Health Reform: **Beyond the Basics**

healthreformbeyondthebasics.org

Assisting Consumers in Plan Comparison and Selection

Center on Budget and Policy Priorities

November 10, 2015

Center on Budget and Policy Priorities

Overview of Plan Design

Beyond the Basics Webinar: Plan Design

Presented October 22, 2015

Topics include:

- Elements of plan design
- Cost sharing charges
- Cost sharing reductions
- Evaluating qualified health plans
- Comparing plan options

- View webinar: www.healthreformbeyondthebasics.org/cbpp-webinar-plan-design

State-Specific Plan Comparison Webinars

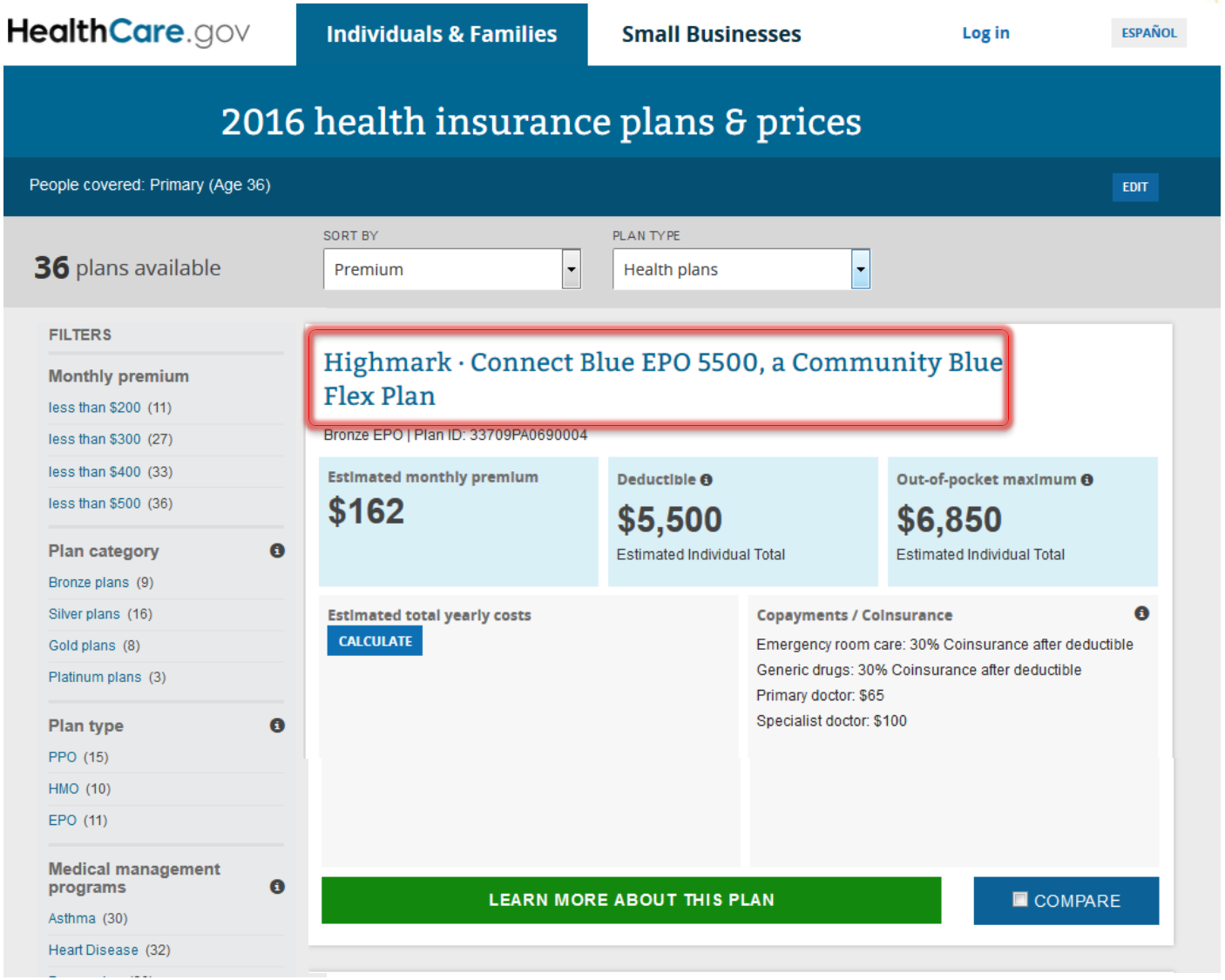
CBPP has presented state-specific plan comparison webinars in the following states:

- Colorado
- Florida
- Illinois (upcoming)
- Indiana
- Iowa
- Kansas (upcoming)
- Michigan
- Missouri
- Nebraska (upcoming)
- North Carolina (upcoming)
- North Dakota
- New Hampshire
- Oregon
- South Dakota
- Tennessee
- Texas
- Virginia
- Wisconsin
- Wyoming

Overview of Marketplace Health Plan Elements

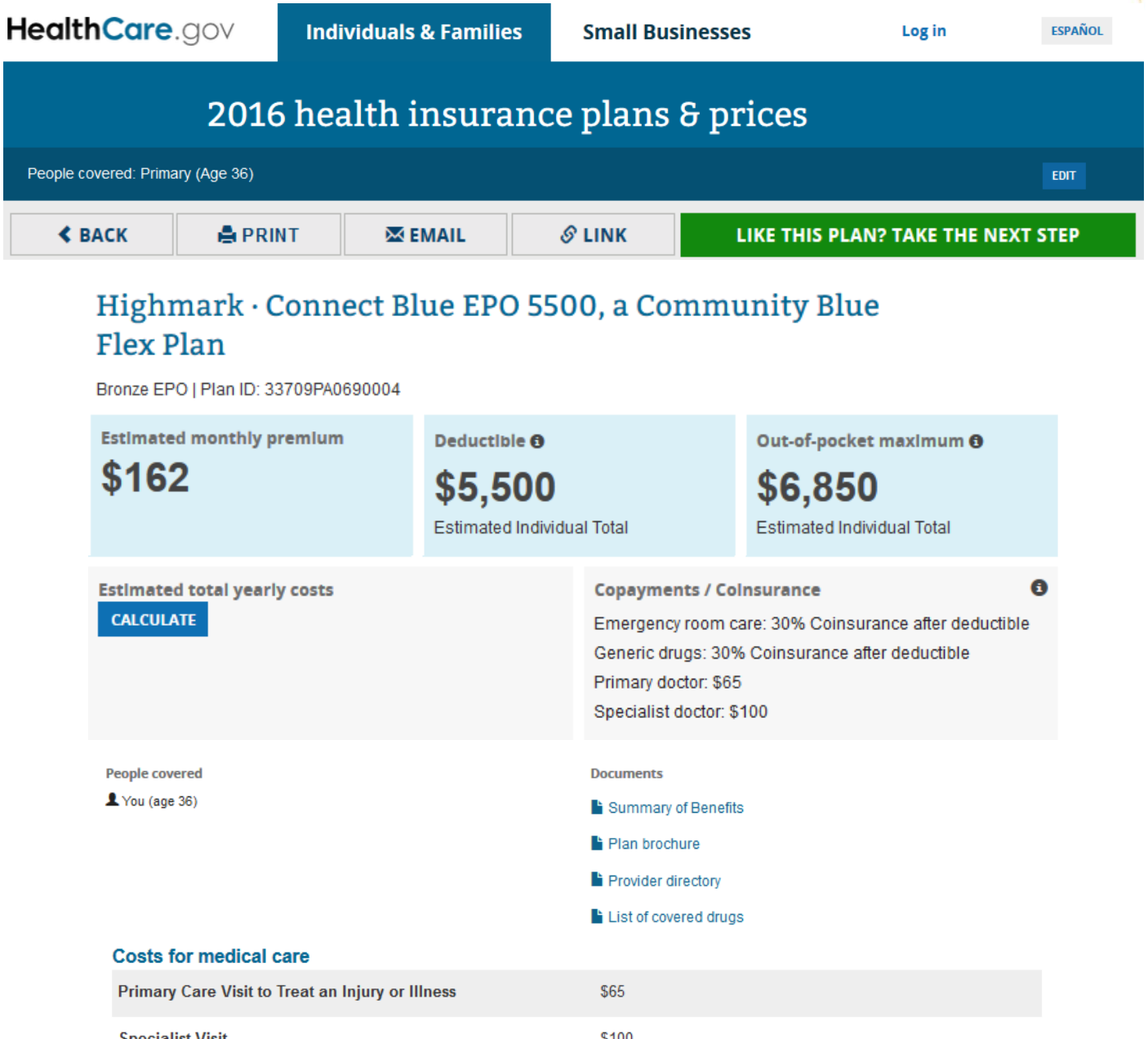
1. Premium
2. Cost Sharing/Plan Design
3. Benefits and Covered Services
4. Drug Formulary
5. Provider Network

Plan Display on Healthcare.gov



***Source**: healthcare.gov, Highmark Connect Blue EPO 5500 individual and family plans in Export, PA*

Plan Display on Healthcare.gov



Plan Display on Healthcare.gov

You (age 36)

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

Costs for medical care

Primary Care Visit to Treat an Injury or Illness	$65
Specialist Visit	$100
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	$60
X-rays and Diagnostic Imaging	$60
Eligible for Health Savings Account (HSA)	No

Prescription drug coverage

Generic Drugs	30% Coinsurance after deductible
Preferred Brand Drugs	30% Coinsurance after deductible
Non-Preferred Brand Drugs	30% Coinsurance after deductible
Specialty Drugs	30% Coinsurance after deductible
List of covered drugs	View
Prescription drug deductible	$0

Hospital services

Emergency Room Services	30% Coinsurance after deductible
Inpatient Hospital Services (e.g. Hospital Stay)	$1500 Copay per Stay
Inpatient Physician and Surgical Services	30% Coinsurance after deductible

Summary of Benefits and Coverage (SBC)

Highmark Blue Cross Blue Shield: Connect Blue EPO 5500, a Community Blue Flex Plan Base On Exchange Zone J

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:** EPO

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.highmarkbcbs.com or by calling 888-510-1084.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$5,500** individual/**$11,000** family preferred value network **$6,500** individual/**$13,000** family enhanced value network. **$6,850** individual/**$13,700** family standard value network	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 4 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 4 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Combined preferred, enhanced, and standard value network: Out-of-pocket up to a total maximum out-of-pocket of **$6,850** individual/**$13,700** family. All in-network services are credited to the preferred, the enhanced, and the standard out-of-pocket.	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.
What is not included in the out–of–pocket limit?	Premiums, balance-billed charges, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket.	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 4 describes any limits on what the plan will pay for *specific* covered services, such as office visits.

Source: Summary of Benefits and Coverage for Highmark Connect Blue EPO 5500 individual and family plans in Export, PA

Summary of Benefits and Coverage (SBC)

Highmark Blue Cross Blue Shield: Connect Blue EPO 5500, a Community Blue Flex Plan Base On Exchange Zone J

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

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

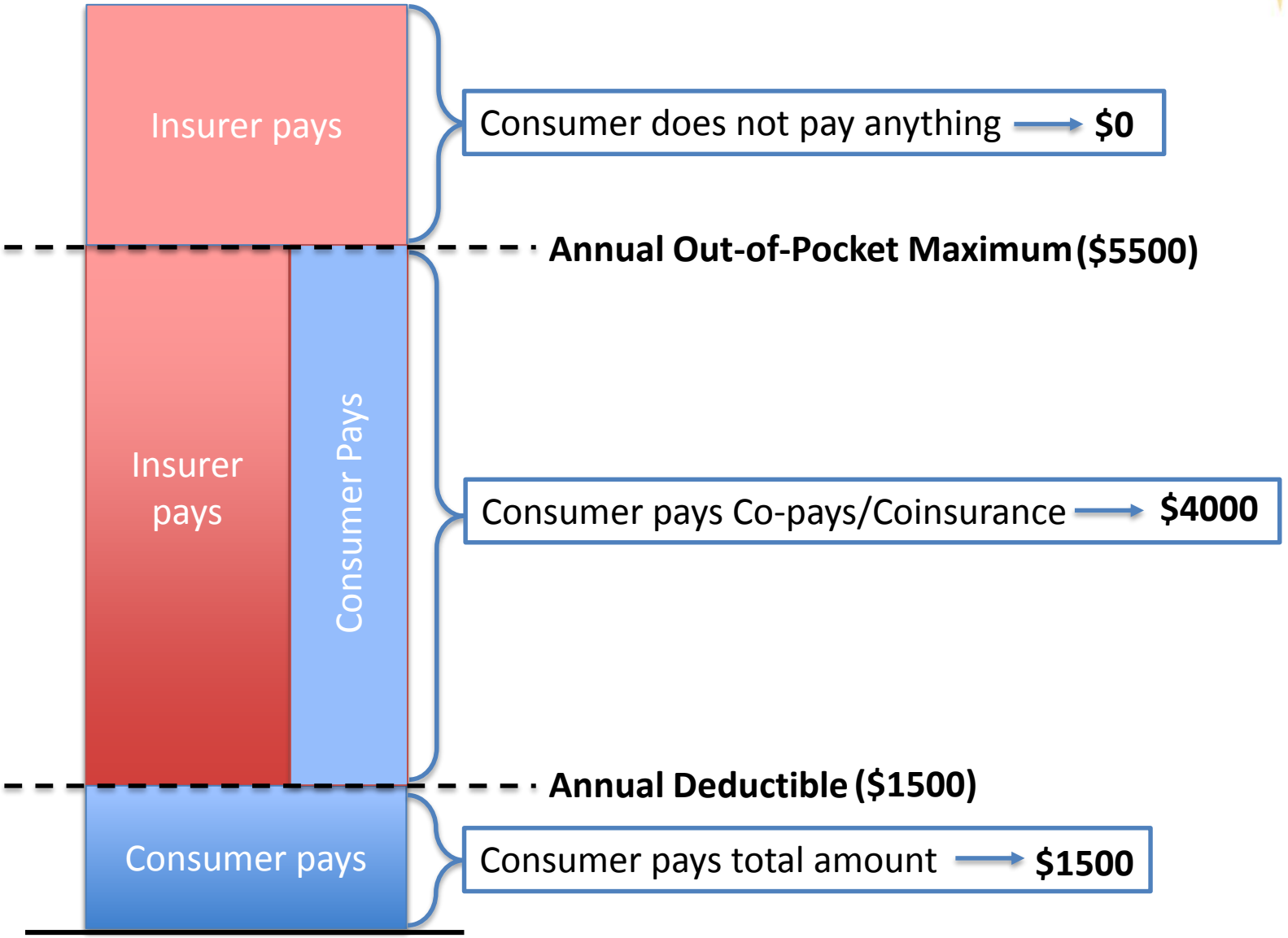
Coverage for: Individual/Family | **Plan Type:** EPO

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **network providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost if You Use a Preferred Value (Network) Provider	Your Cost if You Use an Enhanced Value (Network) Provider	Your Cost if You Use a Standard Value (Network) Provider	Your Cost if You Use an Out-of-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$65 copay/visit	$110 copay/visit	60% coinsurance	Not covered	————none————
	Specialist visit	$100 copay/visit	$160 copay/visit	60% coinsurance	Not covered	————none————
	Other practitioner office visit	$100 copay/visit for chiropractor	$160 copay/visit for chiropractor	50% coinsurance for chiropractor	Not covered	Combined all network tiers: 20 visits per benefit period.
	Preventive care Screening Immunization	No charge for preventive care services	No charge for preventive care services	No charge for preventive care services	No coverage for preventive care services	Please refer to your preventive schedule for additional information.
If you have a test	Diagnostic test (x-ray, blood work)	$60 copay/visit	$110 copay/visit	60% coinsurance	Not covered	————none————
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	60% coinsurance	Not covered	————none————

Source: Summary of Benefits and Coverage for Highmark Connect Blue EPO 5500 individual and family plans in Export, PA

Cost Sharing: Overview



Cost Sharing: Separate vs Combined Deductible

Kaiser Permanente · KP VA Silver 2500/30/Dental/Ped Dental

Silver HMO | Plan ID: 95185VA0530004

Estimated monthly premium	Deductible	Out-of-pocket maximum
$299	$2,500	$6,850
	Estimated individual Total	Estimated Indvidual Total

Prescription drug coverage

Generic Drugs	$15
Preferred Brand Drugs	$55 Copay after deductible
Non-Preferred Brand Drugs	30% Coinsurance after deductible
Specialty Drugs	30% Coinsurance after deductible
List of covered drugs	View
Prescription drug deductible	$500
Prescription drug out-of-pocket maximum	Included in plan's out-of-pocket maximum

Separate

***Source**: HealthCare.gov, Kaiser Permanente VA Silver 2500/30/Dental/Ped Dental in Arlington County, VA*

Cost Sharing: Separate vs Combined Deductible

Kaiser Permanente · KP VA Silver 2500/30/Dental/Ped Dental

Silver HMO | Plan ID: 95185VA0530004

Estimated monthly premium	Deductible	Out-of-pocket maximum
$299	$2,500	$6,850
	Estimated individual Total	Estimated Indvidual Total

Prescription drug coverage

Generic Drugs	$15
Preferred Brand Drugs	$55 Copay after deductible
Non-Preferred Brand Drugs	30% Coinsurance after deductible
Specialty Drugs	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

Combined

***Source**: HealthCare.gov, Kaiser Permanente VA Silver 2500/30/Dental/Ped Dental in Arlington County, VA*

Cost Sharing: Overview of Copays and Coinsurance

Copays

Fixed dollar amount per visit or per day paid by the enrollee.

