

Stand Alone Dental Plan - "High Option"

for children under age 19 only For one child \$700 Two or more children Diagnostic Services Oral Exams twice per year X-Rays Periapicals four per year \$0 Bitewing Radiographs once every year Panoramic or Complete Series once every three years Preventive Services Cleanings twice per year Periodontal Scalling and Root Planing Periodontal Maintenance once every 3 months following periodontic surgery Fluoride twice per year, under age 19 Sealants sealants for children under 19 Basic Services Filings Simple Extractions Major Services Surgical Extractions Endodontic Therapy (i.e. Root Canal Treatment) Periodontal Therapy Crowns and Cast Restorations Prosthodontics (Complete and Partial Dentures; Fixed Bridgework)	Plan Overview Deductible (Does not apply to Preventive & Diagnostic Services)	Member Pays \$60 per member, up to 3 family members
Oral Exams twice per year X-Rays Periapicals four per year X-Rays Periapicals four per year Panoramic or Complete Series once every three years Preventive Services Cleanings twice per year Periodontal Scaling and Root Planing Periodontal Scaling and Root Planing Periodontal Scaling and Root Planing Periodontal Maintenance once every 3 months following periodontic surgery Fluoride twice per year, under age 19 Sealants for children under 19 Basic Services Filings Simple Extractions Major Services Surgical Extractions Endodontic Therapy (i.e. Root Canal Treatment) Periodontal Therapy Crowns and Cast Restorations Prosthodontics (Complete and Partial Dentures; Fixed Bridgework) Other Services Medically-Necessary Orthodontic Services No waiting period Maximums (for adults aged 19 and older only) Applicable Waiting Period for Benefit Diagnostic and Preventive Services No waiting period Maximum (for adults aged 19 and older only)	Out-of-Pocket Maximum for children under age 19 only For one child	•
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Diagnostic and Preventive Services no waiting period Basic Services 6 months		older only)
Basic Services 6 months	Applicable Waiting Period for Benefit	
	Diagnostic and Preventive Services	no waiting period
	Basic Services	6 months
Major Services 12 months	, , , , , , , , , , , , , , , , , , ,	ALEVATE TO THE STATE OF THE STA
Plan Maximum \$2,000 per adult member	iviajor services	- Annual Resemble
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This Plan Design sample is representative and is not intended to be a legal contract. Please see the actual plan documents for a full list of benefit coverage, exclusions and the terms of the policy.

High Option Dental – 87% AV

To: Access Health CT Board of Directors;

Date: April 30, 2014

Subject: 2015 Plan Designs - handout

These charts are a representation of the changes between AHCT's current plans and the 2015 proposed plans.

Bronze

Bronze		2015 Proposed Plans		
AV calculator inputs	current - 2014	Preferred*1	Secondary	Health Sav. Acct.
Medical Deductible	\$3,250	\$5,000	\$5,000	\$4,600
Drug Deductible	n/a	n/a	n/a	n/a
MOOP (Max Out-of-Pocket)	\$6,250	\$6,600	\$6,600	\$6,450
Emergency Room Services	40%d ²	\$200	40%d	\$0 d
All Inpatient Hospital Services (inc. MHSA)	40%d	40%d	40%d	\$0 d
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	\$30 d	\$35	\$40 d (first 3 visits are before deductible)	\$0 d
Specialist Visit	40%d	\$50	40%d	\$0 d
Imaging (CT/PET Scans, MRIs)	40%d	40%d	40%d	\$0 d
Rehabilitative Speech Therapy	40%d	40%d	40%d	\$0 d
Rehabilitative Occupational and Rehabilitative Physical Therapy	40%d	40%d	40%d	\$0 d
Preventive Care/Screening/Immunization	0	0	0	\$0
Laboratory Outpatient and Professional Services	40%d	40%d	40%d	\$0 d
X-rays and Diagnostic Imaging	40%d	40%d	40%d	\$0 d
Skilled Nursing Facility	40%d	40%d	40%d	\$0 d
Outpatient Facility Fee (e.g., ASC)	40%d	40%d	40%d	\$0 d
Outpatient Surgery Physician/Surgical Services	40%d	40%d	40%d	\$0 d
		97.96		
Drugs				
tier 1	\$10 d	\$5	\$5	\$5 d
tier 2	40%d	45%d	50% đ	\$35 d
tier 3	40%d	50% d	50% d	40%d
tier 4	40%d	50% d	50% d	40%d
Maximum # of Days for Charging an IP Copay?	n/a	n/a	n/a	n/a
actuarial value	57.0	59.6	61.9	61.4

