic		See attachment	
	Dental Basic Services Dental Restorative and Orthodontia Services			
	Dental Restorative and Orthood			

Notes:

1) Actuarial values will be determined using the federal actuarial value calculator when it is released. To fit within allowable actuarial values, the cost sharing amounts in the standardized plans may be adjusted.

2) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense.

4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges.

5) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or

outpatient Mental Health/Substance Abuse visits.

specified in another benefit category.

7) Glasses benefit limited to \$100 per year.

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver Copay Plan 100%-150% FPL	Silver Copay Plan 150%-200% FPL	
2/12/2013			
Actuarial Value SUBJECT TO FINAL FEDERAL RULES	94.6%	87.5%	
Overall deductible	\$0	N/A	
Other deductibles for specific services			
Medical	\$0	\$500	
Brand Drugs	\$0	\$50	
Dental	See attachment	See attachment	
Out-of-pocket limit on expenses	\$2,250	\$2,250	

Common Medical		Member Cost	Deductible	Member Cost	Deductible	
Event	Service Type	Share	Applies	Share	Applies	
Visit to a health care provider's	Primary care visit to treat an injury or illness (s footnote)	ee \$4		\$20		
office or clinic	Specialist visit	\$6		\$25		
	Other practitioner office visit	\$4		\$20		
	Preventive care/ screening/ immunization	No cost share		No cost share		
	Laboratory Tests	\$6		\$20		
Tests	X-rays and Diagnostic Imaging	\$10		\$25		
	Imaging (CT/PET scans, MRIs)	\$50		\$100		
Drugs to troat	Generic drugs	\$4		\$8		
Drugs to treat illness or	Preferred brand drugs	\$7		\$18	Х	
	Non-preferred brand drugs	\$10		\$27	Х	
condition	Specialty drugs	10%		15%	Х	
Outpatient	Facility fee (e.g., ASC)	10%		15%	Х	
surgery	Physician/surgeon fees	1076		15%	^	
	Emergency room services (waived if admitted)	\$25		\$75	Х	
	Emergency medical transportation	\$25		\$75	Х	
Need immediate						
attention	Urgent care	\$8		\$40		
Hospital stay	Facility fee (e.g., hospital room) Physician/surgeon fee	10%		15%	Х	
	Mental/Behavioral health outpatient services	\$4		\$20		
Mental health, behavioral health,	Mental/Behavioral health inpatient services	10%		15%	х	
or substance	Substance use disorder outpatient services	\$4		\$20		
abuse needs	needs Substance use disorder inpatient services			15%	х	
Pregnancy	Prenatal and postnatal care	\$4		\$20		
	Delivery and all inpatient Hospital services Professional	10%		15%	Х	
	Home health care	\$4		\$20		
	Rehabilitation services	\$4		\$20		
Help recovering	Habilitation services	\$4		\$20		
or other special health needs	Skilled nursing care	10%		15%	х	
	Durable medical equipment	10%		15%		
	Hospice service	No cost share		No cost share		
	Eye exam (deductible waived)	0%		0%		
Child needs	Glasses	1 pair per year		1 pair per year		
Child needs dental or eye care	Dental check-up - Preventive and Diagnostic Dental Basic Services		See attachment		See attachment	
	Dental Restorative and Orthodontia Services					

Notes:

1) Actuarial values will be determined using the federal actuarial value calculator when it is released. To fit within allowable actuarial values, the cost sharing amounts in the standardized plans may be adjusted.

2) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense.

4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges.

5) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or

outpatient Mental Health/Substance Abuse visits.

specified in another benefit category.

7) Glasses benefit limited to \$100 per year.

