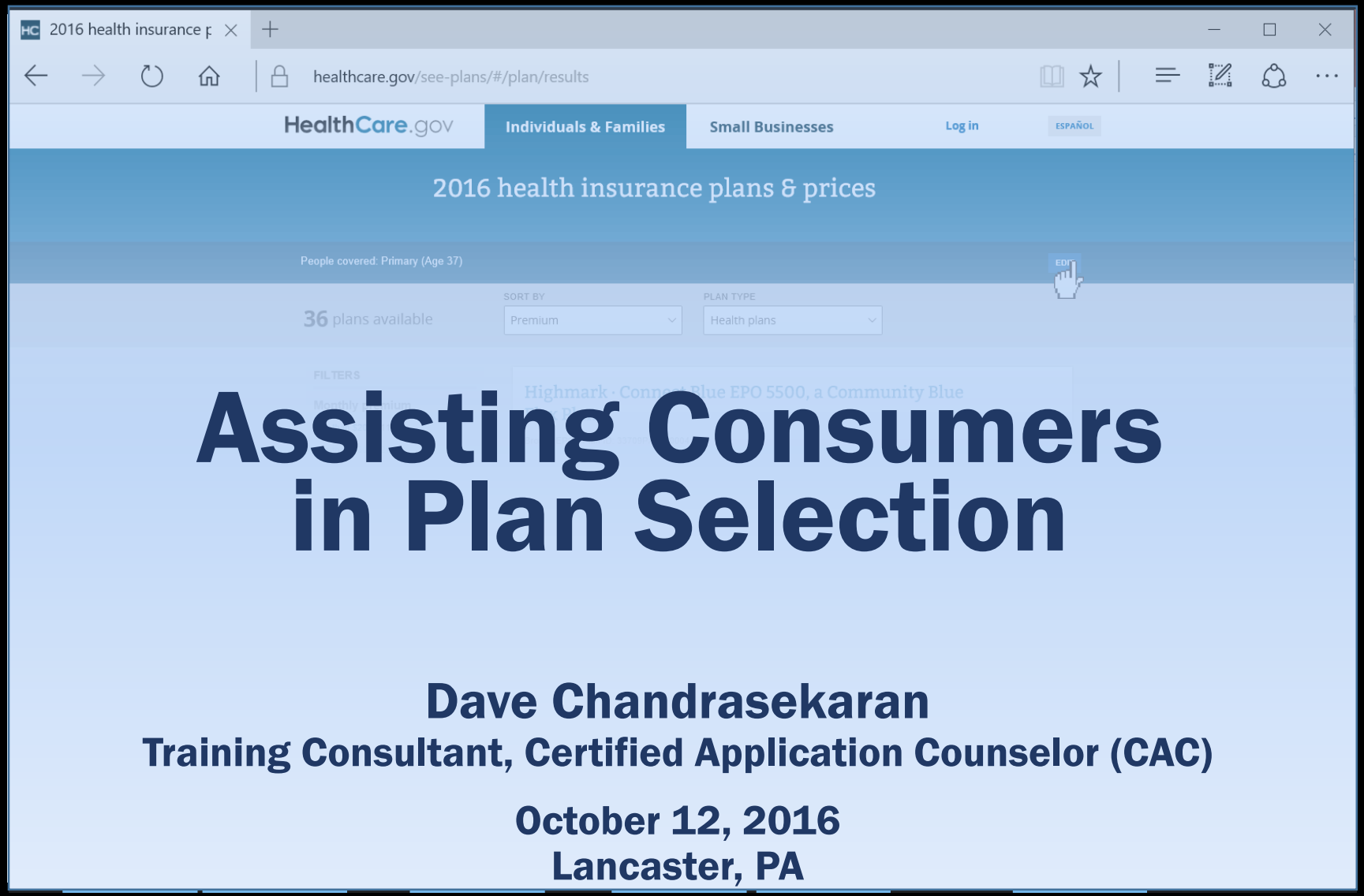


Assisting Consumers in Plan Selection

Dave Chandrasekaran
Training Consultant, Certified Application Counselor (CAC)

October 12, 2016
Lancaster, PA

Today's Presentation

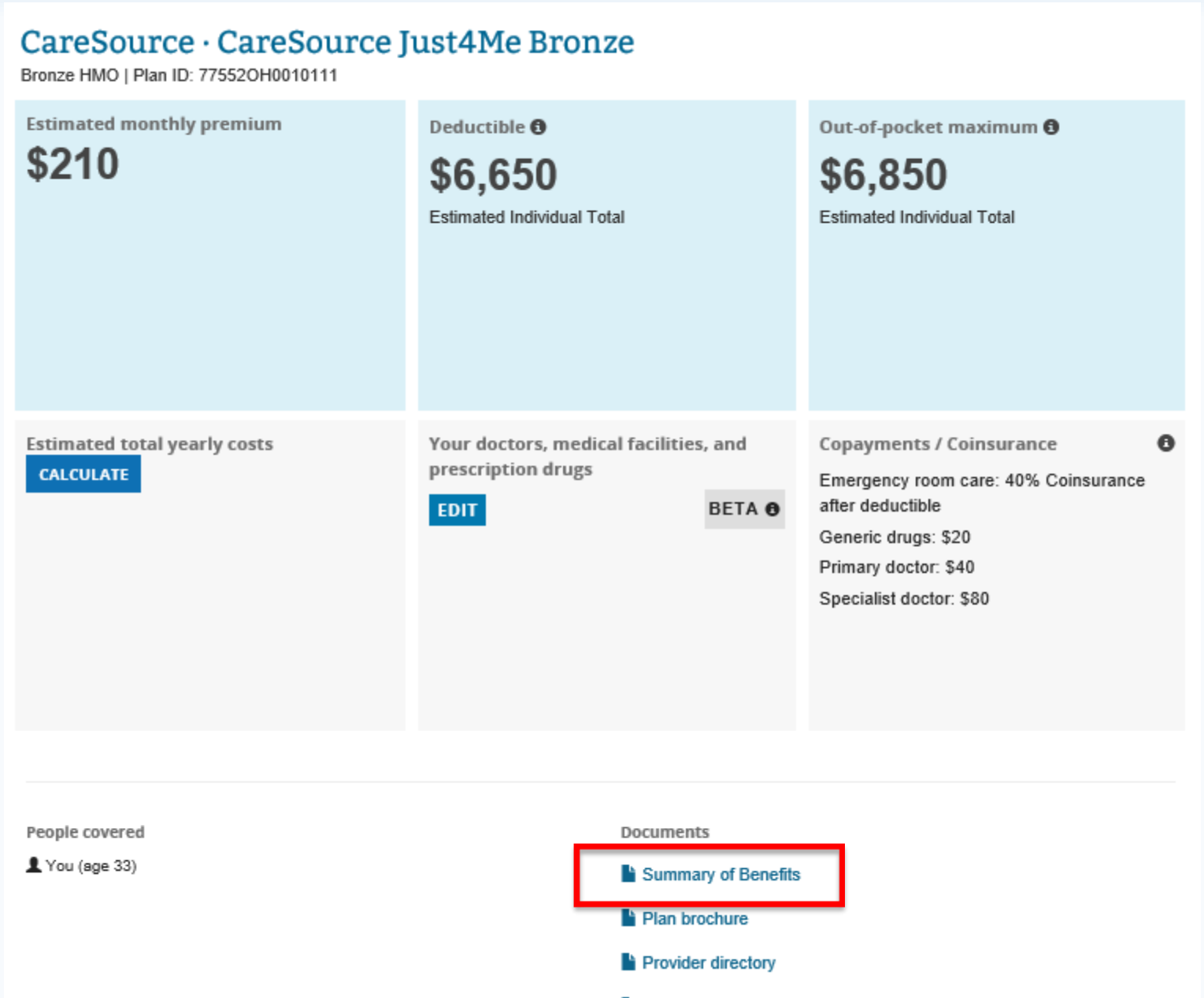
- Section 1: Overview of Marketplace QHPs
  - Elements of private insurance
  - Explaining health insurance terms to consumers
- Section 2: Trends in Marketplace plans
  - Nationwide and regional trends
- Section 3: Plan Comparison & Selection
  - healthcare.gov decision support tools
  - healthcare.gov plan comparison demonstration

Section 1:
Overview of Marketplace QHPs

Elements of Marketplace Health Plans

1. Premium
2. Plan Design/Cost Sharing
3. Covered Benefits
4. Prescription Drug Formulary
5. Provider Network

healthcare.gov Plan Display



Summary of Benefits and Coverage (SBC)

CareSource: Just4Me Bronze

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

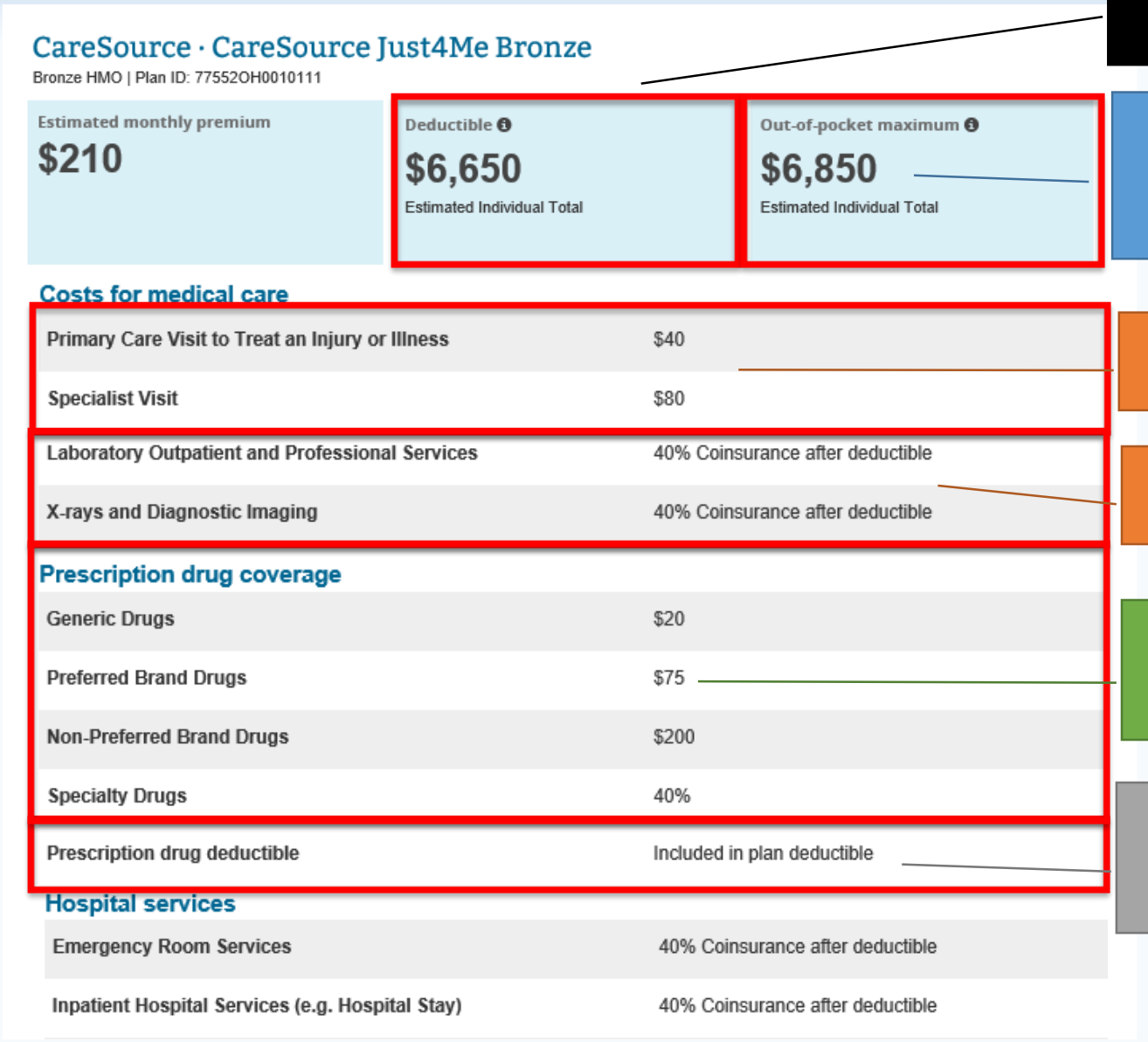
Coverage Period: 01/01/16 – 12/31/16
Coverage for: Individual | Plan Type: HMO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.caresource.com/just4me or by calling 800-479-9502.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	$6,650 Individual / $13,300 Family per Benefit Year. Deductible does not apply to Copayments, Physician Home and Office Services for Primary Care, Physician Home and Office Services for Specialty Care, Prescription Drugs, Preventive Health Services, Urgent Care Services, and Vision Services – Pediatric.	You must pay all the costs up to the Deductible amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the deductible starts over (usually, but not always, January 1st.) See the chart starting on page 2 for how much you pay for covered services after you meet the Deductible.
Are there other Deductibles for specific services?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. $6,850 Individual $13,700 Family	The Out-of-Pocket Limit is the most you could pay during a coverage period for your share of the cost of covered services. Copayments and coinsurance are applied toward the out-of-pocket limit. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges and health care services that are not covered by this plan.	Even though you pay these expenses, they don't count toward the Out-of-Pocket Limit.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes how the plan and you will pay for specific covered services.

***Source**: Summary of Benefits and Coverage for CareSource: Just4Me Bronze plan in Columbus, OH*

Overview of Cost-Sharing



CareSource · CareSource Just4Me Bronze

Bronze HMO | Plan ID: 77552OH0010111

Estimated monthly premium	Deductible	Out-of-pocket maximum
$210	$6,650 Estimated Individual Total	$6,850 Estimated Individual Total

Costs for medical care

Primary Care Visit to Treat an Injury or Illness	$40
Specialist Visit	$80
Laboratory Outpatient and Professional Services	40% Coinsurance after deductible
X-rays and Diagnostic Imaging	40% Coinsurance after deductible

Prescription drug coverage

Generic Drugs	$20
Preferred Brand Drugs	$75
Non-Preferred Brand Drugs	$200
Specialty Drugs	40%
Prescription drug deductible	Included in plan deductible

Hospital services

Emergency Room Services	40% Coinsurance after deductible
Inpatient Hospital Services (e.g. Hospital Stay)	40% Coinsurance after deductible