Coinsurance

Percent of a medical fee/bill paid by the enrollee

Florida Blue (BlueCross BlueShield FL) · BlueOptions All Copay 1505

Gold EPO | National Provider Network | Plan ID: 16842FL0070120

Estimated monthly premium	Deductible	Out-of-pocket maximum
$657	$0 Estimated individual Total	$3,000 Estimated Indvidual Total

Costs for medical care

Primary Care Visit to Treat an Injury or Illness	$25
Specialist Visit	$60

Hospital services

Emergency Room Services	$350
Inpatient Hospital Services (e.g. Hospital Stay) *Limits and exclusions apply*	$600 Copay per Day
Inpatient Physician and Surgical Services	No Charge

Florida Blue (BlueCross BlueShield FL) · BlueSelect Everyday Health 1451

Platinum EPO | National Provider Network | Plan ID: 16842FL0120062

Estimated monthly premium	Deductible	Out-of-pocket maximum
$553	$800 Estimated individual Total	$2,500 Estimated Indvidual Total

Costs for medical care

Primary Care Visit to Treat an Injury or Illness *Limits and exclusions apply*	$15
Specialist Visit	$20

Hospital services

Emergency Room Services	10% Coinsurance after deductible
Inpatient Hospital Services (e.g. Hospital Stay)	10% Coinsurance after deductible
Inpatient Physician and Surgical Services	No Charge

***Source**: HealthCare.gov, Florida Blue (BlueCross BlueShield FL) Blue Options All Copay 1505 and BlueSelect EveryDay Health 1451 Plans in Miami-Dade, Florida*

Cost Sharing: Prescription Drug Copay Tiers

Minuteman Health, Inc. · MyDoc HMO Platinum

Platinum HMO | Plan ID: 61163NH0010001

Estimated monthly premium	Deductible	Out-of-pocket maximum
$360	$0 Estimated individual Total	$5,000 Estimated Indvidual Total

Prescription drug coverage

Generic Drugs	$15
Preferred Brand Drugs	$30
Non-Preferred Brand Drugs	40%
Specialty Drugs	50%
List of covered drugs	View
Prescription drug deductible	Included in plan deductible

***Source**: HealthCare.gov, Minuteman Health MyDoc HMO Platinum plan in Bedford, NH*

Cost Sharing: Additional Tiering of Prescription Drug Copays

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 for Humana Silver 3800/Austin HMOx in Travis County, TX*

Cost Sharing: Additional Tiering of Prescription Drug Copays

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 Indvidual 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

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

Cost Sharing: Services/Copays Exempt from Deductible

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

Cost Sharing: Services/Copays Exempt from Deductible

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

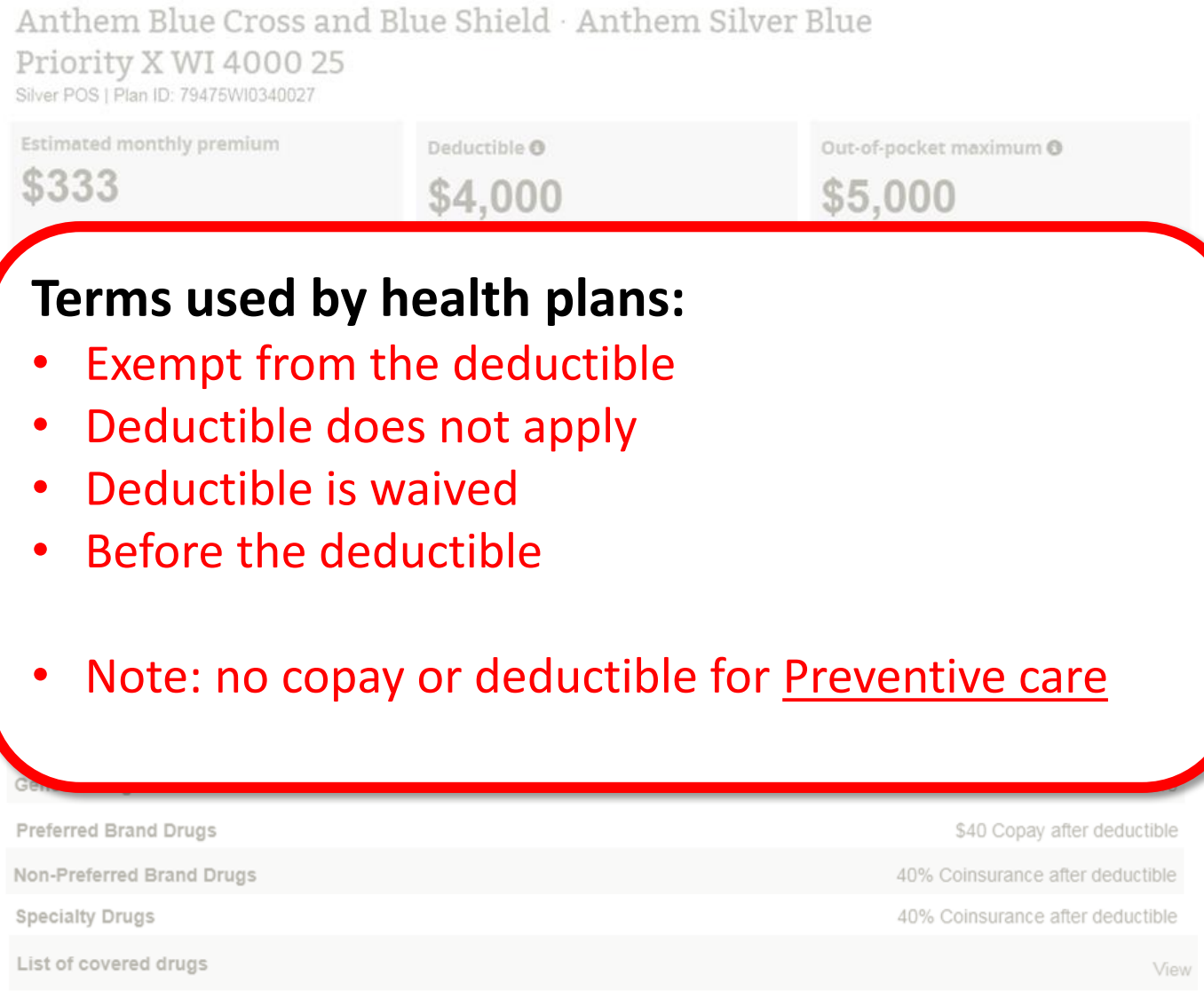
Prescription drug coverage

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

Cost Sharing: Services/Copays Exempt from Deductible



Terms used by health plans:

- Exempt from the deductible
- Deductible does not apply
- Deductible is waived
- Before the deductible

- Note: no copay or deductible for Preventive care

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

Cost Sharing: 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 **(2015)

Cost Sharing: "3-step" Copay Plans

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 in Fairfax County, VA*

Cost Sharing: "3-step" Copay Plans

HealthKeepers, Inc. · Anthem HealthKeepers Bronze X 4650 35

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

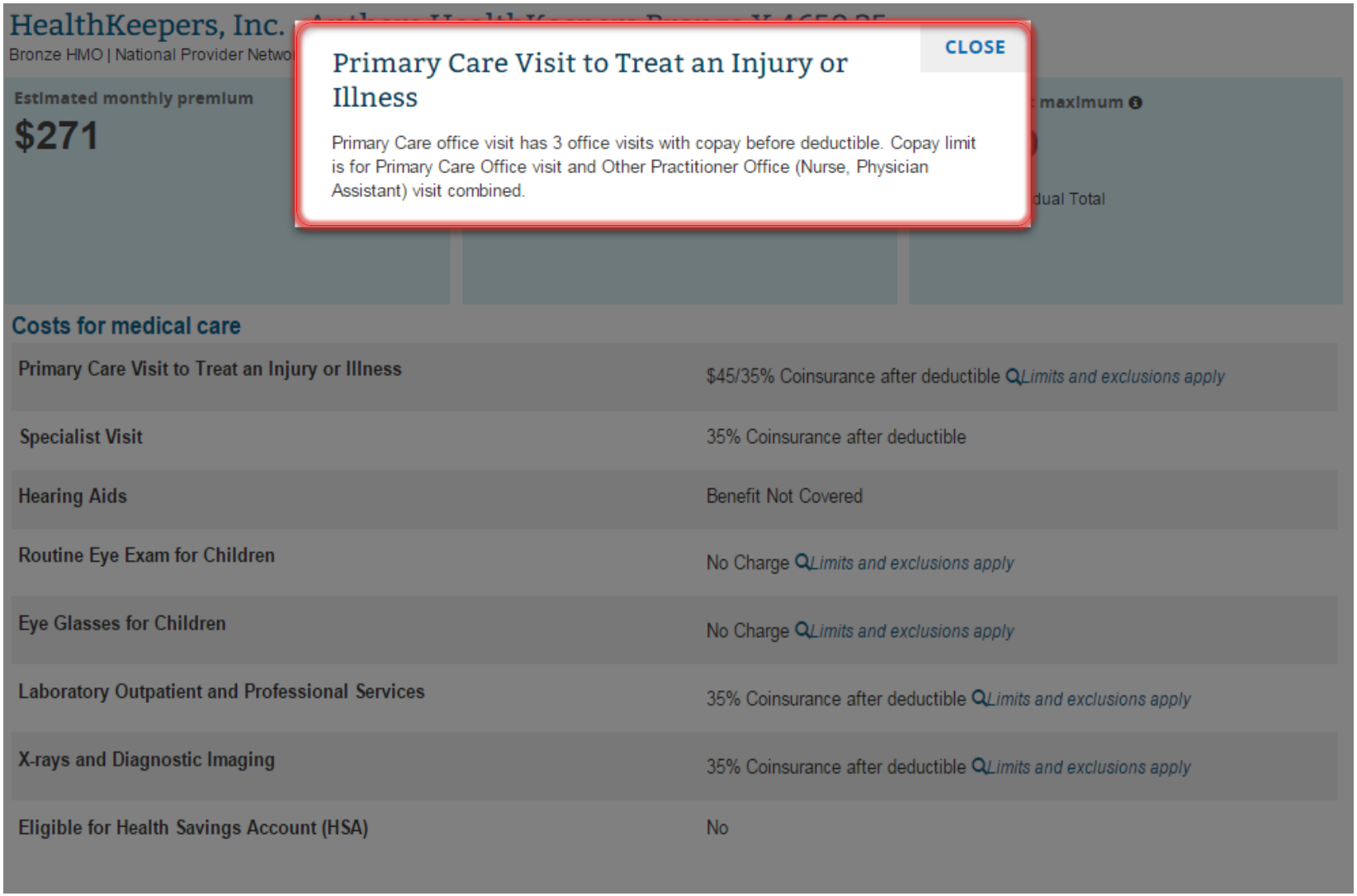
Estimated monthly premium	Deductible	Out-of-pocket maximum
$271	$4,650	$6,850
	Estimated individual Total	Estimated Indvidual Total

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 in Fairfax County, VA*

Cost Sharing: "3-step" Copay Plans



***Source**: HealthCare.gov, Anthem HealthKeepers Bronze X 4650 35 in Fairfax County, VA*

Cost Sharing: Deductible only Plans

Coventry · Coventry Bronze Deductible Only HSA Eligible Carelink

Bronze PPO | Plan ID: 44527MO0160004

Estimated monthly premium	Deductible	Out-of-pocket maximum
$230	$6,450 Estimated individual Total	$6,450 Estimated Indvidual Total

Costs for medical care	
Primary Care Visit to Treat an Injury or Illness	No Charge After Deductible
Specialist Visit	No Charge After Deductible
Laboratory Outpatient and Professional Services	No Charge After Deductible
Prescription drug coverage	
Generic Drugs	No Charge After Deductible
Preferred Brand Drugs	No Charge After Deductible
Non-Preferred Brand Drugs	No Charge After Deductible
Specialty Drugs	No Charge After Deductible
Hospital services	
Emergency Room Services	No Charge After Deductible
Inpatient Hospital Services (e.g. Hospital Stay)	No Charge After Deductible

***Source**: HealthCare.gov, Coventry Bronze Deductible Only HSA Eligible Carelink plan in St. Louis, MO*

Cost Sharing: Cost Sharing Reduction (CSR) Plans

	Silver (70%)	Silver (73%)	Silver (87%)	Silver (94%)
Eligibility Income Levels	> 250% FPL	201%-250%	151%-200%	< 150% FPL
Deductible	$3,800	$3,250	$900	$500
Maximum OOP limit	$6,300	$4,750	$1,500	$750
Primary care visit	$20	$15	$10	$5
Specialist visit	$40	$30	$25	$15
Emergency room care	$250	$200	$200	$150
Inpatient hospitalization	20%	20%	20%	20%
Generic drugs	$20	$15	$10	$8
Preferred brand name	$50	$45	$35	$25
Non-preferred brand	50%	50%	50%	50%
Specialty Drugs	50%	50%	50%	50%

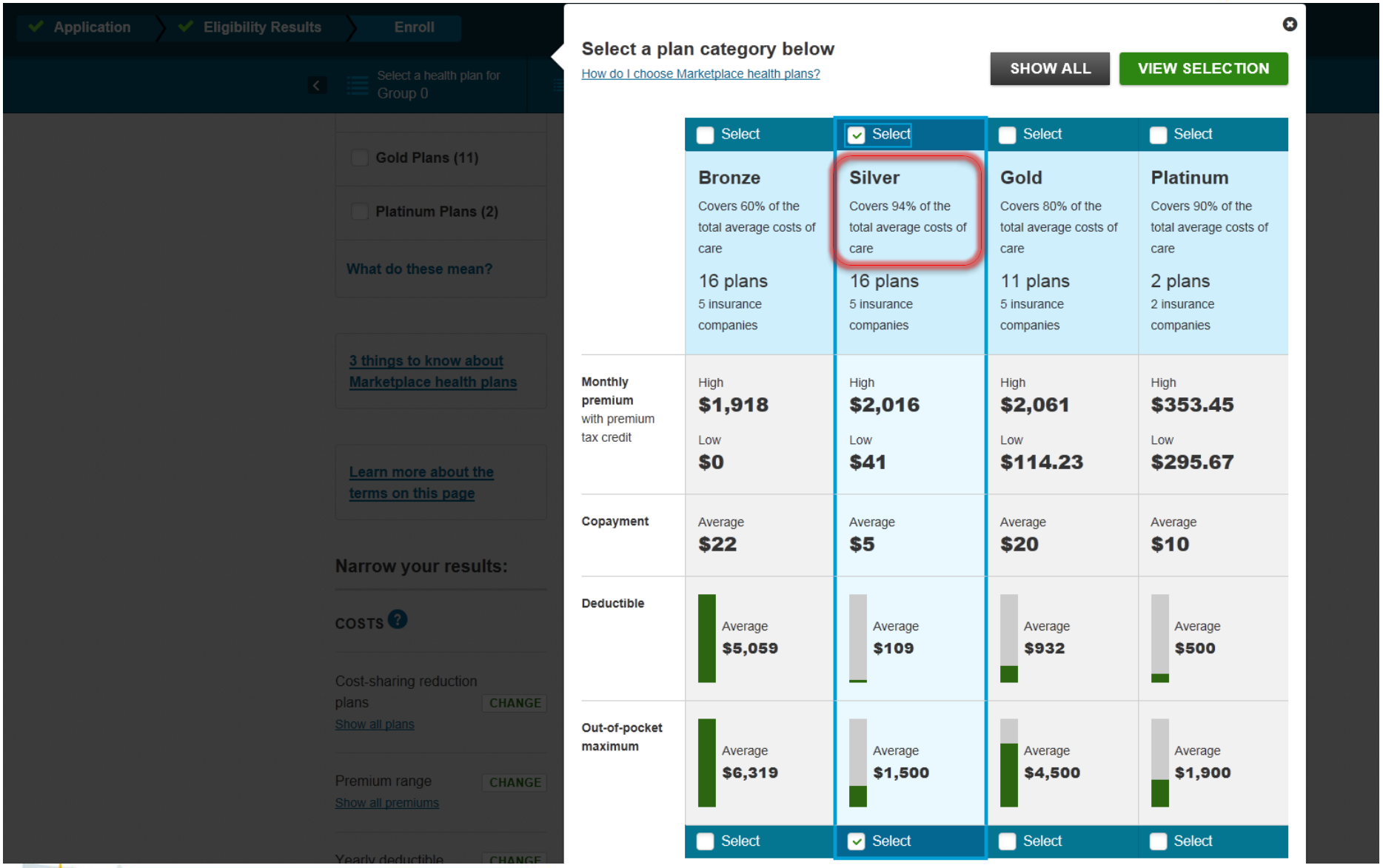
***Source**: Summary of Benefits and Coverage for Humana Louisville HMOx Bronze, Silver variants, Gold, and Platinum plans in Jefferson County, KY*

Cost Sharing: Cost Sharing Reduction (CSR) Plans

	Bronze (60%)	Silver (70%)	Silver (73%)	Gold (80%)	Silver (87%)	Platinum (90%)	Silver (94%)
Eligibility Income Levels	n/a	> 250% FPL	201%-250%	n/a	151%-200%	n/a	< 150% FPL
Premium	$	$$	$$	$$$	$$	$$$$	$$
Deductible	$6,450	$3,800	$3,250	$2,250	$900	$500	$500
Maximum OOP limit	$6,450	$6,300	$4,750	$3,500	$1,500	$1,500	$750
Primary care visit	no charge after ded.	$20	$15	$20	$10	$20	$5
Specialist visit	no charge after ded.	$40	$30	$40	$25	$40	$15
Emergency room care	no charge after ded.	$250	$200	$250	$200	$250	$150
Inpatient hospitalization	no charge after ded.	20%	20%	20%	20%	20%	20%
Generic drugs	no charge after ded.	$20	$15	$10	$10	$10	$8
Preferred brand name	no charge after ded.	$50	$45	$20	$35	$20	$25
Non-preferred brand	no charge after ded.	50%	50%	35%	50%	35%	50%
Specialty Drugs	no charge after ded.	50%	50%	35%	50%	35%	50%

***Source**: Summary of Benefits and Coverage for Humana Louisville HMOx Bronze, Silver variants, Gold, and Platinum plans in Jefferson County, KY*

Cost Sharing: Cost Sharing Reduction (CSR) Plans



Source: HealthCare.gov

Benefits and Covered Services

10 "Essential Health Benefits" All Qualified Health Plans Must Provide

 Ambulatory Patient Services	 Preventive and Wellness Services and Chronic Disease Management
 Emergency Services	 Laboratory Services
 Maternity and Newborn Care	 Prescription Drugs
 Mental Health and Substance Use Disorder Services, including Behavioral Health Treatment	 Rehabilitative and Habilitative Services and Devices
 Hospitalization	 Pediatric Services, including Oral and Vision Care

Benefits and Covered Services

Pediatric Dental Coverage

Kaiser Permanente · KP GA Bronze 5000/50

Bronze HMO | Plan ID: 89942GA0050013

Estimated monthly premium	Deductible	Out-of-pocket maximum
$359	$10,000 Per group	$13,700 Per group
Premium before tax credit: $394	$5,000 Per person in group	$6,850 Per person in group

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

Blue Cross Blue Shield Healthcare Plan of Georgia · BCBSHP Bronze Pathway X HMO 5500

Bronze HMO | Plan ID: 49046GA0410022

Estimated monthly premium	Deductible	Out-of-pocket maximum
$366	$11,000 Per group	$13,700 Per group
Premium before tax credit: $400	$5,500 Per person in group	$6,850 Per person in group

Child dental coverage

Dental Check-Up for Children	10% Coinsurance after deductible
Basic Dental Care - Child	40% Coinsurance after deductible
Orthodontia - Child	50% Coinsurance after deductible
Major Dental Care - Child	50% Coinsurance after deductible

***Source**: Healthcare.gov, Kaiser Permanente KP GA Bronze 5000/50 and Blue Cross Blue Shield Healthcare Plan of Georgia Bronze Pathway x HMO 5500 in Atlanta, GA*

Benefits and Covered Services

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*

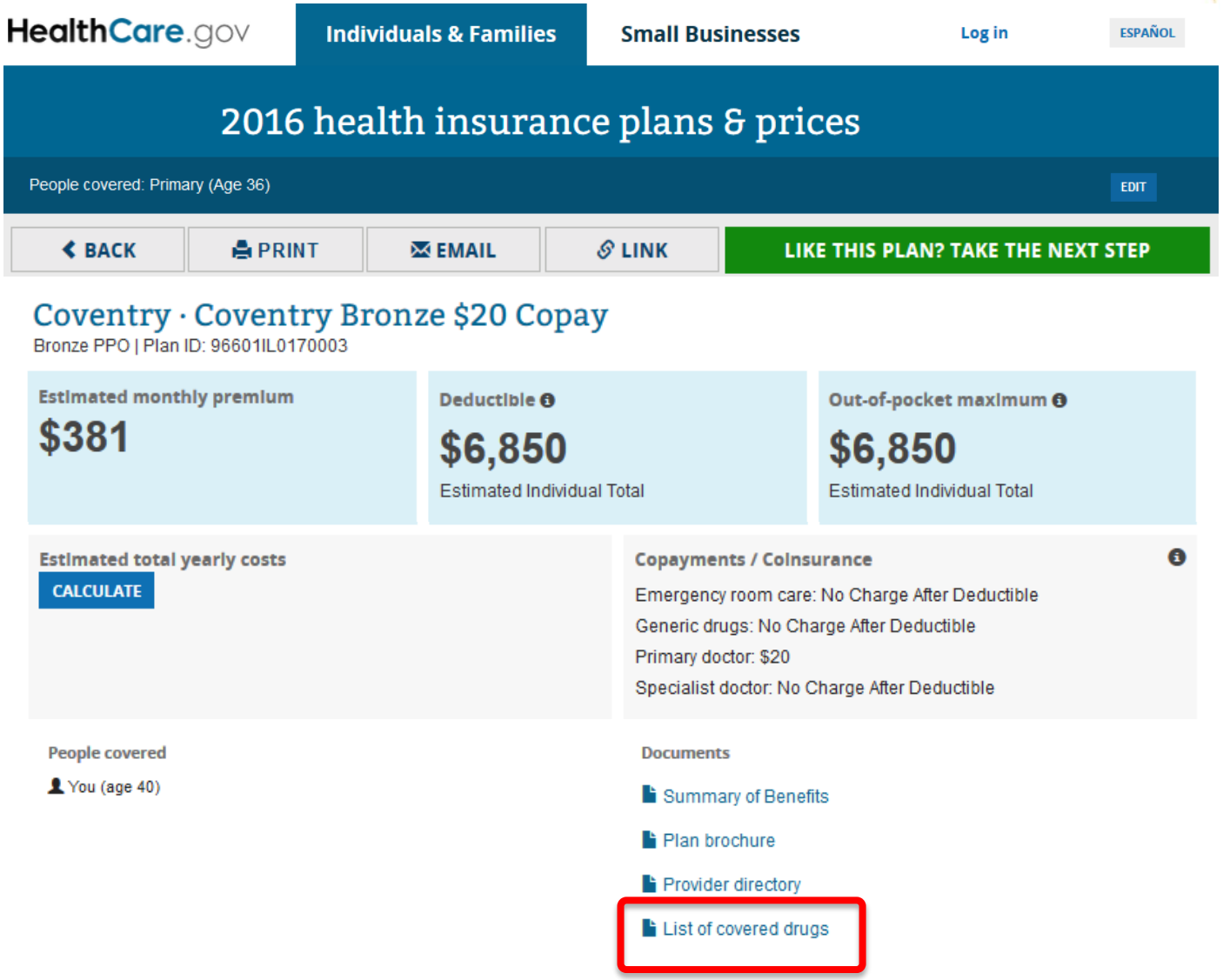
Benefits and Covered Services

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 plans sold in Arlington County, VA*