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Silver Copay Plan 200%-250% FPL		
2/12/2013			
Actuarial Value SUBJECT TO FINAL FEDERAL RULES	73.6%		
Overall deductible	N/A		
Other deductibles for specific services			
Medical	\$1,500		
Brand Drugs	\$500		
Dental	See attachment		
Out-of-pocket limit on expenses	\$5,200		

Common Medical			Member Cost Deductible		
Event	Service Type	9	Share	Applies	
Visit to a health care provider's	Primary care visit to treat an injury or illness (see footnote)		\$45		
office or clinic	Specialist visit Other practitioner office visit		\$55 \$45		
Tests	Preventive care/ screening/ imm Laboratory Tests X-rays and Diagnostic Imaging Imaging (CT/PET scans, MRIs)	No cost share \$45 \$55 \$250			
Drugs to treat illness or condition	Generic drugs Preferred brand drugs Non-preferred brand drugs		\$20 \$30 \$50 20%	X X X	
Outpatient surgery	Specialty drugs Facility fee (e.g., ASC) Physician/surgeon fees	(ad if admitted)	20% 20% \$250	Х	
Need immediate attention				X X	
Hospital stay	Facility fee (e.g., hospital room) Physician/surgeon fee		20%	Х	
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services Mental/Behavioral health inpatient services Substance use disorder outpatient services		\$45 20% \$45	X	
Pregnancy	Substance use disorder inpatient services Prenatal and postnatal care Delivery and all inpatient Hospital		20% \$45	X	
	services Home health care	Professional	20% \$45	X	
Help recovering or other special	Rehabilitation services Habilitation services		\$45 \$45		
health needs	Skilled nursing care Durable medical equipment		20% 20% No cost share	X	
Child needs	Hospice service Eye exam (<i>deductible waived</i>) Glasses Dental check-up - Preventive and Diagnostic		0% 1 pair per year		
dental or eye care	Dental Basic Services Dental Restorative and Orthodontia Services		See attachment		

Notes:

1) Actuarial values will be determined using the federal actuarial value calculator when it is released. To fit within allowable actuarial values, the cost sharing amounts in the standardized plans may be adjusted.

2) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense.

4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges.

5) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or

outpatient Mental Health/Substance Abuse visits.

specified in another benefit category.

7) Glasses benefit limited to \$100 per year.

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Bronze Plan	Bronze HSA Plan	
2/12/2013			
Actuarial Value SUBJECT TO FINAL FEDERAL RULES	60.1%	59.0%	
Overall deductible	\$5000 integrated Med/Rx Ded	\$4500 integrated Med/Rx Ded	
Other deductibles for specific services			
Medical	N/A	N/A	
Brand Drugs	N/A	N/A	
Dental	See attachment	See attachment	
Out-of-pocket limit on expenses	\$6,400	\$6,400	

Common Medical	1		Member Cost Deductible		Member Cost Deductible	
Event	Service Typ	e	Share	Applies	Share	Applies
Visit to a health care provider's	Primary care visit to treat an injury or illness (<i>see footnote</i>)		\$60	After 1st 3 non- preventive visits	40%	х
office or clinic	Specialist visit		\$70	Х	40%	Х
	Other practitioner office visit		\$60	Х	40%	Х
	Preventive care/ screening/ imr	nunization	No cost share		No cost share	
	Laboratory Tests		30%	Х	40%	Х
Tests	X-rays and Diagnostic Imaging		30%	Х	40%	Х
	Imaging (CT/PET scans, MRIs)		30%	Х	40%	Х
Drugs to treat	Generic drugs		\$25	Х	40%	Х
illness or	Preferred brand drugs		\$50	Х	40%	Х
condition	Non-preferred brand drugs		\$75	Х	40%	Х
condition	Specialty drugs		30%	Х	40%	Х
Outpatient	Facility fee (e.g., ASC)		30%	Х	40%	Х
surgery	Physician/surgeon fees		30%	Х	40%	Х
	Emergency room services (wai		\$300	Х	40%	Х
	Emergency medical transportat	tion	\$300	Х	40%	Х
Need immediate attention	Urgent care		\$120	After 1st 3 non- preventive visits	40%	х
Lleenitel star	Facility fee (e.g., hospital room)	30%	Х	40%	Х
Hospital stay	Physician/surgeon fee		30%	Х	40%	Х
	Mental/Behavioral health outpa	tient services	\$60	Х	40%	Х
Mental health, behavioral health,	alth, Mental/Behavioral health inpatient services		30%	х	40%	х
or substance	Substance use disorder outpatient services		\$60	Х	40%	Х
abuse needs	Substance use disorder inpatient services		30%	х	40%	х
Pregnancy	Prenatal and postnatal care		\$60	After 1st 3 non- preventive visits	40%	х
	Delivery and all inpatient	Hospital	30%	Х	40%	Х
	services	Professional	30%	Х	40%	Х
	Home health care		30%	Х	40%	Х
	Rehabilitation services		30%	X	40%	Х
Help recovering	Habilitation services		30%	Х	40%	X
or other special health needs	Skilled nursing care		30%	Х	40%	Х
	Durable medical equipment		30%	Х	40%	Х
	Hospice service		No cost share	Х	No cost share	Х
	Eye exam (deductible waived)		0%		0%	
Child needs	Glasses		1 pair per year		1 pair per year	
dental or eye care	Dental check-up - Preventive and Diagnostic Dental Basic Services		See attachment		See attachment	
	Dental Restorative and Orthodo					