¹ AHCT is waiting on an approval by CCIIO to adhere to a certain interpretation in the AV calculator. The preferred option will only be offered if CCIIO grants such approval. The interpretation supported by the actuary used by AHCT would result in a plan that must be structured like the secondary plan design.

² Benefits followed by a "d" are subject to either the corresponding drug deductible, medical deductible, or in Bronze, a combined deductible.

Silve	er
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2015 Proposed Plans

		Silver std.			
AV calculator inputs	current - 201 4	70%	73% CSR	87% CSR	94% CSR
Medical Deductible	\$3,000	\$2,600	\$2,600	\$400	\$0
Drug Deductible	\$400	\$25	\$400	\$25	\$0
MOOP (Max Out-of-Pocket)	\$6,250	\$6,600	\$5,200	\$1,750	\$600
Emergency Room Services	\$150	\$150	\$150	\$100	\$75
All Inpatient Hospital Services (inc. MHSA)	\$500 d per day \$2,000 max	\$500 d per day \$2,000 max	\$500 d per day \$2,000 max	\$200 d per day \$800 max	\$100 d per day \$400 max
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	\$30	\$30	\$30	\$20	\$20
Specialist Visit	\$45	\$50	\$50	\$35	\$35
Imaging (CT/PET Scans, MRIs)	\$75	\$75	\$75	\$75	\$75
Rehabilitative Speech Therapy	\$30	\$30	\$30	\$20	\$20
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$30	\$30	\$30	\$20	\$20
Preventive Care/Screening/Immunization	0	0	0	0	0
Laboratory Outpatient and Professional Services	\$30	\$35	\$30	\$25	\$20
X-rays and Diagnostic Imaging	\$45	\$45	\$45	\$45	\$45
Skilled Nursing Facility	\$500 d per day \$2,000 max	\$500 d per day \$2,000 max	\$500 d per day \$2,000 max	\$200 d per day \$800 max	\$100 d per day \$400 max
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	\$500 d	\$500 d	\$500 d	\$200 d	\$100 d
Outpatient Surgery Physician/Surgical Services	\$500 d	\$500 d	\$500 d	\$200 d	\$100 d
Drugs					
Drugs Tier 1	\$10.00	\$5	\$5	\$5	\$5
Tier 2	\$25 d	\$30	\$30	\$20	\$20
Tier 3	\$40 d	\$55	\$55	\$35	\$35
Tier 4	40% d	\$60 d	\$60 d	\$50 d	\$50
Maximum # of Days for Charging an IP Copay?	4	4	4	4	4
actuarial value	71.8	71.9	73.3	87.3	94.1

AV calculator inputs	current - 2014	2015
Medical Deductible	\$ 1,000	\$ 1,000
Drug Deductible	\$ 150	\$ 0
МООР	\$ 3,000	\$ 3,000
Emergency Room Services	\$150	\$150
All Inpatient Hospital Services (inc. MHSA)	\$500 d per day \$1,000 max	\$500 d per day \$1,000 max
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	\$20	\$20
Specialist Visit	\$45	\$45
Imaging (CT/PET Scans, MRIs)	\$75	\$75
Rehabilitative Speech Therapy	\$20	\$30
Rehabilitative Occupational and Rehabilitative Physical Therapy	\$20	\$30
Preventive Care/Screening/Immunization	0	0
Laboratory Outpatient and Professional Services	\$20	\$30
X-rays and Diagnostic Imaging	\$45	\$45
Skilled Nursing Facility	\$500 d per day \$1,000 max	\$500 d per day \$1,000 max
Outpatient Facility Fee (e.g., ASC)	\$500 d	\$500 d
Drugs		
Generics	\$10	\$5
Preferred Brand Drugs	\$25 d	\$25
Non-Preferred Brand Drugs	\$40 d	\$50
Specialty Drugs (i.e. high-cost)	30% d	\$60
Maximum # of Days for Charging an IP Copay?	2	2
actuarial value	79.0	80.5