Deductible

Out-of-Pocket Max

copays

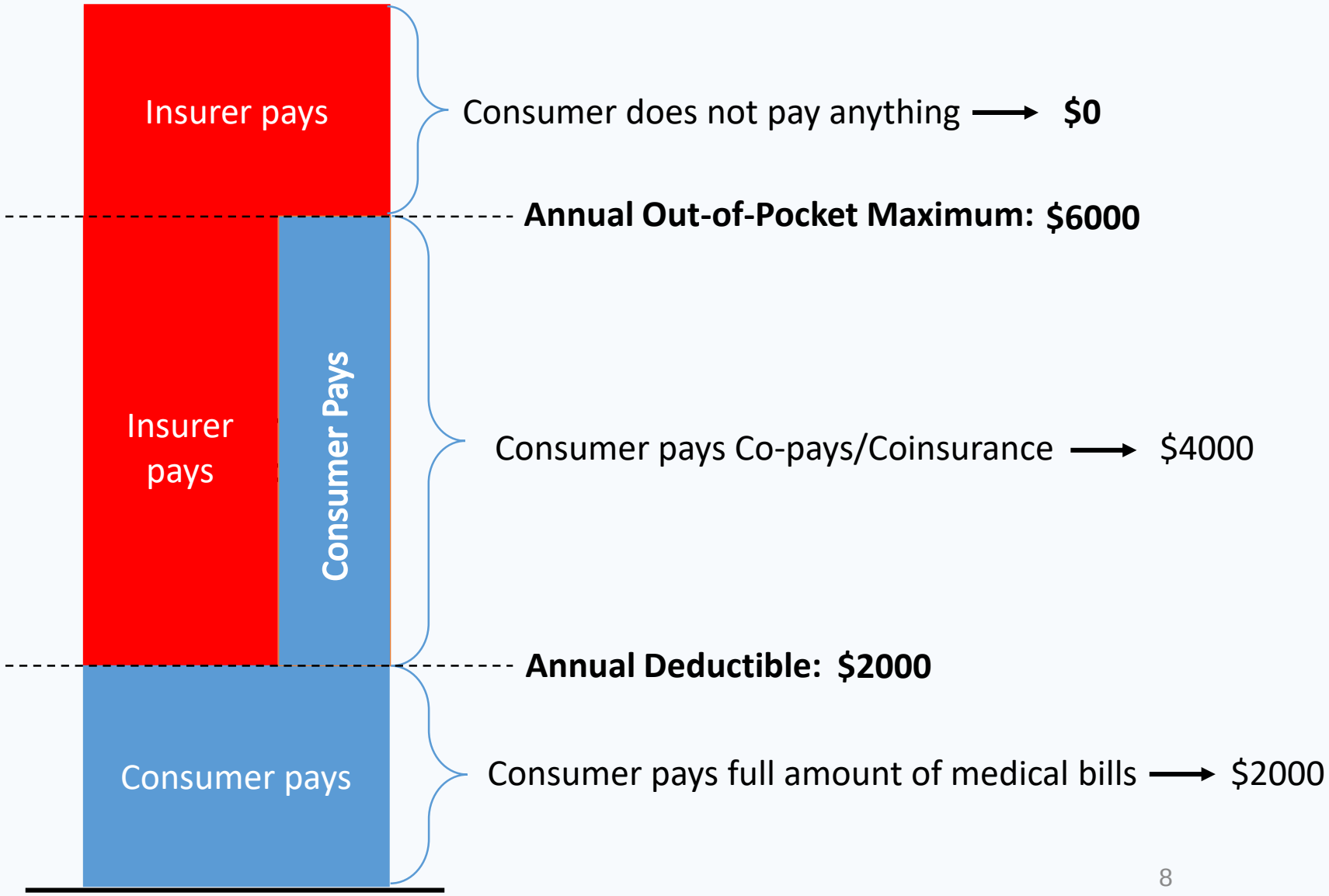
coinsurance

Prescription drug categories

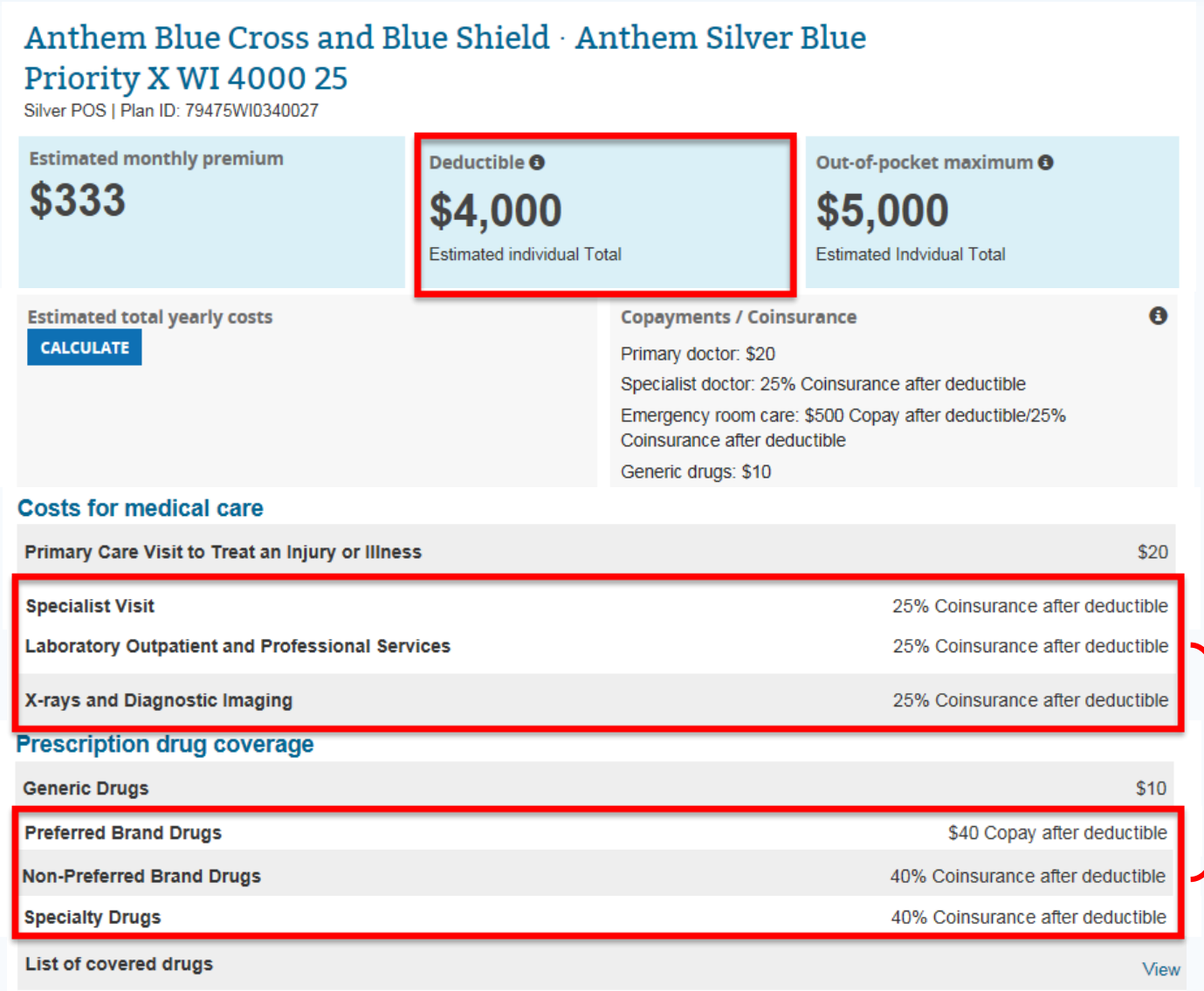
Prescription drug deductible

***Source**: healthcare.gov, CareSource: Just4Me Bronze plan in Columbus, OH*

Explaining Cost-Sharing Terms



Pre-Deductible Coverage



Anthem Blue Cross and Blue Shield · Anthem Silver Blue Priority X WI 4000 25

Silver POS | Plan ID: 79475WI0340027

Estimated monthly premium	Deductible	Out-of-pocket maximum
$333	$4,000	$5,000
	Estimated individual Total	Estimated Indvidual Total

Estimated total yearly costs

CALCULATE

Copayments / Coinsurance

Primary doctor: $20

Specialist doctor: 25% Coinsurance after deductible

Emergency room care: $500 Copay after deductible/25% Coinsurance after deductible

Generic drugs: $10

Costs for medical care

Primary Care Visit to Treat an Injury or Illness	$20
Specialist Visit	25% Coinsurance after deductible
Laboratory Outpatient and Professional Services	25% Coinsurance after deductible
X-rays and Diagnostic Imaging	25% Coinsurance after deductible

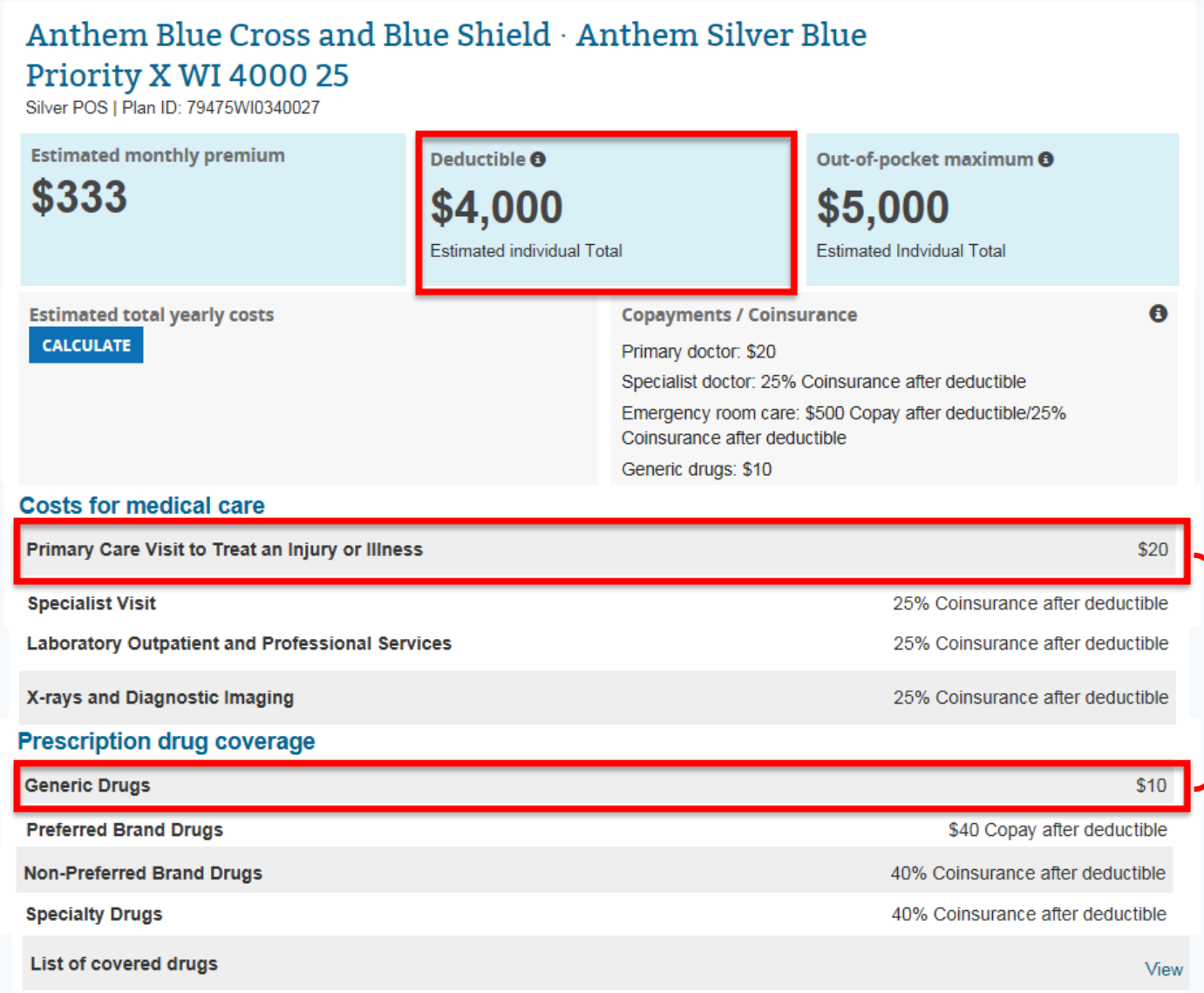
Prescription drug coverage

Generic Drugs	$10
Preferred Brand Drugs	$40 Copay after deductible
Non-Preferred Brand Drugs	40% Coinsurance after deductible
Specialty Drugs	40% Coinsurance after deductible
List of covered drugs	View

deductible applies

***Source**: healthcare.gov, Anthem Blue Cross and Blue Shield Silver Blue Priority X WI 4000 25 plan in Green Bay, WI*

Pre-Deductible Coverage



Anthem Blue Cross and Blue Shield · Anthem Silver Blue Priority X WI 4000 25

Silver POS | Plan ID: 79475WI0340027

Estimated monthly premium	Deductible	Out-of-pocket maximum
$333	$4,000	$5,000
	Estimated individual Total	Estimated Indvidual Total

Estimated total yearly costs

CALCULATE

Copayments / Coinsurance

Primary doctor: $20

Specialist doctor: 25% Coinsurance after deductible

Emergency room care: $500 Copay after deductible/25% Coinsurance after deductible

Generic drugs: $10

Costs for medical care

Primary Care Visit to Treat an Injury or Illness	$20
Specialist Visit	25% Coinsurance after deductible
Laboratory Outpatient and Professional Services	25% Coinsurance after deductible
X-rays and Diagnostic Imaging	25% Coinsurance after deductible

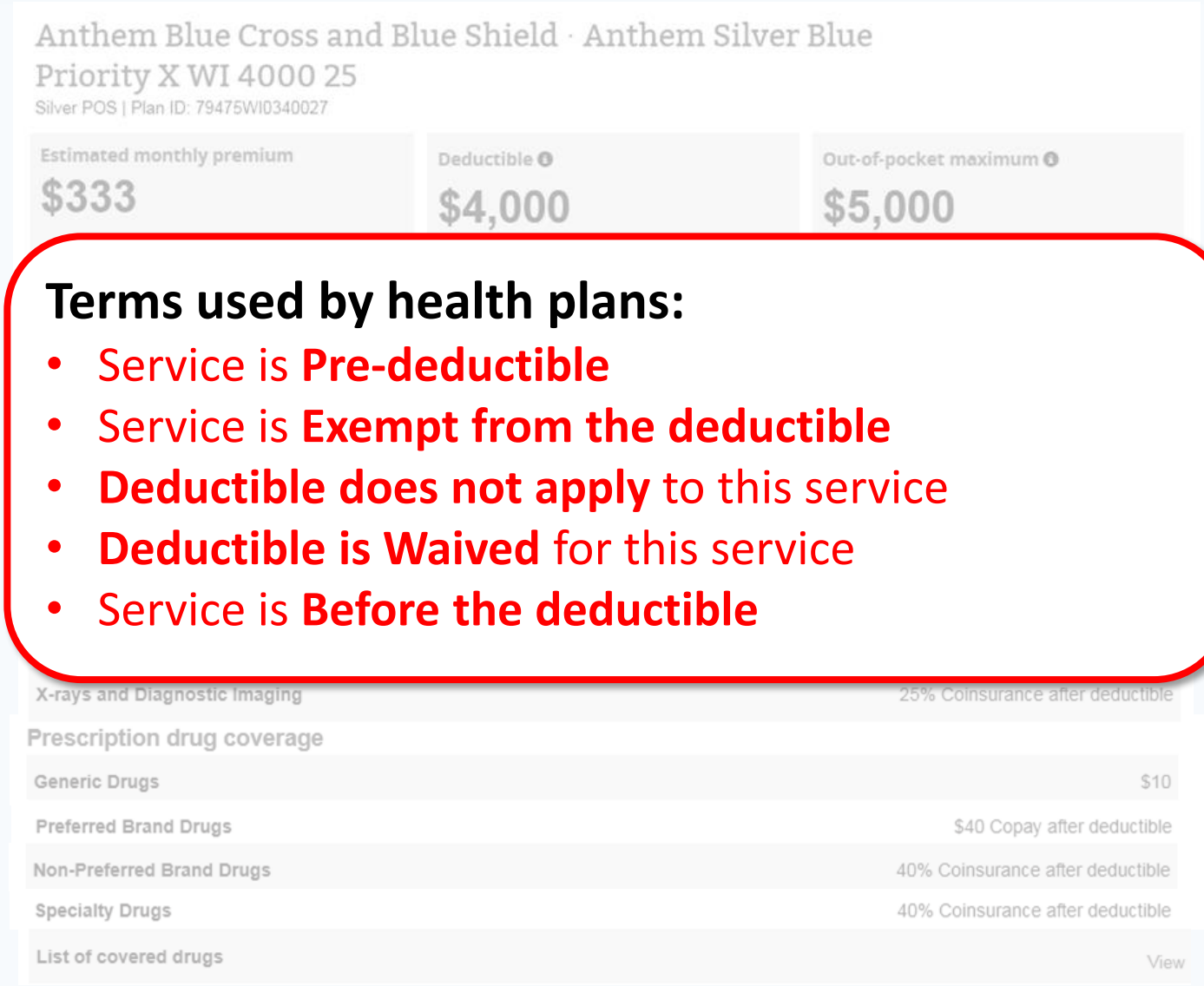
Prescription drug coverage

Generic Drugs	$10
Preferred Brand Drugs	$40 Copay after deductible
Non-Preferred Brand Drugs	40% Coinsurance after deductible
Specialty Drugs	40% Coinsurance after deductible
List of covered drugs	View

deductible does not apply

***Source**: healthcare.gov, Anthem Blue Cross and Blue Shield Silver Blue Priority X WI 4000 25 plan in Green Bay, WI*

Pre-Deductible Coverage



***Source**: healthcare.gov, Anthem Blue Cross and Blue Shield Silver Blue Priority X WI 4000 25 plan in Green Bay, WI*

HSA vs. non-HSA Plans

Kaiser Permanente · KP VA Bronze 4500/50/HSA/Dental/Ped Dental

- Summary of Benefits
- Plan brochure
- Provider directory
- List of covered drugs

