

**State of California
Office of Administrative Law**

In re:
California Health Benefit Exchange

Regulatory Action:

Title 10, California Code of Regulations

Adopt sections: 6460

Amend sections:

Repeal sections:

**NOTICE OF APPROVAL OF EMERGENCY
REGULATORY ACTION**

**Government Code Sections 11346.1 and
11349.6**

OAL File No. 2014-0512-01 E

The California Patient Protection and Affordable Care Act established the California Health Benefit Exchange (HBEX). HBEX is responsible for arranging and contracting with health insurance issuers to provide affordable, quality health insurance coverage to qualified individuals and qualified employers through the Exchange. In this emergency rulemaking action, HBEX adopts the 2015 Standard Benefit Plan Designs, which standardize the way health plans are designed. The 2015 Standard Benefit Plan Designs are incorporated by reference in section 6460 of title 10 of the California Code of Regulations.

OAL approves this emergency regulatory action pursuant to sections 11346.1 and 11349.6 of the Government Code.

This emergency regulatory action is effective on 5/21/2014 and will expire on 11/18/2014. The Certificate of Compliance for this action is due no later than 11/17/2014.

Date: 5/21/2014



Lindsey McNeill
Attorney

For: DEBRA M. CORNEZ
Director

Original: Peter Lee
Copy: Brandon Ross

EMERGENCY

STATE OF CALIFORNIA--OFFICE OF ADMINISTRATIVE LAW

NOTICE PUBLICATION/REGULATIONS SUBMISSION

(See instructions on reverse)

For use by Secretary of State only

STD. 400 (REV. 01-2013)

OAL FILE NUMBERS	NOTICE FILE NUMBER Z-	REGULATORY ACTION NUMBER	EMERGENCY NUMBER 2014-0512-01E
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For use by Office of Administrative Law (OAL) only

ENDORSED FILED IN THE OFFICE OF

2014 MAY 21 PM 2:04

2014 MAY 12 PM 4:01
OFFICE OF ADMINISTRATIVE LAW

Debra Bowen
DEBRA BOWEN
SECRETARY OF STATE

NOTICE	REGULATIONS
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AGENCY WITH RULEMAKING AUTHORITY
California Health Benefit Exchange

AGENCY FILE NUMBER (if any)

A. PUBLICATION OF NOTICE (Complete for publication in Notice Register)

1. SUBJECT OF NOTICE	TITLE(S)	FIRST SECTION AFFECTED	2. REQUESTED PUBLICATION DATE
3. NOTICE TYPE <input type="checkbox"/> Notice re Proposed Regulatory Action <input type="checkbox"/> Other	4. AGENCY CONTACT PERSON	TELEPHONE NUMBER	FAX NUMBER (Optional)
OAL USE ONLY <input type="checkbox"/> Approved as Submitted <input type="checkbox"/> Approved as Modified <input type="checkbox"/> Disapproved/Withdrawn	ACTION ON PROPOSED NOTICE	NOTICE REGISTER NUMBER	PUBLICATION DATE

B. SUBMISSION OF REGULATIONS (Complete when submitting regulations)

1a. SUBJECT OF REGULATION(S) 2015 Standard Benefit Design	1b. ALL PREVIOUS RELATED OAL REGULATORY ACTION NUMBER(S)
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2. SPECIFY CALIFORNIA CODE OF REGULATIONS TITLE(S) AND SECTION(S) (Including title 26, if toxics related)	
SECTION(S) AFFECTED (List all section number(s) individually. Attach additional sheet if needed.)	ADOPT 6460 AMEND REPEAL 10

3. TYPE OF FILING			
<input type="checkbox"/> Regular Rulemaking (Gov. Code §11346)	<input type="checkbox"/> Certificate of Compliance: The agency officer named below certifies that this agency complied with the provisions of Gov. Code §511346.2-11347.3 either before the emergency regulation was adopted or within the time period required by statute.	<input type="checkbox"/> Emergency Readopt (Gov. Code, §11346.1(h))	<input type="checkbox"/> Changes Without Regulatory Effect (Cal. Code Regs., title 1, §100)
<input type="checkbox"/> Resubmittal of disapproved or withdrawn nonemergency filing (Gov. Code §511349.3, 11349.4)	<input type="checkbox"/> Resubmittal of disapproved or withdrawn emergency filing (Gov. Code, §11346.1)	<input type="checkbox"/> File & Print	<input type="checkbox"/> Print Only
<input checked="" type="checkbox"/> Emergency (Gov. Code, §11346.1(b))	<input type="checkbox"/> Other (Specify) _____		

