



# Health Reform: **Beyond the Basics**

[healthreformbeyondthebasics.org](http://healthreformbeyondthebasics.org)

## **Part IV:**

# **Plan Selection Strategies**

## The Right Fit: Helping Consumers Navigate the Plan Selection Process

*Dave Chandrasekaran, Training Consultant,  
Certified Application Counselor (CAC)*

September 25, 2018

# Today's Presentation

- **Section 1: Overview of Marketplace QHPs**
- **Section 2: Trends in Marketplace plans**
- **Section 3: Strategies to Help Consumers**
- **Section 4: Plan Comparison & Selection Demo**

# **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**

# Overview of Cost Sharing

Simple Choice

New PI

## Cigna Health And Life Insurance Company · Cigna US-VA Connect 6650

Bronze | EPO | Plan ID: 41921VA0020012

<p>Estimated monthly premium</p> <p><b>\$264.68</b></p>	<p>Deductible</p> <p><b>\$6,650</b></p> <p>Individual Total</p>	<p>Out-of-pocket maximum</p> <p><b>\$7,150</b></p> <p>Individual Total</p>	<p>Copayments / Coinsurance</p> <p>Emergency room care: 50% Coinsurance after deductible Generic drugs: \$35 Primary doctor: \$45 Copay before deductible/50% Coinsurance after deductible Specialist doctor: 50% Coinsurance after deductible</p>	<p>Estimated total yearly COSTS</p> <p><b>ESTIMATE TOTAL YEARLY COSTS</b></p>
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### Costs for medical care

<b>Deductible</b>	\$6,650 Individual Total
<b>Out-of-pocket maximum</b>	\$7,150 Individual Total
<b>Primary care doctor visit</b>	In Network: \$45 Copay before deductible/50% Coinsurance after deductible Out of Network: Benefit Not Covered
<a href="#">Limits and exclusions apply</a>	
<b>Specialist visit</b>	In Network: 50% Coinsurance after deductible Out of Network: Benefit Not Covered
<b>X-rays and diagnostic imaging</b>	In Network: 50% Coinsurance after deductible Out of Network: Benefit Not Covered
<b>Laboratory outpatient and professional services</b>	In Network: 50% Coinsurance after deductible Out of Network: Benefit Not Covered