Prescription Drug Formulary



***Source**: Healthcare.gov, Coventry Bronze $20 Copay plan in Cook County, IL*

Prescription Drug Formulary

Drug Search

2016 CoventryOne Prescription Drug List

Alphabetical Search

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Brand & Generic Name Search

Search

Therapeutic Class Search

- *Adhd/Anti-Narcolepsy/Anti-Obesity/Anorexiants*
- *Amebicides*
- *Aminoglycosides*
- *Analgesics - Anti-Inflammatory*
- *Analgesics - Nonnarcotic*
- *Analgesics - Opioid*
- *Androgens-Anabolic*
- *Anorectal Agents*
- *Anthelmintics*
- *Antianginal Agents*
- *Antianxiety Agents*
- *Antiarrhythmics*
- *Antiasthmatic And Bronchodilator Agents*
- *Anticoagulants*
- *Anticonvulsants*
- *Antidepressants*
- *Antidiabetics*
- *Antidiarrheals*
- *Antidotes*
- *Antiemetics*
- *Antifungals*
- *Antihistamines*

***Source**: Prescription drug search site for Coventry Bronze $20 Copay plan in Cook County, IL*

Prescription Drug Formulary

Search Results

Start Over

The results of your search are displayed below:
Therapeutic Class Search: *anticoagulants*/*coumarin anticoagulants** - *coumarin anticoagulants***
18 drug(s) found

To view other medications in a therapeutic class, click any class hyperlink in your search results.

Brand Name *Generic Name*	Therapeutic Class *Sub-class*	Dose/Strength	Status	Notes & Restrictions
Jantoven Tablet 5 Mg Oral	*Anticoagulants* *Coumarin Anticoagulants** - *Coumarin Anticoagulants***	TABLET 5 MG	T1 Tier 1	more info
Jantoven Tablet 6 Mg Oral	*Anticoagulants* *Coumarin Anticoagulants** - *Coumarin Anticoagulants***	TABLET 6 MG	T1 Tier 1	more info
Jantoven Tablet 7.5 Mg Oral	*Anticoagulants* *Coumarin Anticoagulants** - *Coumarin Anticoagulants***	TABLET 7.5 MG	T1 Tier 1	more info
warfarin sodium tablet 1 mg oral	*Anticoagulants* *Coumarin Anticoagulants** - *Coumarin Anticoagulants***	TABLET 1 MG	T1 Tier 1	more info
warfarin sodium tablet 10 mg oral	*Anticoagulants* *Coumarin Anticoagulants** - *Coumarin Anticoagulants***	TABLET 10 MG	T1 Tier 1	more info
warfarin sodium tablet 2 mg oral	*Anticoagulants* *Coumarin Anticoagulants** - *Coumarin Anticoagulants***	TABLET 2 MG	T1 Tier 1	more info
warfarin sodium tablet 2.5 mg oral	*Anticoagulants* *Coumarin Anticoagulants** - *Coumarin Anticoagulants***	TABLET 2.5 MG	T1 Tier 1	more info

***Source**: Prescription drug search site for Coventry Bronze $20 Copay plan in Cook County, IL*

Prescription Drug Formulary

CoventryOne.

Drug Search
2016 CoventryOne Prescription Drug List: IA

Start Over

Please select a drug from the list below to continue.

- T2 HumaLOG 100 UNIT/ML SUBCUTANEOUS*
- T2 HumaLOG KwikPen 100 UNIT/ML SUBCUTANEOUS*
- T2 HumaLOG Mix 50/50 KwikPen (50-50) 100 UNIT/ML SUBCUTANEOUS*
- T2 HumaLOG Mix 50/50 SUSPENSION (50-50) 100 UNIT/ML SUBCUTANEOUS*
- T2 HumaLOG Mix 75/25 KwikPen (75-25) 100 UNIT/ML SUBCUTANEOUS*
- T2 HumaLOG Mix 75/25 SUSPENSION (75-25) 100 UNIT/ML SUBCUTANEOUS*
- T2 HumaLOG SOLUTION 100 UNIT/ML SUBCUTANEOUS*

2016 CoventryOne Prescription Drug List: IA

BlueCross BlueShield of Illinois

Drug Name	Drug Tier	Prior Authorization	Step Therapy	Dispensing Limits	Limited Distribution
XIGDUO XR - dapagliflozin-metformin hcl tab sr 24hr 10-1000 mg	4			•	
Rapid-Acting Insulins					
APIDRA - insulin glulisine inj 100 unit/ml	4	•		•	
APIDRA SOLOSTAR - insulin glulisine soln pen-injector inj 100 unit/ml	4	•		•	
HUMALOG - insulin lispro (human) inj 100 unit/ml	4	•		•	
HUMALOG - insulin lispro (human) soln cartridge 100 unit/ml	4	•		•	
HUMALOG KWIKPEN - insulin lispro (human) soln pen-injector 100 unit/ml	4	•		•	
HUMALOG KWIKPEN - insulin lispro (human) soln pen-injector 200 unit/ml	4	•		•	

***Source**: Prescription drug formularies for Coventry Bronze $20 Copay and Blue Cross and Blue Shield of Illinois Blue Choice Bronze PPO 006 plans in Cook County, IL*

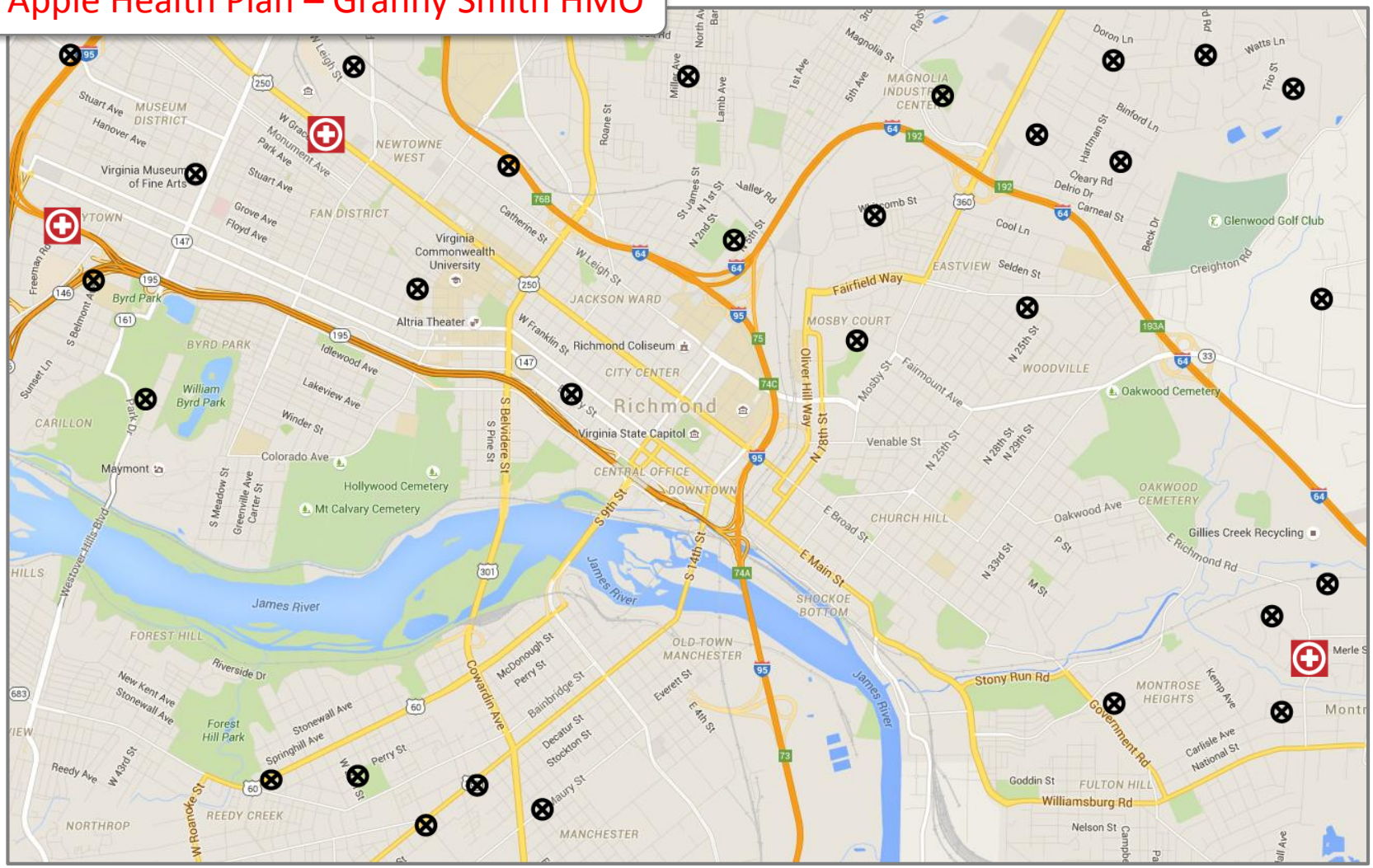
Provider Network: Health Plan Network Types

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

Apple Health Plan – Granny Smith HMO



Narrow network:

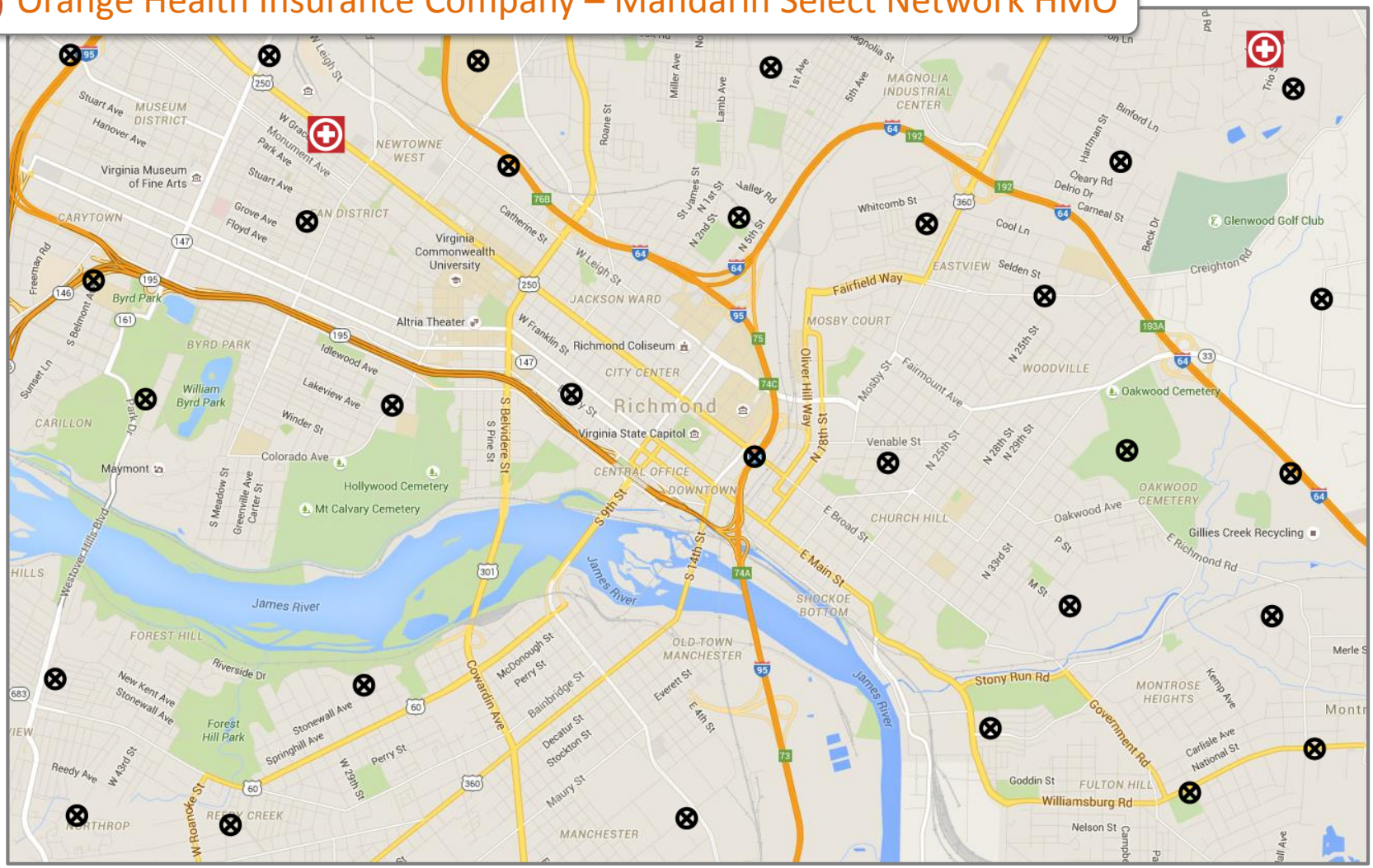
- Fewer doctors
- Several hospitals

In network primary care physician (PCP)

In network hospital

Provider Network

Orange Health Insurance Company – Mandarin Select Network HMO



Narrow network:

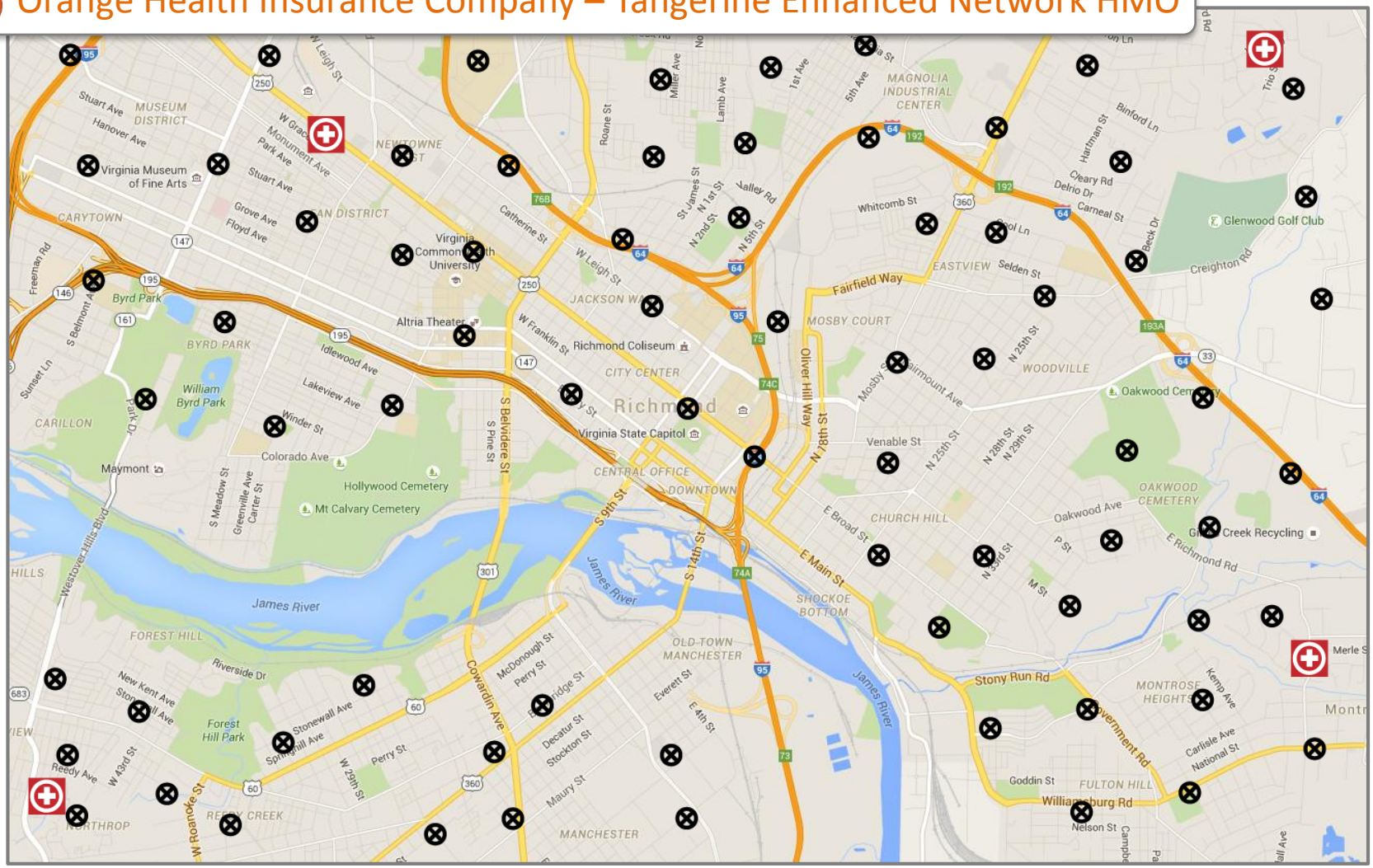
- Fewer doctors
- Several hospitals

⊗ In network primary care physician (PCP)

In network hospital

Provider Network

Orange Health Insurance Company – Tangerine Enhanced Network HMO



Broader network:

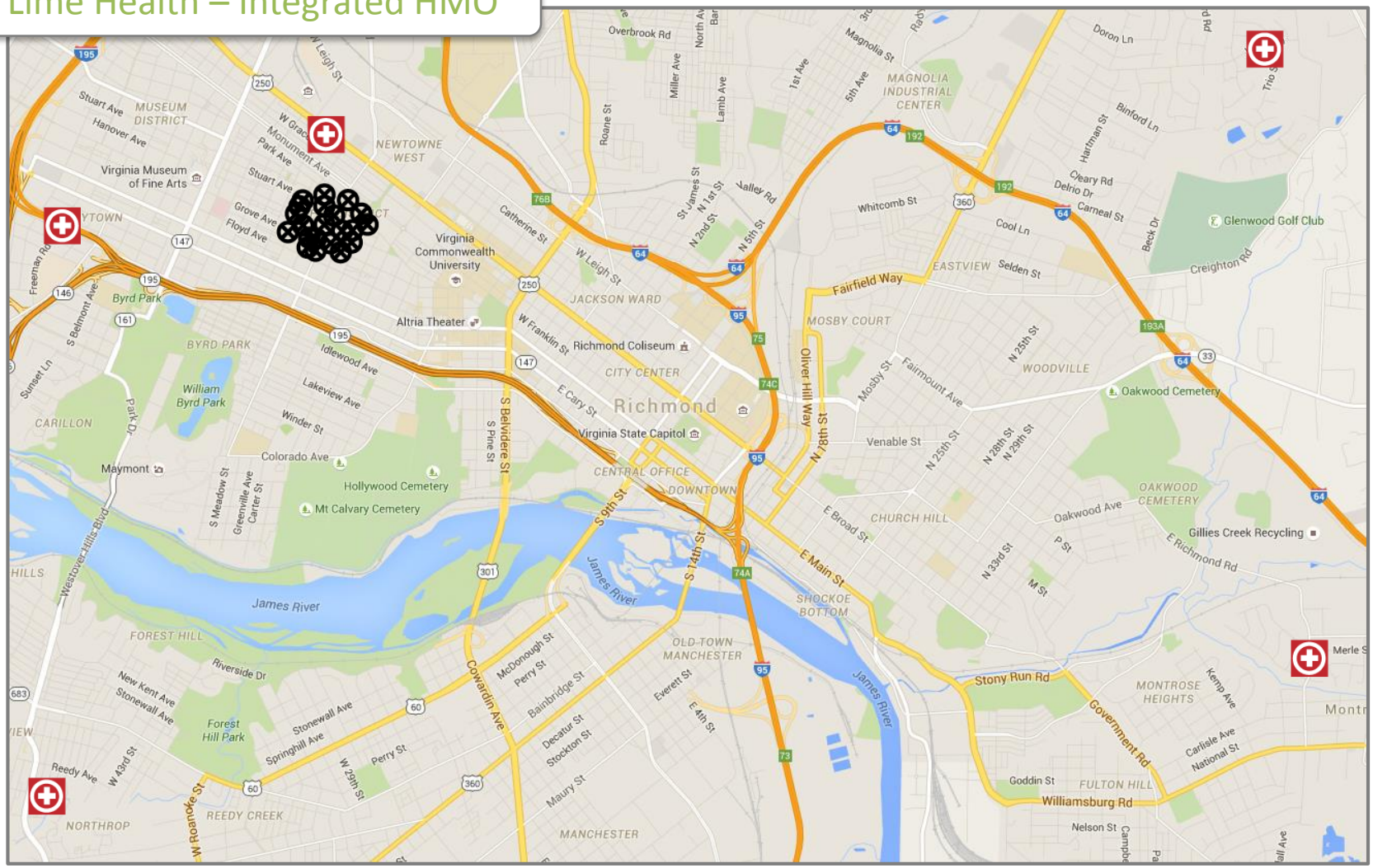
- More doctors
- Several hospitals

⊗ In network primary care physician (PCP)

In network hospital

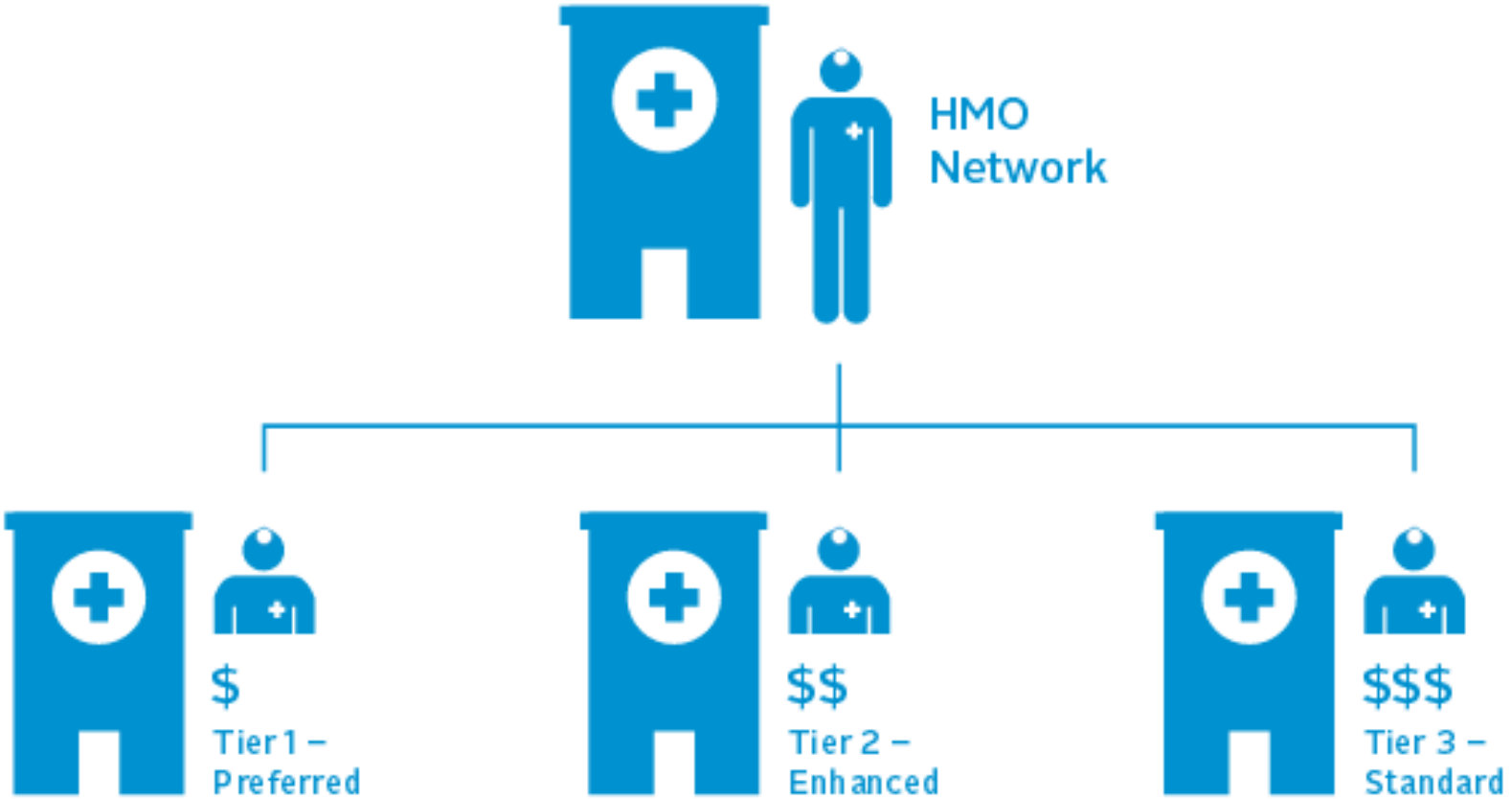
Provider Network

Lime Health – Integrated HMO



Integrated network: • All doctors in one office • Several hospitals

Provider Network: Tiered Network Plans



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

Provider Network: Tiered Network Plans

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*

Provider Network: Confusion and Inaccuracies

BlueCross BlueShield Kansas Solutions, Inc. · BlueCare Solutions Bronze
Bronze HMO | Plan ID: 27811KS0030003

Estimated monthly premium
$214

Deductible
$6,850
Estimated Individual Total

Out-of-pocket
$6,850
Estimated Indivi

Estimated total yearly costs
CALCULATE

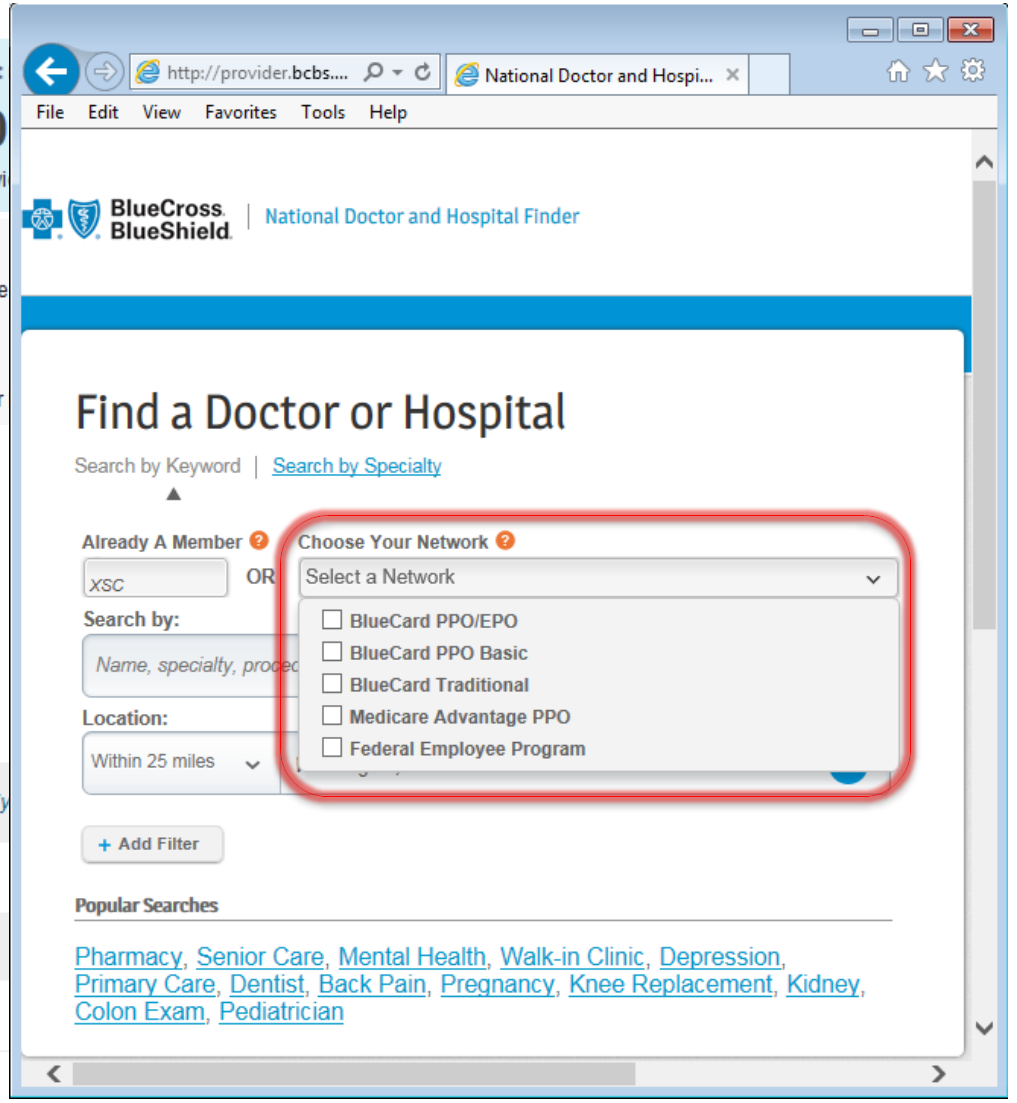
Copayments / Coinsurance
Emergency room care: No Charge
Generic drugs: $15
Primary doctor: $40
Specialist doctor: No Charge After

People covered
You (age 40)

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

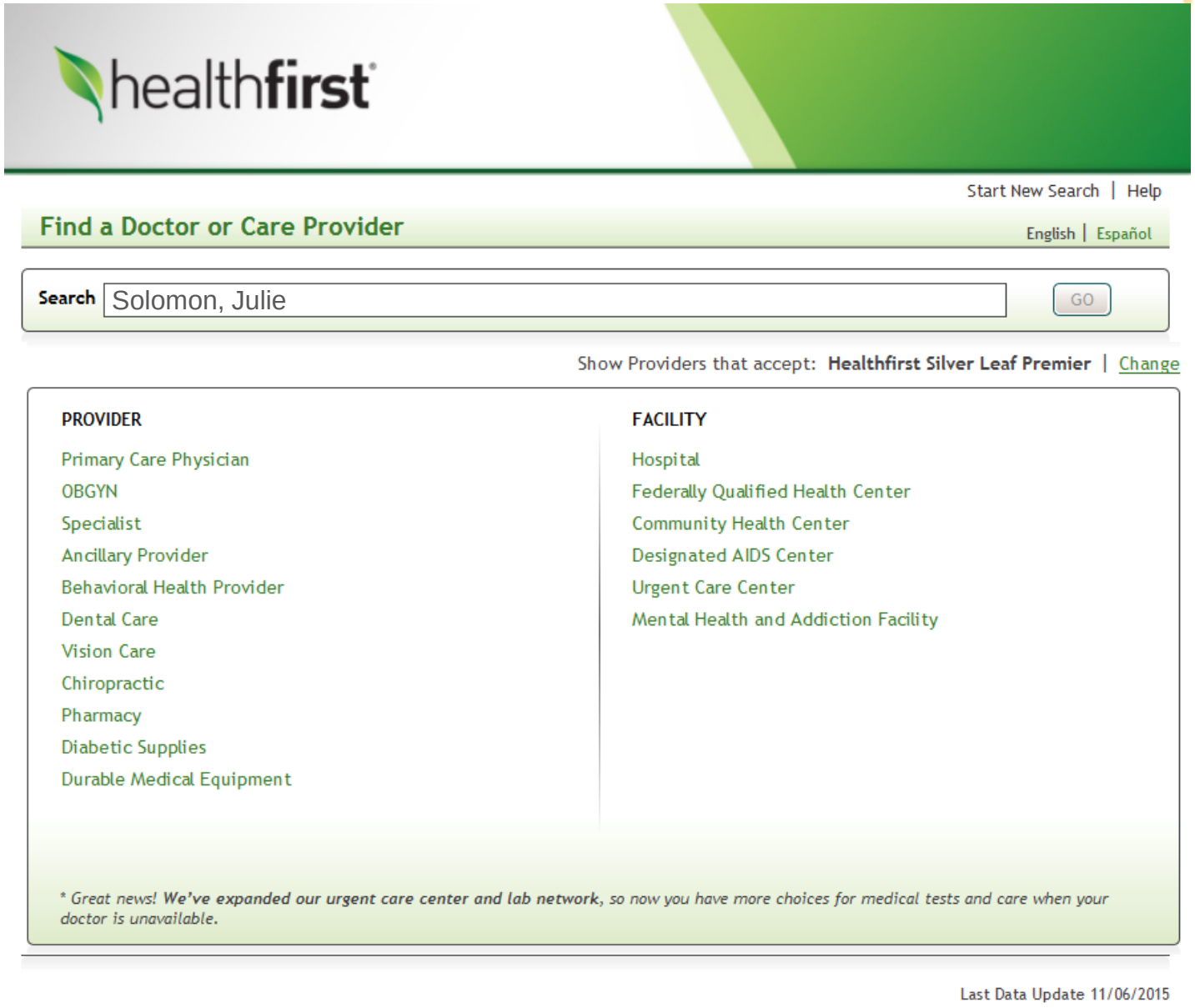
Costs for medical care

Primary Care Visit to Treat an Injury or Illness	$40 *Limits and exclusions apply*
Specialist Visit	No Charge After Deductible
Hearing Aids	Benefit Not Covered
Routine Eye Exam for Children	No Charge After Deductible



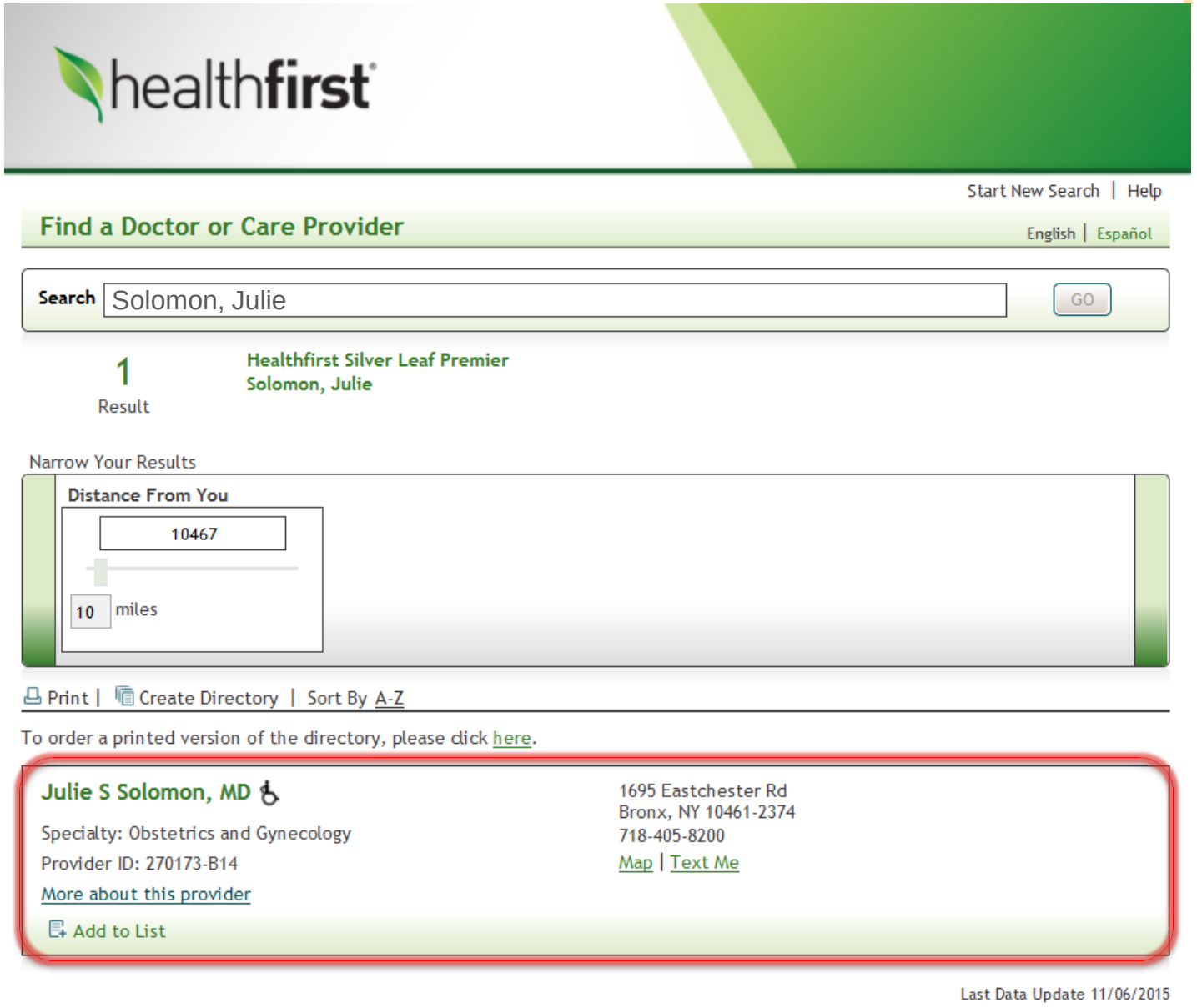
***Source**: HealthCare.gov and Provider Search site for BlueCross BlueShield BlueCare Solutions Plan in Sedgwick County, KS*

Provider Network: Confusion and Inaccuracies



***Source**: HealthFirst Provider Directory for plans in the Bronx, NY*

Provider Network: Confusion and Inaccuracies



***Source**: HealthFirst Provider Directory for plans in the Bronx, NY*

Monthly Premium: Annual Changes

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**: Prices for Silver plans sold in Arlington County, VA*