4. ALL BEGINNING AND ENDING DATES OF AVAILABILITY OF MODIFIED REGULATIONS AND/OR MATERIAL ADDED TO THE RULEMAKING FILE (Cal. Code Regs. title 1, §44 and Gov. Code §11347.1)

5. EFFECTIVE DATE OF CHANGES (Gov. Code, §§ 11343.4, 11346.1(d); Cal. Code Regs., title 1, §100)			
<input type="checkbox"/> Effective January 1, April 1, July 1, or October 1 (Gov. Code §11343.4(a))	<input checked="" type="checkbox"/> Effective on filing with Secretary of State	<input type="checkbox"/> §100 Changes Without Regulatory Effect	<input type="checkbox"/> Effective other (Specify) <u>per agency request 5/20/14</u>

6. CHECK IF THESE REGULATIONS REQUIRE NOTICE TO, OR REVIEW, CONSULTATION, APPROVAL OR CONCURRENCE BY, ANOTHER AGENCY OR ENTITY			
<input type="checkbox"/> Department of Finance (Form STD. 399) (SAM §6660)	<input type="checkbox"/> Fair Political Practices Commission	<input type="checkbox"/> State Fire Marshal	
<input type="checkbox"/> Other (Specify) _____			

7. CONTACT PERSON Brandon Ross	TELEPHONE NUMBER 916-228-8281	FAX NUMBER (Optional)	E-MAIL ADDRESS (Optional) brandon.ross@covered.ca.gov
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8. I certify that the attached copy of the regulation(s) is a true and correct copy of the regulation(s) identified on this form, that the information specified on this form is true and correct, and that I am the head of the agency taking this action, or a designee of the head of the agency, and am authorized to make this certification.

SIGNATURE OF AGENCY HEAD OR DESIGNEE <i>Peter V. Lee</i>	DATE 4/21/14
TYPED NAME AND TITLE OF SIGNATORY Peter V. Lee, Executive Director	

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ENDORSED APPROVED
MAY 21 2014
Office of Administrative Law

Adopt Section 6460, which is all new regulation text to be added, to read:

SECTION 6460: 2015 STANDARD BENEFIT PLAN DESIGNS

- (a) For plan year and calendar year 2015, The California Health Benefit Exchange adopts the Standard Benefit Plan Designs identified as the 2015 Standard Benefit Plan Designs, dated April 17, 2014, which is incorporated by reference.

Authority: Government Code Section 100504

Reference: Government Code Sections 100503 and 100504(c); Health and Safety Code Section 1366.6(e) and Insurance Code Section 10112.3(e)

2015 Standard Benefit Plan Designs

April 17, 2014

2015 Standard Benefit Plan Designs

10.0 EHB

Date: April 17, 2014



Summary of Benefits and Coverage

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

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	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	
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 Erupted	50%		\$65	
	Extraction- Complete Bony			\$160	
Child Orthodontics	Porcelain with Metal Crown			\$300	
	Medically necessary orthodontics	50%		\$1,000	

2015 Standard Benefit Plan Designs

10.0 EHB

Date: April 17, 2014

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Gold Coinsurance Plan	Gold Copay Plan
Actuarial Value - AV Calculator	78.80%	78.60%
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	\$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%		\$500	
	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	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	
	Root Canal- Molar			\$300	
Child Dental Major Services	Gingivectomy per Quad			\$150	
	Extraction- Single Tooth Exposed Root or Erupted	50%		\$65	
	Extraction- Complete Bony			\$160	
	Porcelain with Metal Crown			\$300	
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

2015 Standard Benefit Plan Designs

10.0 EHB

Date: April 17, 2014

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Individual Silver Coinsurance Plan	Individual Silver Copay Plan
Actual Value - AV Calculator	70.30%	69.90%
Individual Overall deductible	N/A	N/A
Other individual deductibles for specific services		
Medical	\$2,000	\$2,000
Brand Drugs	\$250	\$250
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 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		X
Outpatient surgery	Facility fee (e.g., ASC)	20%		20%	
	Physician/surgeon fees	20%		20%	
	Emergency room services (waived if admitted)	\$250	X	\$250	X
Need immediate attention	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% Hospital 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 Sealants per Tooth	No cost share		No cost share	
	Topical Fluoride Application				
Child Dental Basic Services	Space Maintainers - Fixed				
	Amalgam Fill - 1 Surface	20%		\$25	
Child Dental Major Services	Root Canal- Molar			\$300	
	Gingivectomy per Quad			\$150	
	Extraction- Single Tooth Exposed Root or Erupted	50%		\$65	
	Extraction- Complete Bony			\$160	
Child Orthodontics	Porcelain with Metal Crown			\$300	
	Medically necessary orthodontics	50%		\$1,000	

