Reference Materials

January 2020

access health CT

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

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Yellow shading represents change from 2019 Plan Year	2020 Standard Gold	
Plan Overview	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Deductible: Individual (medical)	$1,300	$3,000
Deductible: Family (medical)	$2,600	$6,000
Deductible: Individual (prescription)	$50	$350
Deductible: Family (prescription)	$100	$700
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)	$0	30% coinsurance
Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse)	$20 copayment per visit	30% coinsurance per visit after OON medical deductible
Specialist Office Visits	$40 copayment per visit	30% coinsurance per visit after OON medical deductible
Outpatient Diagnostic Services		
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 medical deductible
Laboratory Services	$10 copayment per service after INET medical deductible	30% coinsurance per service after OON medical deductible
Non-Advanced Radiology (X-ray, Diagnostic)	$40 copayment per service after INET medical deductible	30% coinsurance per service after OON medical deductible
Mammography Ultrasound	$20 copayment per service	30% coinsurance per service after OON medical deductible
Prescription Drugs - Retail Pharmacy (up to 30 day supply per prescription)		
Tier 1	$5 copayment per prescription	30% coinsurance per prescription after OON 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 after OON medical deductible
Durable Medical Equipment	30% coinsurance per equipment/supply	30% coinsurance per equipment / supply after OON medical deductible
Prosthetic Devices	20% coinsurance per equipment/supply	30% 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
Outpatient Services (in a hospital or ambulatory facility)	$500 copayment after INET plan deductible (Outpatient Hospital Facility); $300 copayment after INET plan deductible (Ambulatory Surgery Center)	30% 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)*	$500 copayment per day to a maximum of $1,000 per admission after INET plan deductible	30% coinsurance per admission after OON medical deductible
Emergency and Urgent Care		
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 deductible
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	$0 copay	50% coinsurance per visit after OON medical deductible
Basic Services	20% coinsurance per visit	50% coinsurance per visit after OON medical deductible
Major Services	40% 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)	$40 copayment per visit	30% coinsurance per visit after OON medical deductible

Red italic font signifies field included in Actuarial Value Calculator

Yellow shading represents change from 2019 Plan Year	2020 Standard Silver - 70% AV	
Plan Overview	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Deductible: Individual (medical)	$4,300	$8,600
Deductible: Family (medical)	$8,600	$17,200
Deductible: Individual (prescription)	$250	$500
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)	$0	40% coinsurance
Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse)	$40 copayment per visit	40% coinsurance per visit after OON medical deductible
Specialist Office Visits	$60 copayment per visit	40% coinsurance per visit after OON medical deductible
Outpatient Diagnostic Services		
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
Prescription Drugs - Retail Pharmacy (up to 30 day supply per prescription)		
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 (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)	$500 copayment after INET plan deductible (Outpatient Hospital Facility); $300 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)	$500 copayment per day to a maximum of $2,000 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	$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
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)	$60 copayment per visit	40% coinsurance per visit after OON medical deductible

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Yellow shading represents change from 2019 Plan Year	2020 Standard Silver 73%	
Plan Overview	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Deductible: Individual (medical)	$3,950	$8,600
Deductible: Family (medical)	$7,900	$17,200
Deductible: Individual (prescription)	$250	$500
Deductible: Family (prescription)	$500	$1,000
Out-of-Pocket Maximum: Individual	$6,500	$16,300
Out-of-Pocket Maximum: Family	$13,000	$32,600
Provider Office Visits		
Preventive Visit (Adult/Child)	$0	40% coinsurance
Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse)	$40 copayment per visit	40% coinsurance per visit after OON medical deductible
Specialist Office Visits	$60 copayment per visit	40% coinsurance per visit after OON medical deductible
Outpatient Diagnostic Services		
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
Prescription Drugs - Retail Pharmacy (up to 30 day supply per prescription)		
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 $100 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 (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)	$500 copayment after INET plan deductible (Outpatient Hospital Facility); $300 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)*	$500 copayment per day to a maximum of $2,000 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	$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
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)	$60 copayment per visit	40% coinsurance per visit after OON medical deductible

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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)	$100	$1,000
Out-of-Pocket Maximum: Individual	$2,500	$16,300
Out-of-Pocket Maximum: Family	$5,000	$32,600
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		
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 deductible
Prescription Drugs - Retail Pharmacy (up to 30 day supply per prescription)		
Tier 1	$10 copayment per prescription	40% coinsurance per prescription after OON prescription drug deductible
Tier 2	$25 copayment per prescription	40% coinsurance per prescription after OON prescription drug deductible
Tier 3	$40 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 $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
Outpatient Services (in a hospital or ambulatory facility)	$100 copayment after INET plan deductible (Outpatient Hospital 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 deductible

