Reference Materials January 2020



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HPBQ AC Meeting Date	Exhibit Title	Exhibit Number	Tab*
1/29/2020	AHCT 2020 Standardized Plan - Gold	1.0	А
1/29/2020	AHCT 2020 Standardized Plan – Silver 70% AV	1.1	А
1/29/2020	AHCT 2020 Standardized Plan - Silver 73% AV	1.2	А
1/29/2020	AHCT 2020 Standardized Plan - Silver 87% AV	1.3	А
1/29/2020	AHCT 2020 Standardized Plan - Silver 94% AV	1.4	А
1/29/2020	AHCT 2020 Standardized Plan - Bronze	1.5	А
1/29/2020	AHCT 2020 Standardized Plan – Bronze HSA-Compatible	1.6	А
1/29/2020	Issuer Participation - 2020	2.0	В
1/29/2020	Affordable Care Act - Health Plan Types	3.0	В
1/29/2020	Plan Design Development: AVC Benefit Cost Sharing Categories	4.0	В
1/29/2020	Plan Management Certification Life Cycle	5.0	В
1/29/2020	2020 Plan Mix: Number of Plans Required / Permitted per Issuer	6.0	В
1/29/2020	Summary: 2020 Plan Year Actuarial Value Changes	7.0	В
1/29/2020	Copay Maximums – State Regulation: Imaging Services	8.0	В
1/29/2020	Copay Maximums – State Regulation: Physical Therapy & Occupational Therapy Services	9.0	В
1/29/2020	Deductible and Coinsurance Maximums – Home Health Care Services	10.0	В

*Tabs C through F are reserved for future use (as needed)



Yellow shading represents change from 2019 Plan Year	2020 Standard Go	ld
Plan Overview	In-Network (INET) Member Pays	- Out-of-Network (OON) Member Pays
Deductible: Individual (medical) Deductible: Family (medical)	\$1,300	\$3,000
Deductible: Family (medical) Deductible: Individual (prescription)	\$2,600 \$50	\$6,000 \$350
Deductible: Family (prescription)	\$30	\$350
Out-of-Pocket Maximum: Individual	\$5,250	\$10,500
Out-of-Pocket Maximum: Family	\$10,500	\$21,000
	Provider Office Visits	
Preventive Visit (Adult/Child) Provider Office Visits (Primary Care, Mental & Behavioral	\$0 \$20 copayment per visit	30% coinsurance 30% coinsurance per visit after OON medical
Health, Substance Abuse) Specialist Office Visits	\$40 copayment per visit	deductible 30% coinsurance per visit after OON medical
Specialist Office Visits	Outpatient Diagnostic Services	deductible
Advanced Radiology (CT/PET Scan, MRI)	\$65 copayment per service up to a combined annual maximum of \$375 for MRI and CAT scans; \$400 for PET scans	30% coinsurance per service after OON medica deductible
Laboratory Services	\$10 copayment per service after INET medical deductible	30% coinsurance per service after OON medic deductible
Non-Advanced Radiology (X-ray, Diagnostic)	\$40 copayment per service after INET medical deductible	30% coinsurance per service after OON medica deductible
Mammography Ultrasound	\$20 copayment per service	30% coinsurance per service after OON medica deductible
Prescript	ion Drugs - Retail Pharmacy (up to 30 day supply per prescription)	
Tier 1	\$5 copayment per prescription	30% coinsurance per prescription after OON
1161 ±	25 copayment per prescription	prescription drug deductible
Tier 2	\$35 copayment per prescription	30% coinsurance per prescription after OON prescription drug deductible
Tier 3	\$60 copayment per prescription	30% coinsurance per prescription after OON prescription drug deductible
Tier 4	20% coinsurance up to a maximum of \$100 per prescription after INET prescription drug deductible	30% coinsurance per prescription after OON prescription drug deductible
	Outpatient Rehabilitative and Habilitative Services	
Speech Therapy (40 visits per calendar year limit combined for PT/ST/OT)	\$20 copayment per visit	30% coinsurance per visit after OON medical deductible
Physical and Occupational Therapy (40 visits per calendar year limit combined for PT/ST/OT)	\$20 copayment per visit	30% coinsurance per visit after OON medical deductible
	Other Services	
Chiropractic Services (up to 20 visits per calendar year)	\$40 copayment per visit	30% coinsurance per visit after OON medical deductible
Diabetic Supplies & Equipment	30% coinsurance per equipment/supply	30% coinsurance per equipment / supply afte OON medical deductible
Durable Medical Equipment	30% coinsurance per equipment/supply	30% coinsurance per equipment / supply afte OON medical deductible
Prosthetic Devices	20% coinsurance per equipment/supply	30% coinsurance per equipment / supply afte OON medical deductible
Home Health Care Services	\$0 copay	25% coinsurance per visit after separate \$50
(up to 100 visits per calendar year)	\$500 copayment after INET plan deductible (Outpatient Hospital	deductible
Outpatient Services (in a hospital or ambulatory facility)	Facility); \$300 copayment after INET plan deductible (Ambulatory Surgery	30% coinsurance per visit after OON medical deductible
	Center) Hospital Services	
Inpatient Hospital Services (including MH, SA, maternity,		
hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per calendar year)	\$500 copayment per day to a maximum of \$1,000 per admission after INET plan deductible	30% coinsurance per admission after OON medical deductible
culentur yeurj	Emergency and Urgent Care	<u> </u>
Ambulance Services	\$0 copay	\$0 copay
Emergency Room	\$400 copayment per visit	\$400 copayment per visit
Urgent Care Center or Facility	\$50 copayment per visit	30% coinsurance per visit after OON medical
- •	Pediatric Dental Care (for children under age 19)	deductible
	· · · ·	50% coinsurance per visit after OON medical
Diagnostic & Preventive	\$0 copay	deductible 50% coinsurance per visit after OON medical
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Basic Services	20% coinsurance per visit	deductible
Major Services	20% coinsurance per visit 40% coinsurance per visit	50% coinsurance per visit after OON medical deductible
	40% coinsurance per visit 50% coinsurance per visit	50% coinsurance per visit after OON medical
Major Services Orthodontia Services	40% coinsurance per visit	50% coinsurance per visit after OON medical deductible 50% coinsurance per visit after OON medical
Major Services Orthodontia Services	40% coinsurance per visit 50% coinsurance per visit	50% coinsurance per visit after OON medical deductible 50% coinsurance per visit after OON medical