Bronze | **HMO**
Plan ID: 95185VA0530007

ESTIMATED MONTHLY PREMIUM	ESTIMATED DEDUCTIBLE	ESTIMATED OUT-OF-POCKET MAXIMUM
$217	$4,500	$6,350
Number of people covered: 1	Estimated individual total	Estimated individual total

Costs for Medical Care

Primary Care Visit to Treat an Injury or Illness	*$50 Copay after deductible*
Specialist Visit	*$50 Copay after deductible*
Hearing Aids	*Benefit not covered*
Routine Eye Exam for Children	*$50 Copay after deductible*
Eye Glasses for Children	*No charge*
Laboratory Outpatient and Professional Services	*$50 Copay after deductible*
X-rays and Diagnostic Imaging	*$50 Copay after deductible*
Health Savings Account (HSA) eligible plan	*yes*

Prescription drug coverage

Generic drugs	*$20 Copay after deductible*
Preferred Brand Drugs	*$50 Copay after deductible*
Non-Preferred Brand Drugs	*30% Coinsurance after deductible*
Specialty Drugs	*$50 Copay after deductible*
List of covered drugs	*Click here*
Prescription drug deductible	*$4,500*
Prescription drug out-of-pocket maximum	*Included in out-of-pocket maximum*

Kaiser Permanente · KP VA Bronze 4500/50/Dental/Ped Dental

- Summary of Benefits
- Plan brochure
- Provider directory
- List of covered drugs

Bronze | **HMO**
Plan ID: 95185VA0530006

ESTIMATED MONTHLY PREMIUM	ESTIMATED DEDUCTIBLE	ESTIMATED OUT-OF-POCKET MAXIMUM
$225	$4,500	$6,350
Number of people covered: 1	Estimated individual total	Estimated individual total

Costs for Medical Care

Primary Care Visit to Treat an Injury or Illness	*$50*
Specialist Visit	*$50*
Hearing Aids	*Benefit not covered*
Routine Eye Exam for Children	*$50*
Eye Glasses for Children	*No charge*
Laboratory Outpatient and Professional Services	*$50 Copay after deductible*
X-rays and Diagnostic Imaging	*$50 Copay after deductible*
Health Savings Account (HSA) eligible plan	*no*

Prescription drug coverage

Generic drugs	*$25*
Preferred Brand Drugs	*50% Coinsurance after deductible*
Non-Preferred Brand Drugs	*50% Coinsurance after deductible*
Specialty Drugs	*50% Coinsurance after deductible*
List of covered drugs	*Click here*
Prescription drug deductible	*$500*
Prescription drug out-of-pocket maximum	*Included in out-of-pocket maximum*

***Source**: healthcare.gov, Kaiser Permanente Bronze 4500/50/HSA/Dental/Ped Dental and Bronze 4500/50/Dental/Ped Dental plans in Fairfax County VA (2014)*

No Cost Sharing for Preventive Services

BlueCross BlueShield Nebraska

SelectBlue 5850 HSA Bronze

Coverage Period: 01/01/2016-12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage for: Individual/Family | **Plan Type:** HDHP

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at https://www.nebraskablue.com/individualacacontracts or by calling 1-888-592-8960.

Important Questions	Answers	Why this Matters:
What is the overall **deductible**?	Select In-network: **$5,850** individual / **$11,700** family In-network: **$6,450** individual / **$12,900** family Out-of-network: **$12,900** individual / **$25,800** family Does not apply to most preventive care. Copayments and coinsurance don't count toward the **deductible**.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 3 for how much you pay for covered services after you meet the **deductible**.
Are there other **deductibles** for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an **out-of-pocket limit** on my expenses?	Yes. Select In-network: **$5,850** individual / **$11,700** family In-network: **$6,450** individual / **$12,900** family Out-of-network: **$12,900** individual / **$25,800** family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.

***Source**: Summary of Benefits and Coverage for BlueCross BlueShield SelectBlue 5850 HSA Bronze Plan in Omaha, NE*

In-network Discount in Deductible Phase

Health Insurance Provider
1212 Main Street
Anytown, USA 000000

EXPLANATION OF BENEFITS

Please retain for future reference
Mary Jones MD/ PIN:7654321

Mary Jones, MD
Homeville Medical Center
2121 Elm Ave.
Homeville, USA 000000

Date:	01/01/12
Tax ID #:	0101010101
Check #:	1010101010
Check Amount:	$###.00

Patient Name:	Bill Smith
Patient Account Number:	987654321
Patient ID #	1234567
Member ID:	54321

TREATMENT DATE	AA	SERVICE CODE	BB	SUBMITTED CHARGES	ALLOWED AMOUNT	COPAY AMOUNT	Deductible	You Owe
01/01/12	11	Office visit	11	$150.00	$85.00	$0.00	$85.00	$85.00
01/02/12	11	Office visit	11	$150.00	$85.00	$0.00	$85.00	$85.00
01/03/12	11	Immunization	11	$85.00	$20.00	$0.00	$20.00	$20.00
TOTALS				$385.00	$190.00	$0.00	$190.00	$190.00

Covered Benefits

***Source**: Community HealthCare Association of the Dakotas (CHAD) Get Covered South Dakota initiative*

Dental Coverage for Children/Adults

Coventry · Coventry Bronze Deductible Only HSA Eligible Bon Secours

Bronze POS | Plan ID: 99663VA0140033

Estimated monthly premium	Deductible	Out-of-pocket maximum
$71	$6,450	$6,450
Premium before tax credit: $204	Estimated Individual Total	Estimated Individual Total

Adult dental coverage

Routine Dental Services (Adult)	Benefit Not Covered
Basic Dental Care - Adult	Benefit Not Covered
Orthodontia - Adult	Benefit Not Covered
Major Dental Care - Adult	Benefit Not Covered

Child dental coverage

Dental Check-Up for Children	Benefit Not Covered
Basic Dental Care - Child	Benefit Not Covered
Orthodontia - Child	Benefit Not Covered
Major Dental Care - Child	Benefit Not Covered

Kaiser Permanente · KP VA Bronze 6000/20% /HSA/Dental/Ped Dental

Bronze HMO | Plan ID: 95185VA0530008

Estimated monthly premium	Deductible	Out-of-pocket maximum
$86	$6,000	$6,450
Premium before tax credit: $224	Estimated Individual Total	Estimated Individual Total

Adult dental coverage

Routine Dental Services (Adult)	$30
Basic Dental Care - Adult	39%
Orthodontia - Adult	55%
Major Dental Care - Adult	45%

Child dental coverage

Dental Check-Up for Children	No Charge Limits and exclusions apply
Basic Dental Care - Child	39%
Orthodontia - Child	55%
Major Dental Care - Child	45%

***Source**: Healthcare.gov, Coventry Bronze Deductible Only HSA Eligible Bon Secours plan in Richmond, VA, and Kaiser Permanente KP VA Bronze 6000/20%/HSA/Dental/Ped Dental plans in Arlington County, VA*

Other Covered Services

Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	20% Coinsurance after deductible	Not Covered	——————none——————
	Glasses	No Charge after deductible	Not Covered	1 pair glasses/yr (single OR bifocal lenses) OR 1st purchase of contact lenses/yr OR 2 pair/eye/yr medically necessary contacts (select group of frames and contacts)
	Dental check-up	No charge (Deductible does not apply)	Not Covered	One evaluation, including teeth cleaning, topical fluoride applications, covered 2 times per yr; 2 bitewing x-rays per yr, 1 set full mouth x-rays every 3 yrs.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Hearing Aids
- Long-Term/Custodial Nursing Home Care
- Non-Emergency Care when Traveling Outside the U.S.
- Routine Foot Care
- Weight Loss Programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric Surgery
- Chiropractic Care with limits
- Infertility Treatment with limits
- Private-Duty Nursing with limits
- Routine Dental Services (Adult) with limits
- Routine Eye Exam (Adult)
- Routine Hearing Tests
- Voluntary Termination of Pregnancy with limits

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

***Source**: Summary of Benefits and Coverage for Kaiser Permanente KP VA Bronze 6000/20%/HSA/ Dental/PedDental in Arlington County, VA*

Other Covered Services

	CareFirst BCBS	Innovation Health	Kaiser Permanente	United Healthcare
Abortions			✓	
Acupuncture				
Bariatric surgery	✓		✓	
Chiropractic care	✓	✓	✓	✓
Dental care (adult)			✓	
Infertility treatment			✓	
Hearing aids				
Long-term care				
Private duty nursing	✓	✓	✓	✓
Routine eye exam (adult)			✓	
Routine hearing tests (adult)	✓		✓	
Routine foot care				

***Source**: Summary of Benefits and Coverage for Kaiser Permanente KP VA Bronze 6000/20%/HSA/ Dental/PedDental in Arlington County, VA*

Provider Network Types

Type	Name	PCP Required?	Referrals Required?	Out-of-Network Coverage?
PPO	**Preferred Provider Organization**	No	No	Yes
POS	**Point of Service**	Yes	Maybe	Yes
HMO	**Health Maintenance Organization**	Yes	Yes	No*
EPO	**Exclusive Provider Organization**	No	No	No*

**except for emergency care*

Provider Network Size

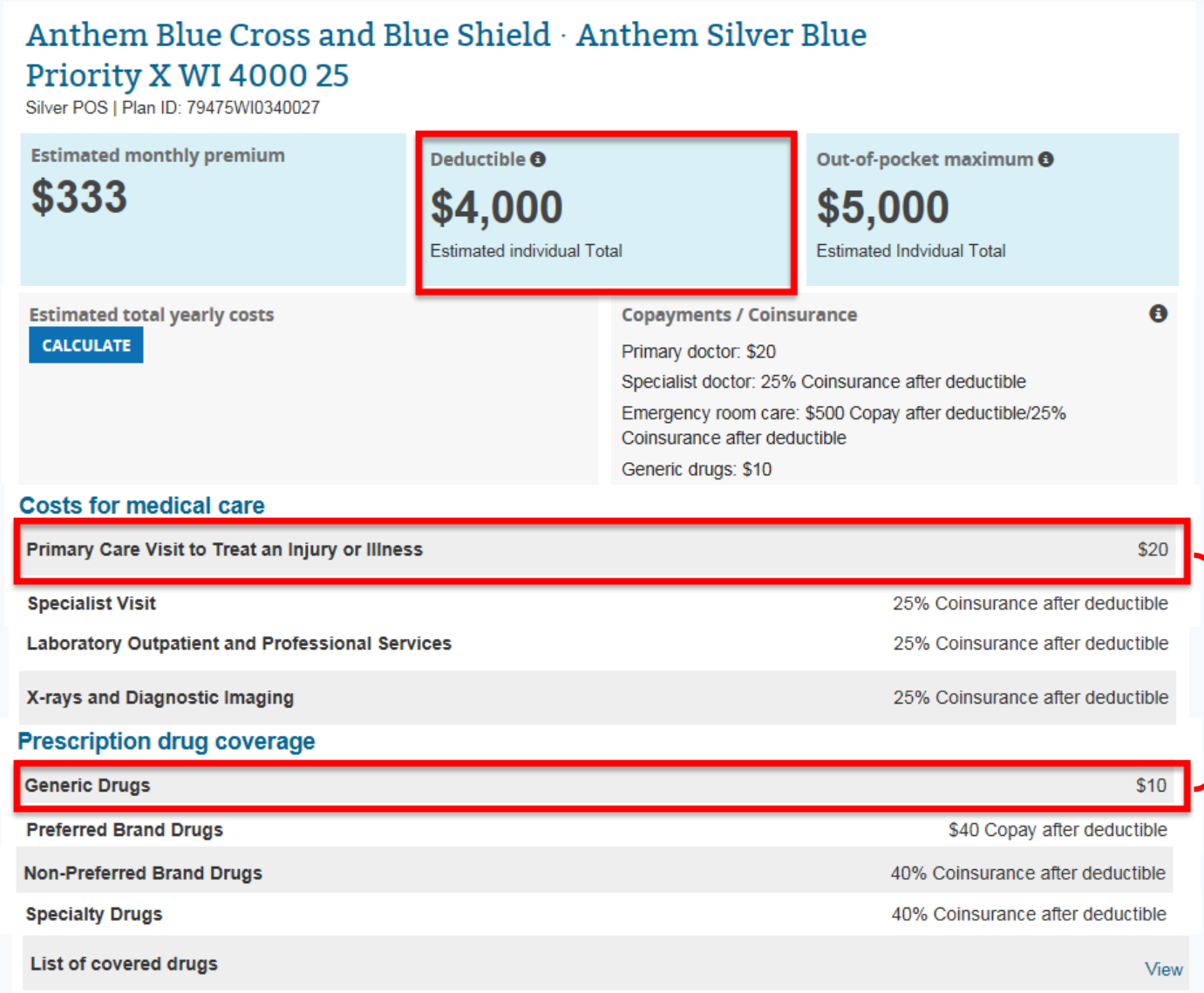
Specialty	Plan/Network Name	Network Type	Network Size*
BlueCross BlueShield of Nebraska	SelectBlue	PPO	269
	BlueEssentials	PPO	311
Coventry	MIPPA	POS	137
	CHI Heath Omaha	HMO	242
	Methodist Health Partners	HMO	195
	Nebraska Health Network	HMO	216
Medica	Medica Insure	PPO	719
UnitedHealthcare	Compass	HMO	1,082

***Number of Primary Care Physicians within a 10 mile radius of 69022 Zip Code in Nebraska**

***Source**: Provider search sites BlueCross BlueShield of Nebraska, Coventry, Medica, and UnitedHealthcare in Omaha, NE*

Section 2:
Trends in Marketplace Plans

Pre-Deductible Coverage



Anthem Blue Cross and Blue Shield · Anthem Silver Blue Priority X WI 4000 25

Silver POS | Plan ID: 79475WI0340027

Estimated monthly premium	Deductible	Out-of-pocket maximum
$333	$4,000	$5,000
	Estimated individual Total	Estimated Indvidual Total

Estimated total yearly costs

CALCULATE

Copayments / Coinsurance

Primary doctor: $20

Specialist doctor: 25% Coinsurance after deductible

Emergency room care: $500 Copay after deductible/25% Coinsurance after deductible

Generic drugs: $10

Costs for medical care

Primary Care Visit to Treat an Injury or Illness	$20
Specialist Visit	25% Coinsurance after deductible
Laboratory Outpatient and Professional Services	25% Coinsurance after deductible
X-rays and Diagnostic Imaging	25% Coinsurance after deductible

Prescription drug coverage

Generic Drugs	$10
Preferred Brand Drugs	$40 Copay after deductible
Non-Preferred Brand Drugs	40% Coinsurance after deductible
Specialty Drugs	40% Coinsurance after deductible
List of covered drugs	View

deductible does not apply

***Source**: healthcare.gov, Anthem Blue Cross and Blue Shield Silver Blue Priority X WI 4000 25 plan in Green Bay, WI*

Partial Exemptions from the Deductible

HealthKeepers, Inc.
Anthem HealthKeepers Bronze X 4650/35%
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2016 – 12/31/2016
Coverage for: Individual + Family | **Plan Type:** HMO