Standard Platinum Plan - 90%

In-Network Member Pays	Out-of-Network Member Pays
\$0	\$2,000
\$0	\$4,000
	4
, <u>-</u>	\$4,000 \$8,000
74,000	49,000
<u> </u>	200/
	20% coinsurance
\$10 copay	20% coinsurance*
\$30 copay	20% coinsurance*
\$50 copay	20% coinsurance*
\$100 copay	\$100 copay
\$0	\$0
\$250 copay per day to a maximum of \$500 per admission	20% coinsurance*
\$250 copay	20% coinsurance*
\$250 copay per day to a maximum of \$500 per admission	20% coinsurance*
pre .	
Covered same as any other illness	Covered same as any other illness
\$0	20% coinsurance*
\$0	20% coinsurance subject to a \$50 deductible
\$75 copay per service up to a combined calendar year maximum of \$375 for MRI and CT scans; \$400 for PET scans	20% coinsurance*
\$30 copay	20% coinsurance*
	\$0 \$0 \$2,000 \$4,000 \$10 copay \$30 copay \$100 copay \$0 \$250 copay per day to a maximum of \$500 per admission \$250 copay per day to a maximum of \$500 per admission \$250 copay per day to a maximum of \$500 per admission \$250 copay per day to a maximum of \$500 per admission \$250 copay per day to a maximum of \$500 per admission \$250 copay per day to a maximum of \$500 per admission \$250 copay per day to a maximum of \$500 per admission \$100 per admission \$250 copay per day to a maximum of \$500 per admission \$250 copay per day to a maximum of \$500 per admission \$100 per admission \$250 copay per day to a maximum of \$500 per admission \$250 copay per day to a maximum of \$500 per admission

^{*}After out-of-network deductible is met



Standard Platinum Plan - 90%

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Outpatient Services		
Laboratory Services	\$10 copay	20% coinsurance*
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) combined 40 visit calendar year maximum	\$10 copay	20% coinsurance*
Chiropractic Care 20 visit calendar maximum	\$30 copay	20% coinsurance*
Other Services		
Durable Medical Equipment	20% coinsurance	20% coinsurance*
Prosthetics	20% coinsurance	20% coinsurance*
Diabetic Supplies & Equipment	20% coinsurance	20% coinsurance*
Prescription Drugs		
Generic Drugs	\$5 copay	20% coinsurance*
Preferred Brand Drugs	\$15 copay	20% coinsurance*
Non-Preferred Brand Drugs	\$30 copay	20% coinsurance*
Specialty Drugs	20% coinsurance 20% coinsura	

Pediatric-Only Services (for children under age 19)

Pediatric Dental Care		
Diagnostic & Preventive (Oral Exam, Cleaning, X-ray)	\$0	50% coinsurance*
Basic Restorative (Filling, Simple Extraction)	20% coinsurance	50% coinsurance*
Major Restorative (Endodontic, Crown)	40% coinsurance	50% coinsurance*
Orthodontia Services medically necessary only	50% coinsurance	50% coinsurance*
Pediatric Vision Care		
Routine Eye Exam	\$10 copay	20% coinsurance
Prescription Eye Glasses one pair of frames & lenses per calendar year	lenses: \$0 collection frames: \$0 non-collection frames: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit equal to the cost of the collection frame and will be entitled to a negotiated discount	100% coinsurance

This Standard Plan Design sample is representative and is not intended to be a legal contract. Please see the actual plan documents for a full list of benefit coverage,

exclusions and the terms of the policy.



