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Connecticut's Health Insurance Marketplace

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 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.

87.3% AVC

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4/28/2014

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Connecticut's Health Insurance Marketplace

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**
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

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87.3% AVC

XVIII

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 ($)	$400.00	$25.00	
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%	
OOP Maximum ($)	$1,750.00		
OOP Maximum if Separate ($)			

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)	☑	☐		$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 Services	☐	☐		$31.00
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	☐	☐		$25.00
X-rays and Diagnostic Imaging	☐	☐		$45.00
Skilled Nursing Facility	☑	☐		$200.00

Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	86%	
Outpatient Surgery Physician/Surgical Services	☑	☑	86%	
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 87% (150-200% FPL), Calculation Successful.
Actuarial Value:	87.3%
Metal Tier:	Gold

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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* *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*	 $5,200 $10,400	 $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.

73.3% AVC

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Connecticut's Health Insurance Marketplace

Standard Silver CSR Plan - 73%

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*	$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

*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

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73.3% 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	$25.00	
Coinsurance (%, Insurer's Cost Share)	100.00%	100.00%	
OOP Maximum ($)	$5,200.00		
OOP Maximum if Separate ($)			

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:	CSR Level of 73% (200-250% FPL), Calculation Successful.
Actuarial Value:	73.3%
Metal Tier:	Silver

XXX

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Connecticut's Health Insurance Marketplace

2015 Plan Design – Preferred Bronze

Standard Bronze Plan 1 - 60%

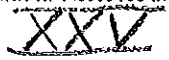
Plan Overview	In-Network Member Pays	Out-of-Network Member Pays
Deductible *Individual* *Family* *(copays are not applied to deductible)*	 $5,000 $10,000	 $10,000 $20,000
Out-of-Pocket Maximum *Individual* *Family*	 $6,600 $13,200	 $13,200 $26,400
Physician Office Visits		
Preventive Care/Screenings/Immunizations	$0	50% coinsurance
Primary Care (injury or illness)	$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% 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 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*	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**

*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.

59.6% AVC



5/24/2013

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Connecticut's Health Insurance Marketplace

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*	~~40% coinsurance*~~ $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	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)

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	~~$30 copay~~ $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

*After in-network deductible is met

**After out-of-network deductible is met

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59.6% AVC

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5/24/2013

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	Bronze

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

Tier 1 Plan Benefit Design	Medical	Drug	Combined
Deductible ($)			$5,000.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$6,600.00
OOP Maximum if Separate ($)			

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	☐	☐		$200.00
All Inpatient Hospital Services (inc. MHSA)	☑	☑	60%	
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 Services	☐	☐		$68.90
Imaging (CT/PET Scans, MRIs)	☑	☑	60%	
Rehabilitative Speech Therapy	☑	☑	60%	
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑	60%	
Preventive Care/Screening/Immunization	☐	☐	60%	$0.00
Laboratory Outpatient and Professional Services	☑	☑	60%	
X-rays and Diagnostic Imaging	☑	☑	60%	
Skilled Nursing Facility	☑	☑	60%	

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Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	60%	
Outpatient Surgery Physician/Surgical Services	☑	☑	60%	
Drugs	☐ All	☐ All		
Generics	☐	☐		$5.00
Preferred Brand Drugs	☑	☑	55%	
Non-Preferred Brand Drugs	☑	☑	50%	
Specialty Drugs (i.e. high-cost)	☑	☑	50%	

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):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	59.6%
Metal Tier:	Bronze

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Connecticut's Health Insurance Marketplace

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 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*	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**

*After in-network deductible is met

**After out-of-network deductible is met

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61.9% AVC

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4/28/2014

access health CT

Connecticut's Health Insurance Marketplace

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

*After in-network deductible is met

**After out-of-network deductible is met

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61.9% AVC

XXX

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	Bronze

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

Tier 1 Plan Benefit Design		
Medical	Drug	Combined
		$5,000.00
		60.00%
		$6,600.00

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate
Medical	☑ All	☑ All		
Emergency Room Services	☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☐		$40.00
Specialist Visit	☑	☐		$50.00
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑		
Rehabilitative Speech Therapy	☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑		
X-rays and Diagnostic Imaging	☑	☑		
Skilled Nursing Facility	☑	☑		

Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑		
Drugs	☑ All	☑ All		
Generics	☐	☐		$5.00
Preferred Brand Drugs	☑	☑	50%	
Non-Preferred Brand Drugs	☑	☑	50%	
Specialty Drugs (i.e. high-cost)	☑	☑	50%	

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):		
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☑	
# Copays (1-10):	4	

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.9%
Metal Tier:	Bronze

XXXX

access health CT
Connecticut's Health Insurance Marketplace

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 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 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**

*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

4/28/2014

access health CT

Connecticut's Health Insurance Marketplace

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)	$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	$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

*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

XXXIV

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	Bronze

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

Tier 1 Plan Benefit Design			
	Medical	Drug	Combined
Deductible ($)			$4,600.00
Coinsurance (%, Insurer's Cost Share)			100.00%
OOP Maximum ($)			$6,450.00
OOP Maximum if Separate ($)			

Click Here for Important Instructions

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

Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑		
Drugs	☑ All	☐ All		
Generics	☑	☐		$5.00
Preferred Brand Drugs	☑	☐		$35.00
Non-Preferred Brand Drugs	☑	☑	60%	
Specialty Drugs (i.e. high-cost)	☑	☑	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):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

XXXX

Output

Status/Error Messages:	Calculation Successful.
Actuarial Value:	61.4%
Metal Tier:	Bronze