Common Medical Event	Services You May Need	Your Cost if You Use a Preferred Network Provider	Your Cost if You Use an In-Network Provider	Your Cost if You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Not Applicable	$45 copay per visit for the first 3 visits and then 35% coinsurance	Not covered	All office visit copayments count towards the same 3 visit limit.
	Specialist visit	Not Applicable	35% coinsurance	Not covered	--------none--------
	Other practitioner office visit	Chiropractor Not Applicable Acupuncture Not Applicable	Chiropractor 35% coinsurance Acupuncture Not covered	Chiropractor Not covered Acupuncture Not covered	Chiropractor Coverage for In-Network Providers is limited to 30 visits per benefit period. Acupuncture --------none--------
	Preventive care/screening/ immunization	Not Applicable	No charge	Not covered	--------none--------
If you have a test	Diagnostic test (x-ray, blood work)	Lab – Office Not Applicable X-Ray – Office Not Applicable	Lab – Office 35% coinsurance X-Ray – Office 35% coinsurance	Lab – Office Not covered X-Ray – Office Not covered	Lab – Office --------none-------- X-Ray – Office --------none--------
	Imaging (CT/PET scans, MRIs)	Not Applicable	35% coinsurance	Not covered	--------none--------
If you need drugs to treat your illness or condition More	Tier1 - Typically Generic	35% coinsurance (retail and home delivery)	35% coinsurance (retail and home delivery)	Not covered	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day supply (home delivery program). No coverage for non-formulary drugs.
	Tier2 - Typically Preferred / Brand	35% coinsurance (retail and home delivery)	35% coinsurance (retail and home delivery)	Not covered	Covers up to a 30 day supply (retail pharmacy). Covers up to a 90 day

***Source**: Summary of Benefits and Coverage for Anthem Healthkeepers Bronze X 4650 35 plan in Fairfax County, VA*

Partial Exemptions from the Deductible

HealthKeepers, Inc. · Anthem HealthKeepers Bronze X 4650 35

Bronze HMO | National Provider Network | Plan ID: 88380VA0720018

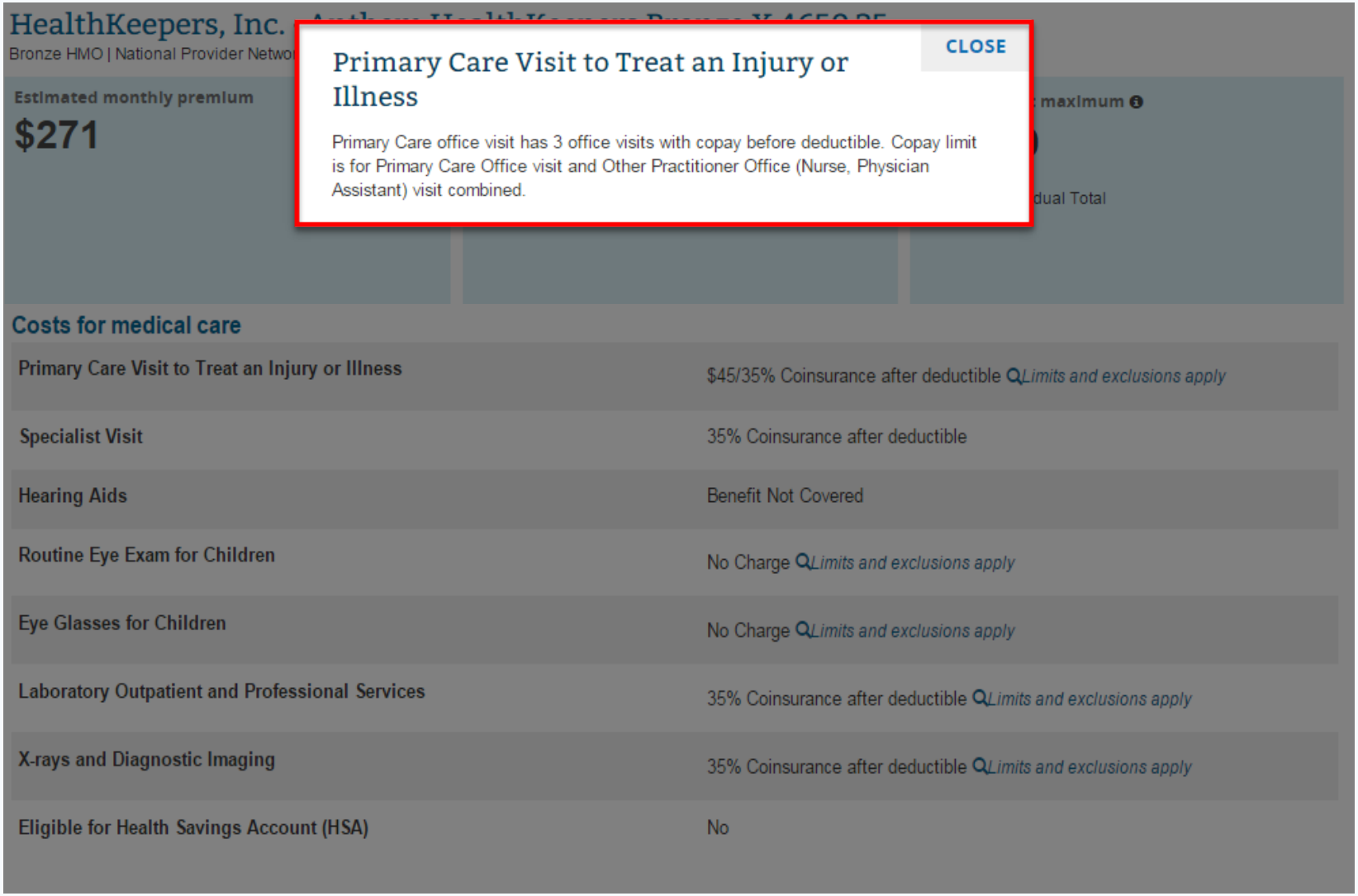
Estimated monthly premium	Deductible	Out-of-pocket maximum
$271	$4,650 Estimated individual Total	$6,850 Estimated Indvidual Total

Costs for medical care

Primary Care Visit to Treat an Injury or Illness	$45/35% Coinsurance after deductible	Limits and exclusions apply
Specialist Visit	35% Coinsurance after deductible	
Hearing Aids	Benefit Not Covered	
Routine Eye Exam for Children	No Charge Limits and exclusions apply	
Eye Glasses for Children	No Charge Limits and exclusions apply	
Laboratory Outpatient and Professional Services	35% Coinsurance after deductible Limits and exclusions apply	
X-rays and Diagnostic Imaging	35% Coinsurance after deductible Limits and exclusions apply	
Eligible for Health Savings Account (HSA)	No	

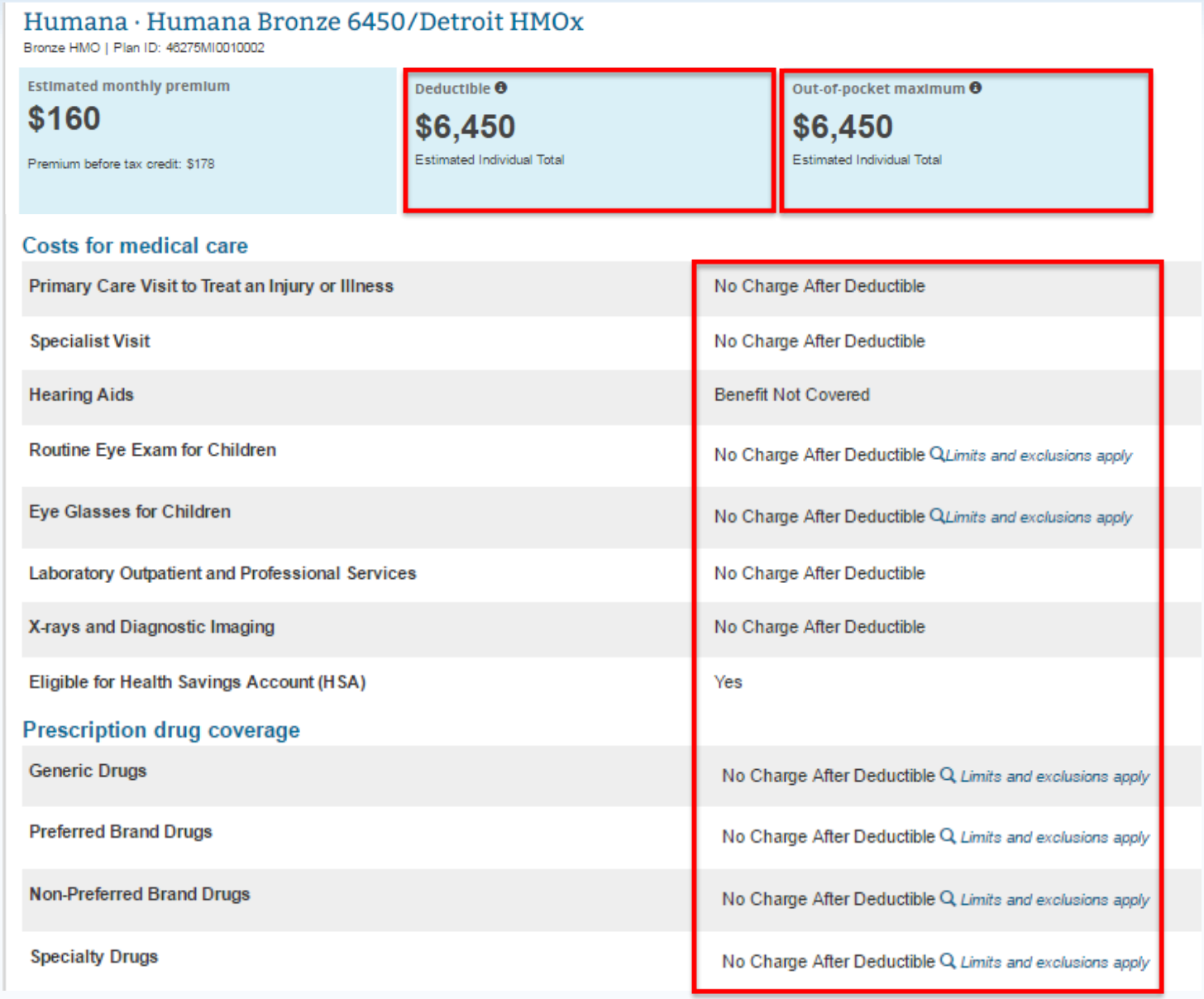
***Source**: healthcare.gov, Anthem Healthkeepers Bronze X 4650 35 plan in Fairfax County, VA*

Partial Exemptions from the Deductible



***Source**: healthcare.gov, Anthem Healthkeepers Bronze X 4650 35 plan in Fairfax County, VA*

Deductible-only Plans



Humana · Humana Bronze 6450/Detroit HMOx

Bronze HMO | Plan ID: 46275MI0010002

Estimated monthly premium	Deductible	Out-of-pocket maximum
$160	$6,450	$6,450
Premium before tax credit: $178	Estimated Individual Total	Estimated Individual Total

Costs for medical care

Primary Care Visit to Treat an Injury or Illness	No Charge After Deductible
Specialist Visit	No Charge After Deductible
Hearing Aids	Benefit Not Covered
Routine Eye Exam for Children	No Charge After Deductible *Limits and exclusions apply*
Eye Glasses for Children	No Charge After Deductible *Limits and exclusions apply*
Laboratory Outpatient and Professional Services	No Charge After Deductible
X-rays and Diagnostic Imaging	No Charge After Deductible
Eligible for Health Savings Account (HSA)	Yes

Prescription drug coverage

Generic Drugs	No Charge After Deductible *Limits and exclusions apply*
Preferred Brand Drugs	No Charge After Deductible *Limits and exclusions apply*
Non-Preferred Brand Drugs	No Charge After Deductible *Limits and exclusions apply*
Specialty Drugs	No Charge After Deductible *Limits and exclusions apply*

***Source**: healthcare.gov, Humana Bronze 6450/Detroit HMOx plan in Wayne County, MI*

Additional Prescription Drug Tiers

Common Medical Event	Services You May Need	Your Cost If You Use an In-Network Provider	Your Cost If You Use an Out-of-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at: www.humana.com/2016-Rx5-Complete or click here	Level 1 - Preferred generics	$10 copay (Retail) $25 copay (Mail order)	Not covered	Preauthorization may be required, penalty will be 100% for certain prescription drugs. 30 day supply (Retail) 90 day supply (Mail Order)
	Level 2 - Non-preferred generics	$20 copay (Retail) $50 copay (Mail order)	Not covered	
	Level 3 - Preferred brands	$50 copay (Retail) $125 copay (Mail order)	Not covered	
	Level 4 - Non-preferred brands	50% coinsurance	Not covered	
	Level 5 - Specialty drugs	50% coinsurance	Not covered	**Specialty Drugs:** 40% coinsurance when filled via a preferred network pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	Not Covered	---none---
	Physician/surgeon fees	20% coinsurance after deductible	Not Covered	---none---
If you need immediate medical attention	Emergency room services	$250 copay/visit. Deductible, then 20% coinsurance	$250 copay/visit. Deductible, then 20% coinsurance	---none---
	Emergency medical transportation	20% coinsurance after deductible	20% coinsurance after deductible	---none---
	Urgent care	$40 copay/visit	Not Covered	---none---

***Source**: Summary of Benefits and Coverage, Humana Silver 3800/Austin HMOx in Travis County, TX*

Additional Prescription Drug Tiers

Humana · Humana Silver 3800/Austin HMOx

Silver HMO | Plan ID: 32673TX0640004

Estimated monthly premium	Deductible	Out-of-pocket maximum
$280	$3,800	$6,300
	Estimated individual Total	Estimated Individual Total

Estimated total yearly costs

CALCULATE

Copayments / Coinsurance

Primary doctor: $20

Specialist doctor: $40

Emergency room care: $250 Copay before deductible/20% Coinsurance after deductible

Generic drugs: $16

Prescription drug coverage

Generic Drugs	$16 *Limits and exclusions apply*
Preferred Brand Drugs	$50 *Limits and exclusions apply*
Non-Preferred Brand Drugs	50% *Limits and exclusions apply*
Specialty Drugs	50% *Limits and exclusions apply*
List of covered drugs	View
Prescription drug deductible	$0
Prescription drug out-of-pocket maximum	Included in plan's out-of-pocket maximum

***Source**: healthcare.gov, Humana Silver 3800/Austin HMOx in Travis County, TX*

Prescription Drug Min/Max Copays

UnitedHealthcare **Bronze Compass 6500** **Coverage Period: 01/01/2016 – 12/31/2016**

Summary of Benefits and Coverage: What This Plan Covers & What it Costs **Coverage for:** Individual & Family **Plan Type:** HMO