Monthly Premium: Annual Changes

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
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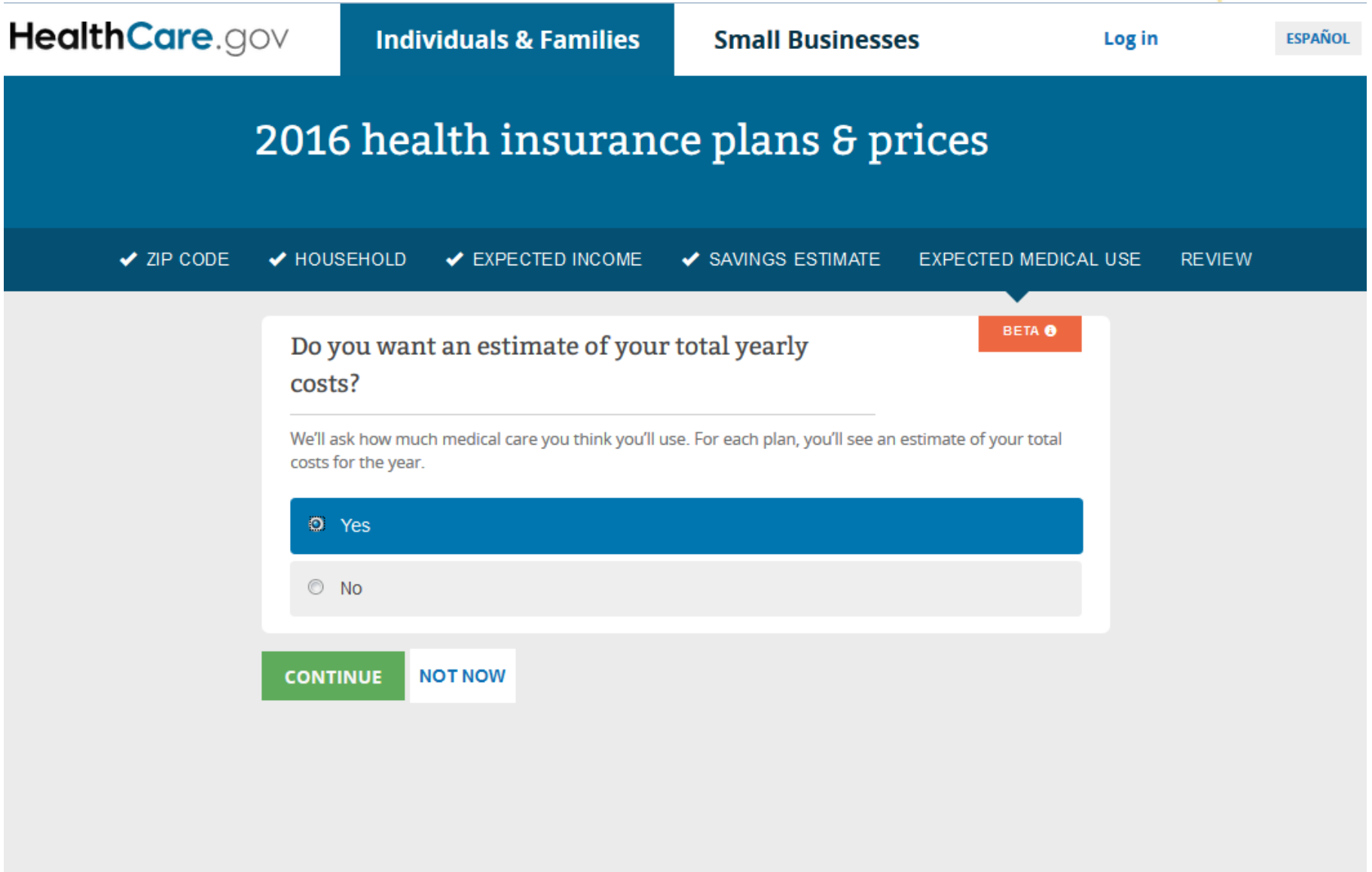
10	Innovation Classic 5000: MO	$1,500.00			CareFirst BlueChoice Plus Silver $2500	$345.00