^{*}After out-of-network deductible is met

User inputs for Plan Parameters				
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	
Apply Inpatient Copay per Day?	<u></u>	HSA/HRA Emp	HSA/HRA Employer Contribution?	
Apply Skilled Nursing Facility Copay per Day?			Annial Controlling Amount Ha	
Use Separate OOP Maximum for Medical and Drug Spending?				
Indicate if Plan Meets CSR Standard?				
Desired Metal Tier	Platinum			
		lier I. Plan Benefit Design	Selgman and a self-self-self-self-self-self-self-self-	
	Seal Medical	Drug	Combined	
Deductible (\$)	\$0.00	\$0.00		
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%		
OOP Maximum (\$)	0′Z\$	\$2,000.00		
OOP Maximum if Separate (\$)				
	•			
Ciick Here for important Instructions				摄
Type of Benefit	Subjecto	Subject to	Coinsurance, if Copay, if	
		Comsurance		STATE OF THE PARTY
Medical	∏ A∐	TR I		
Emergency Room Services			\$100.00	
All Inpatient Hospital Services (inc. MHSA)			\$250.00	
Primary Care Visit to Treat an Injury or Iliness (exc. Preventive, and X-rays)			\$10.00	eteran neierbach
Specialist Visit			\$30.00	
Mental/Behavioral Health and Substance Abuse Disorder Outpatient			06 863	Statement of the Statem
Services]	01.1.75	
Imaging (CT/PET Scans, MRIs)		O	\$75.00	
Rehabilitative Speech Therapy			\$10.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy			\$10.00	
Preventive Care/Screening/Immunization			100% 1000% 1000 1	
Laboratory Outpatient and Professional Services			\$10.00	241-02-1
X-rays and Diagnostic Imaging			\$30.00	******
Skilled Nursing Facility			\$250.00	

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í Ai		
		\$5.00
		\$15.00
		\$30.00
₹.	80%	
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Status/Error Messages:
Actuarial Value:
Metal Tier:

Calculation Successful. 90.7% Platinum



Standard Gold Plan - 80%

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Medical Deductible		and the manual security for each time and each security and an analysis and a state of the security following
Individual	\$1,000	\$3,000
Family (congressors not applied to deductible)	\$2,000	\$6,000
(copays are not applied to deductible) Prescription Drug Deductible		
Individual	40	4350
Family	\$0 \$0	\$350 \$700
(copays are not applied to deductible)	ŞŪ	
Out-of-Pocket Maximum	40.000	46.000
Individual Family	\$3,000 \$6,000	\$6,000 \$12,000
Physician Office Visits]	V12,000
Preventive Care/Screenings/Immunizations	\$0	30% coinsurance
Primary Care (injury or illness)	\$20 copay	30% coinsurance**
Specialist	\$45 copay	30% coinsurance**
Emergency/Urgent Care		
Urgent Care Center or Facility	\$75 copay	30% coinsurance**
Emergency Room	\$150 copay	\$150 copay
Ambulance	\$0	\$0
Hospital Services		
Inpatient	\$500 copay per day to a maximum of \$1,000 per admission*	30% coinsurance**
Outpatient (performed at hospital or ambulatory facility)	\$500 copay*	30% coinsurance**
Skilled Nursing Facility 90 day calendar year maximum	\$500 copay per day to a maximum of \$1,000 per admission*	30% coinsurance**
Mental Health, Substance Abuse & Behavioral Health C		
Mental Health, Substance Abuse & Behavioral Health Services	Covered same as any other illness	Covered same as any other illness
Hospice Care		
Hospice Services	\$0	30% coinsurance**
Outpatient Services		
Home Health Care 100 visit calendar year maximum	\$0	25% coinsurance subject to a \$50 deductible
Advanced Radiology (CT/PET Scan, MRI)	\$75 copay per service up to a combined calendar year maximum of \$375 for MRI and CT scans; \$400 for PET scans	30% coinsurance**

^{*}After in-network medical deductible is met

^{**}After out-of-network deductible is met



Standard Gold Plan - 80%

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Outpatient Services		
Non-Advanced Radiology (X-ray, Diagnostic)	\$45 copay	30% coinsurance**
Laboratory Services	\$30 copay	30% coinsurance**
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) combined 40 visit calendar year maximum	\$30 copay	30% coinsurance**
Chiropractic Care 20 visit calendar maximum	\$45 copay	30% coinsurance**
Other Services		
Durable Medical Equipment	30% coinsurance	30% coinsurance**
Prosthetics	30% coinsurance	30% coinsurance**
Diabetic Supplies & Equipment	30% coinsurance	30% coinsurance**
Prescription Drugs		
Generic Drugs	\$5 copay	30% coinsurance****
Preferred Brand Drugs	\$25 copay	30% coinsurance****
Non-Preferred Brand Drugs	\$50 copay	30% coinsurance****
Specialty Drugs	\$60 copay	30% coinsurance****