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider with a Referral	Your Cost If You Use a Network Provider without a Referral	Your Cost If You Use a Out-of-Network Provider	Limitations & Exceptions
If you have a test	Diagnostic test (x-ray, blood work)	Freestanding: 40% co-ins after deductible	Freestanding: 40% co-ins after deductible	Not Covered	Hospital: 50% co-ins after deductible
	Imaging (CT / PET scans, MRIs)	40% co-ins after deductible	40% co-ins after deductible	Not Covered	Hospital: $500 imaging per occurrence. The $500 applies before the annual deductible.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at uhc.com/rxfind	Tier 1 – Your Lowest-Cost Option	Retail: $10 copay after deductible	Retail: $10 copay after deductible	Not Covered	Provider means pharmacy for purposes of this section. Retail: Up to a 31 day supply. Mail-Order: Not Covered You may need to obtain certain drugs, including certain specialty drugs, from a pharmacy designated by us. Certain drugs may have a pre-authorization requirement or may result in a higher cost. If you use an out-of-network pharmacy, you may be responsible for any amount over the co-insurance amount. Tier 1 Contraceptives covered at No Charge. You may be required to use a lower-cost drug(s). Not all drugs are covered.
	Tier 2 – Your Midrange-Cost Option	Retail: $50 copay after deductible	Retail: $50 copay after deductible	Not Covered	
	Tier 3 – Your Highest-Cost Option	Retail: 20% co-ins after deductible with a $150 copay min	Retail: 20% co-ins after deductible with a $150 copay min	Not Covered	
	Tier 4 – Additional High-Cost Options	Retail: 30% co-ins after deductible with a $300 copay min	Retail: 30% co-ins after deductible with a $300 copay min	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% co-ins after deductible	Not Covered	Not Covered	Hospital: $500 outpatient surgery per occurrence. The $500 applies before the annual deductible.
	Physician / surgeon fees	40% co-ins after deductible	Not Covered	Not Covered	——————none——————

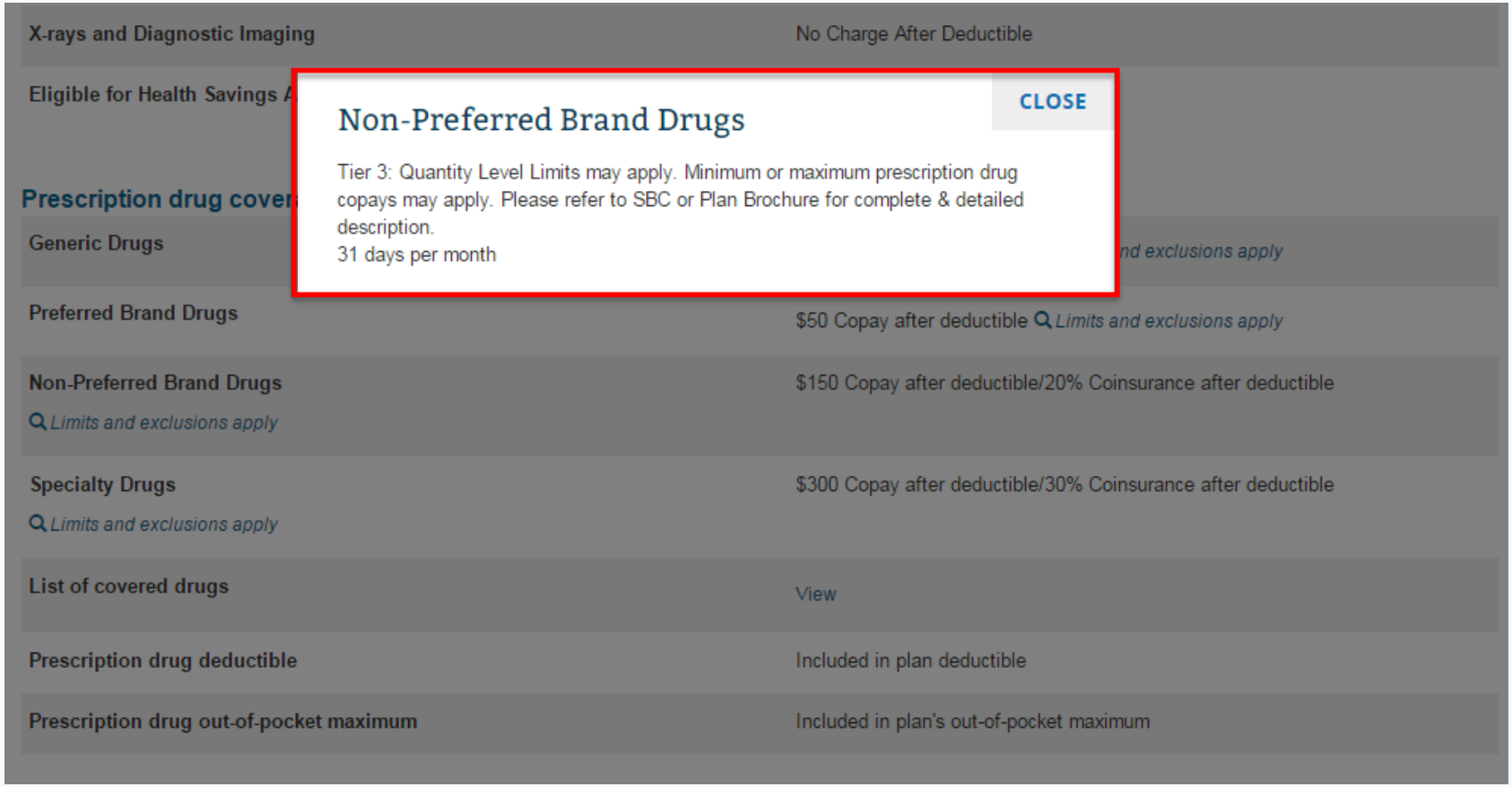
***Source**: Summary of Benefits and Coverage for United Healthcare Bronze Compass 6500 in Sarpy County, NE*

Prescription Drug Min/Max Copays

X-rays and Diagnostic Imaging	No Charge After Deductible
Eligible for Health Savings Account (HSA)	Yes
Prescription drug coverage	
Generic Drugs	$10 Copay after deductible Limits and exclusions apply
Preferred Brand Drugs	$50 Copay after deductible Limits and exclusions apply
Non-Preferred Brand Drugs Limits and exclusions apply	$150 Copay after deductible/20% Coinsurance after deductible
Specialty Drugs Limits and exclusions apply	$300 Copay after deductible/30% Coinsurance after deductible
List of covered drugs	View
Prescription drug deductible	Included in plan deductible
Prescription drug out-of-pocket maximum	Included in plan's out-of-pocket maximum

***Source**: healthcare.gov, United Healthcare Bronze Compass 6500 in Sarpy County, NE*

Prescription Drug Min/Max Copays



X-rays and Diagnostic Imaging	No Charge After Deductible
Eligible for Health Savings A	
Prescription drug cover	
Generic Drugs	nd exclusions apply
Preferred Brand Drugs	$50 Copay after deductible Limits and exclusions apply
Non-Preferred Brand Drugs Limits and exclusions apply	$150 Copay after deductible/20% Coinsurance after deductible
Specialty Drugs Limits and exclusions apply	$300 Copay after deductible/30% Coinsurance after deductible
List of covered drugs	View
Prescription drug deductible	Included in plan deductible
Prescription drug out-of-pocket maximum	Included in plan's out-of-pocket maximum

Non-Preferred Brand Drugs

CLOSE

Tier 3: Quantity Level Limits may apply. Minimum or maximum prescription drug copays may apply. Please refer to SBC or Plan Brochure for complete & detailed description.
31 days per month

***Source**: healthcare.gov, United Healthcare Bronze Compass 6500 in Sarpy County, NE*

Narrow Provider Networks

Modern Healthcare MENU

Vital Signs

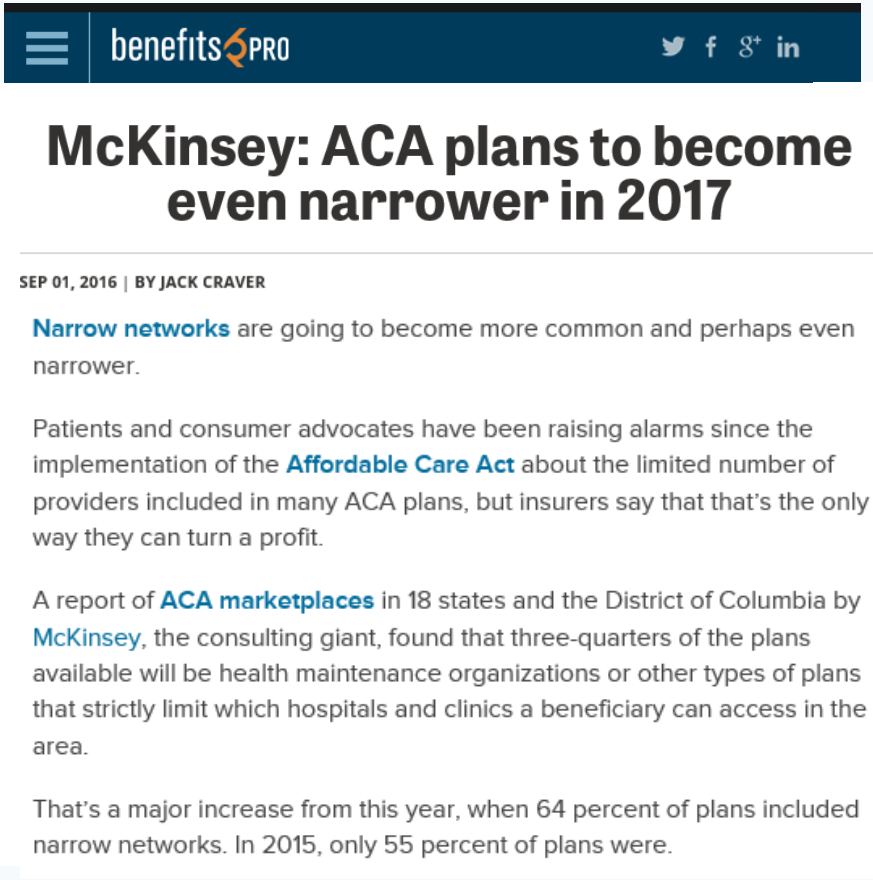
Nearly half of exchange products offer narrow networks, McKinsey study says

By Paul Demko | June 10, 2014

Roughly half of the products sold on exchanges in 2014 were narrow-network plans, according to a study by the McKinsey Center for U.S. Health System Reform (PDF). In the largest city in each state, that figure jumped to 60%.

The vast majority of exchange customers had a choice between broad- or narrow-network plans, the McKinsey study found. Broad network plans were available to 90% of potential customers, while narrow-network plans were an option for 92% of that population.

"When a consumer goes to shop they can actually proactively make that access-price tradeoff, whereas before they might not have had that choice," said Erica Coe, co-leader of the McKinsey Center for U.S. Health System Reform, and an author of the study.



benefitspro

McKinsey: ACA plans to become even narrower in 2017

SEP 01, 2016 | BY JACK CRAVER

Narrow networks are going to become more common and perhaps even narrower.

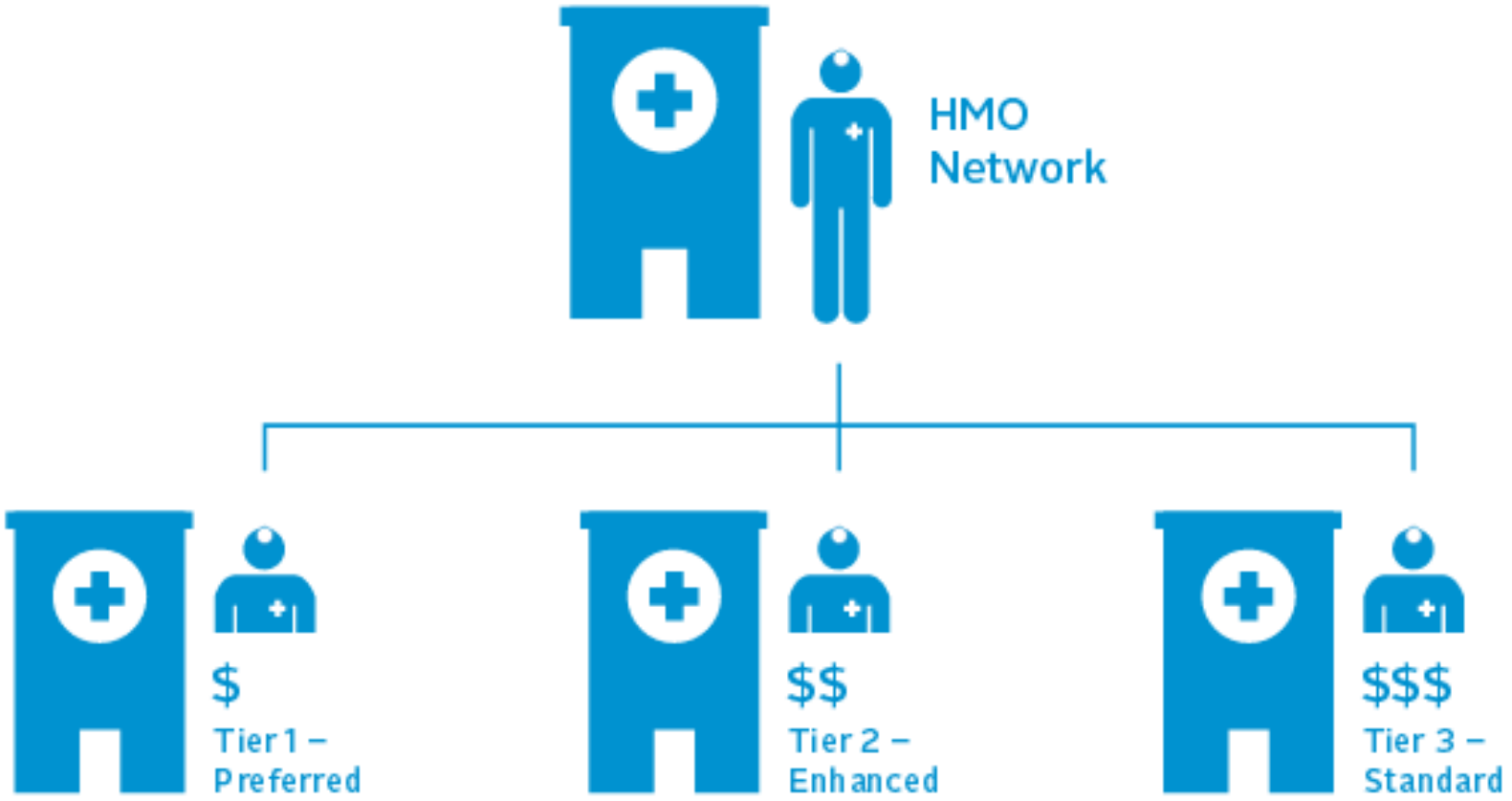
Patients and consumer advocates have been raising alarms since the implementation of the Affordable Care Act about the limited number of providers included in many ACA plans, but insurers say that that's the only way they can turn a profit.

A report of ACA marketplaces in 18 states and the District of Columbia by McKinsey, the consulting giant, found that three-quarters of the plans available will be health maintenance organizations or other types of plans that strictly limit which hospitals and clinics a beneficiary can access in the area.

That's a major increase from this year, when 64 percent of plans included narrow networks. In 2015, only 55 percent of plans were.

***Source**: Modern Healthcare, Vital Signs blog, Nearly half of exchange products offer narrow networks, McKinsey study says (June 10, 2014) and beneditspro, McKinsey: ACA plans to become even narrower in 2017 (September 1, 2016)*

Tiered Provider Networks



***Source**: Plan Brochure for Independence Blue Cross HMO Silver Proactive Plan in Philadelphia County, PA*

Tiered Provider Networks

Common Medical Event	Services You May Need	Your Cost If You Use			Limitations & Exceptions
		Tier 1 - Preferred	Tier 2 - Enhanced	Tier 3 - Standard	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 Copay	$40 Copay, no ded	$50 Copay, no ded	----------none----------
	Specialist visit	$60 Copay	$80 Copay, no ded	$100 Copay, no ded	PCP referral required.
	Other practitioner office visit	$50 Copay	$50 Copay, no ded	$50 Copay, no ded	PCP referral required for spinal manipulation. Visit limits may apply. See benefit booklet.
	Preventive care / screening / immunization	No Charge	No Charge no ded	No Charge no ded	Age and frequency schedules may apply. For colorectal cancer screening, your cost share may vary depending on where you receive service.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 Copay	Subject to ded and $750 Copay	Subject to ded and $1,250 Copay	Precertification may be required. See benefit booklet.
	Physician/surgeon fees	No Charge	5%, after ded	10%, after ded	Precertification may be required. See benefit booklet.
If you need immediate medical attention	Emergency room services	$550 Copay	$550 Copay, no ded	$550 Copay, no ded	----------none----------
	Emergency medical transportation	$200 Copay	$200 Copay, no ded	$200 Copay, no ded	----------none----------
	Urgent care	$100 Copay	$100 Copay, no ded	$100 Copay, no ded	Your costs for urgent care are based on care received at a designated urgent care center or facility, not your physicians office. Costs may vary depending on where you receive care.
If you have a hospital stay	Facility fee (e.g., hospital room)	$500/day; max of 5 copays/ adm	Subject to ded and $900/day; max of 5 copay/ adm	Subject to ded and $1,300/day; max of 5 copays/ adm	Precertification required.