***Source**: Prices for Silver plans sold in Arlington County, VA*

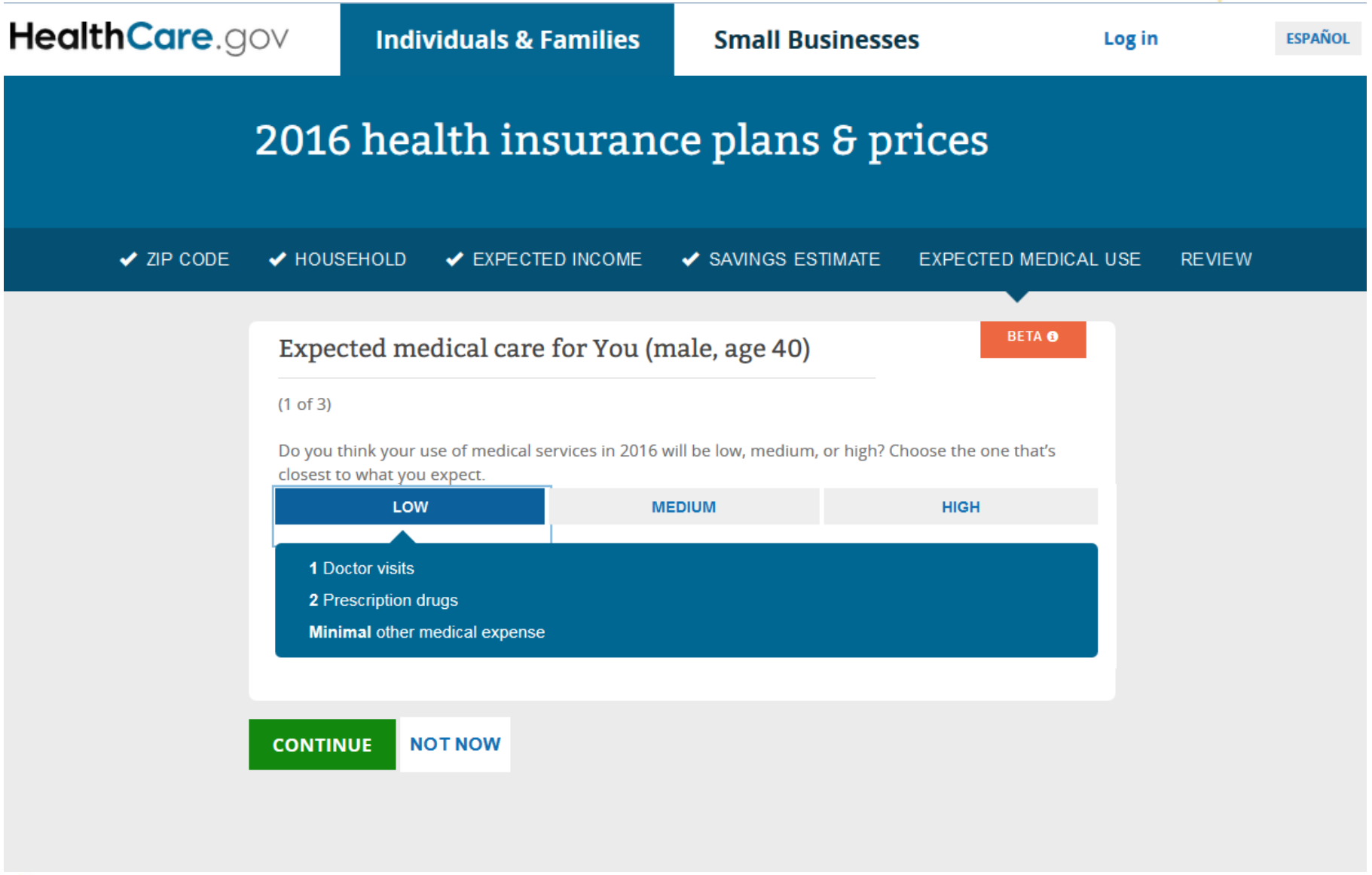
New Tools on Healthcare.gov

Out-of-Pocket Cost Calculator



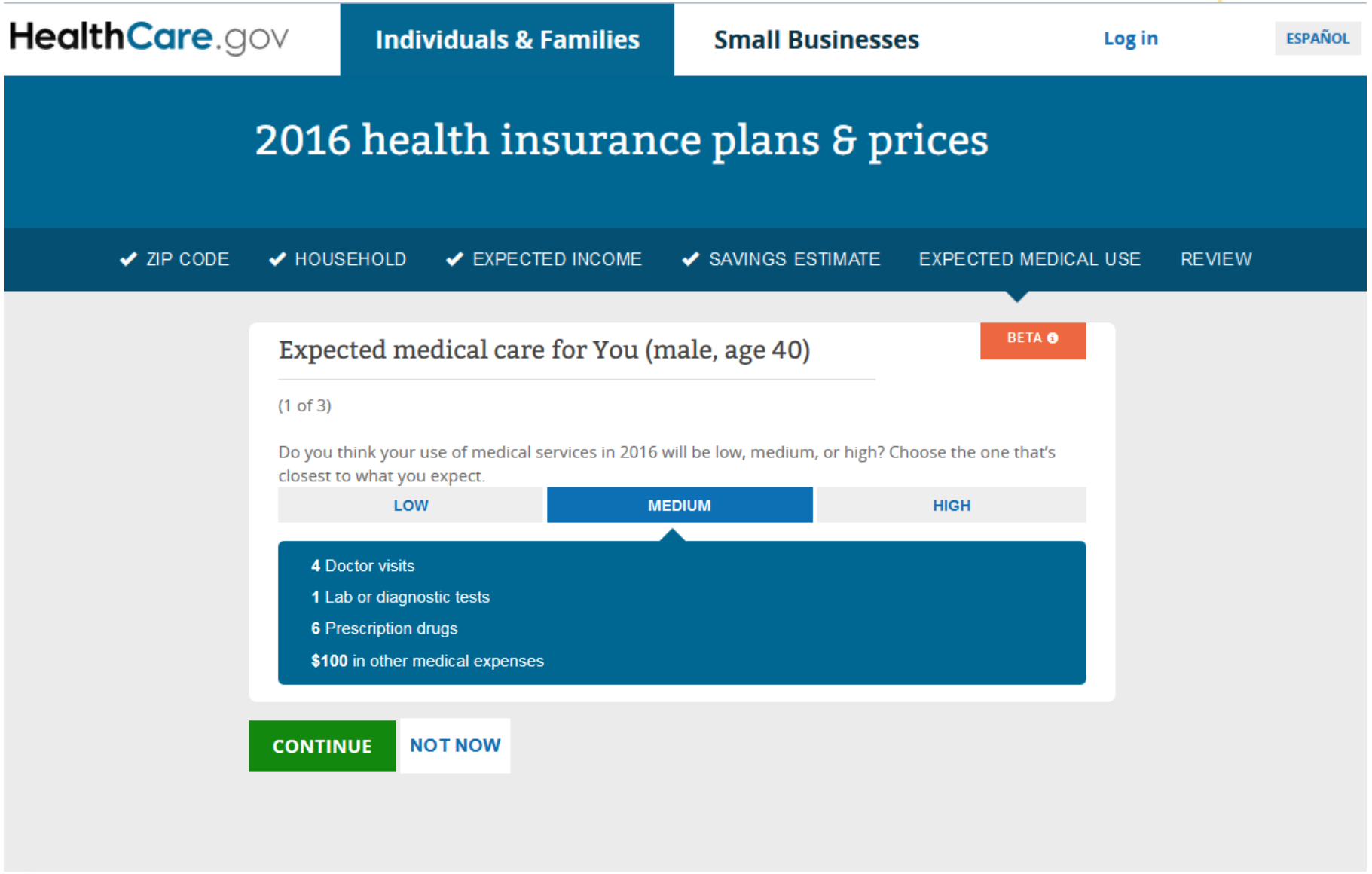
***Source**: Healthcare.gov*

Out-of-Pocket Cost Calculator



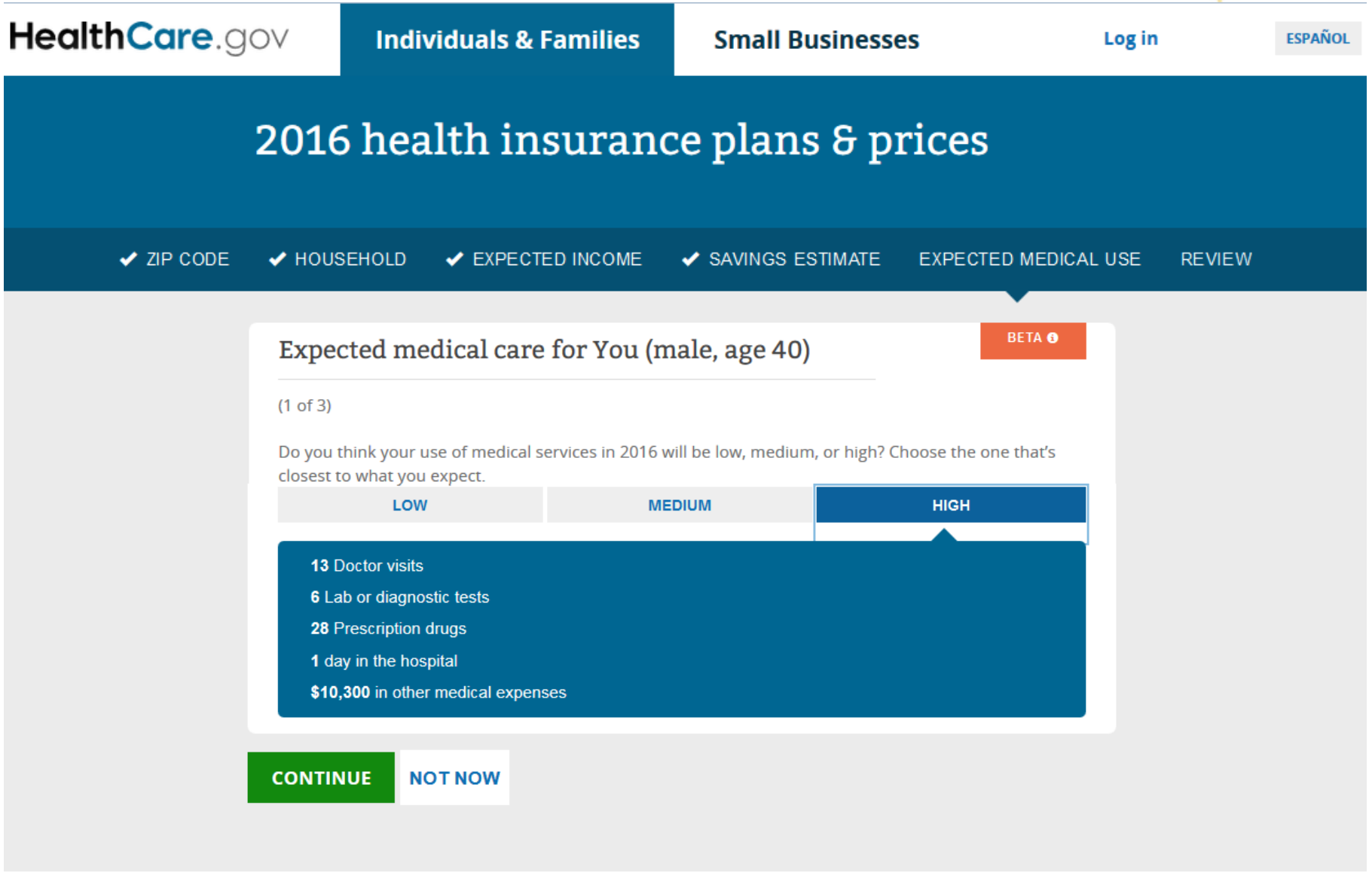
Source: Healthcare.gov

Out-of-Pocket Cost Calculator



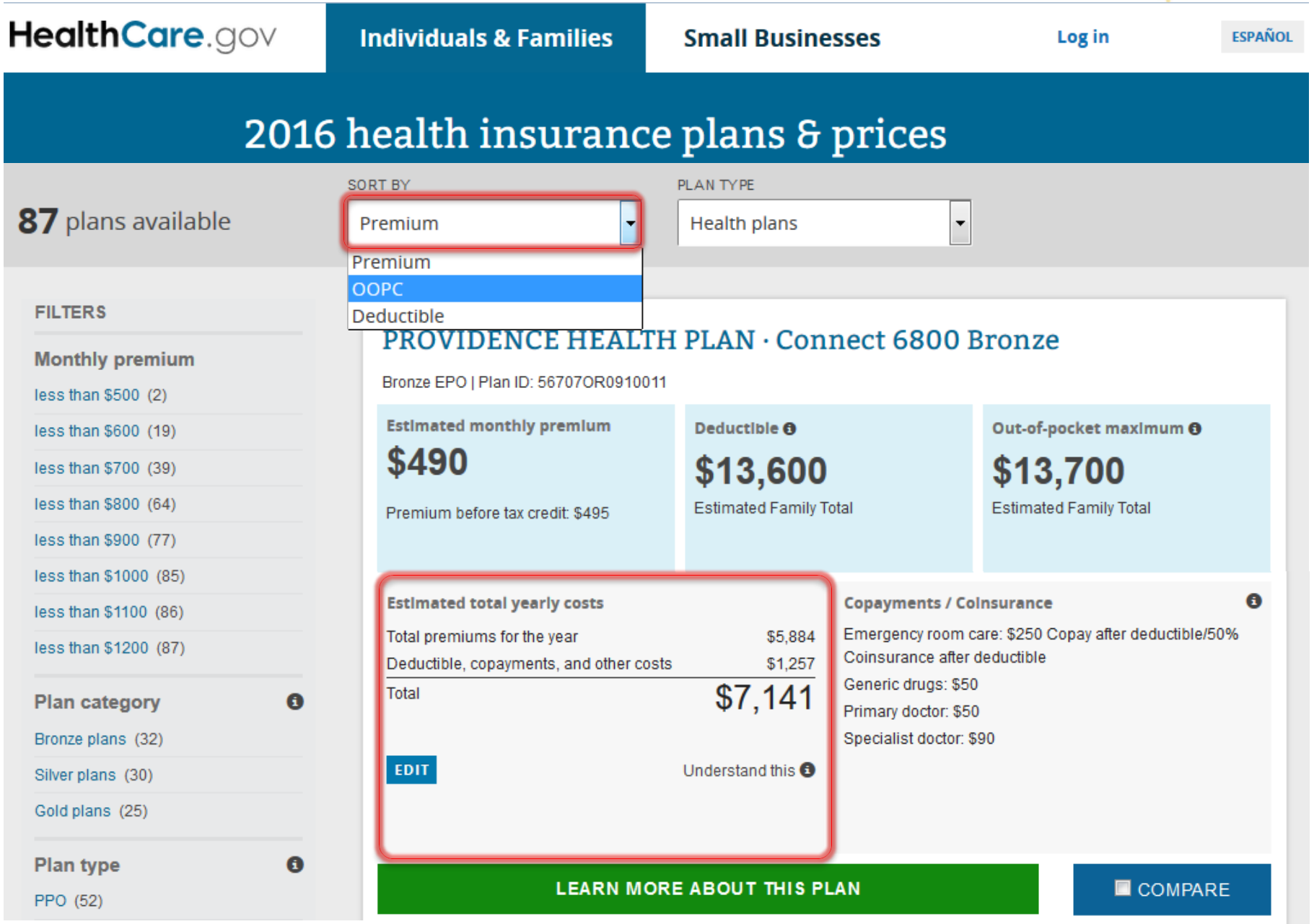
Source: Healthcare.gov

Out-of-Pocket Cost Calculator

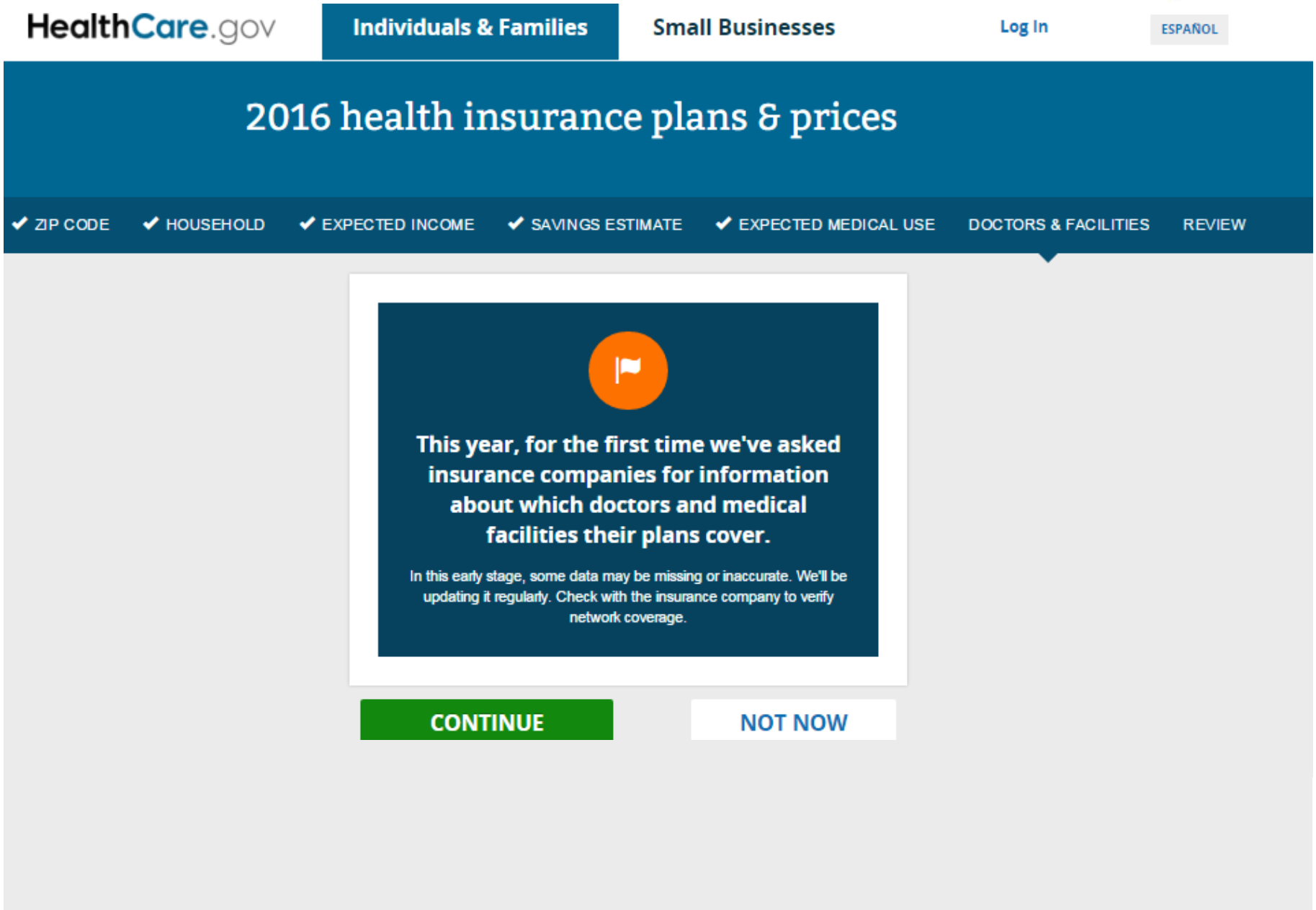


Source: Healthcare.gov

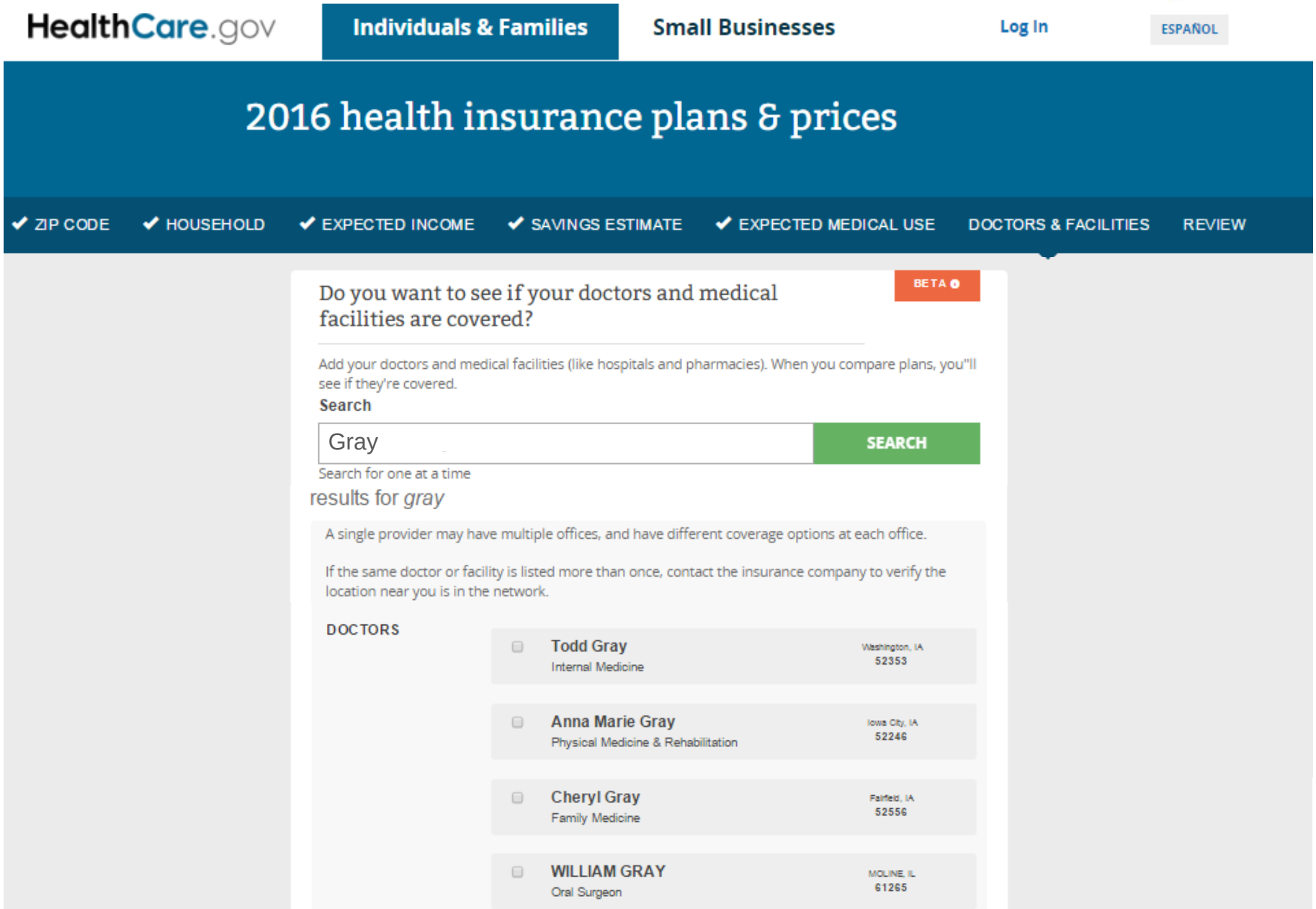
Out-of-Pocket Cost Calculator



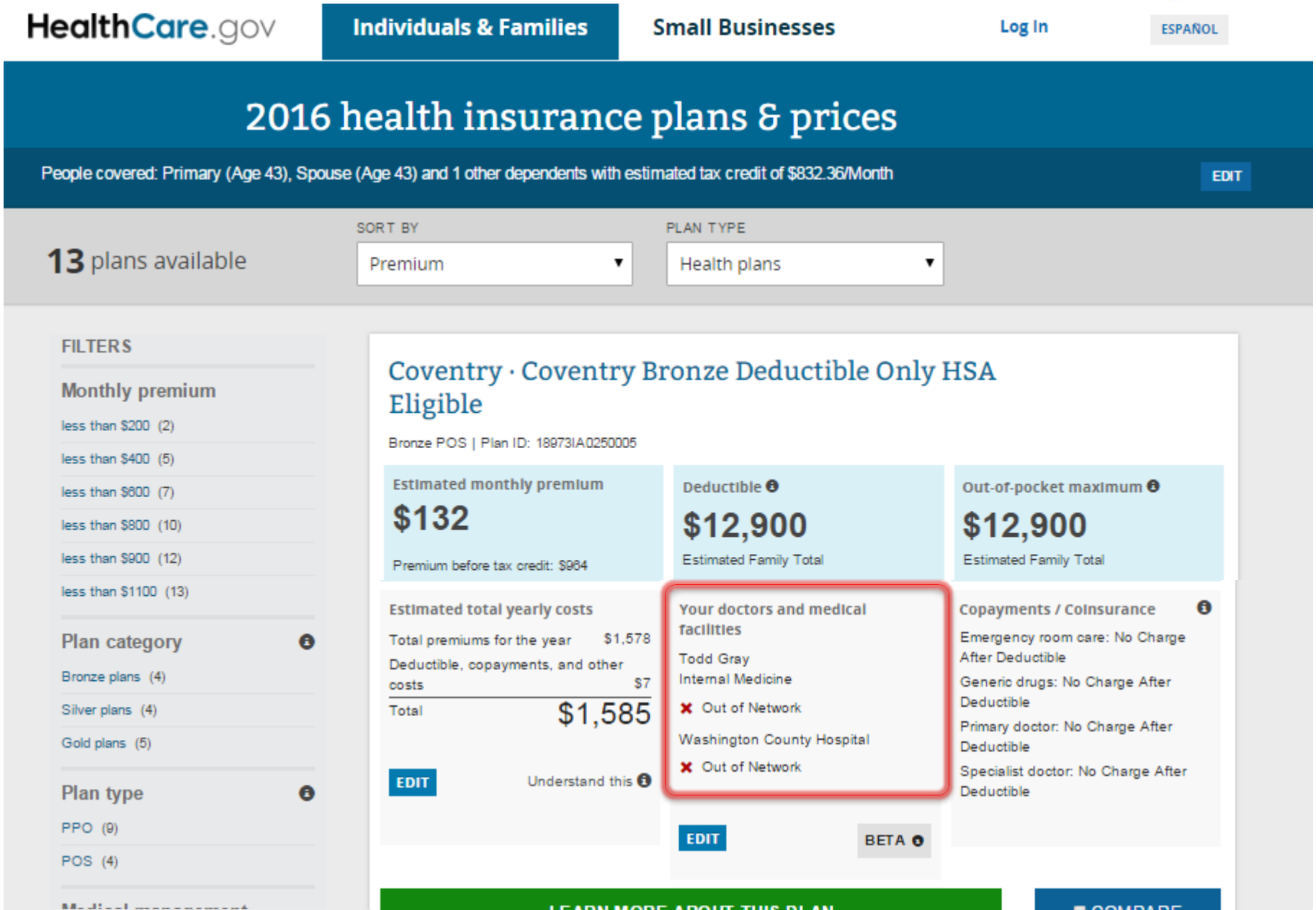
Provider Search Tool



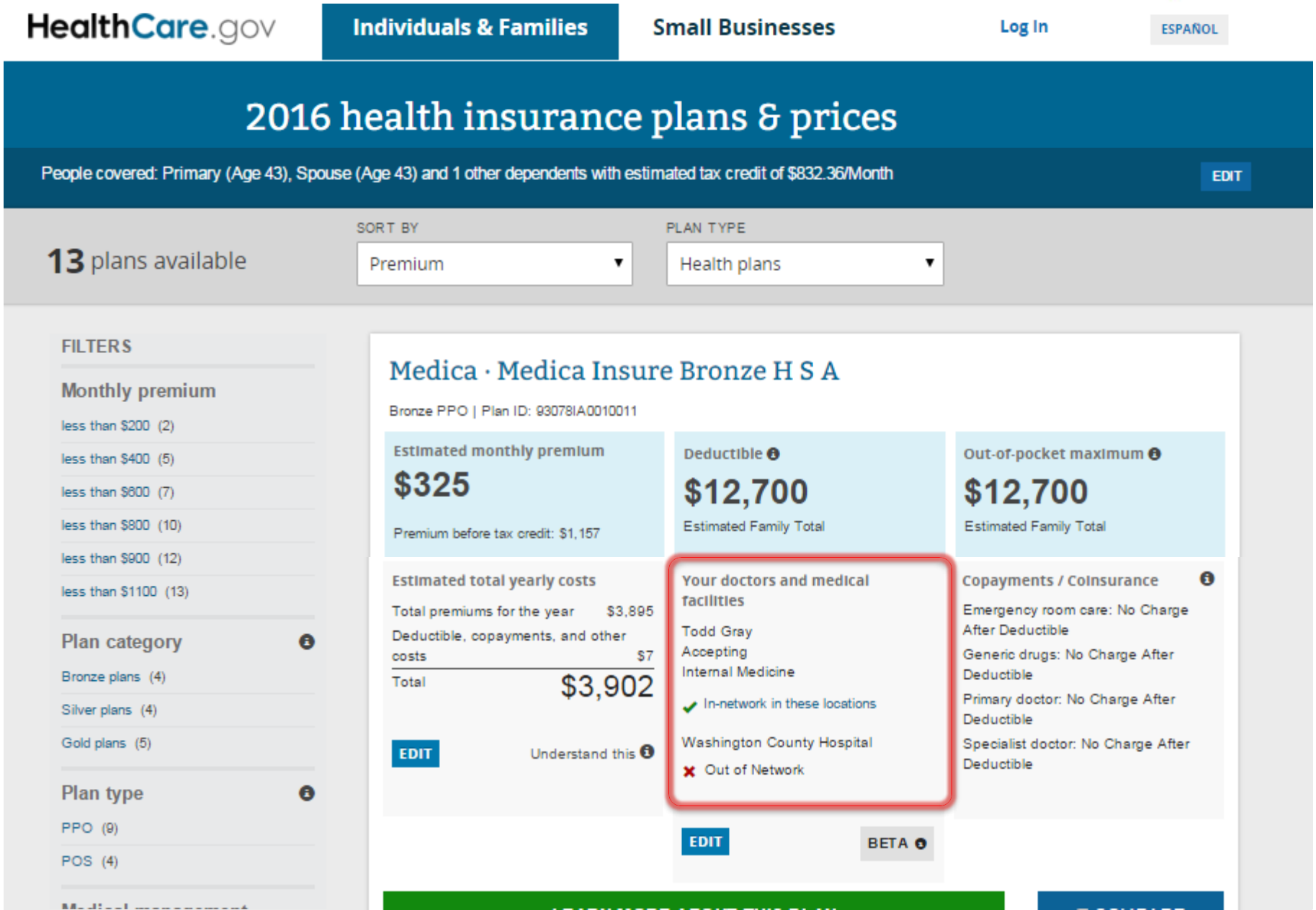
Provider Search Tool



Provider Search Tool



Provider Search Tool

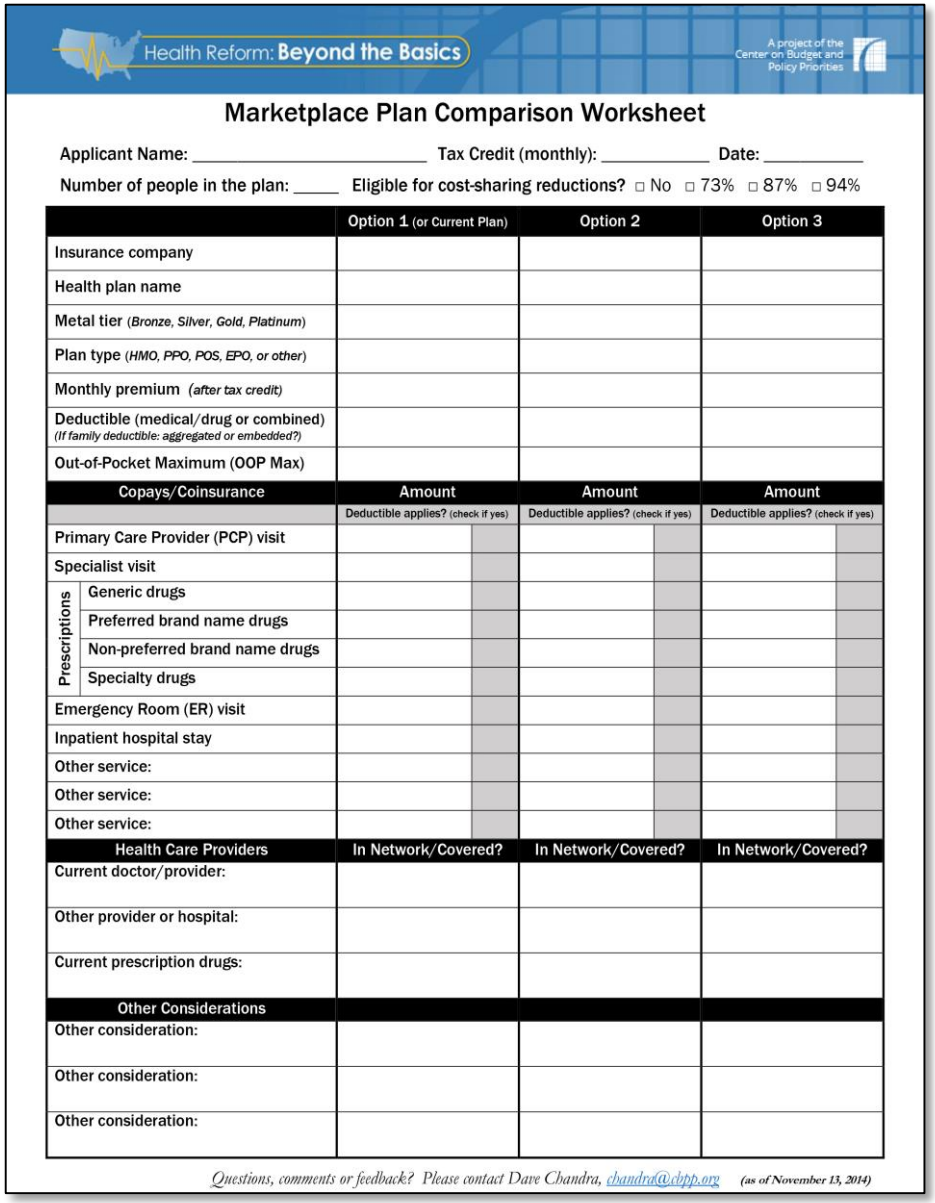


Assisting Consumers in Plan Selection - *Demonstration*

CBPP Marketplace Plan Comparison Worksheet

- Resource for assisters to help consumers evaluate and select a QHP
- Available in both English and Spanish:

  Marketplace Plan Comparison Worksheet



Health Reform: Beyond the Basics

A project of the Center on Budget and Policy Priorities

Marketplace Plan Comparison Worksheet

Applicant Name: _____ Tax Credit (monthly): _____ Date: _____

Number of people in the plan: _____ Eligible for cost-sharing reductions? □ No □ 73% □ 87% □ 94%

	Option 1 (or Current Plan)	Option 2	Option 3
Insurance company			
Health plan name			
Metal tier (*Bronze, Silver, Gold, Platinum*)			
Plan type (*HMO, PPO, POS, EPO, or other*)			
Monthly premium (*after tax credit*)			
Deductible (medical/drug or combined) (*If family deductible: aggregated or embedded?*)			
Out-of-Pocket Maximum (OOP Max)			
Copays/Coinsurance	**Amount**	**Amount**	**Amount**
	Deductible applies? (check if yes)	Deductible applies? (check if yes)	Deductible applies? (check if yes)
Primary Care Provider (PCP) visit			
Specialist visit			
Prescriptions: Generic drugs			
Prescriptions: Preferred brand name drugs			
Prescriptions: Non-preferred brand name drugs			
Prescriptions: Specialty drugs			
Emergency Room (ER) visit			
Inpatient hospital stay			
Other service:			
Other service:			
Other service:			
Health Care Providers	**In Network/Covered?**	**In Network/Covered?**	**In Network/Covered?**
Current doctor/provider:			
Other provider or hospital:			
Current prescription drugs:			
Other Considerations			
Other consideration:			
Other consideration:			
Other consideration:			

Questions, comments or feedback? Please contact Dave Chandra, chandra@cbpp.org (as of November 13, 2014)

Scenario 1: Sasha (single adult)

	Sasha
Age	37
City (County)	Bellevue (Sarpy County), NE
Zip Code	68005
Income	$30,000
Federal Poverty Level	257%
Employer coverage?	no
Insurance status	uninsured