Yellow shading represents change from 2019 Plan Year	2020 Standard Silver - 70% AV			
Plan Overview Deductible: Individual (medical)	In-Network (INET) Member Pays \$4,300	Out-of-Network (OON) Member Pays \$8,600		
Deductible: Family (medical)	\$4,500	\$8,600		
Deductible: Individual (prescription)	\$250	\$17,200		
Deductible: Family (prescription)	\$500	\$1,000		
Out-of-Pocket Maximum: Individual	\$8,150	\$16,300		
Out-of-Pocket Maximum: Family	\$16,300	\$32,600		
	Provider Office Visits			
Preventive Visit (Adult/Child) Provider Office Visits (Primary Care, Mental & Behavioral	\$0 \$40 copayment per visit	40% coinsurance 40% coinsurance per visit after OON medical		
Health, Substance Abuse)		deductible 40% coinsurance per visit after OON medical		
Specialist Office Visits	\$60 copayment per visit Outpatient Diagnostic Services	deductible		
Advanced Radiology (CT/PET Scan, MRI)	\$75 copayment per service up to a combined annual maximum of \$375 for MRI and CAT scans; \$400 for PET scans	40% coinsurance per service after OON medical deductible		
Laboratory Services	\$10 copayment per service after INET deductible	40% coinsurance per service after OON medical deductible		
Non-Advanced Radiology (X-ray, Diagnostic)	\$40 copayment per service after INET deductible	40% coinsurance per service after OON medical deductible		
Mammography Ultrasound	\$20 copayment per service	40% coinsurance per service after OON medical deductible		
Prescripti	on Drugs - Retail Pharmacy (up to 30 day supply per prescription)	400/		
Tier 1	\$10 copayment per prescription	40% coinsurance per prescription after OON prescription drug deductible		
Tier 2	\$45 copayment per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible		
Tier 3	\$70 copayment per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible		
Tier 4	20% coinsurance up to a maximum of \$200 per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible		
	Outpatient Rehabilitative and Habilitative Services			
Speech Therapy (40 visits per calendar year limit combined for PT/ST/OT)	\$30 copayment per visit	40% coinsurance per visit after OON medical deductible		
Physical and Occupational Therapy (40 visits per calendar year limit combined for PT/ST/OT)	\$30 copayment per visit	40% coinsurance per visit after OON medical deductible		
	Other Services			
Chiropractic Services (up to 20 visits per calendar year)	\$50 copayment per visit	40% coinsurance per visit after OON medical deductible		
Diabetic Supplies & Equipment	40% coinsurance per equipment / supply	40% coinsurance per equipment / supply after OON medical deductible		
Durable Medical Equipment	40% coinsurance per equipment / supply	40% coinsurance per equipment / supply after OON medical deductible		
Prosthetic Devices	20% coinsurance per equipment/supply	40% coinsurance per equipment / supply after OON medical deductible		
Home Health Care Services	\$0 copay	25% coinsurance per visit after separate \$50		
(up to 100 visits per calendar year)	\$500 copayment after INET plan deductible (Outpatient Hospital	deductible		
Outpatient Services (in a hospital or ambulatory facility)	Facility); \$300 copayment after INET plan deductible (Ambulatory Surgery Center)	40% coinsurance per visit after OON medical deductible		
	Hospital Services	I		
Inpatient Hospital Services (including MH, SA, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per	\$500 copayment per day to a maximum of \$2,000 per admission after INET plan deductible	40% coinsurance per visit after OON medical deductible		
calendar year)	Emergency and Urgent Care	<u> </u>		
Ambulance Services	\$0 copay	\$0 copay		
Emergency Room	\$450 copayment per visit after INET medical deductible	\$450 copayment per visit after INET medical deductible		
Urgent Care Center or Facility	\$75 copayment per visit	40% coinsurance per visit after OON medical deductible		
	Pediatric Dental Care (for children under age 19)			
Diagnostic & Preventive	\$0 copay	50% coinsurance per visit after OON medical deductible		
Basic Services	40% coinsurance per visit	50% coinsurance per visit after OON medical deductible		
Major Services	50% coinsurance per visit	50% coinsurance per visit after OON medical deductible		
Orthodontia Services (medically necessary only)	50% coinsurance per visit	50% coinsurance per visit after OON medical deductible		
Prescription Eye Glasses (one pair of frames & lenses per calendar year)	Pediatric Vision Care (for children under age 19) \$0 copay for Lenses; \$0 copay for Collection frame; Substantially equal credit for non-collection frame selection	Not Covered		
Routine Eye Exam by Specialist (one exam per calendar year)	\$60 copayment per visit	40% coinsurance per visit after OON medical deductible		