# QHP Metal Tiers

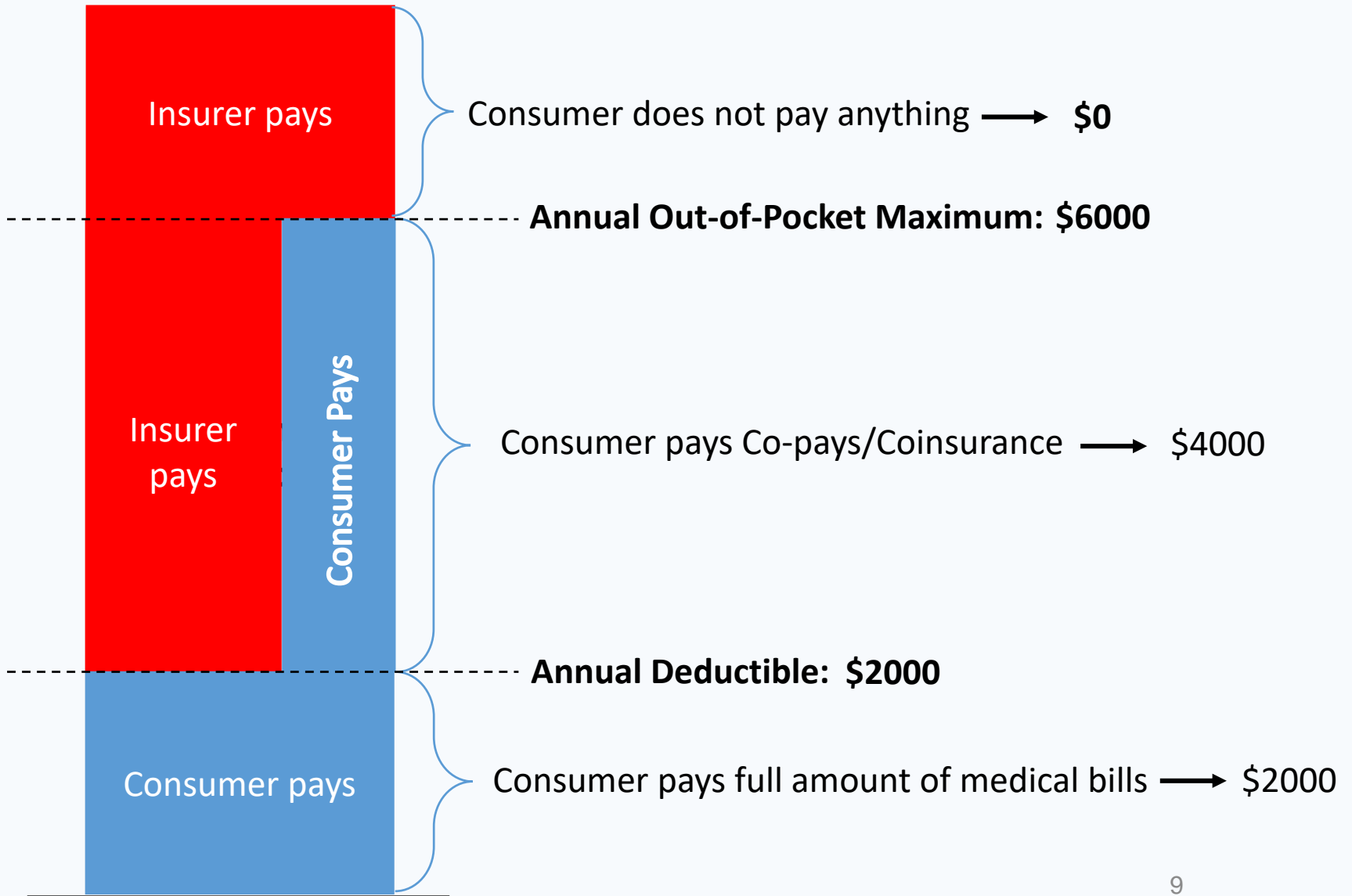
	<b>Bronze (60%)</b>	<b>Silver (70%)</b>	<b>Gold (80%)</b>	<b>Platinum (90%)</b>
Premium	\$216.02	\$310.62	\$327.63	\$522.84
Deductible	\$6,950	\$3,500	\$1,400	\$250
Maximum OOP limit	\$7,350	\$7,350	\$5,000	\$1,500
Primary care visit	\$35	\$25	\$20	\$10
Specialist visit	no charge after ded.	\$75	\$50	10%
Emergency room care	no charge after ded.	\$800	20% after ded.	10% after ded.
Inpatient hospitalization	no charge after ded.	no charge after ded.	20% after ded.	10% after ded.
Generic drugs	\$30	\$20	\$10	\$10
Preferred brand name	30% after ded.	\$65 after ded.	\$40	\$45
Non-preferred brand	50% after ded.	\$100 after ded.	\$75	\$90
Specialty Drugs	50% after ded.	50% after ded.	50% after ded.	50% after ded.

# Cost Sharing Reduction (CSR) Silver Plans

	Silver (70%)	Silver (CSR 73%)	Silver (CSR 87%)	Silver (CSR 94%)
Eligibility	>250%	200%-250%	150%-200%	100%-150%
Premium	\$311.62	\$143.17	\$63.24	\$48.44
Deductible	\$3,500	\$2,650	\$1,250	\$150
Maximum OOP limit	\$7,350	\$5,850	\$2,450	\$1,000
Primary care visit	\$25	\$25	\$5	\$5
Specialist visit	no charge after ded.	\$75	\$25	\$15
Emergency room care	\$800	\$800	\$150	\$75
Inpatient hospitalization	no charge after ded.	no charge after ded.	no charge after ded.	no charge after ded.
Generic drugs	\$20	\$20	\$4	\$2
Preferred brand name	\$65 after ded.	\$65 after ded.	\$15	\$25
Non-preferred brand	\$100 after ded.	\$100 after ded.	\$45	\$45
Specialty Drugs	50% after ded.	50% after ded.	50%	50%