Pediatric-Only Services (for children under age 19)

Pediatric Dental Care		
Diagnostic & Preventive (Oral Exam, Cleaning, X-ray)	\$0	50% coinsurance**
Basic Restorative (Filling, Simple Extraction)	20% coinsurance	50% coinsurance**
Major Restorative (Endodontic, Crown)	40% coinsurance	50% coinsurance**
Orthodontia Services medically necessary only	50% coinsurance	50% coinsurance**
Pediatric Vision Care		
Routine Eye Exam by Specialist	\$45 copay	30% coinsurance
Prescription Eye Glasses one pair of frames & lenses per calendar year	lenses: \$0 collection frames: \$0 non-collection frames: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit equal to the cost of the collection frame and will be entitled to a negotiated discount	100% coinsurance
*Afr		the second second to all all and second to the country

^{*}After in-network medical deductible is met

**After out-of-network medical deductible is met
****After out-of-network prescription drug deductible is met

This Standard Plan Design sample is representative and is not intended to be a legal contract. Please see the actual plan documents for a full list of benefit coverage, exclusions and the terms of the policy.

80.5% AVC

^{***}After in-network prescription drug deductible is met

Copay, if \$58.66 20.00 \$20.00 \$30.00 \$30.00 separate \$150.00 \$500.00 \$45.00 \$75.00 \$30.00 \$500.00 \$45.00 HSA/HRA Employer Contribution? HSA/HRA Options Coinsurance, if Combined Tier Tier 1 Plan Benefit Design CHILD TUS WHERE Coinsurance? Subject to 100.00% \$0.00 \$3,000.00 Medical Deductible? Subject to \$1,000.00 100.00% ₹ Sold OOP Maximum if Separate (\$) Desired Metal Tier Apply Inpatient Copay per Day? Indicate if Plan Meets CSR Standard? Deductíble (\$) Use Integrated Medical and Drug Deductible? Apply Skilled Nursing Facility Copay per Day? Use Separate OOP Maximum for Medical and Drug Spending? Coinsurance (%, Insurer's Cost Share) 00P Maximum (\$) Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays) Mental/Behavioral Health and Substance Abuse Disorder Outpatient Rehabilitative Occupational and Rehabilitative Physical Therapy Laboratory Outpatient and Professional Services Type of Benefit All Inpatient Hospital Services (inc. MHSA) Medical Preventive Care/Screening/Immunization Click Here for Important Instructions User Inputs for Plan Parameters Rehabilitative Speech Therapy X-rays and Diagnostic Imaging Imaging (CT/PET Scans, MRIs) **Emergency Room Services** Skilled Nursing Facility Specialist Visit Services

VII

			# Copays (1-10):
			Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?
			# Visits (1-10):
			Begin Primary Care Cost-Sharing After a Set Number of Visits?
		2	# Days (1-10):
		<u></u>	Set a Maximum Number of Days for Charging an IP Copay?
			Specialty Rx Coinsurance Maximum:
	•		Set a Maximum on Specialty Rx Coinsurance Payments?
			Options for Additional Benefit Design Limits:
\$60.00			Specialty Drugs (i.e. high-cost)
\$50.00			Non-Preferred Brand Drugs
\$25.00		·	Preferred Brand Drugs
. \$5.00			Generics
		☐ AI	Drugs
66%	₹.	짇	Outpatient Surgery Physician/Surgical Services
56%	Į.	Q	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)

MIL

Status/Error Messages:
Actuarial Value:
Metal Tier:

Calculation Successful. 80.5% Gold Output



2015 Proposed Plan Design – Silver

Standard Silver 70%

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Medical Deductible Individual Family	\$2,600 \$5,200	\$6,000 \$12,000
(copays are not applied to deductible) Prescription Drug Deductible Individual		
Family (copays are not applied to deductible)	\$25 \$50	\$350 \$700
Out-of-Pocket Maximum Individual Family	\$6,600 \$13,200	\$12,500 \$25,000
Physician Office Visits		
Preventive Care/Screenings/Immunizations	\$0	40% colnsurance
Primary Care (injury or illness)	\$30 copay	40% coinsurance**
Specialist	\$50 сорау	40% coinsurance**
Emergency/Urgent Care		
Urgent Care Center or Facility	\$75 copay*	40% coinsurance**
Emergency Room	\$150 copay	\$150 copay
Ambulance	\$0	\$0
Hospital Services		
Inpatient	\$500 copay per day to a maximum of \$2,000 per admission*	40% coinsurance**
Outpatient (performed at hospital or ambulatory facility)	\$500 copay*	40% coinsurance**
Skilled Nursing Facility 90 day calendar year maximum	\$500 copay per day to a maximum of \$2,000 per admission*	40% coinsurance**
Mental Health, Substance Abuse & Behavioral Health Ca	re	
Mental Health, Substance Abuse & Behavioral Health Services	Covered same as any other illness	Covered same as any other illness
Hospice Care		
Hospice Services	\$0	40% coinsurance**
Outpatient Services		
Home Health Care 100 visit calendar year maximum	\$0	25% coinsurance subject to a \$50 deductible
Advanced Radiology (CT/PET Scan, MRI)	\$75 copay per service up to a combined calendar year maximum of \$375 for MRI and CT scans; \$400 for PET scans	40% coinsurance**

^{*}After in-network medical deductible is met

^{**}After out-of-network medical deductible is met



Standard Silver 70%

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Outpatient Services		
Non-Advanced Radiology (X-ray, Diagnostic)	\$45 copay	40% coinsurance**
Laboratory Services	\$35 copay	40% coinsurance**
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) combined 40 visit calendar year maximum	\$30 copay	40% coinsurance**
Chiropractic Care 20 visit calendar maximum	\$50 copay	40% coinsurance**
Other Services		
Durable Medical Equipment	40% coinsurance	40% coinsurance**
Prosthetics	40% coinsurance	40% coinsurance**
Diabetic Supplies & Equipment	40% coinsurance	40% coinsurance**
Prescription Drugs		
Generic Drugs	\$5 copay	40% coinsurance****
Preferred Brand Drugs	\$30 copay	40% coinsurance****
Non-Preferred Brand Drugs	\$55 copay	40% coinsurance****
Specialty Drugs	\$60 copay ***	40% coinsurance****

Pediatric-Only Services (for children under age 19)

Pediatric Dental Care		
Diagnostic & Preventive (Oral Exam, Cleaning, X-ray)	\$0	50% coinsurance**
Basic Restorative (Filling, Simple Extraction)	40% coinsurance	50% coinsurance**
Major Restorative (Endodontic, Crown)	50% coinsurance	50% coinsurance**
Orthodontia Services medically necessary only	50% coinsurance	50% coinsurance**
Pediatric Vision Care		
Routine Eye Exam by Specialist	\$50 copay	40% coinsurance
Prescription Eye Glasses one pair of frames & lenses per calendar year	lenses: \$0 collection frames: \$0 non-collection frames: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit equal to the cost of the collection frame and will be entitled to a negotiated discount	100% coinsurance

^{*}After in-network medical deductible is met

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71.9% AVC

^{***}After in-network prescription drug deductible is met

^{**}After out-of-network medical deductible is met
****After out-of-network prescription drug deductible is met