***Source**: Summary of Benefits and Coverage for Independence Blue Cross HMO Silver Proactive Plan in Philadelphia County, PA*

Inaccurate Provider Directories

Improving the Accuracy of Health Insurance Plans' Provider Directories

ISSUE BRIEF / OCTOBER 2015

Inaccuracies in Provider Directories Are Prevalent

Consumers often find that reliable information about health insurance provider networks is not available. Common inaccuracies contained in the provider directories maintained by health plans include:

- Providers who are not actually in the plan's network
- Inaccurate provider contact information, such as incorrect phone numbers
- Inaccurate information about which languages providers speak or the type of health care services they deliver

Research Documenting the Prevalence of Inaccurate Provider Directories

One study of Maryland's qualified health plans (QHPs, plans certified for sale on a health insurance marketplace under the ACA) found that less than half (only 43 percent) of psychiatrists listed in their provider

43%
Less than half of psychiatrists in Maryland QHPs could be reached at the numbers listed for them in the provider directories.[1]

1/3
of psychiatrists listed in New Jersey PPOs had incorrect contact information.[2]

18.2%
of providers in one plan were not practicing at their listed locations.[3]

***Source**: Families USA, Improving the Accuracy of Health Insurance Plans' Provider Directories (October 2015)*

Premium Changes Year to Year

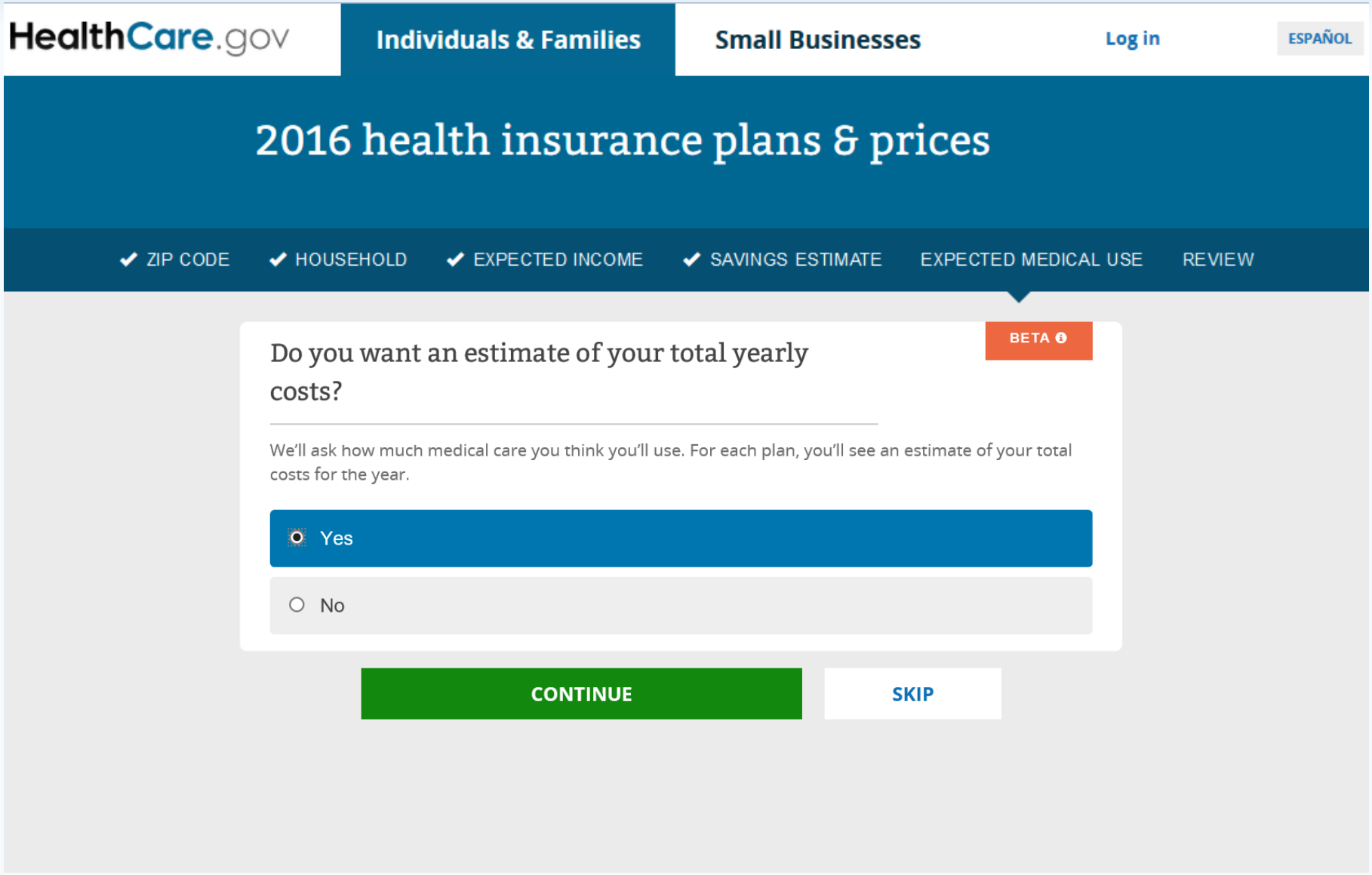
Rank	2014		2015		2016	
	Plan	Price (29 y/o)	Plan	Price (29 y/o)	Plan	Price (29 y/o)
1	Innovation Classic 5000	$228.00	Kaiser Permanente 1750/25%/HSA/ Dental	$239.08	Innovation Health Leap Silver Basic	$237.00
2	Carefirst BlueChoice HSA Silver $1300	$239.00	Innovation Silver $10 Copay	$246.89	Kaiser Permanente VA Silver 2750/20/ HSA/Dental/ Ped dental	$248.00
3	Kaiser Permanente 1750/25/ HSA/Dental	$241.00	Kaiser Permanente 2500/30/Dental	$250.89	United HealthCare, Silver Compass HSA 2000	$253.00
4	CareFirst BlueChoice Silver $2000	$241.00	Kaiser Permanente 1500/30/Dental	$261.08	Innovation Health Leap Silver Plus	$254.00
5	Kaiser Permanente 2500/30/Dental	$245.00	Innovation Silver $5 Copay 2750	$265.10	Kaiser Permanente VA Silver 2500/30/ Dental/Ped Dental	$262.00
6	CareFirst BlueChoice Plus Silver $2500	$251.00	CareFirst BlueChoice Plus Silver $2500	$283.16	United Healthcare, Silver Compass 4500-1	$264.00
7	Innovation Classic 3500 PD	$251.00	CareFirst BlueChoice Plus Silver $2000	$287.90	Kaiser Permanente VA Silver 1500/30/ Dental/Ped Dental	$276.00
8	Kaiser Permanente 1500/30/Dental	$253.00	CareFirst BlueChoice Silver $1300	$288.06	CareFirst BlueChoice HMO HSA Silver $1,350	$312.00
9	GHMSI BCBS Preferred 1500 (MSP)	$264.00	GHMSI BCBS Preferred 1500 (MSP)	$303.58	CareFirst BlueChoice HMO Silver $2,000	$345.00
10	Innovation Classic 5000: MO	$1,500.00			CareFirst BlueChoice Plus Silver $2500	$345.00

***Source**: healthcare.gov, premiums for Silver plans for a 29 year-old in Arlington County, VA*

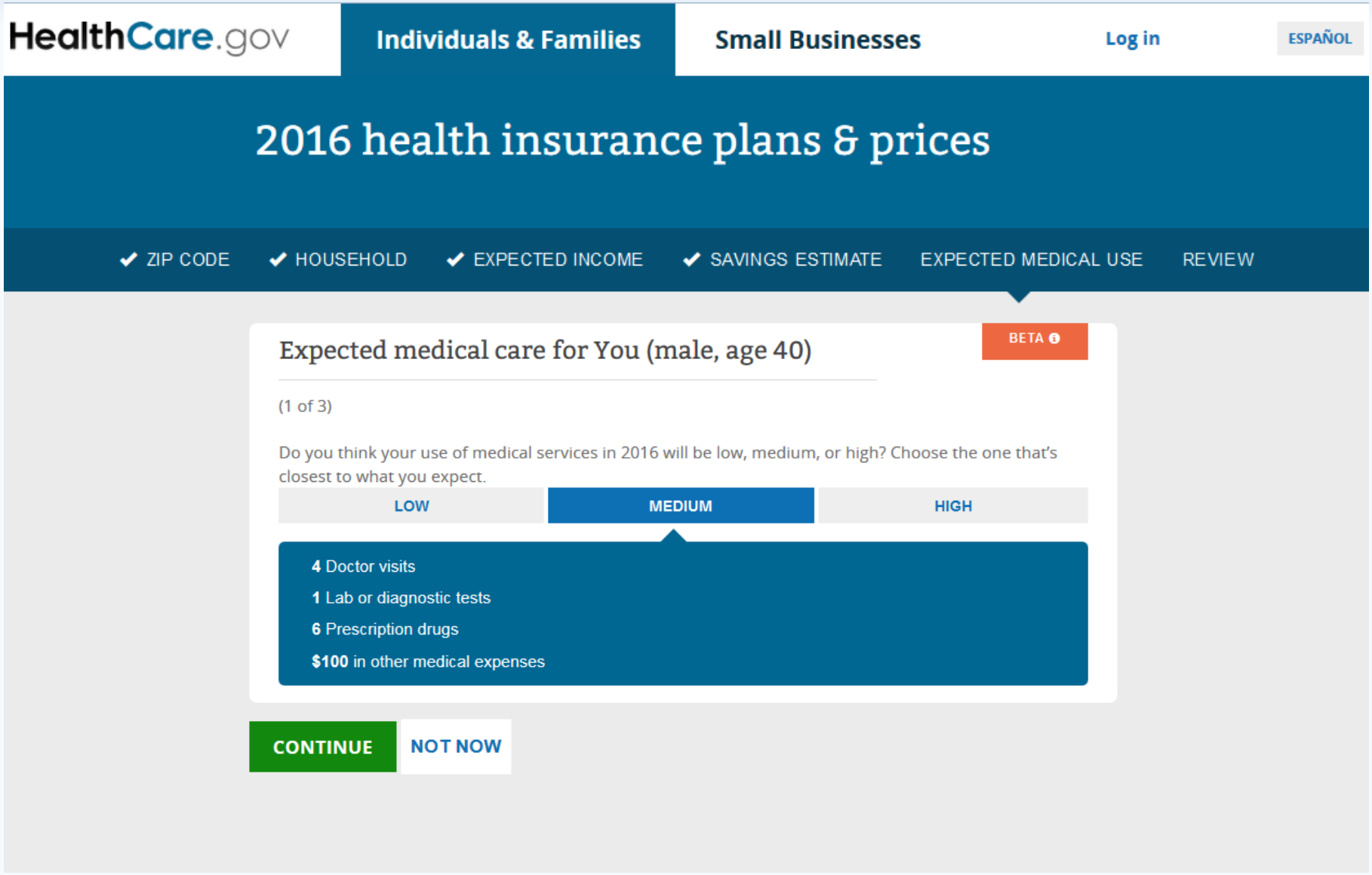
Q & A Session 1

Section 3:
Plan Comparison & Selection

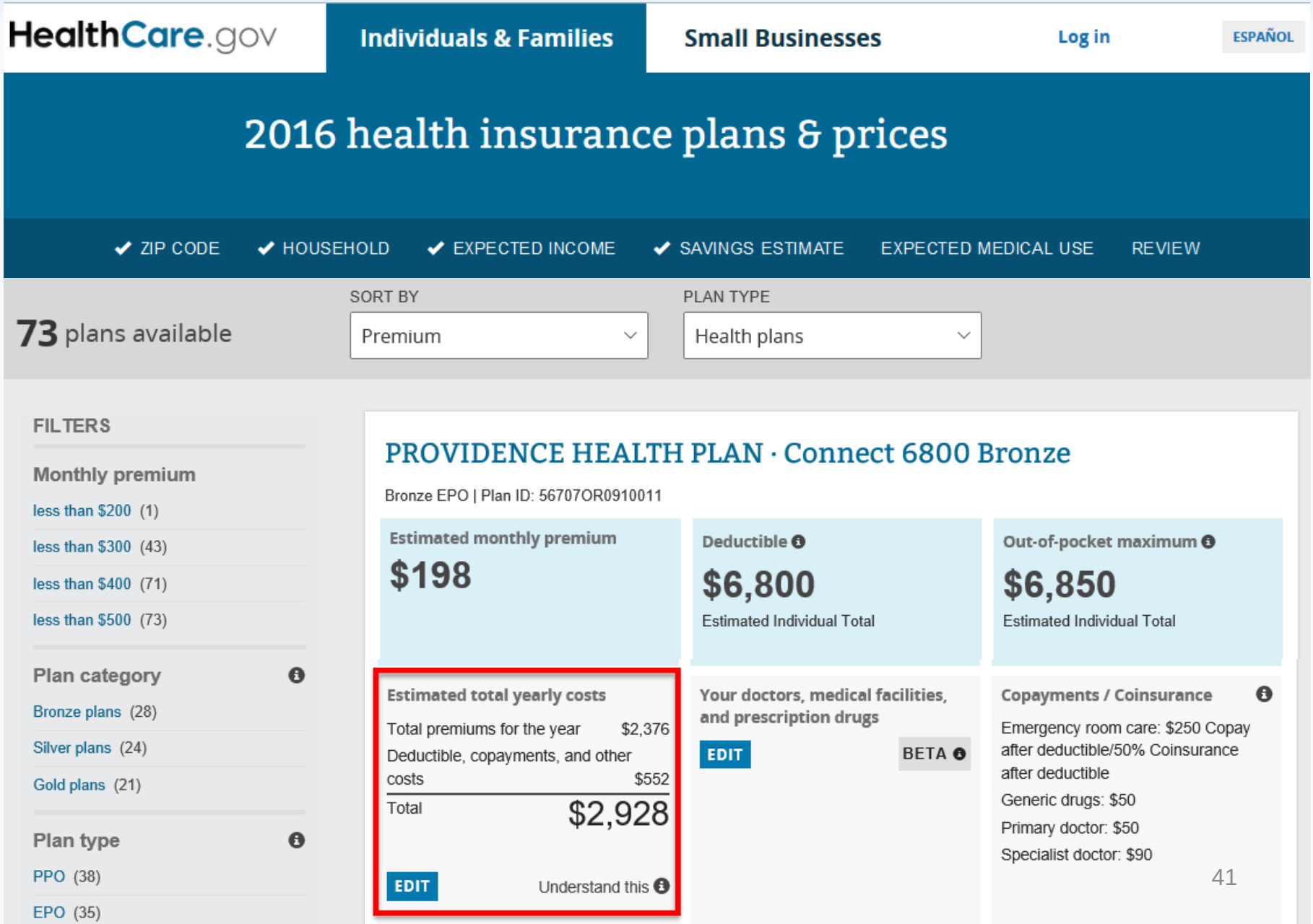
healthcare.gov Out-of-Pocket Cost Calculator