2015 Standard Benefit Plan Designs

10.0 EHB

Date: April 17, 2014

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

	SHOP Silver Coinsurance Plan	SHOP Silver Copay Plan
Actuarial Value - AV Calculator	71.50%	71.00%
Individual Overall deductible	N/A	N/A
Other individual deductibles for specific services		
Medical	\$1,500	\$1,500
Brand Drugs	\$500	\$500
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 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%	
	Emergency room services (waived if admitted)	\$250	X	\$250	X
Need immediate attention	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
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	
	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	No cost share		No cost share	
	Preventive - X-ray Sealants per Tooth	No cost share		No cost share	
	Topical Fluoride Application Space Maintainers - Fixed	No cost share		No cost share	
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 Erupted	50%		\$65	
	Extraction- Complete Bony Porcelain with Metal Crown			\$160 \$300	
Child Orthodontics	Medically necessary orthodontics	50%		\$1,000	

2015 Standard Benefit Plan Designs
10.0 EHB
Date: April 17, 2014

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

	SHOP Silver HSA Plan
Actuarial Value - AV Calculator	71.60%
Individual Overall deductible	\$1,500 integrated Med/Rx Ded
Other individual deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	N/A
Individual 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
Outpatient surgery	Specialty drugs	20%	X
	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	20%	X
	Hospital Professional	20%	X
Help recovering or other special health needs	Home health care	20%	X
	Outpatient Rehabilitation services	20%	X
	Outpatient Habilitation services	20%	X
	Skilled nursing care	20%	X
	Durable medical equipment	20%	X
Child eye care	Hospice service	No cost share	X
	Eye exam	No cost share	
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share	
	Oral Exam		
	Preventive - Cleaning	No cost share	
	Preventive - X-ray	No cost share	
Child Dental Basic Services	Sealants per Tooth		
	Topical Fluoride Application		
Child Dental Major Services	Space Maintainers - Fixed		
	Amalgam Fill - 1 Surface	20%	
	Root Canal- Molar		
	Gingivectomy per Quad		
Child Orthodontics	Extraction- Single Tooth Exposed Root or Erupted	50%	
	Extraction- Complete Bony		
	Porcelain with Metal Crown		

2015 Standard Benefit Plan Designs

10.0 EHB

Date: April 17, 2014

Summary of Benefits and Coverage

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	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 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%	
	Emergency room services (waived if admitted)	\$25		\$75	X
Need immediate attention	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	10%		15%	X
	Hospital Professional	10%		15%	
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 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	No cost share		No cost share	
	Preventive - X-ray	No cost share		No cost share	
	Sealants per Tooth	No cost share		No cost share	
Child Dental Basic Services	Topical Fluoride Application	No cost share		No cost share	
	Space Maintainers - Fixed	No cost share		No cost share	
Child Dental Major Services	Amalgam Fill - 1 Surface	20%		20%	
	Root Canal- Molar				
Child Orthodontics	Gingivectomy per Quad				
	Extraction- Single Tooth Exposed Root or Erupted	50%		50%	
	Extraction- Complete Bony				
Child Orthodontics	Porcelain with Metal Crown				
	Medically necessary orthodontics	50%		50%	

2015 Standard Benefit Plan Designs

10.0 EHB

Date: April 17, 2014

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

Silver Coinsurance Plan
200%-250% FPL

Actual 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

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)	20%	X
Drugs to treat illness or condition	Generic drugs	\$15	
	Preferred brand drugs	\$35	X
	Non-preferred brand drugs	\$60	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%	
	Hospice service	No cost share	
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	No cost share	
	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 Root or Erupted	50%	
	Extraction- Complete Bony		
	Porcelain with Metal Crown		
Child Orthodontics	Medically necessary orthodontics	50%	

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Summary of Benefits and Coverage