Notes:

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2) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values.

3) Cost sharing amounts for all services accumulate toward the maximum out-of-pocket expense.

4) Cost sharing for services with copayments is the lesser of the copayment amount or allowed charges.

5) For the Bronze and Catastrophic plans, deductible is waived for three office or urgent care visits, including prenatal/postnatal visits or

outpatient Mental Health/Substance Abuse visits.

specified in another benefit category.

7) Glasses benefit limited to \$100 per year.

COST SHARING AMOUNTS DESCRIBE THE ENROLLEE'S OUT OF POCKET COSTS	Catastrophic Plan		
2/12/2013			
Actuarial Value SUBJECT TO FINAL FEDERAL RULES	60.4%		
Overall deductible	\$6400 integrated Med/Rx Ded		
Other deductibles for specific services			
Medical	N/A		
Brand Drugs	N/A		
Dental	See attachment		
Out-of-pocket limit on expenses	\$6,400		

Common Medical		Member Cost	Deductible	
Event	Service Type	9	Share	Applies
Visit to a health care provider's	Primary care visit to treat an injury or illness (see footnote)		0%	After 1st 3 non- preventive visits
office or clinic	Specialist visit		0%	Х
	Other practitioner office visit		0%	Х
	Preventive care/ screening/ immunization		No cost share	
	Laboratory Tests		0%	Х
Tests	X-rays and Diagnostic Imaging		0%	Х
	Imaging (CT/PET scans, MRIs)		0%	Х
Drugs to treat	Generic drugs		0%	Х
illness or	Preferred brand drugs		0%	Х
	Non-preferred brand drugs		0%	Х
condition	Specialty drugs		0%	Х
Outpatient	Facility fee (e.g., ASC)		0%	Х
surgery	Physician/surgeon fees		0%	Х
	Emergency room services (wai	ved if admitted)	0%	Х
	Emergency medical transportat	,	0%	Х
Need immediate attention	Urgent care		0%	After 1st 3 non- preventive visits
	Facility fee (e.g., hospital room)		0%	X
Hospital stay	Physician/surgeon fee		0%	X
	Mental/Behavioral health outpatient services		0%	X
Mental health, behavioral health,	Mental/Behavioral health innatient services		0%	X
or substance	Substance use disorder outpation	ent services	0%	Х
abuse needs	Substance use disorder inpatient services		0%	х
Pregnancy	Prenatal and postnatal care		0%	After 1st 3 non- preventive visits
	Delivery and all inpatient	Hospital	0%	Χ
	services	Professional	0%	X
	Home health care		0%	Х
	Rehabilitation services		0%	Х
Help recovering	Habilitation services		0%	Х
or other special health needs	Skilled nursing care		0%	х
	Durable medical equipment		0%	Х
	Hospice service		No cost share	Х
	Eye exam (<i>deductible waived</i>)		0%	
Child needs	Glasses		1 pair per year	
Child needs dental or eye care	Dental check-up - Preventive and Diagnostic Dental Basic Services		See attachment	
	Dental Restorative and Orthodontia Services			

Notes:

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specified in another benefit category.

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