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deductible	Routine Eye Exam by Specialist (one exam per calendar year)	\$60 copayment per visit		

Yellow shading represents change from 2019 Plan Year	2020 Standard Silver	87%
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible: Individual (medical)	\$650	\$8,600
Deductible: Family (medical)	\$1,300	\$17,200
Deductible: Individual (prescription)	\$50	\$500
Deductible: Family (prescription) Out-of-Pocket Maximum: Individual	\$100 \$2,500	\$1,000 \$16,300
Out-of-Pocket Maximum: Handlud	\$2,300	\$10,500
	Provider Office Visits	+/
Preventive Visit (Adult/Child)	\$0	40% coinsurance
Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse)	\$20 copayment per visit	40% coinsurance per visit after OON medical deductible
Specialist Office Visits	\$45 copayment per visit	40% coinsurance per visit after OON medical deductible
	Outpatient Diagnostic Services	deadensie
Advanced Radiology (CT/PET Scan, MRI)	\$60 copayment per service up to a combined annual maximum of \$360 for MRI and CAT scans; \$400 for PET scans	40% coinsurance per service after OON medical deductible
Laboratory Services	\$10 copayment per service after INET deductible	40% coinsurance per service after OON medical deductible
Non-Advanced Radiology (X-ray, Diagnostic)	\$30 copayment per service after INET deductible	40% coinsurance per service after OON medical deductible
Mammography Ultrasound	\$20 copayment per service	40% coinsurance per service after OON medical
Prescrint	ion Drugs - Retail Pharmacy (up to 30 day supply per prescription)	deductible
Tier 1	\$10 copayment per prescription	40% coinsurance per prescription after OON
Tier 2	\$25 copayment per prescription	prescription drug deductible 40% coinsurance per prescription after OON
	\$40 copayment per prescription after INET prescription drug	prescription drug deductible 40% coinsurance per prescription after OON
Tier 3	deductible	prescription drug deductible
Tier 4	20% coinsurance up to a maximum of \$60 per prescription after INET prescription drug deductible	40% coinsurance per prescription after OON prescription drug deductible
	Outpatient Rehabilitative and Habilitative Services	
Speech Therapy (40 visits per calendar year limit combined for PT/ST/OT)	\$20 copayment per visit	40% coinsurance per visit after OON medical deductible
Physical and Occupational Therapy (40 visits per calendar year limit combined for PT/ST/OT)	\$20 copayment per visit	40% coinsurance per visit after OON medical deductible
	Other Services	
Chiropractic Services (up to 20 visits per calendar year)	\$35 copayment per visit	40% coinsurance per visit after OON medical deductible
Diabetic Supplies & Equipment	40% coinsurance per equipment / supply	40% coinsurance per equipment / supply after OON medical deductible
Durable Medical Equipment	40% coinsurance per equipment / supply	40% coinsurance per equipment / supply after OON medical deductible
Prosthetic Devices	20% coinsurance per equipment/supply	40% coinsurance per equipment / supply after OON medical deductible
Home Health Care Services (up to 100 visits per calendar year)	\$0 copay	25% coinsurance per visit after separate \$50 deductible
	\$100 copayment after INET plan deductible (Outpatient Hospital	
Outpatient Services (in a hospital or ambulatory facility)	Facility); \$60 copayment after INET plan deductible (Ambulatory Surgery Center)	40% coinsurance per visit after OON medical deductible
	Hospital Services	
Inpatient Hospital Services (including MH, SA, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per calendar year)	\$100 copayment per day to a maximum of \$400 per admission after INET plan deductible	40% coinsurance per visit after OON medical deductible
	Emergency and Urgent Care	
Ambulance Services	\$0 copay	\$0 copay
Emergency Room	\$150 copayment per visit after INET medical deductible	\$150 copayment per visit after INET medical deductible
Urgent Care Center or Facility	\$35 copayment per visit	40% coinsurance per visit after OON medical deductible
	Pediatric Dental Care (for children under age 19)	
Diagnostic & Preventive	\$0 copay	50% coinsurance per visit after OON medical deductible
Basic Services	40% coinsurance per visit	50% coinsurance per visit after OON medical deductible
Major Services	50% coinsurance per visit	50% coinsurance per visit after OON medical deductible
Orthodontia Services (medically necessary only)	50% coinsurance per visit	50% coinsurance per visit after OON medical deductible
	Pediatric Vision Care (for children under age 19)	
Prescription Eye Glasses (one pair of frames & lenses per calendar year)	\$0 copay for Lenses; \$0 copay for Collection frame; Substantially equal credit for non-collection frame selection	Not Covered
Routine Eye Exam by Specialist (one exam per calendar year)	\$45 copayment per visit	40% coinsurance per visit after OON medical
	¢ is sopayment per visit	deductible