Member Cost Share 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%
Individual Overall deductible	\$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 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%	
	Emergency room services (waived if admitted)	\$25		\$75	X
Need immediate attention	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				
	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	\$25		\$25	
	Root Canal- Molar	\$300		\$300	
	Gingivectomy per Quad	\$150		\$150	
	Extraction- Single Tooth Exposed Root or Erupted	\$65		\$65	
	Extraction- Complete Bony	\$160		\$160	
Child Orthodontics	Porcelain with Metal Crown	\$300		\$300	
	Medically necessary orthodontics	\$1,000		\$1,000	

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Summary of Benefits and Coverage

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

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	\$35	X
	Non-preferred brand drugs	\$60	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%	
	Hospice service	No cost share	
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	No cost share	
	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 Erupted	\$65	
	Extraction- Complete Bony	\$180	
	Porcelain with Metal Crown	\$300	
Child Orthodontics	Medically necessary orthodontics	\$1,000	

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Bronze Plan	Bronze HSA Plan
Actuarial Value - AV Calculator	60.60%	59.40%
Individual Overall deductible	\$5,000 integrated Med/Rx Ded	\$4,500 integrated Med/Rx
Other individual deductibles for specific services		
Medical	N/A	N/A
Brand Drugs	N/A	N/A
Dental	\$0	N/A
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 clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$60	After 1st three non-preventive visits	40%	X
	Specialist visit	\$70	X	40%	X
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	30%	X	40%	X
	X-rays and Diagnostic Imaging	30%	X	40%	X
	Imaging (CT/PET scans, MRIs)	30%	X	40%	X
Drugs to treat illness or condition	Generic drugs	\$15	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	After 1st three non-preventive visits	40%	X
Hospital stay	Facility fee (e.g. hospital room)	30%	X	40%	X
	Physician/surgeon fee	30%	X	40%	X
Mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$60	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health inpatient services	30%	X	40%	X
	Substance use disorder outpatient services	\$60	After 1st three non-preventive visits	40%	X
	Substance use disorder inpatient services	30%	X	40%	X
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services	30%	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 Erupted	50%		50%	
Child Orthodontics	Extraction- Complete Bony				
	Porcelain with Metal Crown				
	Medically necessary orthodontics	50%		50%	

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Summary of Benefits and Coverage

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 Ded
Other individual deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	N/A
Individual 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 three 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 three 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 three non-preventive visits
	Mental/Behavioral health inpatient services	0%	X
	Substance use disorder outpatient services	0%	After 1st three 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		
	Sealants per Tooth	No cost share	
	Topical Fluoride Application		
Child Dental Basic Services	Space Maintainers - Fixed		
	Amalgam Fill - 1 Surface	20%	X
Child Dental Major Services	Root Canal- Molar		X
	Gingivectomy per Quad		X
	Extraction- Single Tooth Exposed Root or Erupted	50%	X
	Extraction- Complete Bony		X
	Porcelain with Metal Crown		X
Child Orthodontics	Medically necessary orthodontics	50%	X

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Notes:

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for the deductibles in 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 premiums) for essential health benefits made by each individual apply to the deductible and out-of-pocket maximum. However, cost sharing payments made for non-emergent out-of-network services that are not plan-authorized exceptions do not apply to the in-network family deductible and out of pocket maximum. 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 carrier pays all costs for covered services for all family members.
- 2) For HDHPs linked to HSAs, in a family plan, each individual in the family must meet a deductible of \$2,600 until the family as a whole meets the family deductible. For HDHPs linked to HSAs, in a family plan, each individual in the family must meet the individual out of pocket maximum amount that is the same as that for self-only coverage until the family as a whole meets the family out of pocket maximum amount.
- 3) 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 copay or coinsurance applies to the prescription supply. Nothing in this note precludes a carrier from offering mail order prescriptions at a reduced cost.
- 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. In the Catastrophic plan, the deductible must apply to copays for non-preventive child dental benefits.

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs

	Platinum Coinsurance Plan	Platinum Copoly Plan
Actual 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

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	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	Not Covered		Not Covered	
Child Dental Basic Services	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Major Services	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
	Root Canal- Molar			Not Covered	
	Gingivectomy per Quad			Not Covered	
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered		Not Covered	
Child Orthodontics	Extraction- Complete Bony			Not Covered	
	Porcelain with Metal Crown			Not Covered	
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Gold Coinsurance Plan	Gold Copay Plan
Actuarial Value - AV Calculator	78.80%	78.60%
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	\$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	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	Not Covered		Not Covered	
	Sealants per Tooth				
Child Dental Basic Services	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Major Services	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
	Root Canal- Molar			Not Covered	
Child Orthodontics	Gingivectomy per Quad			Not Covered	
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered		Not Covered	
	Extraction- Complete Bony			Not Covered	
	Porcelain with Metal Crown			Not Covered	
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