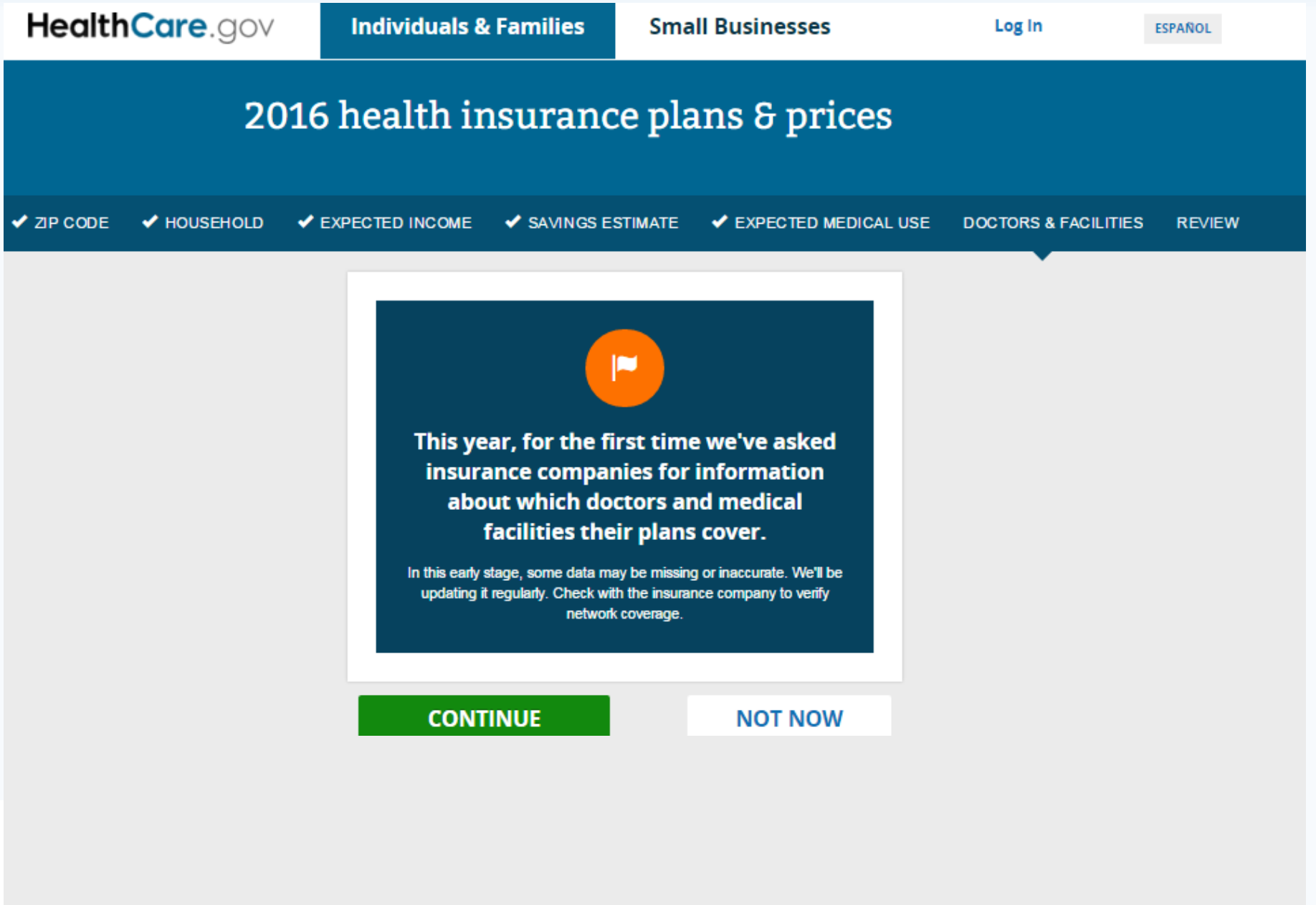
healthcare.gov Out-of-Pocket Cost Calculator



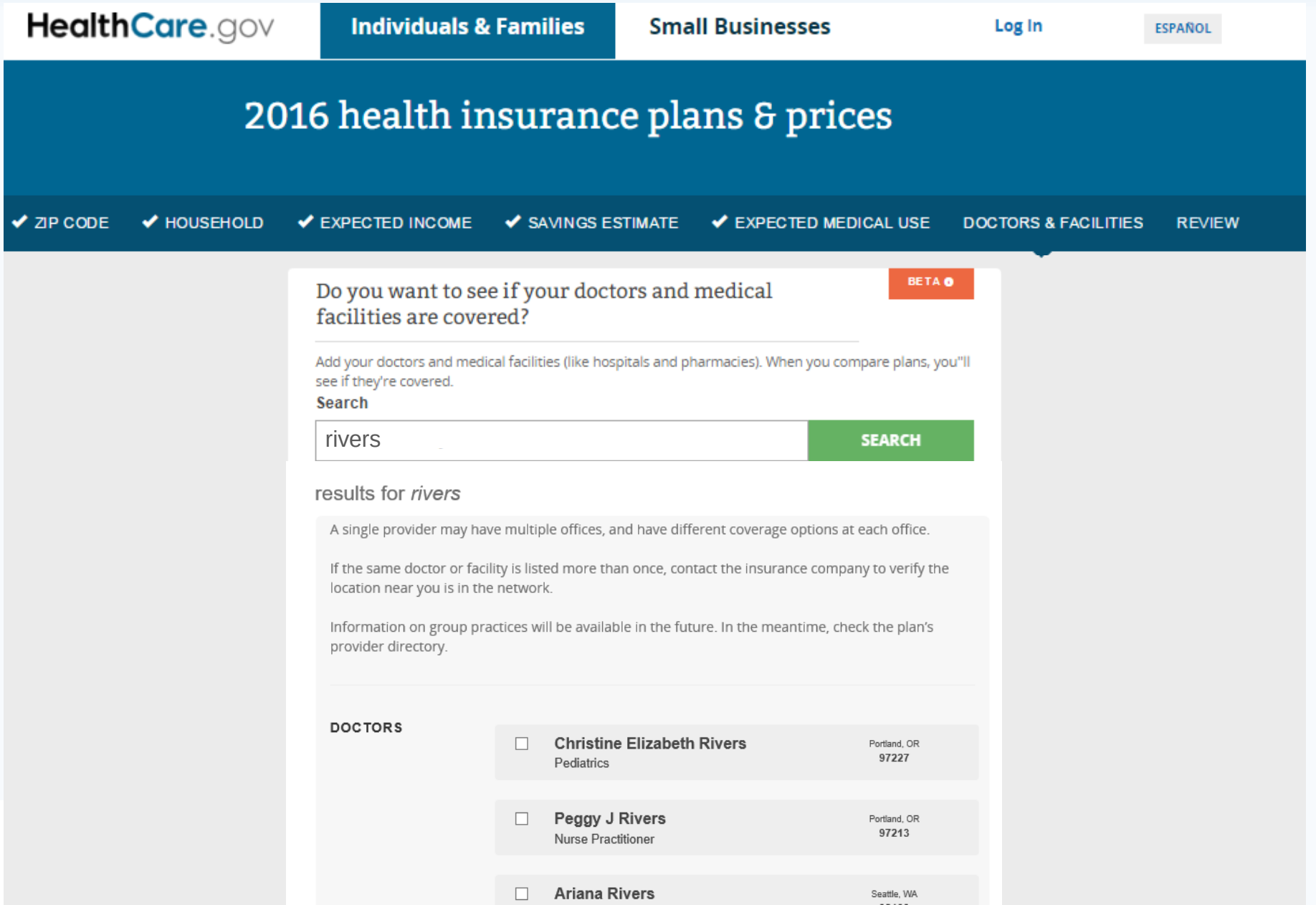
healthcare.gov Out-of-Pocket Cost Calculator



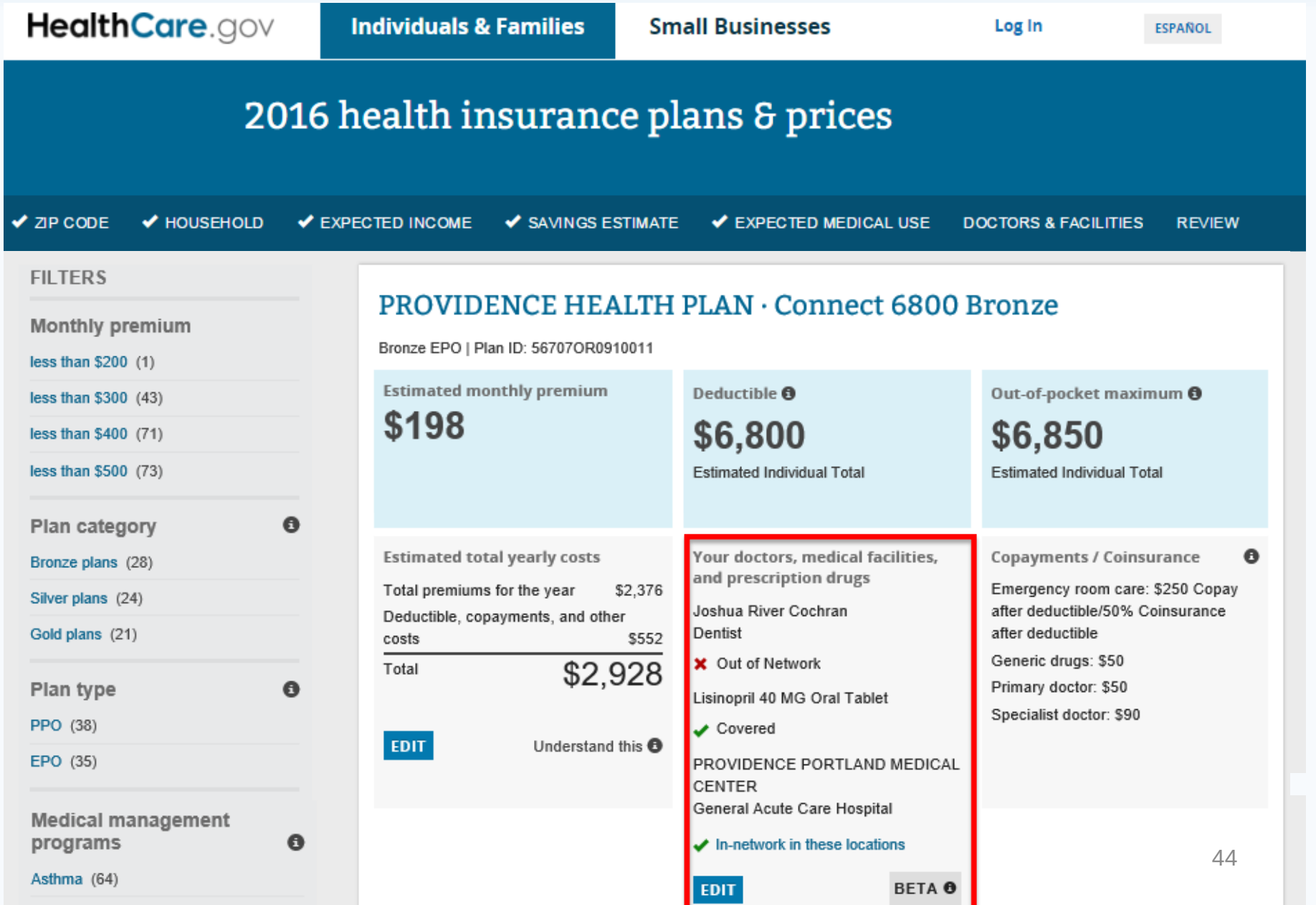
healthcare.gov Provider/Rx Search Tool



healthcare.gov Provider/Rx Search Tool



healthcare.gov Provider/Rx Search Tool



New healthcare.gov Features for 2017

	2016		2017	
	Anonymous Browsing	Plan Shopping	Anonymous Browsing	Plan Shopping
Out-of-Pocket Calculator	✓		✓	✓
Provider and Prescription Drug Search	✓		✓	✓

- **"Simple Choice Plans"**
  - Voluntary for carriers in 2017

- **Quality Rating System (QRS)**

  - Pilot in ~~Michigan, Ohio, Pennsylvania~~, Virginia, and Wisconsin in 2017
- **Provider Network Size Rating**

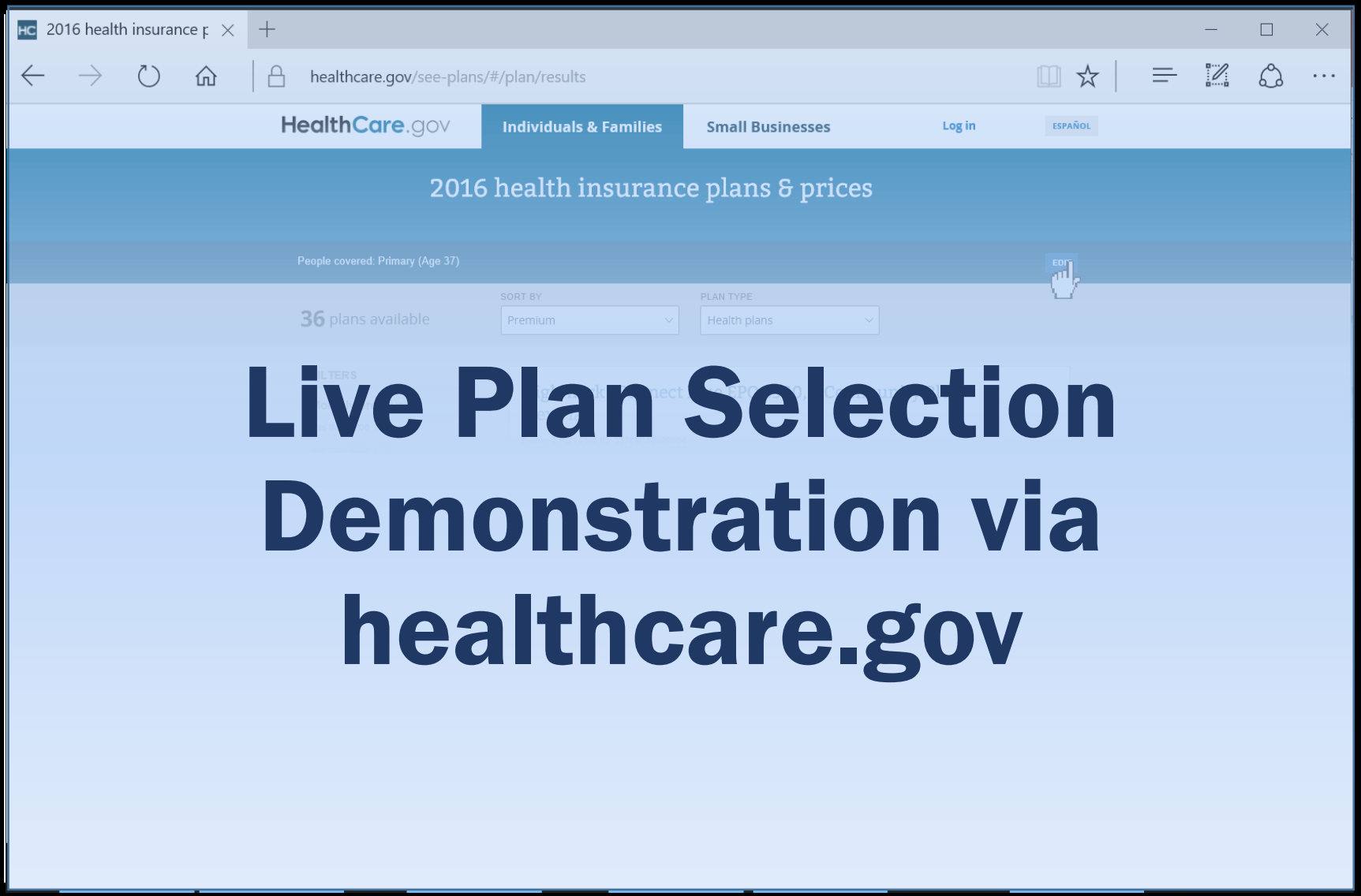
  - 2017 pilot (pilot states not yet released)

