Access Health CT - Members' Cost Sharing for Standard Plan Designs for Qualified Health Plans

				COST SHARING REDUCTION PLANS				
	BRONZE, Option 1: HSA-eligible HDHP	**BRONZE, Option 2: "Catastrophic"**	**SILVER**	**SILVER - CSR-73**	**SILVER - CSR-87**	**SILVER - CSR-94**	**GOLD**	**PLATINUM**
Acturial Value Final AV Calculator)	**61.6%**	**59.3%**	**72.0%**	**73.8%**	**87.8%**	**93.3%**	**81.6%**	**91.8%**
Deductible(s)								
Medical	$ 3,250	$ 6,250	3,000	2,500	500	-	1,000	-
Prescription Drugs			400	250	-		150	
Out-of-Pocket Maximum	$ 6,250	$ 6,250	$ 6,250	$ 5,000	$ 2,250	$ 2,000	$ 3,000	$ 2,000
Medical Benefits	***Subject to Deductible***	***Subject to Deductible***	***Subject to Deductible***	***Subject to Deductible***	***Subject to Deductible***	***No Deductible***	***Subject to Deductible***	***No Deductible***
Office Visits								
Preventive Care/Screening/Immunization	$ -	-	$ -	$ -	$ -	$ -	$ -	$ -
Primary Care Visit	30 ✓	30 ✓ *deductible waived for 3 primary care or mental health visits*	30	30	10	5	20	10
Specialist Visit	40% ✓	- ✓	45	45	30	15	45	30
For routine pre- and post-natal care, copays limited to 10 visits								
Mental Health Visits	30 ✓	30 ✓	30	30	10	5	20	10
Habilitative and Rehabilitative Services (i.e. PT, OT, ST)	40% ✓	- ✓	30	30	10	5	20	10
PT/OT/ST limited to a combined 40 visits								
For treatment of autism spectrum disorder, habilitative services are covered at parity and in accordance with state law								
Laboratory Services	40% ✓	- ✓	30	30	10	5	20	10
X-Rays	40% ✓	- ✓	45	45	30	15	45	30
High-Tech Imaging (CT/PET Scans, MRIs)	40% ✓	- ✓	75	75	75	50	75	75
Total annual copayments cannot exceed $375 for MRIs and CT scans, combined, or $400 for PET scans								
Emergency Room Services	40% ✓	- ✓	150	150	100	75	150	100
Urgent Care	40% ✓	- ✓	75	75	50	50	75	50
Home Health Care	*25%* ✓	- *subject to a $50 deductible*	-	-	-	-	-	-
Inpatient Admission	40% ✓	- ✓	500 ✓	500 ✓	250 ✓	250	500 ✓	250
Apply Copayment per Day (max days per admission specified)			*yes - max 4*	*yes - max. 2*	*yes - max. 2*	*yes - max 2*	*yes - max 2*	*yes - max 2*
Outpatient Surgery	40% ✓	- ✓	500 ✓	500 ✓	250 ✓	250	500 ✓	250
Skilled Nursing Facility	40% ✓	- ✓	500 ✓	500 ✓	250 ✓	250	500 ✓	250
Apply Copayment per Day (max days per admission specified)			*yes - max 4*	*yes - max. 2*	*yes - max. 2*	*yes - max 2*	*yes - max 2*	*yes - max 2*
Prescription Drug Benefit	***Subject to Deductible***	***Subject to Deductible***	***Subject to Rx Deductible***	***Subject to Rx Deductible***	***No Rx Deductible***	***No Deductible***	***Subject to Rx Deductible***	***No Deductible***
Tier 1 (i.e. Generics)	$ 10 ✓	$ - ✓	$ 10	$ 10	$ 5	$ 5	$ 10	$ 5
Tier 2 (i.e. Preferred Brand Drugs)	40% ✓	- ✓	25 ✓	25 ✓	15	15	25 ✓	15
Tier 3 (i.e. Non-Preferred Brand Drugs)	40% ✓	- ✓	40 ✓	40 ✓	30	30	40 ✓	30
Specialty Tier (i.e. Speciality High-Cost Drugs)	40% ✓	- ✓	40% ✓	40 ✓	40	40	30% ✓	20%

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Routine Pediatric Vision Services	***Subject to Deductible***	***Subject to Deductible***	***No Deductible***	***No Deductible***	***No Deductible***	***No Deductible***	***No Deductible***	***No Deductible***
Exam/refraction	- ✓	- ✓	30	30	10	5	20	10
Prescription glasses and frames	- ✓	- ✓	-	-	-	-	-	-
limit one pair per year								
Routine Pediatric Dental Services	***Subject to Deductible***	***Subject to Deductible***	***No Deductible***	***No Deductible***	***No Deductible***	***No Deductible***	***No Deductible***	***No Deductible***
Diagnostic Services								
Oral Exams (2 per year)								
X-Rays								
Periapicals	0% ✓	0% ✓	0%	0%	0%	0%	0%	0%
Bitewing Radiographs (once every 2 years)								
Panorex (once every 3 years)								
Preventative								
Cleanings (2 per year)								
Periodontal cleaings (once every 3 months following perio. surgery)	0% ✓	0% ✓	0%	0%	0%	0%	0%	0%
Flouride (2 per year, under age 19)								
Sealants								
Basic Restorative								
Fillings	50% ✓	0% ✓	40%	40%	20%	20%	20%	20%
Simple extractions								
Major Restorative								
Surgical Extraction								
Endodontics (i.e. Root Canal Treatment) Periodontics								
Crowns and Cast Restorations	50% ✓	0% ✓	50%	50%	40%	40%	40%	40%
Prosthodontics (i.e. Dentures)								
Implants								
Orthodontics (medically necessary only)	50% ✓	0% ✓	50%	50%	50%	50%	50%	50%
Out-of-Network Benefits								
Deductible	$ 6,500	$ 6,500	$ 6,000	$ 6,000	$ 6,000	$ 6,000	$ 3,000	$ 2,000
Emergency and home health care services covered at in-network rate.								
Out-of-Pocket Maximum	12,500	12,500	12,500	12,500	12,500	12,500	6,000	4,000
Member's Coinsurance	50%	50%	40%	40%	40%	40%	30%	20%
Member's cost will be determined relative to carrier's allowable rate.								
Exceptions, per state regulations, member's OON cost sharing for:								
(a) home health care cannot exceed 25% of allowed rate;								
(b) emergency services cannot exceed in-network amount								

Notes:

1. For all copayment-based health plans that incorporate a medical and/or prescription drug deductible, the copayments do not count toward the plan's deductible(s). That is, the member is expected to first pay any required copayment with only the balance of charges paid by the member counting toward the plan's appropriate deductible.