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Yellow shading represents change from 2019 Plan Year	2020 Standard Silver 94%	
Plan Overview	**In-Network (INET) Member Pays**	**Out-of-Network (OON) Member Pays**
Deductible: Individual (medical)	$0	$8,600
Deductible: Family (medical)	$0	$17,200
Deductible: Individual (prescription)	$0	$500
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
Prescription Drugs - Retail Pharmacy (up to 30 day supply per prescription)		
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 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
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)		
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)	$30 copayment per visit	40% coinsurance per visit after OON medical deductible

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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)	$12,400	$24,800
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)	$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	50% coinsurance per visit after OON deductible
Outpatient Diagnostic Services		
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
Prescription 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 INET deductible	50% coinsurance per prescription after OON deductible
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per calendar year limit combined for PT/ST/OT)	$30 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible
Physical and Occupational Therapy (40 visits per calendar year limit combined for PT/ST/OT)	$30 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible
Other Services		
Chiropractic 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
Outpatient Services (in a hospital or ambulatory facility)	$500 copayment after INET plan deductible (Outpatient Hospital Facility); $300 copayment after INET plan deductible (Ambulatory Surgery Center)	50% coinsurance per visit after OON 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)*	$500 copayment per day to a maximum of $1,000 per admission after INET deductible	50% coinsurance per admission after OON deductible
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
Pediatric Dental Care (for children under age 19)		
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
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)	$60 copayment per visit after INET deductible	50% coinsurance per visit after OON deductible

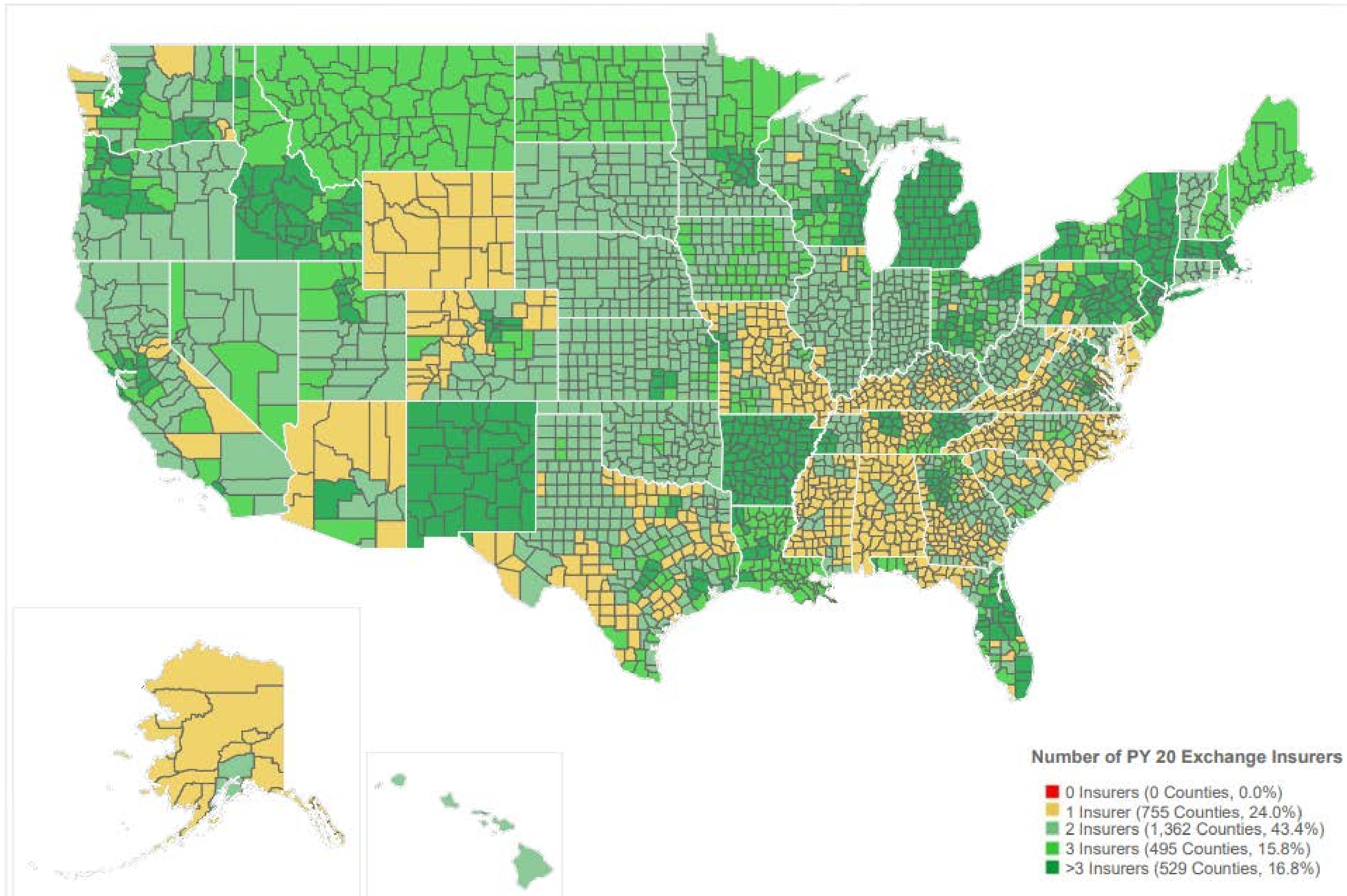
Red italic font signifies field included in Actuarial Value Calculator