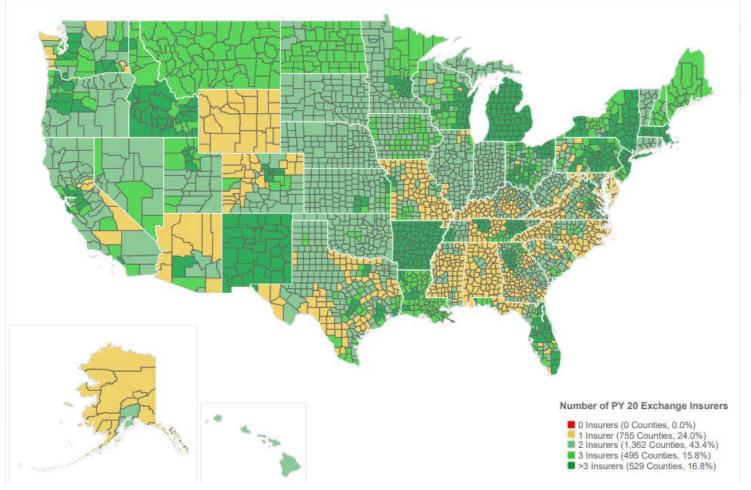
Yellow shading represents change from 2019 Plan Year	2020 Standard Silver	
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible: Individual (medical) Deductible: Family (medical)	\$0 \$0	\$8,600 \$17,200
Deductible: Family (medical) Deductible: Individual (prescription)	\$0	\$17,200
Deductible: Family (prescription)	\$0	\$1,000
Out-of-Pocket Maximum: Individual	\$900	\$16,300
Out-of-Pocket Maximum: Family	\$1,800	\$32,600
	Provider Office Visits	
Preventive Visit (Adult/Child)	\$0	40% coinsurance
Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse)	\$10 copayment per visit	40% coinsurance per visit after OON medical deductible
Specialist Office Visits	\$30 copayment per visit	40% coinsurance per visit after OON medical deductible
	Outpatient Diagnostic Services	
Advanced Radiology (CT/PET Scan, MRI)	\$50 copayment per service up to a combined annual maximum of \$350 for MRI and CAT scans; \$400 for PET scans	40% coinsurance per service after OON medical deductible
Laboratory Services	\$10 copayment per service	40% coinsurance per service after OON medical deductible
Non-Advanced Radiology (X-ray, Diagnostic)	\$25 copayment per service	40% coinsurance per service after OON medical deductible
Mammography Ultrasound	\$20 copayment per service	40% coinsurance per service after OON medical deductible
Prescript	ion Drugs - Retail Pharmacy (up to 30 day supply per prescription)	20230000
Tier 1	\$5 copayment per prescription	40% coinsurance per prescription after OON prescription drug deductible
Tier 2	\$10 copayment per prescription	40% coinsurance per prescription after OON prescription drug deductible
Tier 3	\$30 copayment per prescription	40% coinsurance per prescription after OON prescription drug deductible
Tier 4	20% coinsurance up to a maximum of \$60 per prescription	40% coinsurance per prescription after OON prescription drug deductible
	Outpatient Rehabilitative and Habilitative Services	
Speech Therapy (40 visits per calendar year limit combined for PT/ST/OT)	\$20 copayment per visit	40% coinsurance per visit after OON medical deductible
Physical and Occupational Therapy (40 visits per calendar year limit combined for PT/ST/OT)	\$20 copayment per visit	40% coinsurance per visit after OON medical deductible
	Other Services	
Chiropractic Services (up to 20 visits per calendar year)	\$30 copayment per visit	40% coinsurance per visit after OON medical deductible
Diabetic Supplies & Equipment	40% coinsurance per equipment / supply	40% coinsurance per equipment / supply after OON medical deductible
Durable Medical Equipment	40% coinsurance per equipment / supply	40% coinsurance per equipment / supply after OOM medical deductible
Prosthetic Devices	20% coinsurance per equipment/supply	40% coinsurance per equipment / supply after OOM medical deductible
Home Health Care Services (up to 100 visits per calendar year)	\$0 copay	25% coinsurance per visit after separate \$50 deductible
Outpatient Services (in a hospital or ambulatory facility)	\$75 copayment (Outpatient Hospital Facility); \$45 copayment (Ambulatory Surgery Center)	40% coinsurance per visit after OON medical deductible
	Hospital Services	
Inpatient Hospital Services (including MH, SA, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per calendar year)	\$75 copayment per day to a maximum of \$300 per admission	40% coinsurance per visit after OON medical deductible
· ·	Emergency and Urgent Care	
Ambulance Services	\$0 copay	\$0 copay
Emergency Room	\$50 copayment per visit	\$50 copayment per visit
Urgent Care Center or Facility	\$25 copayment per visit	40% coinsurance per visit after OON medical deductible
	Pediatric Dental Care (for children under age 19)	I
Diagnostic & Preventive	\$0 сорау	50% coinsurance per visit after OON medical deductible
Basic Services	40% coinsurance per visit	50% coinsurance per visit after OON medical deductible
Major Services	50% coinsurance per visit	50% coinsurance per visit after OON medical deductible
Orthodontia Services (medically necessary only)	50% coinsurance per visit	50% coinsurance per visit after OON medical deductible
	Pediatric Vision Care (for children under age 19)	
Prescription Eye Glasses (one pair of frames & lenses per calendar year)	\$0 copay for Lenses; \$0 copay for Collection frame; Substantially equal credit for non-collection frame selection	Not Covered
		40% coinsurance per visit after OON medical