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Summary of Benefits and Coverage

Member Cost Share 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%
Individual Overall deductible	N/A	N/A
Other individual deductibles for specific services		
Medical	\$2,000	\$2,000
Brand Drugs	\$250	\$250
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 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%	
	Emergency room services (waived if admitted)	\$250	X	\$250	X
Need immediate attention	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% Hospital 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	Not Covered		Not Covered	
Child Dental Basic Services	Sealants per Tooth				
	Topical Fluoride Application				
	Space Maintainers - Fixed				
	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
Child Dental Major Services	Root Canal- Molar			Not Covered	
	Gingivectomy per Quad			Not Covered	
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered		Not Covered	
	Extraction- Complete Bony			Not Covered	
Child Orthodontics	Porcelain with Metal Crown			Not Covered	
	Medically necessary orthodontics	Not Covered		Not Covered	

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Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

	SHOP Silver Coinsurance Plan	SHOP Silver Copay Plan
Actuarial Value - AV Calculator	71.50%	71.00%
Individual Overall deductible	N/A	N/A
Other individual deductibles for specific services		
Medical	\$1,500	\$1,500
Brand Drugs	\$500	\$500
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 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%	
	Emergency room services (waived if admitted)	\$250	X	\$250	X
Need immediate attention	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
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				
	Preventive - X-ray	Not Covered		Not Covered	
	Sealants per Tooth				
	Topical Fluoride Application				
Child Dental Major Services	Space Maintainers - Fixed				
	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
Child Orthodontics	Root Canal- Molar			Not Covered	
	Gingivectomy per Quad			Not Covered	
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered		Not Covered	
	Extraction- Complete Bony Porcelain with Metal Crown			Not Covered	
	Medically necessary orthodontics	Not Covered		Not Covered	

2015 Standard Benefit Plan Designs

9.5 EHB

Date: April 17, 2014

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

SHOP

**Silver
HSA Plan**

Actual Value - AV Calculator	71.60%
Individual Overall deductible	\$1,500 integrated Med/Rx Ded
Other individual deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	N/A
Individual 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
Outpatient surgery	Specialty drugs	20%	X
	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	Not Covered	
	Sealants per Tooth Topical Fluoride Application Space Maintainers - Fixed		
Child Dental Basic Services	Amalgam Fill - 1 Surface	Not Covered	
Child Dental Major Services	Root Canal- Molar		
	Gingivectomy per Quad		
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered	
	Extraction- Complete Bony Porcelain with Metal Crown		
Child Orthodontics	Medically necessary orthodontics	Not Covered	

2015 Standard Benefit Plan Designs

9.5 EHB

Date: April 17, 2014

Summary of Benefits and Coverage

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	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 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%	
	Emergency room services (waived if admitted)	\$25		\$75	X
Need immediate attention	Emergency medical transportation	\$25		\$75	X
	Urgent care	\$8		\$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	10%		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%	
	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	Not Covered		Not Covered	
	Topical Fluoride Application				
Child Dental Basic Services	Space Maintainers - Fixed				
	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
Child Dental Major Services	Root Canal- Molar				
	Gingivectomy per Quad				
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered		Not Covered	
	Extraction- Complete Bony Porcelain with Metal Crown				
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

2015 Standard Benefit Plan Designs

9.5 EHB

Date: April 17, 2014

Summary of Benefits and Coverage

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

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)	20%	X
Drugs to treat illness or condition	Generic drugs	\$15	
	Preferred brand drugs	\$35	X
	Non-preferred brand drugs	\$60	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
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	
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share	
	Oral Exam		
	Preventive - Cleaning		
	Preventive - X-ray		
	Sealants per Tooth	Not Covered	
Child Dental Basic Services	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Major Services	Amalgam Fill - 1 Surface	Not Covered	
	Root Canal- Molar		
Child Orthodontics	Gingivectomy per Quad		
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered	
	Extraction- Complete Bony		
	Porcelain with Metal Crown		
Child Orthodontics	Medically necessary orthodontics	Not Covered	