	2020 Standard Bronze HSA	
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	$6,550	$12,900
Out-of-Pocket Maximum: Family	$13,100	$25,800
Provider Office Visits		
Preventive Visit (Adult/Child)	$0	50% coinsurance
Provider Office Visits (Primary Care, Mental & Behavioral Health, Substance Abuse)	10% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON deductible
Specialist Office Visits	10% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON
Outpatient Diagnostic Services		
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)	10% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON
Mammography Ultrasound	10% coinsurance per service after INET plan deductible is met	50% coinsurance per service after OON
Prescription Drugs - Retail Pharmacy (up to 30 day supply per prescription)		
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
Outpatient Rehabilitative and Habilitative Services		
Speech Therapy (40 visits per calendar year limit combined for PT/ST/OT)	10% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Physical and Occupational Therapy (40 visits per calendar year limit combined for PT/ST/OT)	10% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Other Services		
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 after 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 deductible is met
Emergency Room	10% coinsurance per service after INET plan deductible is met	10% coinsurance per service after INET plan deductible is met
Urgent Care Center or Facility	10% coinsurance per service after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
Pediatric Dental Care (for children under age 19)		
Diagnostic & Preventive	$0 copay	50% coinsurance per visit after OON plan deductible is met
Basic Services	40% coinsurance per visit after INET plan 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 (medically necessary only)	50% coinsurance per visit after INET plan deductible is met	50% coinsurance per visit after OON plan deductible is met
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

Red italic font signifies field included in Actuarial Value Calculator

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

- 0 Insurers (0 Counties, 0.0%)
- 1 Insurer (755 Counties, 24.0%)
- 2 Insurers (1,362 Counties, 43.4%)
- 3 Insurers (495 Counties, 15.8%)
- >3 Insurers (529 Counties, 16.8%)