Yellow shading represents change from 2019 Plan Year	2020 Standard Bronze (Non-HSA)						
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays					
Deductible: Individual (medical & Rx)	\$6,200	\$12,400					
Deductible: Family (medical & Rx) Out-of-Pocket Maximum: Individual	\$12,400 \$8,150	\$24,800 \$16,300					
Out-of-Pocket Maximum: Family	\$16,300	\$32,600					
Provider Office Visits							
Preventive Visit (Adult/Child)	\$0	50% coinsurance					
Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse)	\$40 copayment per visit	50% coinsurance per visit after OON deductible					
Specialist Office Visits	\$60 copayment per visit after INET deductible Outpatient Diagnostic Services	50% coinsurance per visit after OON deductible					
Advanced Radiology (CT/PET Scan, MRI)	\$75 copay per service after INET deductible up to a combined annual maximum of \$375 for MRI and CT scans; \$400 for PET scans	50% coinsurance per service after OON deductible					
Laboratory Services	\$10 copayment per service after INET deductible	50% coinsurance per service after OON deductible					
Non-Advanced Radiology (X-ray, Diagnostic)	\$40 copayment per service after INET deductible	50% coinsurance per service after OON deductible					
Mammography Ultrasound	\$20 copayment per service after INET deductible	50% coinsurance per service after OON deductible					
Prescripti	on Drugs - Retail Pharmacy (up to 30 day supply per prescription)						
Tier 1	\$10 copayment per prescription	50% coinsurance per prescription after OON deductible					
Tier 2	50% coinsurance per prescription after INET deductible	50% coinsurance per prescription after OON deductible					
Tier 3	50% coinsurance per prescription after INET deductible	50% coinsurance per prescription after OON deductible					
Tier 4	50% coinsurance up to a maximum of \$500 per prescription after	50% coinsurance per prescription after OON					
	INET deductible Outpatient Rehabilitative and Habilitative Services	deductible					
Speech Therapy	\$30 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible					
(40 visits per calendar year limit combined for PT/ST/OT) Physical and Occupational Therapy	\$30 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible					
(40 visits per calendar year limit combined for PT/ST/OT)	50% consurance per visit arter OON deductible						
Chiropractic Services	Other Services						
(up to 20 visits per calendar year)	\$50 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible					
Diabetic Supplies & Equipment	40% coinsurance per equipment/supply after INET deductible	50% coinsurance per equipment / supply after OON deductible					
Durable Medical Equipment	40% coinsurance per equipment/supply after INET deductible	50% coinsurance per equipment / supply after OON deductible					
Prosthetic Devices	20% coinsurance per equipment/supply	50% coinsurance per equipment / supply after OON medical deductible					
Home Health Care Services (up to 100 visits per calendar year)	25% coinsurance per visit after separate \$50 deductible	25% coinsurance per visit after separate \$50 deductible					
	\$500 copayment after INET plan deductible (Outpatient Hospital						
Outpatient Services (in a hospital or ambulatory facility)	Facility); \$300 copayment after INET plan deductible (Ambulatory Surgery	50% coinsurance per visit after OON deductible					
	Center)						
	Hospital Services	1					
Inpatient Hospital Services (including MH, SA, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per	\$500 copayment per day to a maximum of \$1,000 per admission after INET deductible	50% coinsurance per admission after OON deductible					
calendar year)	Emergency and Urgent Care						
Ambulance Services	\$0 copay after INET deductible	\$0 copay after INET deductible					
Emergency Room	\$450 copayment per visit after INET deductible	\$450 copayment per visit after INET deductible					
Urgent Care Center or Facility	\$75 copayment per visit	50% coinsurance per visit after OON deductible					
	EON coincurance permitti after CON de trutt						
Diagnostic & Preventive	\$0 copay	50% coinsurance per visit after OON deductible					
Basic Services	45% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible					
Major Services	50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible					
Orthodontia Services (medically necessary only)	50% coinsurance per visit after INET deductible	50% coinsurance per visit after OON deductible					
Prescription Eye Glasses (one pair of frames & lenses per calendar year)	Pediatric Vision Care (for children under age 19) \$0 copay for Lenses; \$0 copay for Collection frame; Substantially equal credit for non-collection frame selection	Not Covered					
Routine Eye Exam by Specialist (one exam per calendar year)	\$60 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible					