User inputs 101 rian raianeters				
Use Integrated Medical and Drug Deductible?			HSA/HRA Options	
Apply Inpatient Copay per Day?	5	HSA/HRA Emp	HSA/HRA Employer Contribution?	
Apply Skilled Nursing Facility Copay per Day?			Mark de la parte de la par	
Use Separate OOP Maximum for Medical and Drug Spending?		Annual Contro	Ameral Contribution Amount	
Indicate if Plan Meets CSR Standard?				
Desired Metal Tier	Silver			
	多数型型電影の画力を	Tier 1 Plan Benefit Design	Sign and British Shorts	
	Medical	Drug Drug	Combined	
Deductible (\$)	\$2,600.00	\$25.00		
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%		
00P Maximum (\$)	\$6,600.00	00:00		
OOP Maximum if Separate (\$)			920.53	
Click Here for Important Instructions				
Type of Benefit	Subject to Dedictible?	Subject to Consurance?	Coinsurance, if Co	Copay, if separate
y man hanne de management de la company de l	A			
Emergency Room Services			Š	\$150.00
All Inpatient Hospital Services (inc. MHSA)	\ <u>\</u>		₹\$	\$500.00
Primary Care Visit to Treat an Injury or Iliness (exc. Preventive, and X-rays)		_	V \$	\$30.00
Specialist Visit			\$	\$50.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient			· ·	\$58.00
Services				00 242
Imaging (CT/PET Scans, MRIs)][,	\$73.00
Rehabilitative Speech Therapy			<i>γ</i>	\$30.00
Rehabilitative Occupational and Rehabilitative Physical Therapy			\$	\$30.00
Preventive Care/Screening/Immunization			190%	0000
Laboratory Outpatient and Professional Services			O	\$35.00
X-rays and Diagnostic Imaging			\(\)	\$45.00
Skilled Nursing Facility	<u>\</u>		₹	\$500.00

	•		# Copays (1-10):
			Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?
			•
	<u> </u>		# Visits (1-10):
			Begin Primary Care Cost-Sharing After a Set Number of Visits?
	!	4	# Days (1-10):
	_	\	Set a Maximum Number of Days for Charging an IP Copay?
			Specialty Rx Coinsurance Maximum:
			Set a Maximum on Specialty Rx Coinsurance Payments?
	J		Options for Additional Benefit Design Limits:
\$60.00		∠	Specialty Drugs (i.e. high-cost)
\$55.00			Non-Preferred Brand Drugs
\$30,00			Preferred Brand Drugs
\$5.00			Generics
	☐ All	☐ All	Drugs
66%	<u></u>	Ū.	Outpatient Surgery Physician/Surgical Services
66%	区	Q	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)

XII

Status/Error Messages:
Actuarial Value:
Metal Tier:

Calculation Successful. 71.9% Silver

Output



2015 Proposed Plan Design – Silver 94% CSR

Standard Silver CSR Plan - 94%

In-Network	Out-of-Network
Member Pays	Member Pays
\$0	\$6,000
\$0	\$12,000
Auto-survivarious	
	\$350
\$0	\$700
1	\$12,500
\$1,200	\$25,000
\$0	40% coinsurance
\$20 copay	40% coinsurance**
\$35 copay	40% coinsurance**
\$50 сорау	40% coinsurance**
\$75 copay	\$75 copay
\$0	\$0
\$100 copay per day to a maximum of \$400 per admission	40% coinsurance**
\$100 copay	40% coinsurance**
\$100 copay per day to a maximum of	40% coinsurance**
the second secon	
are	
Covered same as any other illness	Covered same as any other illness
\$0	40% coinsurance**
¢o.	25% coinsurance subject to
Şυ	a \$50 deductible
\$75 copay per service up to a	
1	40% coinsurance**
1	
	\$0 \$0 \$0 \$0 \$0 \$600 \$1,200 \$1,200 \$50 copay \$35 copay \$75 copay \$75 copay \$0 \$100 copay per day to a maximum of \$400 per admission \$100 copay \$100 copay per day to a maximum of \$400 per admission \$100 copay \$100 copay per day to a maximum of \$400 per admission \$100 copay \$100 copay per day to a maximum of \$400 per admission \$100 copay \$100

^{*}After in-network medical deductible is met

^{**}After out-of-network medical deductible is met



Standard Silver CSR Plan - 94%

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Outpatient Services	ivicinisci i dys	Weinber 1 dy 5
Non-Advanced Radiology (X-ray, Diagnostic)	\$45 copay	40% coinsurance**
Laboratory Services	\$20 copay	40% coinsurance**
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) combined 40 visit calendar year maximum	\$20 copay	40% coinsurance**
Chiropractic Care 20 visit calendar maximum	\$35 copay	40% coinsurance**
Other Services		
Durable Medical Equipment	40% coinsurance	40% coinsurance**
Prosthetics	40% coinsurance	40% coinsurance**
Diabetic Supplies & Equipment	40% coinsurance	40% coinsurance**
Prescription Drugs		
Generic Drugs	\$5 copay	40% coinsurance****
Preferred Brand Drugs	\$20 copay	40% coinsurance****
Non-Preferred Brand Drugs	\$35 copay	40% coinsurance****
Specialty Drugs	\$50 copay	40% coinsurance****

