access health CT

Connecticut's Health Insurance Marketplace

Stand Alone Dental Plan – "High Option"

Plan Overview	Member Pays
Deductible *(Does not apply to Preventive & Diagnostic Services)*	$60 per member, up to 3 family members
Out-of-Pocket Maximum *for children under age 19 only* For one child Two or more children	 $350 $700
Diagnostic Services	
Oral Exams *twice per year*	$0
X-Rays	
Periapicals *four per year*	
Bitewing Radiographs *once every year*	
Panoramic **or Complete Series** *once every three years*	
Preventive Services	
Cleanings *twice per year*	$0
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	
Fillings	20% after deductible
Simple Extractions	
Major Services	
Surgical Extractions	40% after deductible
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	50% after deductible
Waiting Periods and Plan Maximums (*for adults aged 19 and older only*)	
Applicable Waiting Period for Benefit	
Diagnostic and Preventive Services	no waiting period
Basic Services	6 months
Major Services	12 months
Plan Maximum	$2,000 per adult member

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.

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

		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
Drugs				
tier 1	$10 d	$5	$5	$5 d
tier 2	40%d	45%d	50% d	$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.

Silver

		2015 Proposed Plans			
AV calculator inputs	current - 2014	Silver std. 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					
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

Gold

AV calculator inputs	current - 2014	2015
Medical Deductible	$ 1,000	$ 1,000
Drug Deductible	$ 150	$ 0
MOOP	$ 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

access health CT

Connecticut's Health Insurance Marketplace

Standard Platinum Plan - 90%

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Deductible *Individual* *Family* *(copays are not applied to deductible)*	 $0 $0	 $2,000 $4,000
Out-of-Pocket Maximum *Individual* *Family*	 $2,000 $4,000	 $4,000 $8,000
Physician Office Visits		
Preventive Care/Screenings/Immunizations	$0	20% coinsurance
Primary Care (injury or illness)	$10 copay	20% coinsurance*
Specialist	$30 copay	20% coinsurance*
Emergency/Urgent Care		
Urgent Care Center or Facility	$50 copay	20% coinsurance*
Emergency Room	$100 copay	$100 copay
Ambulance	$0	$0
Hospital Services		
Inpatient	$250 copay per day to a maximum of $500 per admission	20% coinsurance*
Outpatient (performed at hospital or ambulatory facility)	$250 copay	20% coinsurance*
Skilled Nursing Facility *90 day calendar year maximum*	$250 copay per day to a maximum of $500 per admission	20% coinsurance*
Mental Health, Substance Abuse & Behavioral Health Care		
Mental Health, Substance Abuse & Behavioral Health Services	Covered same as any other illness	Covered same as any other illness
Hospice Care		
Hospice Services	$0	20% coinsurance*
Outpatient Services		
Home Health Care *100 visit calendar year maximum*	$0	20% 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	20% coinsurance*
Non-Advanced Radiology (X-ray, Diagnostic)	$30 copay	20% coinsurance*

*After out-of-network 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.

Exhibit 6R – 91.8%

8/30/2013

access health CT

Connecticut's Health Insurance Marketplace

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% 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	$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

*After out-of-network 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.

User Inputs for Plan Parameters

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?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Platinum

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)	$0.00	$0.00	
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%	
OOP Maximum ($)	$2,000.00		
OOP Maximum if Separate ($)			

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☐ All	☐ All		
Emergency Room Services	☐	☐		$100.00
All Inpatient Hospital Services (inc. MHSA)	☐	☐		$250.00
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$10.00
Specialist Visit	☐	☐		$30.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$24.40
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00
Rehabilitative Speech Therapy	☐	☐		$10.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$10.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$10.00
X-rays and Diagnostic Imaging	☐	☐		$30.00
Skilled Nursing Facility	☐	☐		$250.00

Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	83%	
Outpatient Surgery Physician/Surgical Services	☐	☑	83%	
Drugs	☐ All	☐ All		
Generics	☐	☐		$5.00
Preferred Brand Drugs	☐	☐		$15.00
Non-Preferred Brand Drugs	☐	☐		$30.00
Specialty Drugs (i.e. high-cost)	☐	☑	80%	

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?	☑
# Days (1-10):	2
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

Status/Error Messages:	Calculation Successful.
Actuarial Value:	90.7%
Metal Tier:	Platinum

access health CT
Connecticut's Health Insurance Marketplace

2015 Proposed Plan Design – Gold

Standard Gold Plan - 80%

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Medical Deductible *Individual* *Family* *(copays are not applied to deductible)*	 $1,000 $2,000	 $3,000 $6,000
Prescription Drug Deductible *Individual* *Family* *(copays are not applied to deductible)*	 $0 $0	 $350 $700
Out-of-Pocket Maximum *Individual* *Family*	 $3,000 $6,000	 $6,000 $12,000
Physician Office Visits		
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 Care		
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

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

IV

4/28/2014

access health CT

Connecticut's Health Insurance Marketplace

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

*After in-network medical deductible is met

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

***After in-network prescription drug 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

4/28/2014

User Inputs for Plan Parameters

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?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)	$1,000.00	$0.00	
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%	
OOP Maximum ($)	$3,000.00		
OOP Maximum if Separate ($)			