	2020 Standard Bronze HS	A
Plan Overview	In-Network (INET) Member Pays	Out-of-Network (OON) Member Pays
Deductible: Individual (medical & Rx)	\$5,685	\$9,200
Deductible: Family (medical & Rx)	\$11,370	\$18,400
Out-of-Pocket Maximum: Individual Out-of-Pocket Maximum: Family	\$6,550 \$13,100	\$12,900 \$25,800
	Provider Office Visits	\$25,600
Preventive Visit (Adult/Child)	\$0	50% coinsurance
Provider Office Visits (Primary Care, Mental & Behavioral	10% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON
Health, Substance Abuse)	10% consurance per visit after fixer plan deductible is met	deductible
Specialist Office Visits	10% coinsurance per visit after INET plan deductible is met Outpatient Diagnostic Services	50% coinsurance per visit after OON
Advanced Radiology (CT/PET Scan, MRI)	10% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON
Laboratory Services	10% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON
Non-Advanced Radiology (X-ray, Diagnostic) Mammography Ultrasound	10% coinsurance per service after INET plan deductible is met 10% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON 50% coinsurance per service after OON
	tion Drugs - Retail Pharmacy (up to 30 day supply per prescription)	50% consulance per service after OON
Tier 1	10% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Tier 2	15% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Tier 3	25% coinsurance per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Tier 4	30% coinsurance up to a maximum of \$500 per prescription after INET plan deductible is met	50% coinsurance per prescription after OON plan deductible is met
Speech Therapy (40 visits per calendar year limit combined	Outpatient Rehabilitative and Habilitative Services 10% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan
for PT/ST/OT) Physical and Occupational Therapy (40 visits per calendar	10% coinsurance per visit after INET plan deductible is met	deductible is met 50% coinsurance per visit after OON plan
year limit combined for PT/ST/OT)	Other Services	deductible is met
Chiropractic Services (up to 20 visits per calendar year)	10% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Diabetic Supplies & Equipment	10% coinsurance per equipment/supply after INET plan deductible is met	50% coinsurance per equipment/supply after OON plan deductible is met
Durable Medical Equipment	10% coinsurance per equipment/supply after INET plan deductible is met	50% coinsurance per equipment/supply afte OON plan deductible is met
Prosthetic Devices	10% coinsurance per equipment/supply	50% coinsurance per equipment / supply after OON medical deductible
Home Health Care Services (up to 100 visits per calendar year)	10% coinsurance per visit after INET plan deductible is met	25% coinsurance per visit after OON plan deductible is met
Outpatient Services (in a hospital or ambulatory facility)	10% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
	Hospital Services	
Inpatient Hospital Services (including MH, SA, maternity, hospice and skilled nursing facility*) *(skilled nursing facility stay is limited to 90 days per calendar year)	10% coinsurance per admission after INET plan deductible is met	50% coinsurance per admission after OON plan deductible is met
· ·	Emergency and Urgent Care	
Ambulance Services	10% coinsurance per service after INET plan deductible is met	10% coinsurance per service after INET plan
Emergency Room	10% coinsurance per service after INET plan deductible is met	deductible is met 10% coinsurance per service after INET plan
Urgent Care Center or Facility	10% coinsurance per service after INET plan deductible is met	deductible is met 50% coinsurance per visit after OON plan
orgent care center of racinty		deductible is met
Diagnostic & Preventive	Pediatric Dental Care (for children under age 19) \$0 copay	50% coinsurance per visit after OON plan
Basic Services	40% coinsurance per visit after INET plan deductible is met	deductible is met 50% coinsurance per visit after OON plan deductible is met
Major Services	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Orthodontia Services	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
(medically necessary only)	Pediatric Vision Care (for children under age 19)	
Prescription Eye Glasses (one pair of frames & lenses per calendar year)	Lenses: \$0 copayment after INET plan deductible is met; Collection frame: \$0 copayment after INET plan deductible is met; Non-collection frame: members choosing to upgrade from a collection frame to a non- collection frame will be given a credit substantially equal to the cost of the collection frame and will be entitled to any discount negotiated by the carrier with the retailer.	Not Covered
Routine Eye Exam by Specialist (one exam per calendar year)	10% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met

Issuer Participation - 2020

County by County Plan Year 2020 Insurer Participation in Health Insurance Exchanges



-Federally-facilitated Exchange (FFE) data reflected on this map is point in time as of 09/27/2019. -State-based Exchange (SBE) data is self-reported from the Exchanges to CMS (CA, CO, CT, DC, ID, MA, MD, MN, NY, NV, RI, VT, WA) and is point in time as of 10/21/2019.

