Access Health CT
2019 Alternative Standard Silver Plan Design Exhibit
Individual Market

2019 - Ind Market Silver Coinsurance Plan, 70% AV

	2019 Individual Market Silver 70% Plan – Coinsurance Option	
	In-Network	Out-of-Network
Medical Deductible	$3,500 (2x family)	$7,400 (2x family)
Rx Deductible	$250 (2x family)	$500 (2x family)
Coinsurance	30%	40%
Out-of-pocket Maximum	$7,900 (2x family)	$15,800 (2x family)
Preventive	$0	40%
Primary Care	30%	40% (after ded.)
Specialist Care	30% (after ded.)	40% (after ded.)
Urgent Care	30% (after ded.)	40% (after ded.)
Emergency Room	30% (after ded.)	30% (after in-network ded.)
Ambulance	30% (after ded.)	30% (after in-network ded.)
Inpatient Hospital	30% (after ded.)	40% (after ded.)
Outpatient Hospital	30% (after ded.)	40% (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	30% (after ded.)	40% (after ded.)
Non-Advanced Radiology (X-ray, Diagnostic)	30% (after ded.)	40% (after ded.)
Laboratory Services	30% (after ded.)	40% (after ded.)
Mammography Ultrasound	30% (after ded.)	40% (after ded.)
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	30% (after ded.)	40% (after ded.)
Chiropractic Care 20 visit calendar maximum	30% (after ded.)	40% (after ded.)
Diabetic Supplies & Equipment	30% (after ded.)	40% (after ded.)
Durable Medical Equipment	30% (after ded.)	40% (after ded.)
Home Health Care Services (up to 100 visits per calendar year)	25% (after separate $50 ded.)	25% (after separate $50 ded.)

	2019 Individual Market Silver 70% Plan – Coinsurance Option	
	In-Network	Out-of-Network
Pediatric Dental Care: Preventive	0%	50% (after ded.)
Pediatric Dental Care: Basic Services	30% (after ded.)	50% (after ded.)
Pediatric Dental Care: Major Services	40% (after ded.)	50% (after ded.)
Pediatric Dental Care: Orthodontia	50% (after ded.)	50% (after ded.)
Pediatric Vision: Prescription Eye Glasses (one pair of frames & lenses per cal yr)	30% (after ded.)	Not Covered
Pediatric Vision: Routine Eye Exam by Specialist (one exam per calendar year)	30% (after ded.)	40% (after ded.)
All Other Medical	30%	40% (after ded.)
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 * / 30% / 30% / 30% (all but generic after Rx ded., $200 max per spec. script)	40% (after OON Rx ded.)
2018 AVC Results	**N/A**	
2019 AVC Results	**70.11% - 70.89%**	
Difference	N/A	

Pediatric Dental Care & Pediatric Vision for children under age 19

2019 - Ind Market Silver Coinsurance Plan, 73% AV

	2019 Individual Market Silver 73% Plan – Coinsurance Option	
	In-Network	Out-of-Network
Medical Deductible	$2,600 (2x family)	$7,400 (2x family)
Rx Deductible	$250 (2x family)	$500 (2x family)
Coinsurance	30%	40%
Out-of-pocket Maximum	$6,300 (2x family)	$15,800 (2x family)
Preventive	$0	40%
Primary Care	30%	40% (after ded.)
Specialist Care	30% (after ded.)	40% (after ded.)
Urgent Care	30% (after ded.)	40% (after ded.)
Emergency Room	30% (after ded.)	30% (after in-network ded.)
Ambulance	30% (after ded.)	30% (after in-network ded.)
Inpatient Hospital	30% (after ded.)	40% (after ded.)
Outpatient Hospital	30% (after ded.)	40% (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	30% (after ded.)	40% (after ded.)
Non-Advanced Radiology (X-ray, Diagnostic)	30% (after ded.)	40% (after ded.)
Laboratory Services	30% (after ded.)	40% (after ded.)
Mammography Ultrasound	30% (after ded.)	40% (after ded.)
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	30% (after ded.)	40% (after ded.)
Chiropractic Care 20 visit calendar maximum	30% (after ded.)	40% (after ded.)
Diabetic Supplies & Equipment	30% (after ded.)	40% (after ded.)
Durable Medical Equipment	30% (after ded.)	40% (after ded.)
Home Health Care Services (up to 100 visits per calendar year)	25% (after separate $50 ded.)	25% (after separate $50 ded.)

	2019 Individual Market Silver 73% Plan – Coinsurance Option	
	In-Network	Out-of-Network
Pediatric Dental Care: Preventive	0%	50% (after ded.)
Pediatric Dental Care: Basic Services	30% (after ded.)	50% (after ded.)
Pediatric Dental Care: Major Services	40% (after ded.)	50% (after ded.)
Pediatric Dental Care: Orthodontia	50% (after ded.)	50% (after ded.)
Pediatric Vision: Prescription Eye Glasses (one pair of frames & lenses per cal yr)	30% (after ded.)	Not Covered
Pediatric Vision: Routine Eye Exam by Specialist (one exam per calendar year)	30% (after ded.)	40% (after ded.)
All Other Medical	30%	40% (after ded.)
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 * / 30% / 30% / 30% (all but generic after Rx ded., $100 max per spec. script)	40% (after OON Rx ded.)
2018 AVC Results	**N/A**	
2019 AVC Results	**73.52%**	
Difference	N/A	

