

2015 Proposed Plan Design – Silver 87% CSR

# Standard Silver CSR Plan - 87%

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays		
Medical Deductible Individual Family (copays are not applied to deductible)	\$400 \$800	\$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	\$1,750 \$3,500	\$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	\$100 copay	\$100 copay		
Ambulance	\$0	\$0		
Hospital Services				
Inpatient	\$200 copay per day to a maximum of \$800 per admission*	40% coinsurance**		
Outpatient (performed at hospital or ambulatory facility)	\$200 copay*	40% coinsurance**		
Skilled Nursing Facility 90 day calendar year maximum	\$200 copay per day to a maximum of \$800 per admission*	40% coinsurance**		
Mental Health, Substance Abuse & Behavioral Health Ca	are			
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**		

<sup>\*</sup>After in-network medical deductible is met

<sup>\*\*</sup>After out-of-network medical deductible is met



### Standard Silver CSR Plan - 87%

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	\$25 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**
Pedlatric 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

<sup>\*</sup>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.

87.3% AVC

<sup>\*\*\*</sup>After in-network prescription drug deductible is met

User Inputs for Plan Parameters				ſ
Use Integrated Medical and Drug Deductible?			William HSA/HRA Options	\$4 .77.
Apply Inpatient Copay per Day?	<u> </u>	HSA/HRA Emp	HSA/HRA Employer Contribution?	
Use Separate OOP Maximum for Medical and Drug Spending?		Annual Contr	Annual Control to Amount	
Indicate if Plan Meets CSR Standard? Desired Metal Tier	Plog			] .
	Name of the least	Tier 1 Plan Benefit Design	Sign of the second seco	
	Wedical with	Drug (Fig.	Combined William	
Deductible (\$)	\$400.00	\$25.00		
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%		
(\$) Maximum (\$)		\$1,750.00		
OOP Maximum II Separate (S)				
Click Here for Important Instructions				<u> </u>
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if Copay, if different separate	10.147 30.747 30.747
Medical	₽ □	☐ All		
Emergency Room Services			\$100.00	
All Inpatient Hospital Services (inc. MHSA)	<u> </u>		\$200.00	
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			\$31.00	
Jungan (TT/OCT Crane MARie)			\$75.00	
Rehabilitative Speech Therapy			\$20.00	
Rehabilitative Occupational and Rehabilitative Physical Therapy			\$20.00	
Preventive Care/Screening/Immunization			10000	
Laboratory Outpatient and Professional Services			\$25.00	
X-rays and Diagnostic Imaging			\$45.00	
Skilled Nursing Facility	>		\$200.00	



	}		
			# Copays (1-10):
			Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?
	<u>l</u> .		# Visits (1-10):
			Begin Primary Care Cost-Sharing After a Set Number of Visits?
•	<u>l</u>	4	# Days (1-10):
		Q	Set a Maximum Number of Days for Charging an IP Copay?
	<b>l</b>		Specialty Rx Coinsurance Maximum:
			Set a Maximum on Specialty Rx Coinsurance Payments?
	)		Options for Additional Benefit Design Limits:
\$50.00		Q	Specialty Drugs (i.e. high-cost)
\$35.00			Non-Preferred Brand Drugs
\$20.00			Preferred Brand Drugs
\$5.00			Generics
	☐ All	D AL	Drugs
86%	₹.	<u>.</u>	Outpatient Surgery Physician/Surgical Services
86%	₹.	₹.	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)

XX

Status/Error Messages:
Actuarial Value:
Metal Tier:

CSR Level of 87% (150-200% FPL), Calculation Successful. 87.3% Gold

Output



2015 Proposed Plan Design – Silver 73% CSR

# Standard Silver CSR Plan - 73%

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays			
Medical Deductible					
Individual	\$2,600	\$6,000 \$12,000			
Family (in the deductible)	\$5,200				
(copays are not applied to deductible)  Prescription Drug Deductible					
Individual		4			
Family	\$25	\$350 \$700			
(copays are not applied to deductible)	\$50				
Out-of-Pocket Maximum	45.000				
Individual	\$5,200 \$10,400	\$12,500 \$25,000			
Family Physician Office Visits	\$10,400	<b>Ψ23,000</b>			
Preventive Care/Screenings/Immunizations	\$0	40% coinsurance			
Primary Care (injury or illness)	\$30 copay	40% coinsurance**			
Specialist	\$50 copay	40% coinsurance**  40% coinsurance**  \$150 copay  \$0			
Emergency/Urgent Care	420 ooba4				
Urgent Care Center or Facility	\$75 copay*				
Emergency Room	\$150 copay				
Ambulance	\$0				
Hospital Services					
Inpatient	\$500 copay per day to a maximum of \$2,000 per admission*	40% coinsurance**  40% coinsurance**  40% coinsurance**			
Outpatient (performed at hospital or ambulatory facility)	\$500 copay*				
Skilled Nursing Facility 90 day calendar year maximum	\$500 copay per day to a maximum of \$2,000 per admission*				
Mental Health, Substance Abuse & Behavioral Health Ca	ire				
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**			