Data source: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Final-2020-County-Coverage-Map.pdf

Tab B: EXHIBIT 2.0

Number of PY 20 Exchange Insurers





Affordable Care Act - Health Plan Types

Tab B: EXHIBIT 3.0

• 90%* • 80%* Gold Platinum Silver Bronze • 70%* • 60%*

Metal Levels: Actuarial Value & Average Overall Cost of Providing Essential Health Benefits (EHBs)

*CMS regulations allow for a 'de minimis' range for the Actuarial Value (AV) calculation for each metal level, and for Silver Cost Sharing Reduction plans

Per regulations effective for the 2018 Plan Year, 'de minimis' AV ranges are as follows:

- Platinum: 86% 92%
- Gold: 76% 82%
- Silver: 66% 72%**
- Bronze: 56% 62% (AV range permitted for 'Expanded Bronze' plans is up to 65%; plan must include at least 1 major service not subject to deductible or is a High Deductible Health Plan)
- **Silver Cost Sharing Reduction (CSR) Plans:
- 73% CSR: 72% 74%, but must be at least 2 points greater than 'standard' Silver plan
- 87% CSR: 86% 88%
- 94% CSR: 93% 95%

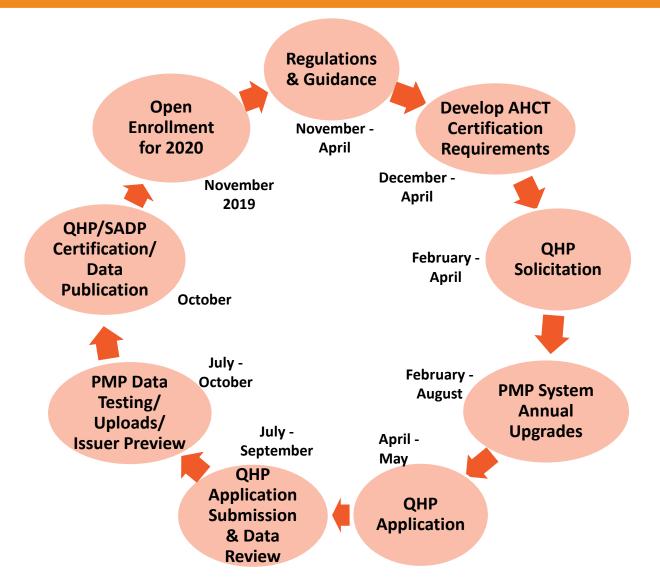


Plan Design Development: AVC Benefit Cost Sharing Categories

Tab B: EXHIBIT 4.0

Astronial Malue Calendates (AMC) Investo	Description Description
Actuarial Value Calculator (AVC) Inputs	Prescription Drug Benefits
Integrated Medical and Drug Deductible? (Yes or No)	Subject to Deductible (Yes or No)
Apply Inpatient Copay per Day? (Yes or No)	Subject to Coinsurance (Yes or No)
Apply Skilled Nursing Facility Copay per Day? (Yes or No)	Coinsurance (Insurer's Cost Share) or Copay Values (Member Cost Share)
Use Separate OOP Maximum for Medical and Drug Spending? (Yes or No)	Generics
Deductible (\$) for Medical, Drug or Combined	Preferred Brand Drugs
Coinsurance (%, Insurer's Cost Share)	Non-Preferred Brand Drugs
Maximum Out-of-Pocket (MOOP)	Specialty Drugs (i.e. high-cost)
MOOP if Separate (\$)	Options for Additional Benefit Design Limits:
Medical Benefits:	Set a Maximum on Specialty Rx Coinsurance Payments? (Yes or No)
Subject to Deductible (Yes or No)	If yes, value:
Subject to Coinsurance (Yes or No)	Set a Maximum Number of Days for Charging an IP Copay? (Yes or No)
Coinsurance (Insurer's Cost Share) or Copay Values (Member Cost Share)	If yes, value from 1-10:
Emergency Room Services	
All Inpatient Hospital Services (inc. MHSU)	Begin Primary Care Cost-Sharing After a Set Number of Visits? (Yes or No)
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	If yes, value from 1-10:
Specialist Visit	Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? (Yes or No)
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	If yes, value from 1-10:
Imaging (CT/PET Scans, MRIs)	Other Elements for Consideration Not Included as a Separate Field in AVC
Speech Therapy	Out-of-Network Deductible and Cost Sharing
Occupational and Physical Therapy	Chiropractic Services
Preventive Care/Screening/Immunization	Diabetic Equipment and Supplies
Laboratory Outpatient and Professional Services	Durable Medical Equipment
X-rays and Diagnostic Imaging	Home Health Care
Skilled Nursing Facility	Mammography Ultrasound
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	Urgent Care
Outpatient Surgery Physician/Surgical Services	Pediatric Services, including vision (exam & hardware) and dental

Plan Management Certification Life Cycle Tab B: EXHIBIT 5.0



Each plan year, the cycle begins with the release of regulations and guidance, including the Actuarial Value Calculator (AVC) tool used to develop standardized plans, and ends once Open Enrollment commences