Scenario 1: Sasha (single adult)

Health Reform: Beyond the Basics

A project of the Center on Budget and Policy Priorities

Marketplace Plan Comparison Worksheet

Applicant Name: **Sasha** Tax Credit (monthly): **$95** Date: **11/10/15**

Number of people in the plan: **1** Eligible for cost-sharing reductions? ☒ No ☐ 73% ☐ 87% ☐ 94%

	Option 1	Option 2	Option 3
Insurance company			
Health plan name			
Metal tier (*Bronze, Silver, Gold, Platinum*)			
Plan type (*HMO, PPO, POS, EPO, or other*)			
Monthly premium *(after tax credit)*			

Scenario 1: Sasha (single adult)

	Option 1	Option 2	Option 3
Insurance company	Coventry		
Health plan name	Bronze HSA Eligible MIPPA		
Metal tier (*Bronze, Silver, Gold, Platinum*)	Bronze		
Plan type (*HMO, PPO, POS, EPO, or other*)	POS		
Monthly premium *(after tax credit)*	$140		
Deductible (medical/drug or combined)	$6,450 (combined)		
Out-of-Pocket Maximum (OOP Max)	$6,450		

Copays/Coinsurance		Amount	Deductible applies? (check if yes)	Amount	Deductible applies? (check if yes)	Amount	Deductible applies? (check if yes)
Primary Care Provider (PCP) visit		no charge	✓				
Specialist visit		no charge	✓				
Prescriptions	Generic drugs	no charge	✓				
	Preferred brand name drugs	no charge	✓				
	Non-preferred brand name drugs	no charge	✓				
	Specialty drugs	no charge	✓				
Emergency Room (ER) visit		no charge	✓				
Inpatient hospital stay		no charge	✓				
Other service:							
Other service:							
Other service:							

Scenario 1: Sasha (single adult)

	Option 1	Option 2	Option 3
Insurance company	Coventry	Coventry	
Health plan name	Bronze HSA Eligible MIPPA	Bronze $15 Copay MIPPA	
Metal tier (*Bronze, Silver, Gold, Platinum*)	Bronze	Bronze	
Plan type (*HMO, PPO, POS, EPO, or other*)	POS	POS	
Monthly premium *(after tax credit)*	$140	$153	
Deductible (medical/drug or combined)	$6,450 (combined)	$6,850 (combined)	
Out-of-Pocket Maximum (OOP Max)	$6,450	$6,850	
Copays/Coinsurance	**Amount**	**Amount**	**Amount**
	Deductible applies? (check if yes)	**Deductible applies?** (check if yes)	**Deductible applies?** (check if yes)
Primary Care Provider (PCP) visit	no charge ✓	$15	
Specialist visit	no charge ✓	no charge ✓	
Prescriptions: Generic drugs	no charge ✓	no charge ✓	
Prescriptions: Preferred brand name drugs	no charge ✓	no charge ✓	
Prescriptions: Non-preferred brand name drugs	no charge ✓	no charge ✓	
Prescriptions: Specialty drugs	no charge ✓	no charge ✓	
Emergency Room (ER) visit	no charge ✓	no charge ✓	
Inpatient hospital stay	no charge ✓	no charge ✓	
Other service:			
Other service:			
Other service:			

Scenario 1: Sasha (single adult)

		Option 1		Option 2		Option 3	
Insurance company		Coventry		Coventry		Coventry	
Health plan name		Bronze HSA Eligible MIPPA		Bronze $15 Copay MIPPA		Silver $10 Copay MIPPA	
Metal tier (*Bronze, Silver, Gold, Platinum*)		Bronze		Bronze		Silver	
Plan type (*HMO, PPO, POS, EPO, or other*)		POS		POS		POS	
Monthly premium *(after tax credit)*		$140		$153		$205	
Deductible (medical/drug or combined)		$6,450 (combined)		$6,850 (combined)		$3,500/$500	
Out-of-Pocket Maximum (OOP Max)		$6,450		$6,850		$6,250	
Copays/Coinsurance		**Amount**		**Amount**		**Amount**	
		Deductible applies? (check if yes)		**Deductible applies?** (check if yes)		**Deductible applies?** (check if yes)	
Primary Care Provider (PCP) visit		no charge	✓	$15		$10	
Specialist visit		no charge	✓	no charge	✓	$75	
Prescriptions	**Generic drugs**	no charge	✓	no charge	✓	$15	✓
	Preferred brand name drugs	no charge	✓	no charge	✓	$40	✓
	Non-preferred brand name drugs	no charge	✓	no charge	✓	$80	✓
	Specialty drugs	no charge	✓	no charge	✓	50%	✓
Emergency Room (ER) visit		no charge	✓	no charge	✓	$500	✓
Inpatient hospital stay		no charge	✓	no charge	✓	$500/30%	✓
Other service:							
Other service:							
Other service:							

Identify Sasha's Priorities for Insurance

- Cheapest monthly payment?
- Manageable deductible?
- Low copays/coinsurance?
- Having "first dollar" coverage/some services exempt from the deductible?
- Lowest yearly cost (from OOP cost calculator)?

Scenario 2: James and Ann (married couple)

	James	Ann
Age	52	45
County	Chicago (Cook County), IL	
Zip Code	60651	
Income	$0	$23,000
Federal Poverty Level	146%	
Employer coverage?	no	no
Insurance status	uninsured	uninsured

Scenario 2: James and Ann (married couple)

Health Reform: Beyond the Basics

A project of the Center on Budget and Policy Priorities

Marketplace Plan Comparison Worksheet

Applicant Name: **James and Ann** Tax Credit (monthly): **$446** Date: **11/10/15**

Number of people in the plan: **2** Eligible for cost-sharing reductions? ☐ No ☐ 73% ☐ 87% ☒ 94%

	Option 1	Option 2	Option 3
Insurance company			
Health plan name			
Metal tier (*Bronze, Silver, Gold, Platinum*)			
Plan type (*HMO, PPO, POS, EPO, or other*)			
Monthly premium *(after tax credit)*			

Scenario 2: James and Ann (married couple)

	Option 1	Option 2	Option 3
Insurance company			
Health plan name			
Plan type (*HMO, PPO, POS, EPO, or other*)			
Monthly premium *(after tax credit)*			
Deductible (medical/drug or combined)			
Out-of-Pocket Maximum (OOP Max)			

Copays/Coinsurance		Amount	Deductible applies? (check if yes)	Amount	Deductible applies? (check if yes)	Amount	Deductible applies? (check if yes)
Primary Care Provider (PCP) visit							
Specialist visit							
Prescriptions	Generic drugs						
	Preferred brand name drugs						
	Non-preferred brand name drugs						
	Specialty drugs						
Emergency Room (ER) visit							
Inpatient hospital stay							
Other service: Laboratory Services							
Other service: X-rays and Diagnostic Imaging							

Health Care Providers	In Network/Covered?	In Network/Covered?	In Network/Covered?
Current doctor/provider:			
Other provider or hospital:			
Current prescription drugs:			

Scenario 2: James and Ann (married couple)

	Option 1		Option 2		Option 3	
Insurance company	Ambetter Balanced Care 1					
Health plan name	Sinai/IlliniCare Health					
Plan type (*HMO, PPO, POS, EPO, or other*)	Silver HMO					
Monthly premium *(after tax credit)*	$79					
Deductible (medical/drug or combined)	$0 (combined)					
Out-of-Pocket Maximum (OOP Max)	$1,300					
Copays/Coinsurance	**Amount**		**Amount**		**Amount**	
	Deductible applies? (check if yes)		**Deductible applies?** (check if yes)		**Deductible applies?** (check if yes)	
Primary Care Provider (PCP) visit	$1	n/a				
Specialist visit	$10	n/a				
Prescriptions: Generic drugs	$1	n/a				
Prescriptions: Preferred brand name drugs	$25	n/a				
Prescriptions: Non-preferred brand name drugs	20%	n/a				
Prescriptions: Specialty drugs	20%	n/a				
Emergency Room (ER) visit	20%	n/a				
Inpatient hospital stay	20%	n/a				
Other service: Laboratory Services	20%	n/a				
Other service: X-rays and Diagnostic Imaging	20%	n/a				
Health Care Providers	**In Network/Covered?**		**In Network/Covered?**		**In Network/Covered?**	
Current doctor/provider:						
Other provider or hospital:						
Current prescription drugs:						

Scenario 2: James and Ann (married couple)

		Option 1		Option 2		Option 3	
Insurance company		Ambetter Balanced Care 1		BCBS, Illinois			
Health plan name		Sinai/IlliniCare Health		BlueCare Direct 102			
Plan type (*HMO, PPO, POS, EPO, or other*)		Silver HMO		Silver HMO			
Monthly premium *(after tax credit)*		$79		$215			
Deductible (medical/drug or combined)		$0 (combined)		$600 (combined)			
Out-of-Pocket Maximum (OOP Max)		$1,300		$1,200			
Copays/Coinsurance		**Amount**		**Amount**		**Amount**	
		Deductible applies? (check if yes)		**Deductible applies?** (check if yes)		**Deductible applies?** (check if yes)	
Primary Care Provider (PCP) visit		$1	n/a	$10			
Specialist visit		$10	n/a	$20			
Prescriptions	Generic drugs	$1	n/a	no charge			
	Preferred brand name drugs	$25	n/a	20%	✓		
	Non-preferred brand name drugs	20%	n/a	30%	✓		
	Specialty drugs	20%	n/a	40%	✓		
Emergency Room (ER) visit		20%	n/a	$500/20%	✓		
Inpatient hospital stay		20%	n/a	$300/day			
Other service: Laboratory Services		20%	n/a	$5			
Other service: X-rays and Diagnostic Imaging		20%	n/a	$5			
Health Care Providers		**In Network/Covered?**		**In Network/Covered?**		**In Network/Covered?**	
Current doctor/provider:							
Other provider or hospital:							
Current prescription drugs:							

Scenario 2: James and Ann (married couple)

		Option 1		Option 2		Option 3	
Insurance company		Ambetter Balanced Care 1		BCBS, Illinois		Land of Lincoln Mutual	
Health plan name		Sinai/IlliniCare Health		BlueCare Direct 102		Presence Health LLH 3 tier	
Plan type (*HMO, PPO, POS, EPO, or other*)		Silver HMO		Silver HMO		Silver PPO	
Monthly premium *(after tax credit)*		$79		$215		$272	
Deductible (medical/drug or combined)		$0 (combined)		$600 (combined)		$0 (combined)	
Out-of-Pocket Maximum (OOP Max)		$1,300		$1,200		$1,400	
Copays/Coinsurance		**Amount**		**Amount**		**Amount**	
		Deductible applies? (check if yes)		**Deductible applies?** (check if yes)		**Deductible applies?** (check if yes)	
Primary Care Provider (PCP) visit		$1	n/a	$10		$10	n/a
Specialist visit		$10	n/a	$20		$35	n/a
Prescriptions	Generic drugs	$1	n/a	no charge		T1A: $0, T1B: $10	n/a
	Preferred brand name drugs	$25	n/a	20%	✓	$15	n/a
	Non-preferred brand name drugs	20%	n/a	30%	✓	10%	n/a
	Specialty drugs	20%	n/a	40%	✓	T1A: 10%, T1B: 50%	n/a
Emergency Room (ER) visit		20%	n/a	$500/20%	✓	$300	n/a
Inpatient hospital stay		20%	n/a	$300/day		$100/ day	n/a
Other service: Laboratory Services		20%	n/a	$5		$10	n/a
Other service: X-rays and Diagnostic Imaging		20%	n/a	$5		$10	n/a
Health Care Providers		**In Network/Covered?**		**In Network/Covered?**		**In Network/Covered?**	
Current doctor/provider:							
Other provider or hospital:							
Current prescription drugs:							

Scenario 2: James and Ann (married couple)

		Option 1		Option 2		Option 3	
Insurance company		Ambetter Balanced Care 1		BCBS, Illinois		Land of Lincoln Mutual	
Health plan name		Sinai/IlliniCare Health		BlueCare Direct 102		Presence Health LLH 3 tier	
Plan type (*HMO, PPO, POS, EPO, or other*)		Silver HMO		Silver HMO		Silver PPO	
Monthly premium *(after tax credit)*		$79		$215		$272	
Deductible (medical/drug or combined)		$0 (combined)		$600 (combined)		$0 (combined)	
Out-of-Pocket Maximum (OOP Max)		$1,300		$1,200		$1,400	
Copays/Coinsurance		**Amount**		**Amount**		**Amount**	
		Deductible applies? (check if yes)		**Deductible applies?** (check if yes)		**Deductible applies?** (check if yes)	
Primary Care Provider (PCP) visit		$1	n/a	$10		$10	n/a
Specialist visit		$10	n/a	$20		$35	n/a
Prescriptions	Generic drugs	$1	n/a	no charge		T1A: $0, T1B: $10	n/a
	Preferred brand name drugs	$25	n/a	20%	✓	$15	n/a
	Non-preferred brand name drugs	20%	n/a	30%	✓	10%	n/a
	Specialty drugs	20%	n/a	40%	✓	T1A: 10%, T1B: 50%	n/a
Emergency Room (ER) visit		20%	n/a	$500/20%	✓	$300	n/a
Inpatient hospital stay		20%	n/a	$300/day		$100/ day	n/a
Other service: Laboratory Services		20%	n/a	$5		$10	n/a
Other service: X-rays and Diagnostic Imaging		20%	n/a	$5		$10	n/a
Health Care Providers		**In Network/Covered?**		**In Network/Covered?**		**In Network/Covered?**	
Current doctor/provider: Dr. Gaziano (PCP)							
Other provider or hospital:							
Current prescription drugs:							

Scenario 2: James and Ann (married couple)

		Option 1		Option 2		Option 3	
Insurance company		Ambetter Balanced Care 1		BCBS, Illinois		Land of Lincoln Mutual	
Health plan name		Sinai/IlliniCare Health		BlueCare Direct 102		Presence Health LLH 3 tier	
Plan type (*HMO, PPO, POS, EPO, or other*)		Silver HMO		Silver HMO		Silver PPO	
Monthly premium *(after tax credit)*		$79		$215		$272	
Deductible (medical/drug or combined)		$0 (combined)		$600 (combined)		$0 (combined)	
Out-of-Pocket Maximum (OOP Max)		$1,300		$1,200		$1,400	
Copays/Coinsurance		**Amount**		**Amount**		**Amount**	
		Deductible applies? (check if yes)		**Deductible applies?** (check if yes)		**Deductible applies?** (check if yes)	
Primary Care Provider (PCP) visit		$1	n/a	$10		$10	n/a
Specialist visit		$10	n/a	$20		$35	n/a
Prescriptions	Generic drugs	$1	n/a	no charge		T1A: $0, T1B: $10	n/a
	Preferred brand name drugs	$25	n/a	20%	✓	$15	n/a
	Non-preferred brand name drugs	20%	n/a	30%	✓	10%	n/a
	Specialty drugs	20%	n/a	40%	✓	T1A: 10%, T1B: 50%	n/a
Emergency Room (ER) visit		20%	n/a	$500/20%	✓	$300	n/a
Inpatient hospital stay		20%	n/a	$300/day		$100/ day	n/a
Other service: Laboratory Services		20%	n/a	$5		$10	n/a
Other service: X-rays and Diagnostic Imaging		20%	n/a	$5		$10	n/a
Health Care Providers		**In Network/Covered?**		**In Network/Covered?**		**In Network/Covered?**	
Current doctor/provider: Dr. Gaziano (PCP)							
Other provider or hospital: # of Cardiologists							
Current prescription drugs:							

Scenario 2: James and Ann (married couple)

		Option 1		Option 2		Option 3	
Insurance company		Ambetter Balanced Care 1		BCBS, Illinois		Land of Lincoln Mutual	
Health plan name		Sinai/IlliniCare Health		BlueCare Direct 102		Presence Health LLH 3 tier	
Plan type (*HMO, PPO, POS, EPO, or other*)		Silver HMO		Silver HMO		Silver PPO	
Monthly premium *(after tax credit)*		$79		$215		$272	
Deductible (medical/drug or combined)		$0 (combined)		$600 (combined)		$0 (combined)	
Out-of-Pocket Maximum (OOP Max)		$1,300		$1,200		$1,400	
Copays/Coinsurance		**Amount**		**Amount**		**Amount**	
		Deductible applies? (check if yes)		**Deductible applies?** (check if yes)		**Deductible applies?** (check if yes)	
Primary Care Provider (PCP) visit		$1	n/a	$10		$10	n/a
Specialist visit		$10	n/a	$20		$35	n/a
Prescriptions	Generic drugs	$1	n/a	no charge		T1A: $0, T1B: $10	n/a
	Preferred brand name drugs	$25	n/a	20%	✓	$15	n/a
	Non-preferred brand name drugs	20%	n/a	30%	✓	10%	n/a
	Specialty drugs	20%	n/a	40%	✓	T1A: 10%, T1B: 50%	n/a
Emergency Room (ER) visit		20%	n/a	$500/20%	✓	$300	n/a
Inpatient hospital stay		20%	n/a	$300/day		$100/ day	n/a
Other service: Laboratory Services		20%	n/a	$5		$10	n/a
Other service: X-rays and Diagnostic Imaging		20%	n/a	$5		$10	n/a
Health Care Providers		**In Network/Covered?**		**In Network/Covered?**		**In Network/Covered?**	
Current doctor/provider: Dr. Gaziano (PCP)							
Other provider or hospital: # of Cardiologists							
Current prescription drugs: Metformin							

Scenario 2: James and Ann (married couple)

		Option 1		Option 2		Option 3	
Insurance company		Ambetter Balanced Care 1		BCBS, Illinois		Land of Lincoln Mutual	
Health plan name		Sinai/IlliniCare Health		BlueCare Direct 102		Presence Health LLH 3 tier	
Plan type (*HMO, PPO, POS, EPO, or other*)		Silver HMO		Silver HMO		Silver PPO	
Monthly premium *(after tax credit)*		$79		$215		$272	
Deductible (medical/drug or combined)		$0 (combined)		$600 (combined)		$0 (combined)	
Out-of-Pocket Maximum (OOP Max)		$1,300		$1,200		$1,400	
Copays/Coinsurance		**Amount**		**Amount**		**Amount**	
		Deductible applies? (check if yes)		**Deductible applies?** (check if yes)		**Deductible applies?** (check if yes)	
Primary Care Provider (PCP) visit		$1	n/a	$10		$10	n/a
Specialist visit		$10	n/a	$20		$35	n/a
Prescriptions	Generic drugs	$1	n/a	no charge		T1A: $0, T1B: $10	n/a
	Preferred brand name drugs	$25	n/a	20%	✓	$15	n/a
	Non-preferred brand name drugs	20%	n/a	30%	✓	10%	n/a
	Specialty drugs	20%	n/a	40%	✓	T1A: 10%, T1B: 50%	n/a
Emergency Room (ER) visit		20%	n/a	$500/20%	✓	$300	n/a
Inpatient hospital stay		20%	n/a	$300/day		$100/ day	n/a
Other service: Laboratory Services		20%	n/a	$5		$10	n/a
Other service: X-rays and Diagnostic Imaging		20%	n/a	$5		$10	n/a
Health Care Providers		**In Network/Covered?**		**In Network/Covered?**		**In Network/Covered?**	
Current doctor/provider: Dr. Gaziano (PCP)		✗		✗		✓	
Other provider or hospital: # of Cardiologists							
Current prescription drugs: Metformin							

Scenario 2: James and Ann (married couple)