<sup>\*</sup>After in-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,

<sup>\*\*</sup>After out-of-network medical deductible is met



### Standard Silver CSR Plan - 73%

Plan Overview	In-Network	Out-of-Network		
	Member Pays	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	\$30 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		

<sup>\*</sup>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

#### 00005 Copay, if \$150.00 \$75.00 \$30.00 \$45.00 separate \$500.00 \$30.00 \$58.00 \$30.00 \$500.00 \$50.00 \$35.00 HSA/HRA Employer Contribution? HSA/HRA Options Coinsurance, if Combined different Tier 1. Plan Benefit Design Tier 1 TO THE PARTY OF TH Coinsurance? Subject to 100.00% \$25.00 ₹ \$5.200.00 Medical **Deductible?** Þ \$2,600.00 Subject to 100.00% ₹ Silve Desired Metal Tier OOP Maximum if Separate (\$) Indicate if Plan Meets CSR Standard? Deductible (\$) Coinsurance (%, Insurer's Cost Share) Apply Skilled Nursing Facility Copay per Day? Use Separate OOP Maximum for Medical and Drug Spending? 00P Maximum (\$) Use Integrated Medical and Drug Deductible? Apply Inpatient Copay per Day? 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 K-rays and Diagnostic Imaging Imaging (CT/PET Scans, MRIs) **Emergency Room Services** Skilled Nursing Facility Specialist Visit Services

Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? # Copays (1-10):	# Visits (1-10):	Begin Primary Care Cost-Sharing After a Set Number of Visits?	# 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?	Options for Additional Benefit Design Limits:	Specialty Drugs (i.e. high-cost)	Non-Preferred Brand Drugs	Preferred Brand Drugs	Generics	Drugs	Outpatient Surgery Physician/Surgical Services	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)
			4	<u></u>				<u>s</u>			t comments	☐ <u>A</u>	<u>(</u>	Q
	٠		,									<u>≥</u>	₹	(L)
							٠	\$60.00	\$55.00	\$30.00	\$5.00		56%	56%

VIXX

Status/Error Messages:
Actuarial Value:
Metal Tier:

?

CSR Level of 73% (200-250% FPL), Calculation Successful. 73.3% Silver



2015 Plan Design – Preferred Bronze

### Standard Bronze Plan 1 - 60%

Plan Overview	In-Network	Out-of-Network
	Member Pays	Member Pays
Deductible Individual Family (copays are not applied to deductible)	\$5,000 \$10,000	\$10,000 \$20,000
Out-of-Pocket Maximum Individual Family	\$6,600 \$13,200	\$13,200 \$26,400
Physician Office Visits		
Preventive Care/Screenings/Immunizations	\$0	50% colnsurance
Primary Care (injury or illness)	\$35 copay	50% coinsurance**
Specialist	\$50 copay	50% coinsurance**
Emergency/Urgent Care		
Urgent Care Center or Facility	40% coinsurance*	50% coinsurance**
Emergency Room	. \$200 copay	\$200 copay
Ambulance	\$0*	\$0*
Hospital Services		
Inpatient	40% colnsurance*	50% coinsurance**
Outpatient (performed at hospital or ambulatory facility)	40% colnsurance*	50% coinsurance**
Skilled Nursing Facility 90 doy calendar year maximum	40% colinsurance*	50% coinsurance**
Mental Health, Substance Abuse & Behavloral Health Ca	re	
Mental Health, Substance Abuse & Behavioral Health Services	्रिट्रिकेट Covered same as any other Illness	Covered same as any other illness
Hospice Care		
Hospice Services	\$0*	50% coinsurance**
Outpatient Services		
Home Health Care 100 visit calendar year maximum	25% coinsurance subject to a \$50 deductible	25% coinsurance subject to a \$50 deductible
Advanced Radiology (CT/PET Scan, MRI)	40% coinsurance*	. 50% coinsurance**
Non-Advanced Radiology (X-ray, Diagnostic)	40% coinsurance*	50% coinsurance**