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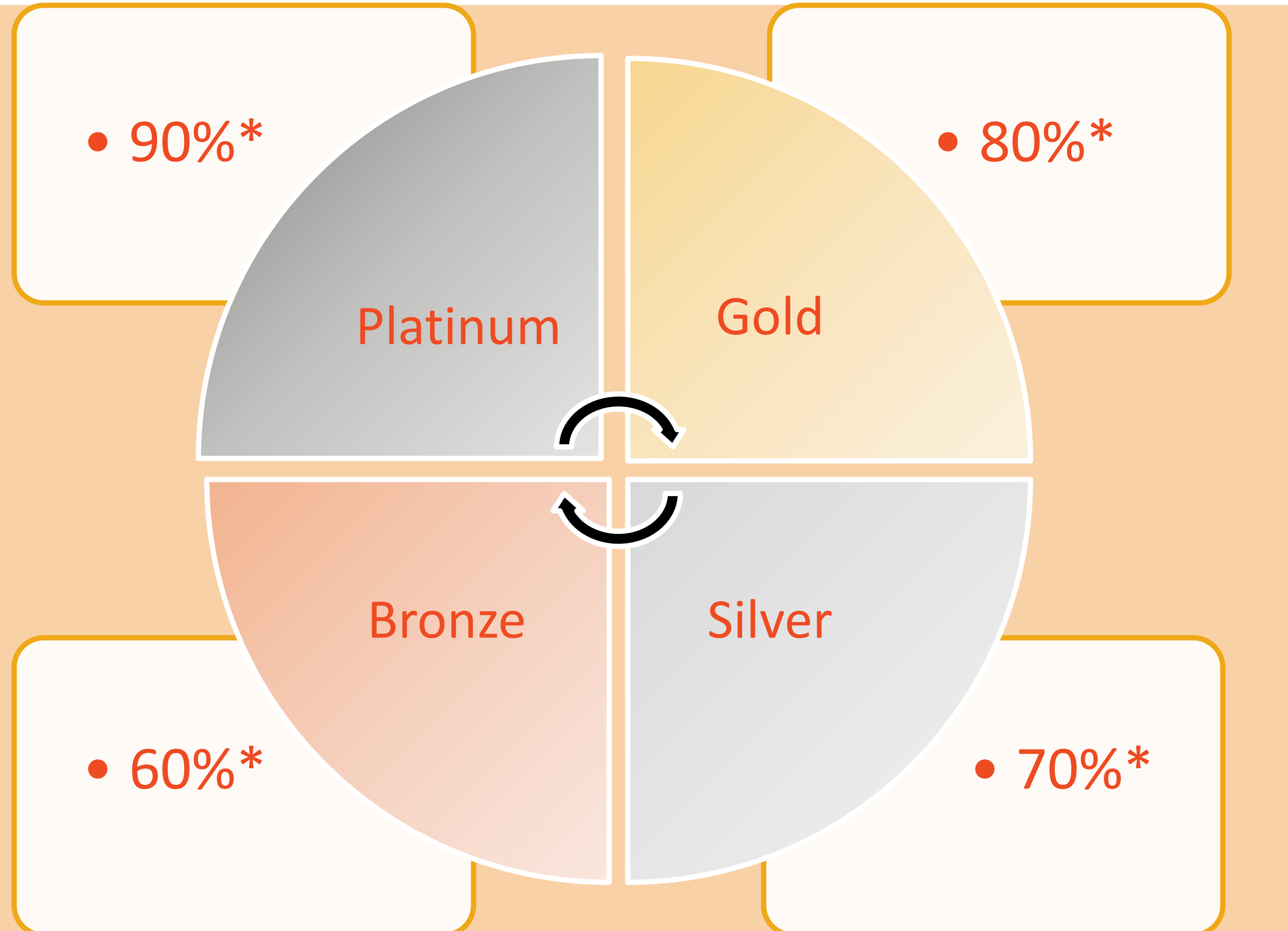
Affordable Care Act - Health Plan Types

Tab B: EXHIBIT 3.0

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%*

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Plan Design Development: AVC Benefit Cost Sharing Categories

Tab B: EXHIBIT 4.0

Actuarial Value Calculator (AVC) Inputs
Integrated Medical and Drug Deductible? (Yes or No)
Apply Inpatient Copay per Day? (Yes or No)
Apply Skilled Nursing Facility Copay per Day? (Yes or No)
Use Separate OOP Maximum for Medical and Drug Spending? (Yes or No)
Deductible ($) for Medical, Drug or Combined
Coinsurance (%, Insurer's Cost Share)
Maximum Out-of-Pocket (MOOP)
MOOP if Separate ($)

Medical Benefits: **Subject to Deductible (Yes or No)** **Subject to Coinsurance (Yes or No)** **Coinsurance (Insurer's Cost Share) or Copay Values (Member Cost Share)**
Emergency Room Services
All Inpatient Hospital Services (inc. MHSU)
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)
Specialist Visit
Mental/Behavioral Health and Substance Use Disorder Outpatient Services
Imaging (CT/PET Scans, MRIs)
Speech Therapy
Occupational and Physical Therapy
Preventive Care/Screening/Immunization
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