		Option 1		Option 2		Option 3	
Insurance company		Ambetter Balanced Care 1		BCBS, Illinois		Land of Lincoln Mutual	
Health plan name		Sinai/IlliniCare Health		BlueCare Direct 102		Presence Health LLH 3 tier	
Plan type (*HMO, PPO, POS, EPO, or other*)		Silver HMO		Silver HMO		Silver PPO	
Monthly premium *(after tax credit)*		$79		$215		$272	
Deductible (medical/drug or combined)		$0 (combined)		$600 (combined)		$0 (combined)	
Out-of-Pocket Maximum (OOP Max)		$1,300		$1,200		$1,400	
Copays/Coinsurance		**Amount**		**Amount**		**Amount**	
		Deductible applies? (check if yes)		**Deductible applies?** (check if yes)		**Deductible applies?** (check if yes)	
Primary Care Provider (PCP) visit		$1	n/a	$10		$10	n/a
Specialist visit		$10	n/a	$20		$35	n/a
Prescriptions	Generic drugs	$1	n/a	no charge		T1A: $0, T1B: $10	n/a
	Preferred brand name drugs	$25	n/a	20%	✓	$15	n/a
	Non-preferred brand name drugs	20%	n/a	30%	✓	10%	n/a
	Specialty drugs	20%	n/a	40%	✓	T1A: 10%, T1B: 50%	n/a
Emergency Room (ER) visit		20%	n/a	$500/20%	✓	$300	n/a
Inpatient hospital stay		20%	n/a	$300/day		$100/ day	n/a
Other service: Laboratory Services		20%	n/a	$5		$10	n/a
Other service: X-rays and Diagnostic Imaging		20%	n/a	$5		$10	n/a
Health Care Providers		**In Network/Covered?**		**In Network/Covered?**		**In Network/Covered?**	
Current doctor/provider: Dr. Gaziano (PCP)		✗		✗		✓	
Other provider or hospital: # of Cardiologists		26 (10 mi.) 38 (20 mi.)		52 (10 mi.) 154 (20 mi.)		0 (10 mi.) 1 (20 mi.)	
Current prescription drugs: Metformin							

Scenario 2: James and Ann (married couple)

		Option 1		Option 2		Option 3	
Insurance company		Ambetter Balanced Care 1		BCBS, Illinois		Land of Lincoln Mutual	
Health plan name		Sinai/IlliniCare Health		BlueCare Direct 102		Presence Health LLH 3 tier	
Plan type (*HMO, PPO, POS, EPO, or other*)		Silver HMO		Silver HMO		Silver PPO	
Monthly premium *(after tax credit)*		$79		$215		$272	
Deductible (medical/drug or combined)		$0 (combined)		$600 (combined)		$0	
Out-of-Pocket Maximum (OOP Max)		$1,300		$1,200		$1,400	
Copays/Coinsurance		**Amount**		**Amount**		**Amount**	
		Deductible applies? (check if yes)		**Deductible applies?** (check if yes)		**Deductible applies?** (check if yes)	
Primary Care Provider (PCP) visit		$1	n/a	$10		$10	n/a
Specialist visit		$10	n/a	$20		$35	n/a
Prescriptions	**Generic drugs**	$1	n/a	no charge		T1A: $0, T1B: $10	n/a
	Preferred brand name drugs	$25	n/a	20%	✓	$15	n/a
	Non-preferred brand name drugs	20%	n/a	30%	✓	10%	n/a
	Specialty drugs	20%	n/a	40%	✓	T1A: 10%, T1B: 50%	n/a
Emergency Room (ER) visit		20%	n/a	$500/20%	✓	$300	n/a
Inpatient hospital stay		20%	n/a	$300/day		$100/ day	n/a
Other service: Laboratory Services		20%	n/a	$5		$10	n/a
Other service: X-rays and Diagnostic Imaging		20%	n/a	$5		$10	n/a
Health Care Providers		**In Network/Covered?**		**In Network/Covered?**		**In Network/Covered?**	
Current doctor/provider: Dr. Gaziano (PCP)		✗		✗		✓	
Other provider or hospital: # of Cardiologists		26 (10 mi.) 38 (20 mi.)		52 (10 mi.) 154 (20 mi.)		0 (10 mi.) 1 (20 mi.)	
Current prescription drugs: Metformin		Yes (Tier 1)		Yes (Tier 1,2,3,4)		Yes (Tier 1A, 1B)	

Identify James's and Ann's Priorities for Insurance

- Cheapest monthly payment?
- Manageable deductible?
- Low copays/coinsurance?
- Having "first dollar" coverage/some services exempt from the deductible?
- Lowest yearly cost (from OOP cost calculator)?
- Current doctor in network?
- Size of network
- Prescription drugs covered?

Scenario 2: the Green Family (family of 5)

	Rosa	Dan	Jennifer*	Kristy	Cara
Age	43	43	20	16	10
County (Zip Code)	Asheville (Buncombe County), NC, 28801				
Income	$25,000	$20,000	$0	$0	$0
FPL	161 %FPL				
Employer coverage	no	no	no	no	no
Insurance status	uninsured	uninsured	uninsured	on Medicaid	on Medicaid

**Jennifer can be claimed as a tax dependent as a qualifying relative because she is receives more than half of her support from her parents and makes less than $3,950*

Scenario 3: the Green Family (family of 3)

	Option 1	Option 2	Option 3
Insurance company	United Healthcare		
Health plan name	Bronze Compass 4200		
Plan type (*HMO, PPO, POS, EPO, or other*)	Bronze HMO		
Monthly premium *(after tax credit)*	$13		
Deductible (in-network/out-of-network)	$8,400 (combined)		
OOP Maximum (in-network/out-of-network)	$13,200		
Copays/Coinsurance	**Amount**	**Amount**	**Amount**
	Deductible applies? (check if yes)	Deductible applies? (check if yes)	Deductible applies? (check if yes)
Primary Care Provider (PCP) visit	30% ✓		
Specialist visit	30% ✓		
Prescriptions: Generic drugs	30% ✓		
Prescriptions: Preferred brand name drugs	30% ✓		
Prescriptions: Non-preferred brand name drugs	30% ✓		
Prescriptions: Specialty drugs	30% ✓		
Emergency Room (ER) visit	30% ✓		
Inpatient hospital stay	30% ✓		
Other Considerations			
Other Consideration:			
Other Consideration:			
Other Consideration:			

Scenario 3: the Green Family (family of 3)

	Option 1		Option 2		Option 3	
Insurance company	United Healthcare		Aetna			
Health plan name	Bronze Compass 4200		Coventry Ded Only HSA			
Plan type (*HMO, PPO, POS, EPO, or other*)	Bronze HMO		Bronze POS			
Monthly premium *(after tax credit)*	$13		$19			
Deductible (in-network/out-of-network)	$8,400 (combined)		$12,900 (combined)			
OOP Maximum (in-network/out-of-network)	$13,200		$12,900			
Copays/Coinsurance	**Amount**		**Amount**		**Amount**	
	Deductible applies? (check if yes)		**Deductible applies?** (check if yes)		**Deductible applies?** (check if yes)	
Primary Care Provider (PCP) visit	30%	✓	no charge	✓		
Specialist visit	30%	✓	no charge	✓		
Prescriptions: Generic drugs	30%	✓	no charge	✓		
Prescriptions: Preferred brand name drugs	30%	✓	no charge	✓		
Prescriptions: Non-preferred brand name drugs	30%	✓	no charge	✓		
Prescriptions: Specialty drugs	30%	✓	no charge	✓		
Emergency Room (ER) visit	30%	✓	no charge	✓		
Inpatient hospital stay	30%	✓	no charge	✓		
Other Considerations						
Other Consideration:						
Other Consideration:						
Other Consideration:						

Scenario 3: the Green Family (family of 3)

		Option 1		Option 2		Option 3	
Insurance company		United Healthcare		Aetna		United Healthcare	
Health plan name		Bronze Compass 4200		Coventry Ded Only HSA		Silver Compass 5000	
Plan type (*HMO, PPO, POS, EPO, or other*)		Bronze HMO		Bronze POS		Silver HMO	
Monthly premium *(after tax credit)*		$13		$19		$132	
Deductible (in-network/out-of-network)		$8,400 (combined)		$12,900 (combined)		$1,600/$0	
OOP Maximum (in-network/out-of-network)		$13,200		$12,900		$3,700	
Copays/Coinsurance		**Amount**		**Amount**		**Amount**	
		Deductible applies? (check if yes)		**Deductible applies?** (check if yes)		**Deductible applies?** (check if yes)	
Primary Care Provider (PCP) visit		30%	✓	no charge	✓	$20	
Specialist visit		30%	✓	no charge	✓	$40	
Prescriptions	Generic drugs	30%	✓	no charge	✓	$10	n/a
	Preferred brand name drugs	30%	✓	no charge	✓	$40	n/a
	Non-preferred brand name drugs	30%	✓	no charge	✓	$80	n/a
	Specialty drugs	30%	✓	no charge	✓	$160	n/a
Emergency Room (ER) visit		30%	✓	no charge	✓	20%	✓
Inpatient hospital stay		30%	✓	no charge	✓	20%	✓
Other Considerations							
Other Consideration:							
Other Consideration:							
Other Consideration:							

Scenario 3: the Green Family (family of 3)

		Option 1		Option 2		Option 3	
Insurance company		United Healthcare		Aetna		United Healthcare	
Health plan name		Bronze Compass 4200		Coventry Ded Only HSA		Silver Compass 5000	
Plan type (*HMO, PPO, POS, EPO, or other*)		Bronze HMO		Bronze POS		Silver HMO	
Monthly premium *(after tax credit)*		$13		$19		$132	
Deductible (in-network/out-of-network)		$8,400 (combined)		$12,900 (combined)		$1,600/$0	
OOP Maximum (in-network/out-of-network)		$13,200		$12,900		$3,700	
Copays/Coinsurance		**Amount**		**Amount**		**Amount**	
		Deductible applies? (check if yes)		**Deductible applies?** (check if yes)		**Deductible applies?** (check if yes)	
Primary Care Provider (PCP) visit		30%	✓	no charge	✓	$20	
Specialist visit		30%	✓	no charge	✓	$40	
Prescriptions	Generic drugs	30%	✓	no charge	✓	$10	n/a
	Preferred brand name drugs	30%	✓	no charge	✓	$40	n/a
	Non-preferred brand name drugs	30%	✓	no charge	✓	$80	n/a
	Specialty drugs	30%	✓	no charge	✓	$160	n/a
Emergency Room (ER) visit		30%	✓	no charge	✓	20%	✓
Inpatient hospital stay		30%	✓	no charge	✓	20%	✓
Other Considerations							
Other Consideration: out-of-network coverage?		✗		✓		✗	
Other Consideration:							
Other Consideration:							

Scenario 3: the Green Family (family of 3)

		Option 1		Option 2		Option 3	
Insurance company		United Healthcare		Aetna		United Healthcare	
Health plan name		Bronze Compass 4200		Coventry Ded Only HSA		Silver Compass 5000	
Plan type (*HMO, PPO, POS, EPO, or other*)		Bronze HMO		Bronze POS		Silver HMO	
Monthly premium *(after tax credit)*		$13		$19		$132	
Deductible (in-network/out-of-network)		$8,400 (combined)		$12,900 (combined)		$1,600/$0	
OOP Maximum (in-network/out-of-network)		$13,200		$12,900		$3,700	
Copays/Coinsurance		**Amount**		**Amount**		**Amount**	
		Deductible applies? (check if yes)		**Deductible applies?** (check if yes)		**Deductible applies?** (check if yes)	
Primary Care Provider (PCP) visit		30%	✓	no charge	✓	$20	
Specialist visit		30%	✓	no charge	✓	$40	
Prescriptions	Generic drugs	30%	✓	no charge	✓	$10	n/a
	Preferred brand name drugs	30%	✓	no charge	✓	$40	n/a
	Non-preferred brand name drugs	30%	✓	no charge	✓	$80	n/a
	Specialty drugs	30%	✓	no charge	✓	$160	n/a
Emergency Room (ER) visit		30%	✓	no charge	✓	20%	✓
Inpatient hospital stay		30%	✓	no charge	✓	20%	✓
Other Considerations							
Other Consideration: out-of-network coverage?		✗		✓		✗	
Other Consideration: Spanish Speaking PCPs							
Other Consideration:							

Scenario 3: the Green Family (family of 3)

		Option 1		Option 2		Option 3	
Insurance company		United Healthcare		Aetna		United Healthcare	
Health plan name		Bronze Compass 4200		Coventry Ded Only HSA		Silver Compass 5000	
Plan type (*HMO, PPO, POS, EPO, or other*)		Bronze HMO		Bronze POS		Silver HMO	
Monthly premium *(after tax credit)*		$13		$19		$132	
Deductible (in-network/out-of-network)		$8,400 (combined)		$12,900 (combined)		$1,600/$0	
OOP Maximum (in-network/out-of-network)		$13,200		$12,900		$3,700	
Copays/Coinsurance		**Amount**		**Amount**		**Amount**	
		Deductible applies? (check if yes)		**Deductible applies?** (check if yes)		**Deductible applies?** (check if yes)	
Primary Care Provider (PCP) visit		30%	✓	no charge	✓	$20	
Specialist visit		30%	✓	no charge	✓	$40	
Prescriptions	Generic drugs	30%	✓	no charge	✓	$10	n/a
	Preferred brand name drugs	30%	✓	no charge	✓	$40	n/a
	Non-preferred brand name drugs	30%	✓	no charge	✓	$80	n/a
	Specialty drugs	30%	✓	no charge	✓	$160	n/a
Emergency Room (ER) visit		30%	✓	no charge	✓	20%	✓
Inpatient hospital stay		30%	✓	no charge	✓	20%	✓
Other Considerations							
Other Consideration: out-of-network coverage?		✗		✓		✗	
Other Consideration: Spanish Speaking PCPs		16 (5 mi.) 29 (10 mi.)		6 (5 mi.) 6 (10 mi.)		16 (5 mi.) 29 (10 mi.)	
Other Consideration:							

Scenario 3: the Green Family (family of 3)

	Option 1				Option 3	
Insurance company	United Healthcare				United Healthcare	
Health plan name	Bronze Compass 4200				Silver Compass 5000	
Plan type (*HMO, PPO, POS, EPO, or other*)	Bronze HMO		**Annual Cost**	**Annual Cost**	Silver HMO	
Monthly premium *(after tax credit)*	$13		$156	$1,584	$132	
Deductible (in-network/out-of-network)	$8,400 (combined)		$6,400	$1,600	$1,600/$0	
OOP Maximum (in-network/out-of-network)	$13,200				$3,700	
Copays/Coinsurance	**Amount**				**Amount**	
	Deductible applies? (check if yes)				Deductible applies? (check if yes)	
Primary Care Provider (PCP) visit	30%	✓		$80	$20	
Specialist visit	30%	✓			$40	
Prescriptions: Generic drugs	30%	✓		$480	$10	n/a
Prescriptions: Preferred brand name drugs	30%	✓			$40	n/a
Prescriptions: Non-preferred brand name drugs	30%	✓			$80	n/a
Prescriptions: Specialty drugs	30%	✓			$160	n/a
Emergency Room (ER) visit	30%	✓			20%	✓
Inpatient hospital stay	30%	✓		$480	20%	✓
Other Considerations						
Other Consideration: out-of-network coverage?	✗				✗	
Other Consideration: Spanish Speaking PCPs	16 (5 mi.) 29 (10 mi.)				16 (5 mi.) 29 (10 mi.)	
			$6,556	**$4,224**		

Health care needs:	• 4 PCP visits per year ($120/visit) • Four generic prescriptions per month ($40 retail) • Hospitalization ($4,000 bill)

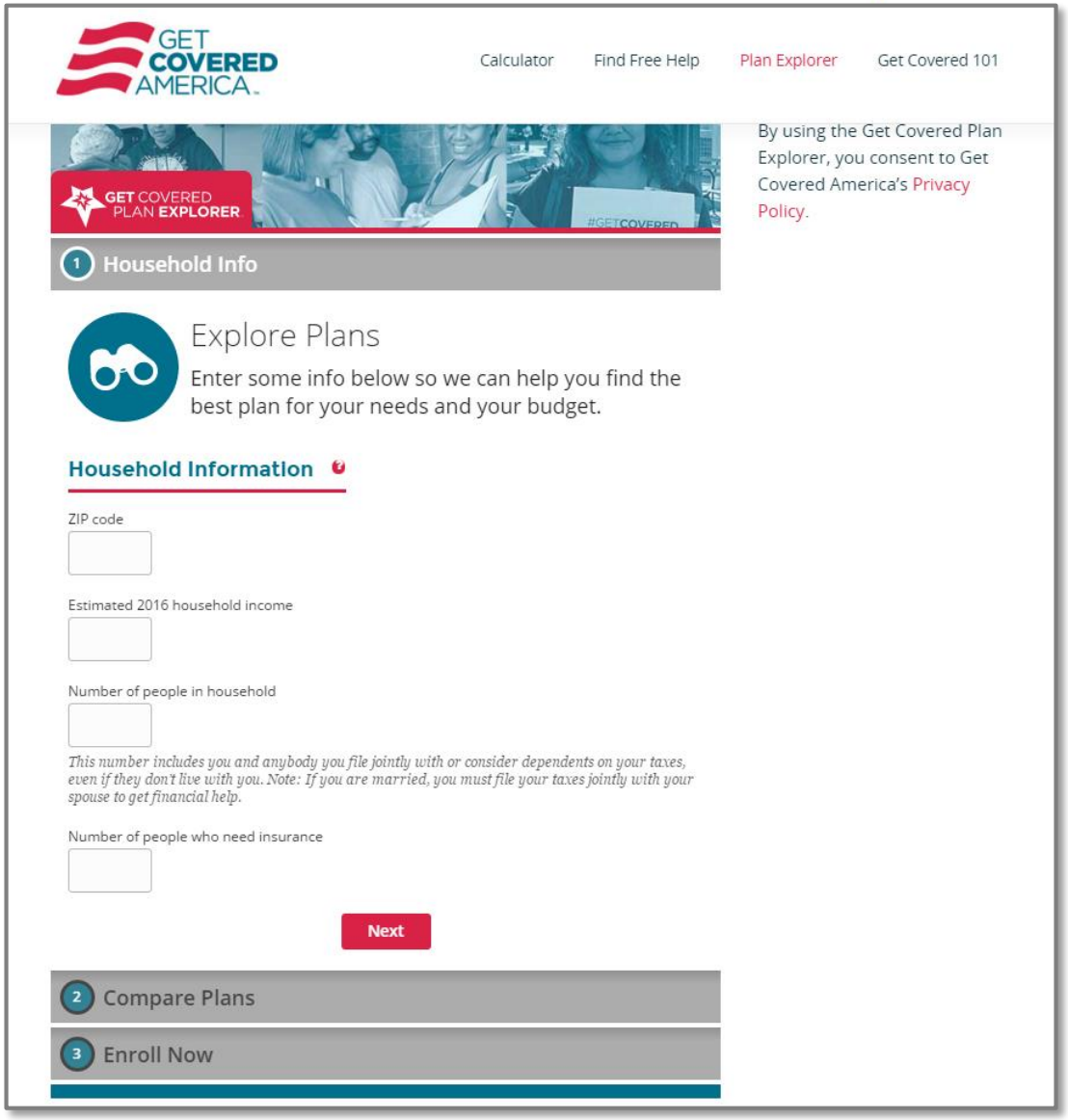
Identify the Green Family's Priorities for Insurance

- Cheapest monthly payment?
- Manageable deductible?
- Low copays/coinsurance?
- Having "first dollar" coverage/some services exempt from the deductible?
- Lowest yearly cost (from OOP cost calculator)?
- Current doctor in network?
- Size of network
- Prescription drugs covered?
- Out-of-network coverage?
- Language spoken by provider
- Lowest yearly cost (based on consumer's actual utilization)

Get Covered America: Plan Comparison Tool

Provides:

- Out-of-pocket cost calculator that allows tailoring of expected health expenditures
- Plan comparison
- Provider look up tool



Source: Enroll America, www.getcoveredamerica.org/explorer

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For more information and resources, please visit:

www.healthreformbeyondthebasics.org

This is a project of the Center on Budget and Policy Priorities, www.cbpp.org