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☐ All	☐ All		
Emergency Room Services	☐	☐		$150.00
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00
Specialist Visit	☐	☐		$45.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		~~$58.00~~ $48.80 JL
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00
Rehabilitative Speech Therapy	☐	☐		$30.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$30.00
X-rays and Diagnostic Imaging	☐	☐		$45.00
Skilled Nursing Facility	☑	☐		$500.00

Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	66%	
Outpatient Surgery Physician/Surgical Services	☑	☑	66%	
Drugs	☐ All	☐ All		
Generics	☐	☐		$5.00
Preferred Brand Drugs	☐	☐		$25.00
Non-Preferred Brand Drugs	☐	☐		$50.00
Specialty Drugs (i.e. high-cost)	☐	☐		$60.00

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?	☑
# Days (1-10):	2
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

Status/Error Messages:	Calculation Successful.
Actuarial Value:	80.5%
Metal Tier:	Gold

access health CT
Connecticut's Health Insurance Marketplace

2015 Proposed Plan Design – Silver

Standard Silver 70%

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Medical Deductible *Individual* *Family* *(copays are not applied to deductible)*	 $2,600 $5,200	 $6,000 $12,000
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% coinsurance
Primary Care (injury or illness)	$30 copay	40% coinsurance**
Specialist	$50 copay	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 Care		
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

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.

71.9% AVC

IX

4/28/2014

access health CT

Connecticut's Health Insurance Marketplace

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

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

***After in-network prescription drug 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.

71.9% AVC

4/28/2014

User Inputs for Plan Parameters

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?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	Silver

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)	$2,600.00	$25.00	
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%	
OOP Maximum ($)	$6,600.00		
OOP Maximum if Separate ($)			

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☐ All	☐ All		
Emergency Room Services	☐	☐		$150.00
All Inpatient Hospital Services (inc. MHSA)	☑	☐		$500.00
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$30.00
Specialist Visit	☐	☐		$50.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$58.00
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00
Rehabilitative Speech Therapy	☐	☐		$30.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$30.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$35.00
X-rays and Diagnostic Imaging	☐	☐		$45.00
Skilled Nursing Facility	☑	☐		$500.00

Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	66%	
Outpatient Surgery Physician/Surgical Services	☑	☑	66%	
Drugs	☐ All	☐ All		
Generics	☐	☐		$5.00
Preferred Brand Drugs	☐	☐		$30.00
Non-Preferred Brand Drugs	☐	☐		$55.00
Specialty Drugs (i.e. high-cost)	☑	☐		$60.00

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?	☑	
# 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

Status/Error Messages:	Calculation Successful.
Actuarial Value:	71.9%
Metal Tier:	Silver

access health CT
Connecticut's Health Insurance Marketplace

2015 Proposed Plan Design – Silver 94% CSR

Standard Silver CSR Plan - 94%

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Medical Deductible *Individual* *Family* *(copays are not applied to deductible)*	 $0 $0	 $6,000 $12,000
Prescription Drug Deductible *Individual* *Family* *(copays are not applied to deductible)*	 $0 $0	 $350 $700
Out-of-Pocket Maximum *Individual* *Family*	 $600 $1,200	 $12,500 $25,000
Physician Office Visits		
Preventive Care/Screenings/Immunizations	$0	40% coinsurance
Primary Care (injury or illness)	$20 copay	40% coinsurance**
Specialist	$35 copay	40% coinsurance**
Emergency/Urgent Care		
Urgent Care Center or Facility	$50 copay	40% coinsurance**
Emergency Room	$75 copay	$75 copay
Ambulance	$0	$0
Hospital Services		
Inpatient	$100 copay per day to a maximum of $400 per admission	40% coinsurance**
Outpatient (performed at hospital or ambulatory facility)	$100 copay	40% coinsurance**
Skilled Nursing Facility *90 day calendar year maximum*	$100 copay per day to a maximum of $400 per admission	40% coinsurance**
Mental Health, Substance Abuse & Behavioral Health Care		
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

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% AVC

4/24/2014

access health CT

Connecticut's Health Insurance Marketplace

Standard Silver CSR Plan - 94%

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	$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 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 in-network prescription drug 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% AVC

XIV

4/24/2014

User Inputs for Plan Parameters

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?	☐
Indicate if Plan Meets CSR Standard?	☑
Desired Metal Tier	Platinum

HSA/HRA Options	
HSA/HRA Employer Contribution?	☐
Annual Contribution Amount	

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)	$0.00	$0.00	
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%	
OOP Maximum ($)	$600.00		
OOP Maximum if Separate ($)			

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	☐ All	☐ All		
Emergency Room Services	☐	☐		$75.00
All Inpatient Hospital Services (inc. MHSA)	☐	☐		$100.00
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☐	☐		$20.00
Specialist Visit	☐	☐		$35.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☐	☐		$25.00
Imaging (CT/PET Scans, MRIs)	☐	☐		$75.00
Rehabilitative Speech Therapy	☐	☐		$20.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	☐	☐		$20.00
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☐	☐		$20.00
X-rays and Diagnostic Imaging	☐	☐		$45.00
Skilled Nursing Facility	☐	☐		$100.00

Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☐	☑	93%	
Outpatient Surgery Physician/Surgical Services	☐	☑	93%	
Drugs	☐ All	☐ All		
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?	☑	
# 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

Status/Error Messages:	CSR Level of 94% (100-150% FPL), Calculation Successful.
Actuarial Value:	94.1%
Metal Tier:	Platinum