2015 Standard Benefit Plan Designs

9.5 EHB

Date: April 17, 2014

Summary of Benefits and Coverage

Member Cost Share 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%
Individual Overall deductible	\$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 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%	
	Emergency room services (waived if admitted)	\$25		\$75	X
Need immediate attention	Emergency medical transportation	\$25		\$75	X
	Urgent care	\$6		\$30	
Hospital stay	Facility fee (e.g. hospital room)				
	Physician/surgeon fee	10%		15%	X
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				
Help recovering or other special health needs	Hospital Professional	10%		15%	X
	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				
	Preventive - Cleaning				
	Preventive - X-ray	Not Covered		Not Covered	
	Sealants per Tooth	Not Covered		Not Covered	
Child Dental Basic Services	Topical Fluoride Application				
	Space Maintainers - Fixed				
Child Dental Major Services	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
	Root Canal- Molar	Not Covered		Not Covered	
	Gingivectomy per Quad	Not Covered		Not Covered	
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered		Not Covered	
	Extraction- Complete Bony	Not Covered		Not Covered	
	Porcelain with Metal Crown	Not Covered		Not Covered	
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

2015 Standard Benefit Plan Designs

9.5 EHB

Date: April 17, 2014

Summary of Benefits and Coverage

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

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	\$35	X
	Non-preferred brand drugs	\$60	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
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%	
	Hospice service	No cost share	
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		
	Space Maintainers - Fixed	Not Covered	
Child Dental Basic Services	Amalgam Fill - 1 Surface	Not Covered	
Child Dental Major Services	Root Canal- Molar	Not Covered	
	Gingivectomy per Quad	Not Covered	
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered	
	Extraction- Complete Bony	Not Covered	
	Porcelain with Metal Crown	Not Covered	
Child Orthodontics	Medically necessary orthodontics	Not Covered	

2015 Standard Benefit Plan Designs

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Date: April 17, 2014

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Bronze Plan	Bronze HSA Plan
Actuarial Value - AV Calculator	60.60%	59.40%
Individual Overall deductible	\$5,000 integrated Med/Rx Ded	\$4,500 integrated Med/Rx
Other individual deductibles for specific services		
Medical	N/A	N/A
Brand Drugs	N/A	N/A
Dental	\$0	N/A
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 clinic visit	Primary care visit or non-specialist practitioner visit to treat an injury or illness	\$60	After 1st three non-preventive visits	40%	X
	Specialist visit	\$70	X	40%	X
	Preventive care/ screening/ immunization	No cost share		No cost share	
Tests	Laboratory Tests	30%	X	40%	X
	X-rays and Diagnostic Imaging	30%	X	40%	X
	Imaging (CT/PET scans, MRIs)	30%	X	40%	X
Drugs to treat illness or condition	Generic drugs	\$15	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
	Emergency room services (waived if admitted)	\$300	X	40%	X
Need immediate attention	Emergency medical transportation	\$300	X	40%	X
	Urgent care	\$120	After 1st three non-preventive visits	40%	X
Hospital stay	Facility fee (e.g. hospital room)	30%	X	40%	X
	Physician/surgeon fee	30%	X	40%	X
Mental health, behavioral health, or substance abuse needs	Menta/Behavioral health outpatient services	\$60	After 1st three non-preventive visits	40%	X
	Mental/Behavioral health inpatient services	30%	X	40%	X
	Substance use disorder outpatient services	\$60	After 1st three non-preventive visits	40%	X
	Substance use disorder inpatient services	30%	X	40%	X
Pregnancy	Prenatal care and preconception visits	No cost share		No cost share	
	Delivery and all inpatient services	30%	X	40%	X
	Hospital Professional	30%	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
Child eye care	Hospice service	No cost share	X	No cost share	X
	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	Not Covered		Not Covered	
	Topical Fluoride Application Space Maintainers - Fixed				
Child Dental Basic Services	Amalgam Fill - 1 Surface	Not Covered		Not Covered	
Child Dental Major Services	Root Canal- Molar				
	Gingivectomy per Quad				
	Extraction- Single Tooth Exposed Root or Erupted Extraction- Complete Bony Porcelain with Metal Crown	Not Covered		Not Covered	
Child Orthodontics	Medically necessary orthodontics	Not Covered		Not Covered	