Pediatric-Only Services (for children under age 19)

Pediatric-Only Services (for children under age 19) Pediatric Dental Care		
Diagnostic & Preventive (Oral Exam, Cleaning, X-ray)	\$0	50% coinsurance**
Basic Restorative (Filling, Simple Extraction)	40% coinsurance	50% coinsurance**
Major Restorative (Endodontic, Crown)	50% coinsurance	50% coinsurance**
Orthodontia Services medically necessary only	50% coinsurance	50% coinsurance**
Pediatric Vision Care		
Routine Eye Exam by Specialist	\$35 copay	40% coinsurance
Prescription Eye Glasses one pair of frames & lenses per calendar year	lenses: \$0 collection frames: \$0 non-collection frames: Members choosing to upgrade from a collection frame to a non-collection frame will be given a credit equal to the cost of the collection frame and will be entitled to a negotiated discount	100% coinsurance

^{*}After in-network medical deductible is met

**After out-of-network medical deductible is met

****After out-of-network prescription drug deductible is met

This Standard Plan Design sample is representative and is not intended to be a legal contract. Please see the actual plan documents for a full list of benefit coverage,

exclusions and the terms of the policy. $94.1\% \, \text{AVC}$

^{***}After in-network prescription drug deductible is met

Copay, if 20.00 separate \$100.00 \$20.00 \$25.00 \$75.00 \$20.00 \$20.00 \$20.00 \$45.00 \$100.00 \$75.00 \$35.00 HSA/HRA Employer Contribution? HSA/HRA Options Coinsurance, if Combined Tier 1 Plan Benefit Design Tier 1 Coinsurance? Subject to 00.00 Drug \$0.00 ₹ \$600.00 Medical Deductible? Subject to 100.00% \$0.00 ₹ Platinum OOP Maximum if Separate (\$) |關國國 Indicate if Plan Meets CSR Standard? Desired Metal Tier Coinsurance (%, Insurer's Cost Share) Use Integrated Medical and Drug Deductible? Apply Inpatient Copay per Day? Apply Skilled Nursing Facility Copay per Day? Use Separate OOP Maximum for Medical and Drug Spending? Deductible (\$) OOP Maximum (\$) Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays) Mental/Behavioral Health and Substance Abuse Disorder Outpatient Rehabilitative Occupational and Rehabilitative Physical Therapy Laboratory Outpatient and Professional Services Type of Benefit Medical All Inpatient Hospital Services (inc. MHSA) Preventive Care/Screening/Immunization Click Here for Important Instructions User Inputs for Plan Parameters Rehabilitative Speech Therapy X-rays and Diagnostic Imaging Imaging (CT/PET Scans, MRIs) **Emergency Room Services** Skilled Nursing Facility Specialist Visit Services

			ON COLOR HANDER CONTROL OF THE PROPERTY OF THE
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		<u>.</u>	93%
Outpatient Surgery Physician/Surgical Services		✓	93%
Drugs	IIA	LI AII	
Generics			\$5.00
Preferred Brand Drugs			\$20.00
Non-Preferred Brand Drugs			\$35.00
Specialty Drugs (i.e. high-cost)			\$50.00
Options for Additional Benefit Design Limits:		•	
Set a Maximum on Specialty Rx Coinsurance Payments?			
Specialty Rx Coinsurance Maximum:			
Set a Maximum Number of Days for Charging an IP Copay?	<u></u>		
# Days (1-10):	4		
Begin Primary Care Cost-Sharing After a Set Number of Visits?			
# Visits (1-10):	-		
•			
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?		-	
# Copays (1-10):		,	
Output			

XVI

Status/Error Messages:
Actuarial Value:
Metal Tier:

CSR Level of 94% (100-150% FPL), Calculation Successful. 94.1%

Platinum