Pediatric Dental Care & Pediatric Vision for children under age 19

2019 - Ind Market Silver Coinsurance Plan, 87% AV

	2019 Individual Market Silver 87% Plan – Coinsurance Option	
	In-Network	Out-of-Network
Medical Deductible	$500 (2x family)	$7,400 (2x family)
Rx Deductible	$50 (2x family)	$500 (2x family)
Coinsurance	20%	40%
Out-of-pocket Maximum	$2,300 (2x family)	$15,800 (2x family)
Preventive	$0	40%
Primary Care	20%	40% (after ded.)
Specialist Care	20% (after ded.)	40% (after ded.)
Urgent Care	20% (after ded.)	40% (after ded.)
Emergency Room	20% (after ded.)	20% (after in-network ded.)
Ambulance	20% (after ded.)	20% (after in-network ded.)
Inpatient Hospital	20% (after ded.)	40% (after ded.)
Outpatient Hospital	20% (after ded.)	40% (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	20% (after ded.)	40% (after ded.)
Non-Advanced Radiology (X-ray, Diagnostic)	20% (after ded.)	40% (after ded.)
Laboratory Services	20% (after ded.)	40% (after ded.)
Mammography Ultrasound	20% (after ded.)	40% (after ded.)
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	20% (after ded.)	40% (after ded.)
Chiropractic Care 20 visit calendar maximum	20% (after ded.)	40% (after ded.)
Diabetic Supplies & Equipment	20% (after ded.)	40% (after ded.)
Durable Medical Equipment	20% (after ded.)	40% (after ded.)
Home Health Care Services (up to 100 visits per calendar year)	25% (after separate $50 ded.)	25% (after separate $50 ded.)

	2019 Individual Market Silver 87% Plan – Coinsurance Option	
	In-Network	Out-of-Network
Pediatric Dental Care: Preventive	0%	50% (after ded.)
Pediatric Dental Care: Basic Services	30% (after ded.)	50% (after ded.)
Pediatric Dental Care: Major Services	40% (after ded.)	50% (after ded.)
Pediatric Dental Care: Orthodontia	50% (after ded.)	50% (after ded.)
Pediatric Vision: Prescription Eye Glasses (one pair of frames & lenses per cal yr)	20% (after ded.)	Not Covered
Pediatric Vision: Routine Eye Exam by Specialist (one exam per calendar year)	20% (after ded.)	40% (after ded.)
All Other Medical	20%	40% (after ded.)
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 * / 20% / 20% / 20% (all but generic after Rx ded., $60 max per spec. script)	40% (after OON Rx ded.)
2018 AVC Results	**N/A**	
2019 AVC Results	**87.52%**	
Difference	N/A	

Pediatric Dental Care & Pediatric Vision for children under age 19

2019 - Ind Market Silver Coinsurance Plan, 94% AV

	2019 Individual Market Silver 94% Plan – Coinsurance Option	
	In-Network	Out-of-Network
Medical Deductible	$0	$7,400 (2x family)
Rx Deductible	$0	$500 (2x family)
Coinsurance	20%	40%
Out-of-pocket Maximum	$750 (2x family)	$15,800 (2x family)
Preventive	$0	40%
Primary Care	20%	40% (after ded.)
Specialist Care	20%	40% (after ded.)
Urgent Care	20%	40% (after ded.)
Emergency Room	20%	20%
Ambulance	20%	20%
Inpatient Hospital	20%	40% (after ded.)
Outpatient Hospital	20%	40% (after ded.)
Advanced Radiology (CT/PET Scan, MRI)	20%	40% (after ded.)
Non-Advanced Radiology (X-ray, Diagnostic)	20%	40% (after ded.)
Laboratory Services	20%	40% (after ded.)
Mammography Ultrasound	20%	40% (after ded.)
Rehabilitative & Habilitative Therapy (Physical, Speech, Occupational) Combined 40 visit calendar year maximum, separate for each type	20%	40% (after ded.)
Chiropractic Care 20 visit calendar maximum	20%	40% (after ded.)
Diabetic Supplies & Equipment	20%	40% (after ded.)
Durable Medical Equipment	20%	40% (after ded.)
Home Health Care Services (up to 100 visits per calendar year)	25% (after separate $50 ded.)	25% (after separate $50 ded.)

	2019 Individual Market Silver 94% Plan – Coinsurance Option	
	In-Network	Out-of-Network
Pediatric Dental Care: Preventive	0%	50% (after ded.)
Pediatric Dental Care: Basic Services	30% (after ded.)	50% (after ded.)
Pediatric Dental Care: Major Services	40% (after ded.)	50% (after ded.)
Pediatric Dental Care: Orthodontia	50% (after ded.)	50% (after ded.)
Pediatric Vision: Prescription Eye Glasses (one pair of frames & lenses per cal yr)	20%	Not Covered
Pediatric Vision: Routine Eye Exam by Specialist (one exam per calendar year)	20%	40% (after ded.)
All Other Medical	20%	40% (after ded.)
Generic / Preferred Brand / Non-Preferred Brand / Specialty Rx	$5 * / 20% / 20% / 20% ($60 max per spec. script)	40% (after OON Rx ded.)
2018 AVC Results	**N/A**	
2019 AVC Results	**94.76%**	
Difference	N/A	

Pediatric Dental Care & Pediatric Vision for children under age 19