Comprehensive Analysis of Plans in your Area

Silver Plans

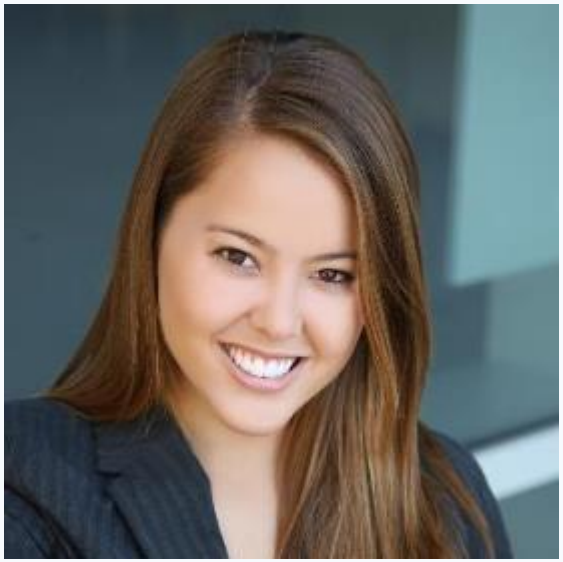
Insurance Company	Ambetter	Ambetter	Ambetter	Ambetter	Ambetter	Ambetter	CareSource	Molina	CareSource	UnitedHealthcare
Plan Name	Balanced Care 2	Balanced Care 1	Balanced Care 2 + Vision	Balanced Care 1 + Vision	Balanced Care 10	Balanced Care 10 + Vision	Just4Me Silver	Marketplace Silver Plan	Just4Me Silver with Dental and Vision	Silver Compass HSA 3000
Metal Tier	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver
Plan Type	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO	HMO
Monthly Premium	**$83.00**	**$89.00**	**$91.00**	**$97.00**	**$99.00**	**$107.00**	**$113.00**	**$131.00**	**$143.00**	**$201.00**
Medical Deductible - individual	$1,750	$350	$1,750	$350	$1,000	$1,000	$1,000	$450	$1,000	$800
Drug Deductible - individual	Included in Medical	Included in Medical	Included in Medical	Included in Medical	Included in Medical	Included in Medical	Included in Medical	Included in Medical	Included in Medical	Included in Medical
Out Of Pocket Max - individual	$1,750	$2,250	$1,750	$2,250	$1,750	$1,750	$2,000	$2,250	$2,000	$2,250
Primary Care Physician	$1	$1	$1	$1	$1	$1	no charge	$10	no charge	no charge after deductible
Specialist	$5	$10	$5	$10	$5	$5	no charge	$30	no charge	no charge after deductible
Diagnostic Test	no charge after deductible	20% after deductible	no charge after deductible	20% after deductible	20% after deductible	20% after deductible	no charge after deductible	$10	no charge after deductible	no charge after deductible
Imaging	no charge after deductible	20% after deductible	no charge after deductible	20% after deductible	20% after deductible	20% after deductible	no charge after deductible	$30	no charge after deductible	no charge after deductible
Generic Drugs	$1	$5	$1	$5	$1	$1	no charge	$5	no charge	$5 after deductible
Preferred Brand Drugs	$25	$25	$25	$25	$25	$25	$25	$30	$25	$35 after deductible
Non-preferred Brand Drugs	no charge after deductible	20% after deductible	no charge after deductible	20% after deductible	20% after deductible	20% after deductible	$120	20$	$120	$150 after deductible/
Specialty Drugs	no charge after deductible	20% after deductible	no charge after deductible	20% after deductible	20% after deductible	20% after deductible	40%	20%	40%	$300 after deductible/
Emergency Room	no charge after deductible	20% after deductible	no charge after deductible	20% after deductible	20% after deductible	20% after deductible	$300 after deductible	$150	$300 after deductible	no charge after deductible
Inpatient Facility	no charge after deductible	20% after deductible	no charge after deductible	20% after deductible	20% after deductible	20% after deductible	$300/stay after deductible	20% after deductible	$300/stay after deductible	no charge after deductible
Inpatient Physician fees	no charge after deductible	20% after deductible	no charge after deductible	20% after deductible	20% after deductible	20% after deductible	10% after deductible	20% after deductible	10% after deductible	no charge after deductible
Mental Health outpatient	$1	$1	$1	$1	$1	$1	no charge after deductible	$10	no charge after deductible	no charge after deductible
Mental Health inpatient	no charge after deductible	20% after deductible	no charge after deductible	20% after deductible	20% after deductible	20% after deductible	$300/stay after deductible	20% after deductible	$300/stay after deductible	no charge after deductible

***Source**: healthcare.gov, Silver plans for a 50-year old making $20,000 in Cleveland, OH*



Live Plan Selection Demonstration via healthcare.gov

SCENARIO 1: Jennifer



Applicant(s) (age): Jennifer (32)

Location: Dauphin County

Zip Code: 17104

Annual Income: $30,000

Doctors/Providers?	No
Prescription Drugs?	No
Health Status?	Mostly healthy
Other Priorities?	Mostly concerned about cost

SCENARIO 1: Jennifer

SCENARIO 1: Jennifer

	Plan 1	Plan 2	Plan 3
Insurance company			
Health plan name			
Metal level/Network Type			
Monthly premium *(after tax credit)*			
Deductible (in-network/out-of-network)			
OOP Maximum (in-network/out-of-network)			
Copay	**Deductible applies?**	**Deductible applies?**	**Deductible applies?**
Primary Care Provider			
Specialist Visit			
Rx Tier 1			
Rx Tier 2			
Rx Tier 3			
Rx Tier 4			
Emergency Room Visit			
Inpatient Hospital Stay			
Other Service:			
Other Service:			
Health Care Providers	**In Network/Covered?**	**In Network/Covered?**	**In Network/Covered?**
Provider/Rx: **Dr.**			
Provider/Rx:			
Provider/Rx:			

SCENARIO 1: Jennifer

	Plan 1		Plan 2		Plan 3	
Insurance company	Aetna		Ambetter		Geisinger Helath Plan	
Health plan name	PinnacleHealth Ded-only HSA		PinnacleHealth $15 Copay		Marketplace Extra 10/50/2000	
Metal level/Network Type	Bronze HMO		Bronze HMO		Silver HMO	
Monthly premium *(after tax credit)*	$159		$172		$195	
Deductible (in-network/out-of-network)	$6,450		$6,850		$2,000	
OOP Maximum (in-network/out-of-network)	$6,450		$6,850		$6,250	
Copay	**Deductible applies?**		**Deductible applies?**		**Deductible applies?**	
Primary Care Provider	no charge	✓	$15		$10	
Specialist Visit	no charge	✓	no charge	✓	$50	
Rx Tier 1	no charge	✓	no charge	✓	$3	
Rx Tier 2	no charge	✓	no charge	✓	$50	✓
Rx Tier 3	no charge	✓	no charge	✓	$85	✓
Rx Tier 4	no charge	✓	no charge	✓	50%	✓
Emergency Room Visit	no charge	✓	no charge	✓	$250	
Inpatient Hospital Stay	no charge	✓	no charge	✓	30%	✓
Other Service:						
Other Service:						
Health Care Providers	**In Network/Covered?**		**In Network/Covered?**		**In Network/Covered?**	
Provider/Rx: **Dr.**						
Provider/Rx:						
Provider/Rx:						

SCENARIO 1: Jennifer

Identifying Jennifer's priorities:

- Cheapest monthly payment?
- Manageable deductible?
- Low copays/coinsurance?
- Having "first dollar" coverage? (i.e. some services exempt from the deductible)?

SCENARIO 2: Jim and Michelle

Applicant(s) (age): Jim (52), Michelle (45)

Location: Allegheny County

Zip Code: 15218

Annual Income: $24,000

Doctors/Providers?	Dr. Heather Hohmann (OB/GYN) for Michelle
Prescription Drugs?	Metformin 500mg XR for Jim
Health Status?	Jim has Diabetes
Other Services?	Interested in cost for Laboratory Services

SCENARIO 2: Jim and Michelle

	Plan 1	Plan 2	Plan 3
Insurance company			
Health plan name			
Metal level/Network Type			
Monthly premium *(after tax credit)*			
Deductible (in-network/out-of-network)			
OOP Maximum (in-network/out-of-network)			
Copay	**Deductible applies?**	**Deductible applies?**	**Deductible applies?**
Primary Care Provider			
Specialist Visit			
Rx Tier 1			
Rx Tier 2			
Rx Tier 3			
Rx Tier 4			
Emergency Room Visit			
Inpatient Hospital Stay			
Other Service: **Labs**			
Other Service:			
Health Care Providers	**In Network/Covered?**	**In Network/Covered?**	**In Network/Covered?**
Provider/Rx: **Dr. Hohmann**			
Provider/Rx: **Metformin 500mg XR**			
Provider/Rx:			

SCENARIO 2: Jim and Michelle

	Plan 1		Plan 2		Plan 3	
Insurance company	UPMC		UPMC		UnitedHealthcare	
Health plan name	Advantage $3,250/$10 Partner		Advantage $1,750/$30 Partner		Silver Compass HSA 2000-1	
Metal level/Network Type	Silver EPO		Silver EPO		Silver HMO	
Monthly premium *(after tax credit)*	$77		$86		$126	
Deductible (in-network/out-of-network)	$1,700		$1,000		$1,100	
OOP Maximum (in-network/out-of-network)	$4,500		$4,500		$2,250	
Copay	**Deductible applies?**		**Deductible applies?**		**Deductible applies?**	
Primary Care Provider	$5		$15		$10	✓
Specialist Visit	$25		$30		$30	✓
Rx Tier 1	$4		$4		$5	✓
Rx Tier 2	$15		$15		$40	✓
Rx Tier 3	$45		$45		$120	✓
Rx Tier 4	50%		50%		$250	✓
Emergency Room Visit	$150		20%	✓	$250	✓
Inpatient Hospital Stay	no charge	✓	20%	✓	$750/stay	✓
Other Service: **Labs**	$15		$15		No charge	✓
Other Service:						
Health Care Providers	**In Network/Covered?**		**In Network/Covered?**		**In Network/Covered?**	
Provider/Rx: **Dr. Hohmann**	×		×		✓	
Provider/Rx: **Metformin 500mg XR**	Yes (Tier 1)		Yes (Tier 1)		Yes (Tier 1)	
Provider/Rx:						

SCENARIO 2: Jim and Michelle

Identifying Jim and Michelle's priorities:

- Cheapest monthly payment?
- Manageable deductible?
- Low copays/coinsurance?
- Having "first dollar" coverage? (i.e. some services exempt from the deductible)?
- Cost for a specific service?
- Current doctor in network?
- Prescription drug(s) covered?

SCENARIO 3: Rodriguez Family

Applicant(s) (age): Marco (43), Maria (43), Mariela (19), Daniel (13), and David (8)

Location: Philadelphia County

Zip Code: 19143

Annual Income: $45,000

Doctors/Providers?	Dr. Leah Lande (Pulmonologist) for Mariela
Prescription Drugs?	Advair (100-50mcg inhaler) for Mariela
Other Issues/ Providers?	Marco is considering procedure at Mercy Philadelphia Hospital

SCENARIO 3: Rodriguez Family

	Plan 1	Plan 2	Plan 3
Insurance company			
Health plan name			
Metal level/Network Type			
Monthly premium *(after tax credit)*			
Deductible (in-network/out-of-network)			
OOP Maximum (in-network/out-of-network)			
Copay	**Deductible applies?**	**Deductible applies?**	**Deductible applies?**
Primary Care Provider			
Specialist Visit			
Rx Tier 1			
Rx Tier 2			
Rx Tier 3			
Rx Tier 4			
Emergency Room Visit			
Inpatient Hospital Stay			
Other Service:			
Other Service:			
Health Care Providers	**In Network/Covered?**	**In Network/Covered?**	**In Network/Covered?**
Provider/Rx: **Dr. Leah Adkins**			
Provider/Rx: **Advair 100-50 mcg inhaler**			
Provider/Rx: **Mercy Philadelphia Hospital**			

SCENARIO 3: Rodriguez Family

	Plan 1		Plan 2		Plan 3	
Insurance company	Independence Blue Cross		UnitedHealthcare		Independence Blue Cross	
Health plan name	Keystone HMO Bronze		Bronze Compass HSA 5500-1		Keystone Silver Proactive Value	
Metal level/Network Type	Bronze HMO		Bronze HMO		Silver HMO	
Monthly premium *(after tax credit)*	$39		$53		$167	
Deductible (in-network/out-of-network)	$12,000		$11,000		$1,000	
OOP Maximum (in-network/out-of-network)	$13,700		$13,000		$3,000	
Copay	**Deductible applies?**		**Deductible applies?**		**Deductible applies?**	
Primary Care Provider	$50		no charge	✓	$10	
Specialist Visit	$100		no charge	✓	$20	
Rx Tier 1	$15		$10	✓	$4	
Rx Tier 2	50%	✓	$50	✓	30%	
Rx Tier 3	50%	✓	$120/20%	✓	40%	
Rx Tier 4	50%	✓	$250/30%	✓	50%	
Emergency Room Visit	$500		$500		$150	
Inpatient Hospital Stay	$700/day		No charge	✓	$50/day	
Other Service:						
Other Service:						
Health Care Providers	**In Network/Covered?**		**In Network/Covered?**		**In Network/Covered?**	
Provider/Rx: **Dr. Leah Adkins**	✓		✓		✓	
Provider/Rx: **Advair 100-50 mcg inhaler**	Yes (Tier 4)		Yes (Tier 3)		Yes (Tier 4)	
Provider/Rx: **Mercy Philadelphia Hospital**	✗		✓		✗	

SCENARIO 3: Rodriguez Family

	Plan 1				Plan 2	
Insurance company	Independence Blue Cross				Independence Blue Cross	
Health plan name	Keystone HMO Bronze				Keystone Silver Proactive Value	
Metal level/Network Type	Bronze HMO		**Annual Cost**	**Annual Cost**	Silver HMO	
Monthly premium *(after tax credit)*	$39		$468	$2,004	$167	
Deductible (in-network/out-of-network)	$12,000				$1,000	
OOP Maximum (in-network/out-of-network)	$13,700				$3,000	
Copay	**Deductible applies?**				**Deductible applies?**	
Primary Care Provider	$50		$250	$50	$10	
Specialist Visit	$100		$500	$150	$20	
Rx Tier 1	$15				$4	
Rx Tier 2	50%	✓			30%	
Rx Tier 3	50%	✓			40%	
Rx Tier 4	50%	✓	$750	$350	50%	
Emergency Room Visit	$500				$150	
Inpatient Hospital Stay	$700/day		$3,500	$250	$50/day	
Other Service:						
	rk/Covered?		**$5,468**	**$2,804**	**In Network/Covered?**	
	✓				✓	
	(Tier 4)				Yes (Tier 4)	
	×				×	

5 primary care visits ($100 each)
5 specialist visits ($150 each)
2 prescriptions ($350 each)
1 hospital stay for surgery (5 days)

SCENARIO 3: Rodriguez Family

Identifying Jim and Michelle's priorities:

- Cheapest monthly payment?
- Manageable deductible?
- Low copays/coinsurance?
- Having "first dollar" coverage? (i.e. some services exempt from the deductible)?
- Cost for a specific service?
- Current doctor in network?
- Prescription drug(s) covered?
- Lowest overall annual cost (premiums + anticipated cost-sharing)

Q & A Session 2

GOOD LUCK IN OEP 4!!!

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