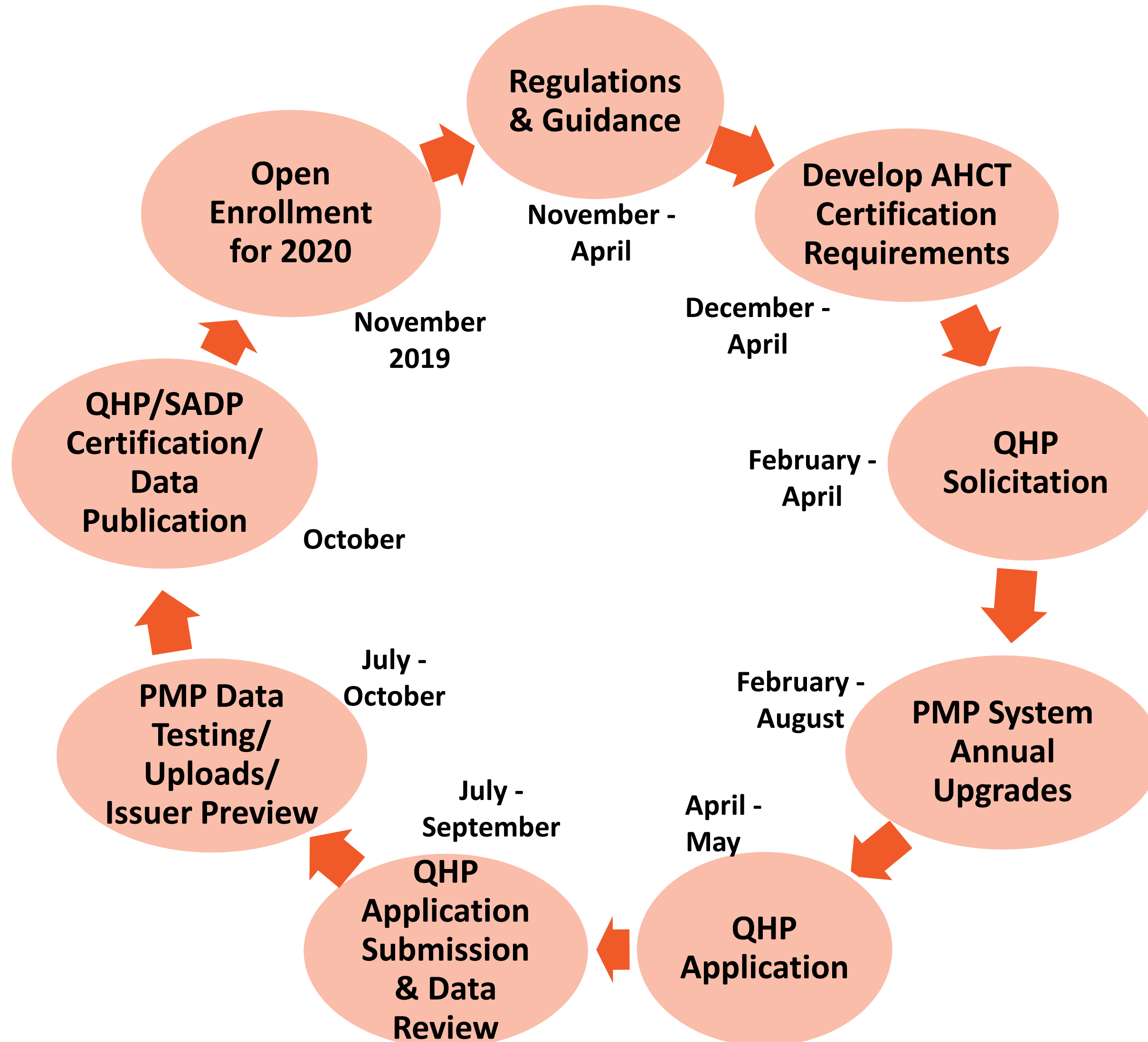
Prescription Drug Benefits **Subject to Deductible (Yes or No)** **Subject to Coinsurance (Yes or No)** **Coinsurance (Insurer's Cost Share) or Copay Values (Member Cost Share)**
Generics
Preferred Brand Drugs
Non-Preferred Brand Drugs
Specialty Drugs (i.e. high-cost)

Options for Additional Benefit Design Limits:
Set a Maximum on Specialty Rx Coinsurance Payments? (Yes or No) If yes, value:
Set a Maximum Number of Days for Charging an IP Copay? (Yes or No) If yes, value from 1-10:
Begin Primary Care Cost-Sharing After a Set Number of Visits? (Yes or No) If yes, value from 1-10:
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays? (Yes or No) If yes, value from 1-10:

Other Elements for Consideration Not Included as a Separate Field in AVC
Out-of-Network Deductible and Cost Sharing
Chiropractic Services
Diabetic Equipment and Supplies
Durable Medical Equipment
Home Health Care
Mammography Ultrasound
Urgent Care
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

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

Tab B: EXHIBIT 6.0

	INDIVIDUAL MARKET		SHOP
Metal Level	Standardized Plans	Non-Standard Plans	Total
Platinum	N/A	2	4 (Optional)
Gold	1	3	Min 1 – Max 6
Silver	1	0	Min 2 – Max 6
Bronze	2	3	Min 2 – Max 4
Catastrophic	N/A	1	N/A
TOTAL	4 Required	9 Optional	5 Required / 15 Optional
Maximum	13		20

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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
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%
2020 AV Range	73.8% to 75.1%	88.1% to 88.6%	94.9% to 95.0%

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%
2019 AV Range	73.3% to 73.5%	87.3% to 87.5%	94.76%
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

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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

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Deductible and Coinsurance Maximums – Home Health Care Services

Tab B: EXHIBIT 10.0

- 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