<sup>\*</sup>After in-network deductible is met

<sup>\*\*</sup>After out-of-network deductible is met



### Standard Bronze Plan 1 - 60%

	In-Network Member Pays	Out-of-Network Member Pays
Outpatient Services		
Laboratory Services	40% coinsurance <sup>3</sup>	50% coinsurance**
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) combined 40 visit calendar year maximum	40% coinsurance*	50% coinsurance**
Chiropractic Care 20 visit calendar maximum	#8% coinsurance*	50% coinsurance**
Other Services		
Durable Medical Equipment	40% colnsurance*	50% colnsurance**
Prosthetics	40% colnsurance*	50% coinsurance**
Diabetic Supplies & Equipment	40% coinsurance*	50% coinsurance**
Prescription Drugs		
Generic Drugs	\$5 copay	50% colnsurance**
Preferred Brand Drugs	45% coinsurance*	50% coinsurance**
Non-Preferred Brand Drugs	50% coinsurance*	50% coinsurance**
Specialty Drugs	50% coinsurance	50% coinsurance**

Pediatric-Only Services (for children under age 19)

-ediatric-only services (for children ditael age 23)	1, 22, 2 1, 22, 2 1, 22, 2 1, 22, 2 1, 22, 2 1, 2 2	
<sup>o</sup> edlatric 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**
Orthodontla Services  medically necessary only	50% colnsurance*	50% coinsurance**
Pediatric Vision Care		
Routine Eye Exam by Specialist	\$30 copay \$ 50 Wray	50% 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

<sup>\*</sup>After in-network deductible is met

<sup>\*\*</sup>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.

5/24/2013

User Inputs for Plan Parameters	1			
Use Integrated Medical and Drug Deductible?	·		HSA/HRA Options	
Apply Inpatient Copay per Day?		HSA/HRA Emplo	HSA/HRA Employer Contribution?	
Apply Skilled Nursing Facility Copay per Day?	□ (			
Use Separate OOP Maximum for Medical and Drug Spending?	1			
Indicate if Plan Meets CSR Standard?				
Desired Metal Tier	Bronze -			
		בייים בייים		
(ع) دایزیس، او در			\$5 000 00	
Deductible (5) Coinsurance (%, Insurer's Cost Share)			100.00%	
OOP Maximum (\$)			\$6,600.00	
OOP Maximum if Separate (\$)				
Click Here for Important Instructions		Tier1		
Type of Benefit	Subject to	Subject to	Coinsurance, if	Copay, if
Medical	₹	₹ }][		
Emergency Room Services				\$200.00
All Inpatient Hospital Services (inc. MHSA)	<u> </u>	5	%09	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$35.00
Specialist Visit				\$50.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient				\$68.90
Services			7003	
Imaging (CT/PET Scans, MRIs)	5	2]	90%	
Rehabilitative Speech Therapy	5	<b></b>	%09	
Rehabilitative Occupational and Rehabilitative Physical Therapy	ি	<u></u>	%09	
Preventive Care/Screening/Immunization				0000
Laboratory Outpatient and Professional Services	>	ত্য	%09	
X-rays and Diagnostic Imaging	<b></b>	ত	%09	
Skilled Nursing Facility	<u> </u>	ত	%09	

XXVII

			# 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?
	ļ		# 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?
			Options for Additional Benefit Design Limits:
50%	V	[]	Specialty Drugs (i.e. high-cost)
50%		乜	Non-Preferred Brand Drugs
55%	\sqrt{\sq}\sqrt{\sq}}\sqrt{\sq}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}}	Ū.	Preferred Brand Drugs
\$5.00			Generics
	<u>A</u>		Drugs
60%	<	<b>∠</b>	Outpatient Surgery Physician/Surgical Services
60%	Q	S	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)

Output

Status/Error Messages:
Actuarial Value:
Metal Tier:

Calculation Successful. 59.6%

XXVIII

Bronze



# 2015 Proposed Plan Design -

# **Secondary Bronze**

### Standard Bronze Plan 1 - 60%

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Deductible Individual Family (copays are not applied to deductible)	\$5,000 \$10,000	\$10,000 \$20,000
Out-of-Pocket Maximum Individual Family	\$6,600 \$13,200	\$13,200 \$26,400
Physician Office Visits		
Preventive Care/Screenings/Immunizations	\$0	50% coinsurance
Primary Care (injury or illness)	\$40 copay* The first 3 mental health and first 3 medical visits are before deductible, then must meet deductible before cost sharing resumes	50% coinsurance**
Specialist	\$50 copay*	50% coinsurance**
Emergency/Urgent Care		
Urgent Care Center or Facility	40% coinsurance*	50% coinsurance**
Emergency Room	40% coinsurance*	40% coinsurance*
Ambulance	\$0*	\$0*
Hospital Services		
Inpatient	40% coinsurance*	50% coinsurance**
Outpatient (performed at hospital or ambulatory facility)	40% coinsurance*	50% coinsurance**
Skilled Nursing Facility 90 day calendar year maximum	40% coinsurance*	50% coinsurance**
Mental Health, Substance Abuse & Behavioral Health C	are	
Mental Health, Substance Abuse & Behavioral Health Services	Covered same as any other illness	Covered same as any other illness
Hospice Care		
Hospice Services	\$0*	50% coinsurance**
Outpatient Services		
Home Health Care 100 visit calendar year maximum	25% coinsurance subject to a \$50 deductible*	25% coinsurance subject to a \$50 deductible
Advanced Radiology (CT/PET Scan, MRI)	40% coinsurance*	50% coinsurance**
Non-Advanced Radiology (X-ray, Diagnostic)	40% coinsurance*	50% coinsurance**

<sup>\*</sup>After in-network deductible is met

<sup>\*\*</sup>After out-of-network deductible is met



#### Standard Bronze Plan 1 - 60%

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

<sup>\*</sup>After in-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.

61.9% AVC

<sup>\*\*</sup>After out-of-network deductible is met

User Inputs for Plan Parameters			
Use Integrated Medical and Drug Deductible?	<b></b>		HSA/HRA Options
Apply Inpatient Copay per Day?		HSA/HRA Emplo	HSA/HRA Employer Contribution?
Apply Skilled Nursing Facility Copay per Day?		Annual Contribution Amount	1100円 大田の子の一番の一番の一番の一番の一番の一番の一番の一番の一番の一番の一番の一番の一番の
Use Separate OOP Maximum for Medical and Drug Spending?			
Indicate if Plan Meets CSR Standard? Desired Metal Tier	Bronze		
		Tier 1 Plan Benefit Design	ign
	Medical	AND PUBLISHED	Combined III
Deductible (\$)			\$5,000.00
			\$6,600.00
OOP Maximum if Separate (\$)			
Click Here for Important Instructions			
Type of Benefit	Subject to	Subject to	Coinsurance, if Copay, if
strong and the control of the contro	Z All	Z All	
Emergency Boom Services	5	<u> </u>	
All Inpatient Hospital Services (inc. MHSA)	<b>&gt;</b>	>	
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	>	<u> </u>	\$40.00
Specialist Visit	<b>&gt;</b>		\$50.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient	D	<b>\( \)</b>	
Services			
Imaging (CI/PEI Scans, Mixis)	][	]	
Rehabilitative Speech Therapy	>	>	- Address - Addr
Rehabilitative Occupational and Rehabilitative Physical Therapy	7	2	
Preventive Care/Screening/Immunization			100%
Laboratory Outpatient and Professional Services	5	<b></b>	
X-rays and Diagnostic Imaging	5	<b></b>	
Skilled Nursing Facility	5	D	

	I	4	# Copays (1-10):
			Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?
	,	<b>☑</b>	
			# Visits (1-10):
			Begin Primary Care Cost-Sharing After a Set Number of Visits?
	L		# Days (1-10):
			Set a Maximum Number of Days for Charging an IP Copay?
	l		Specialty Rx Coinsurance Maximum:
			Set a Maximum on Specialty Rx Coinsurance Payments?
	I		Options for Additional Benefit Design Limits:
50%	<	·	Specialty Drugs (i.e. high-cost)
50%	থ	Q	Non-Preferred Brand Drugs
50%	₹.	Q	Preferred Brand Drugs
\$5.00			Generics
	₹ Al	<ul><li>□</li><li>≥</li></ul>	Drugs
	ৌ	₹.	Outpatient Surgery Physician/Surgical Services
	Q	\(\mathbb{Z}\)	Outpatient Facility Fee (e.g., Ambulatory Surgery Center)

Status/Error Messages:
Actuarial Value:
Metal Tier:

Calculation Successful. 61.9%
Bronze

Output



# 2015 Proposed Plan Design – Bronze HSA

### Standard HSA Bronze Plan - 60%

Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Deductible Individual Family (copays are not applied to deductible)	\$4,600 \$9,200	\$9,200 \$18,400
Out-of-Pocket Maximum Individual Family	\$6,450 \$12,900	\$12,900 \$25,800
Physician Office Visits		
Preventive Care/Screenings/Immunizations	\$0	50% coinsurance
Primary Care (injury or illness)	\$0 copay*	50% coinsurance**
Specialist	\$0 copay*	50% coinsurance**
Emergency/Urgent Care		
Urgent Care Center or Facility	\$0 copay*	50% coinsurance**
Emergency Room	\$0 copay*	\$0 copay*
Ambulance	\$0 copay*	\$0*
Hospital Services		
Inpatient	\$0 copay*	50% coinsurance**
Outpatient (performed at hospital or ambulatory facility)	\$0 copay*	50% coinsurance**
Skilled Nursing Facility 90 day calendar year maximum	\$0 copay*	50% coinsurance**
Mental Health, Substance Abuse & Behavioral Health Ca	ire	
Mental Health, Substance Abuse & Behavioral Health Services	Covered same as any other illness	Covered same as any other illness
Hospice Care		
Hospice Services	\$0 copay*	50% coinsurance**
Outpatient Services		
Home Health Care 100 visit calendar year maximum	25% coinsurance*	25% coinsurance subject to a \$50 deductible
Advanced Radiology (CT/PET Scan, MRI)	\$0 copay*	50% coinsurance**
Non-Advanced Radiology (X-ray, Diagnostic)	\$0 copay*	50% coinsurance**

<sup>\*</sup>After in-network deductible is met

<sup>\*\*</sup>After out-of-network deductible is met



### Standard HSA Bronze Plan - 60%

	In-Network Member Pays	Out-of-Network Member Pays
Outpatient Services		
Laboratory Services	\$0 copay*	50% coinsurance**
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) combined 40 visit calendar year maximum	\$0 copay*	50% coinsurance**
Chiropractic Care 20 visit calendar maximum	\$0 copay*	50% coinsurance**
Other Services		
Durable Medical Equipment	\$0 copay*	50% coinsurance**
Prosthetics	\$0 copay*	50% coinsurance**
Diabetic Supplies & Equipment	\$0 copay*	50% coinsurance**
Prescription Drugs		
Generic Drugs	\$5 copay*	50% coinsurance**
Preferred Brand Drugs	\$35 copay*	50% coinsurance**
Non-Preferred Brand Drugs	40% coinsurance*	50% coinsurance**
Specialty Drugs	40% coinsurance*	50% coinsurance**

Pediatric-Only Services (for children under age 19)

Pediatric Dental Care		
Diagnostic & Preventive (Oral Exam, Cleaning, X-ray)	\$o	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	\$0 copay	50% 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

<sup>\*</sup>After in-network 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.

61.4% AVC

User Inputs for Plan Parameters	1			
. Use Integrated Medical and Drug Deductible?	<b></b>	<b>发展的 1000000000000000000000000000000000000</b>	HSA/HRA Options	
Apply Inpatient Copay per Day?		HSA/HRA Emp	HSA/HRA Employer Contribution?	
Apply Skilled Nursing Facility Copay per Day?		Anoual Contri	Annual Conf. Dution Amount	
Use Separate OOP Maximum for Medical and Drug Spending?	] [			
Indicate if Plan Meets CSR Standard?  Desired Metal Tier	Bronze		,	
		Tier 1 Plan Benefit Design	ssign and a second	
	Medical	Drug Till	Combined	
Deductible (\$) (\$) (\$) (\$) (\$) (\$) (\$) (\$)			\$4,600.00	
OOP Maximum (\$)			\$6,450.00	
00P Maximum if Separate (\$)				
Click Here for Important Instructions				endistancialista anguanas
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate
Medical	<u>\</u>	☐ Ail		
Emergency Room Services	>			\$0.00
All Inpatient Hospital Services (inc. MHSA)	2			\$0.00
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)				\$0.00
Specialist Visit	<b>\(\)</b>			\$0.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	<u> </u>			\$0.00
Imaging (CT/PET Scans, MRIs)				\$0.00
Rehabilitative Speech Therapy				\$0.00
Rehabilitative Occupational and Rehabilitative Physical Therapy	<u> </u>			\$0.00

\$0.00

되되고

Laboratory Outpatient and Professional Services

X-rays and Diagnostic Imaging

Skilled Nursing Facility

Preventive Care/Screening/Immunization

\$0.00

Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	<u>(</u>	<u>\</u>	
Outpatient Surgery Physician/Surgical Services	S	<b>∠</b>	
Drugs	√ Al	. Ali	
Generics	Z		\$5.00
Preferred Brand Drugs	<b>√</b>		\$35.00
Non-Preferred Brand Drugs	<u>\</u>	Z	60%
Specialty Drugs (i.e. high-cost)	<u>.</u>	<	60%
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):			
Begin Primary Care Cost-Sharing After a Set Number of Visits?			
# Visits (1-10):			
The state of the s			
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?			
# Copays (1-10):			
Output			

XXXVI

Status/Error Messages: Actuarial Value: Metal Tier:

Calculation Successful. 61.4%
Bronze