2015 Standard Benefit Plan Designs

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Date: April 17, 2014

Summary of Benefits and Coverage

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 Ded
Other individual deductibles for specific services	
Medical	N/A
Brand Drugs	N/A
Dental	N/A
Individual 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 three 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 three 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 three non-preventive visits
	Mental/Behavioral health inpatient services	0%	X
	Substance use disorder outpatient services	0%	After 1st three 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
Child eye care	Hospice service	No cost share	X
	Eye exam	No cost share	
Child Dental Diagnostic and Preventive	1 pair of glasses per year (or contact lenses in lieu of glasses)	No cost share	x
	Oral Exam		
	Preventive - Cleaning		
	Preventive - X-ray	No cost share	
	Sealants per Tooth		
Child Dental Basic Services	Topical Fluoride Application		
	Space Maintainers - Fixed		
Child Dental Major Services	Amalgam Fill - 1 Surface	Not Covered	
	Root Canal- Molar		
	Gingivectomy per Quad		
	Extraction- Single Tooth Exposed Root or Erupted	Not Covered	
Child Orthodontics	Extraction- Complete Bony		
	Porcelain with Metal Crown		
Child Orthodontics	Medically necessary orthodontics	Not Covered	

2015 Standard Benefit Plan Designs 9.5 EHB

Notes:

- 1) Family deductibles and out-of-pocket maximums are equal to 2 times the individual values. Except for the deductibles in 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 premiums) for essential health benefits made by each individual apply to the deductible and out-of-pocket maximum. However, cost sharing payments made for non-emergent out-of-network services that are not plan-authorized exceptions do not apply to the in-network family deductible and out of pocket maximum. 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 carrier pays all costs for covered services for all family members.
- 2) For HDHPs linked to HSAs, in a family plan, each individual in the family must meet a deductible of \$2,600 until the family as a whole meets the family deductible. For HDHPs linked to HSAs, in a family plan, each individual in the family must meet the individual out of pocket maximum amount that is the same as that for self-only coverage until the family as a whole meets the family out of pocket maximum amount.
- 3) 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 copay or coinsurance applies to the prescription supply. Nothing in this note precludes a carrier from offering mail order prescriptions at a reduced cost.



2015 Dental Standard Benefit Plan Designs

Date: April 17, 2014

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

Standalone Dental Plan Standalone Dental Plan

Pediatric Dental EHB Copay Plan Pediatric Dental EHB Coinsurance Plan

Up to Age 19

Up to Age 19

Actuarial Value	83.0%	86.8%
Individual Deductible (waived for Diagnostic & Preventive)	\$0	\$65 In Network/ \$65 Out of Network
Family Deductible (Two or more children) (waived for Diagnostic & Preventive)	\$0	\$130 In Network/ \$130 Out of Network
Individual Out of Pocket Maximum	\$350	\$350
Family Out of Pocket Maximum (Two or More Children)	\$700	\$700
Office Copay	\$0	\$0
Waiting Period <small>(Waived Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d))</small>	None	None
Annual Benefit Limit <small>(the maximum amount the dental plan will pay in the benefit year)</small>	None	None

Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Diagnostic & Preventive	Oral Exam	\$0		0%	
	Preventive - Cleaning	\$0		0%	
	Preventive - X-ray	\$0		0%	
	Sealants per Tooth	\$0		0%	
	Topical Fluoride Application	\$0		0%	
	Space Maintainers - Fixed	\$0		0%	
Basic Services	Amalgam Fill - One Surface	\$25		20%	x
	Root Canal - Molar	\$300			
Major Services - Crowns and Casts, Endodontics, Periodontics, Prosthodontics, Oral Surgery	Gingivectomy per Quad	\$150			
	Extraction- Single Tooth Exposed Root or Erupted	\$65		50%	x
	Extraction - Complete Bony	\$160			
	Crown - Porcelain with Metal	\$300			
Orthodontia	Medically Necessary Orthodontia	\$350		50%	x

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Standalone Dental Plan or Family Dental Plan)

- 1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.
- 2) Cost sharing payments made by each individual child for in-network services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
- 3) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family deductible, if applicable, as well as the family out-of-pocket maximum.
- 4) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.

Adult Dental Benefit Notes (only applicable to the Family Dental Plan)

- 5) Each adult is responsible for an individual deductible.
- 6) Families eligible to purchase a Family Dental Plan must include at least one adult who has purchased a Qualified Health Plan through the Exchange.
- 7) If a child is enrolled in the Family Dental Plan, all children in the family under age 19 years must be enrolled in the same Family Dental Plan.
- 8) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.