Note: timeframes subject to change



2020 Plan Mix: Number of Plans Required / Permitted per Issuer

INDIVIDUAL MARKET SHOP Non-Standard Plans Metal Level **Standardized Plans** Total N/A 2 4 (Optional) Platinum 3 Gold Min 1 - Max 61 Silver 1 0 Min 2 - Max 62 3 Bronze Min 2 - Max 4Catastrophic N/A 1 N/A 5 Required / 4 Required 9 Optional TOTAL **15 Optional** 13 Maximum 20

access health CT

Summary: 2020 Plan Year Actuarial Value Changes*

Tab B: EXHIBIT 7.0

Initial Actuarial Value Assessment of AHCT Standardized Plans Using Draft 2020 AV Calculator Released by CMS in January 2019

Individual Market	Gold	Silver Copay	Silver Coinsurance	Bronze	Bronze HSA
Permissible AV Range	76.0%-82.0%	66.0%-72.0%	66.0%-72.0%	56.0%-65.0% ¹	56.0%-65.0% ¹
2019 AV Range	80.% to 82.0%	70.1% to 71.9%	70.1% to 70.4%	64.0% to 64.6%	62.5%
2020 AV Range	82.2% to 82.8%	71.8% to 73.1%	70.8% to 71.4%	65.4% to 66.0%	63.7%

¹ Bronze plan designs are eligible for new expanded "de minimis" range

Individual Market - CSR Plan Variations: Silver Copay	73% AV CSR	87% AV CSR	94% AV CSR	Individual Market - CSR Plan Variations: Silver Coinsurance	73% AV CSR	87% AV CSR	94% AV CSR
Permissible AV Range	72.0%-74.0% ²	86.0%-88.0%	93.0%-95.0%	Permissible AV Range	72.0%-74.0% ²	86.0%-88.0%	93.0%-95.0%
2019 AV Range	72.3% to 73.9%	86.9% to 87.9%	93.9% to 94.7%	2019 AV Range	73.3% to 73.5%	87.3% to 87.5%	94.76%
2020 AV Range	73.8% to 75.1%	88.1% to 88.6%	94.9% to 95.0%	2020 AV Range	73.8% to 74.5%	87.9% to 88.03%	95.01%

² 73.0% CSR Silver must be have a differential of 2.0%+ with Standard Silver

*Information extracted from Wakely Consulting presentation to HPBQ Advisory Committee on 1/31/19, incorporating 2020 draft AVC results reported by participating carriers

Plans with AV ranges in red font were not compliant with the 2020 AV requirements



Copay Maximums – State Regulation

Tab B: EXHIBIT 8.0

- Copayments for in-network imaging services
 - Connecticut General Statute (CGS)
 - 38a-511 (individual health insurance policy)
 - 38a-550 (group health insurance policy)
 - No health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society that provides coverage under a health insurance policy or contract for magnetic resonance imaging or computed axial tomography may:
 - require total copayments in excess of three hundred seventy-five dollars for all such in-network imaging services combined annually, or
 - require a copayment in excess of seventy-five dollars for each in-network magnetic resonance imaging or computed axial tomography, provided the physician ordering the radiological services and the physician rendering such services are not the same person or are not participating in the same group practice.
 - No health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society that provides coverage under a health insurance policy or contract for *positron emission tomography* may:
 - require total copayments in excess of four hundred dollars for all such in-network imaging services combined annually, or
 - require a copayment in excess of one hundred dollars for each in-network positron emission tomography, provided the physician ordering the radiological service and the physician rendering such service are not the same person or are not participating in the same group practice.
 - Does not apply to a high deductible plan specified in section 38a-493



Copay Maximums – State Regulation

Tab B: EXHIBIT 9.0

- Copayments for in-network physical therapy and in-network occupational therapy services
 - Connecticut General Statute (CGS)
 - 38a-511a (individual health insurance policy)
 - 38a-550a (group health insurance policy)
 - Applies to policies providing coverage for basic hospital expense coverage, basic medical-surgical expense coverage, major medical expense coverage, hospital or medical service plan contract and hospital and medical coverage provided to subscribers of a health care center
 - Copayments may not be imposed that exceed a maximum of thirty dollars per visit for in-network (1) physical therapy services rendered by a physical therapist licensed under section 20-73, or (2) occupational therapy services rendered by an occupational therapist licensed under section 20-74b or 20-74c



Deductible and Coinsurance Maximums – Home Health Care Services

- Mandatory coverage for home health care
 - Connecticut General Statute (CGS)
 - Sec. 38a-493 (individual health insurance policy)
 - Sec. 38a-520 (group health insurance policy)
 - Applies to policies providing coverage for basic hospital expense coverage, basic medical-surgical expense coverage, major medical expense coverage, accident only coverage, limited benefit health coverage, hospital or medical service plan contract and hospital and medical coverage provided to subscribers of a health care center
 - Home health care benefits may be subject to an annual deductible of not more than fifty dollars for each person covered under a policy and may be subject to a coinsurance provision that provides for coverage of not less than seventy-five per cent of the reasonable charges for such services.
 - Specified high deductible plans are not subject to the deductible limits outlined above