2015 Dental Standard Benefit Plan Designs

Date: April 17, 2014

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Family Dental Plan	
	Pediatric Dental EHB Copay Plan	Adult Dental Copay Plan
	Up to Age 19	Age 19 and Older
Actuarial Value	83.0%	Not Calculated
Individual Deductible (waived for Diagnostic & Preventive)	\$0	\$0
Family Deductible (Two or more children) (waived for Diagnostic & Preventive)	\$0	\$0
Individual Out of Pocket Maximum	\$350	Not Applicable
Family Out of Pocket Maximum (Two or More Children)	\$700	Not Applicable
Office Copay	\$0	\$0
Waiting Period <small>(Waived Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d))</small>	None	None
Annual Benefit Limit <small>(the maximum amount the dental plan will pay in the benefit year)</small>	None	None

Procedure Category	Service Type	Member Cost Share	Deductible Applies	Member Cost Share	Deductible Applies
Diagnostic & Preventive	Oral Exam	\$0		\$0	
	Preventive - Cleaning	\$0		\$0	
	Preventive - X-ray	\$0		\$0	
	Sealants per Tooth	\$0		Not Covered	
	Topical Fluoride Application	\$0		Not Covered	
	Space Maintainers - Fixed	\$0		Not Covered	
Basic Services	Amalgam Fill - One Surface	\$25		\$25	
	Root Canal - Molar	\$300		\$300	
Major Services - Crowns and Casts, Endodontics, Periodontics, Prosthodontics, Oral Surgery	Gingivectomy per Quad	\$150		\$150	
	Extraction- Single Tooth Exposed Root or Erupted	\$65		\$65	
	Extraction - Complete Bony	\$160		\$160	
	Crown - Porcelain with Metal	\$300		\$300	
Orthodontia	Medically Necessary Orthodontia	\$350		Not Covered	

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Standalone Dental Plan or Family Dental Plan)

- 1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.
- 2) Cost sharing payments made by each individual child for in-network services accrue to the child's out-of-pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
- 3) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family deductible, if applicable, as well as the family out-of-pocket maximum.
- 4) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.

Adult Dental Benefit Notes (only applicable to the Family Dental Plan)

- 5) Each adult is responsible for an individual deductible.
- 6) Families eligible to purchase a Family Dental Plan must include at least one adult who has purchased a Qualified Health Plan through the Exchange.
- 7) If a child is enrolled in the Family Dental Plan, all children in the family under age 19 years must be enrolled in the same Family Dental Plan.
- 8) Only Enrollees of a Platinum, Gold, Silver, or Bronze Qualified Health Plan are eligible to purchase the Standalone or Family Dental Plans.



2015 Dental Standard Benefit Plan Designs

Date: April 17, 2014

Summary of Benefits and Coverage

Member Cost Share amounts describe the Enrollee's out of pocket costs.

	Family Dental Plan	
	Pediatric Dental EHB Coinsurance Plan	Adult Dental Coinsurance Plan
	Up to Age 19	Age 19 and Older
Actuarial Value	86.8%	Not Calculated
Individual Deductible (waived for Diagnostic & Preventive)	\$65 In Network/ \$65 Out of Network	\$50 In Network/ \$50 Out of Network
Family Deductible (Two or more children) (waived for Diagnostic & Preventive)	\$130 In Network/ \$130 Out of Network	Not Applicable
Individual Out of Pocket Maximum	\$350	Not Applicable
Family Out of Pocket Maximum (Two or More Children)	\$700	Not Applicable
Office Copay	\$0	\$0
Waiting Period <small>(Waived Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6 (10)(d))</small>	None	6 months for Major Services, Waived with Proof of Prior Coverage
Annual Benefit Limit <small>(the maximum amount the dental plan will pay in the benefit year)</small>	None	\$1,500

Procedure Category	Service Type	Member Cost Share %	Deductible Applies	Member Cost Share	Deductible Applies
Diagnostic & Preventive	Oral Exam	0%		0%	
	Preventive - Cleaning	0%		0%	
	Preventive - X-ray	0%		0%	
	Sealants per Tooth	0%		Not Covered	
	Topical Fluoride Application	0%		Not Covered	
	Space Maintainers - Fixed	0%		Not Covered	
Basic Services	Amalgam Fill - One Surface	20%	x	20%	x
	Root Canal - Molar				
Major Services - Crowns and Casts, Endodontics, Periodontics, Prosthodontics, Oral Surgery	Gingivectomy per Quad				
	Extraction- Single Tooth Exposed Root or Erupted	50%	x	50%	x
	Extraction - Complete Bony				
	Crown - Porcelain with Metal				
Orthodontia	Medically Necessary Orthodontia	50%	x	Not Covered	

Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Standalone Dental Plan or Family Dental Plan)

- 1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of-pocket maximum is reached.
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