Source: UPMC Silver CSR Plans in Pittsburgh, PA

# Explaining Cost-Sharing Terms





# First Dollar Coverage

## Common Ground Healthcare Cooperative · Envision Aurora Bellin PPO - Silver 5200/80

★★★★☆  
Overall Rating **3**  
Details

Silver | PPO | Plan ID: 87416WI0010057

Estimated monthly premium <b>\$360.82</b>	<b>Deductible</b> <b>\$5,200</b> Individual Total	Out-of-pocket maximum <b>\$7,150</b> Individual Total	Copayments / Coinsurance Emergency room care: \$300 Copay after deductible Generic drugs: \$10 Primary doctor: \$50 Specialist doctor: \$80	Estimated total yearly costs <b>ESTIMATE TOTAL YEARLY COSTS</b>	Medical providers & prescription drugs covered <b>SEE IF PROVIDERS &amp; DRUGS ARE COVERED</b>
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### Costs for medical care

<b>Primary care doctor visit</b>	In Network: \$50 Out of Network: 50% Coinsurance after deductible
<b>Specialist visit</b>	In Network: \$80 Out of Network: 50% Coinsurance after deductible

<b>X-rays and diagnostic imaging</b>	In Network: 20% Coinsurance after deductible Out of Network: 50% Coinsurance after deductible
<b>Laboratory outpatient and professional services</b>	In Network: 20% Coinsurance after deductible Out of Network: 50% Coinsurance after deductible

### Prescription drug coverage

<b>Generic drugs</b>	In Network: \$10 Out of Network: \$10
<b>Preferred brand drugs</b> <i>Q Limits and exclusions apply</i>	In Network: \$50 Copay after deductible Out of Network: \$50 Copay after deductible
<b>Non-preferred brand drugs</b> <i>Q Limits and exclusions apply</i>	In Network: \$75 Copay after deductible Out of Network: \$75 Copay after deductible
<b>Specialty drugs</b> <i>Q Limits and exclusions apply</i>	In Network: 20% Coinsurance after deductible Out of Network: 50% Coinsurance after deductible

**deductible applies**

Source: healthcare.gov, Common Ground Healthcare Envision Aurora Bellin PPO Silver 5200/80 in Green Bay, WI (2017)

# First Dollar Coverage

## Common Ground Healthcare Cooperative · Envision Aurora Bellin PPO - Silver 5200/80

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### Costs for medical care

<b>Primary care doctor visit</b>	In Network: \$50 Out of Network: 50% Coinsurance after deductible	<b>deductible does not apply</b>
<b>Specialist visit</b>	In Network: \$80 Out of Network: 50% Coinsurance after deductible	
<b>X-rays and diagnostic imaging</b>	In Network: 20% Coinsurance after deductible Out of Network: 50% Coinsurance after deductible	
<b>Laboratory outpatient and professional services</b>	In Network: 20% Coinsurance after deductible Out of Network: 50% Coinsurance after deductible	
<b>Prescription drug coverage</b>		
<b>Generic drugs</b>	In Network: \$10 Out of Network: \$10	
<b>Preferred brand drugs</b>	In Network: \$50 Copay after deductible Out of Network: \$50 Copay after deductible	
<b>Non-preferred brand drugs</b>	In Network: \$75 Copay after deductible Out of Network: \$75 Copay after deductible	
<b>Specialty drugs</b>	In Network: 20% Coinsurance after deductible Out of Network: 50% Coinsurance after deductible	

Source: healthcare.gov, Common Ground Healthcare Envision Aurora Bellin PPO Silver 5200/80 in Green Bay, WI (2017)

# First Dollar Coverage

## Common Ground Healthcare Cooperative · Envision Aurora Bellin PPO - Silver 5200/80

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### Terms used to describe First Dollar Coverage:

- Service is ***Pre-deductible***
- Service is ***Exempt from the deductible***
- ***Deductible does not apply*** to this service
- ***Deductible is Waived*** for this service
- Service is ***before the deductible***
- ***Service is not subject to the deductible***
- Absence of the words ***“after deductible”***

Q Limits and exclusions apply

#### Non-preferred brand drugs

In Network: \$75 Copay after deductible  
Out of Network: \$75 Copay after deductible

Q Limits and exclusions apply

#### Specialty drugs

In Network: 20% Coinsurance after deductible  
Out of Network: 50% Coinsurance after deductible

Q Limits and exclusions apply

# HSA vs. non-HSA Plans

## Kaiser Permanente · KP GA Signature Bronze

Bronze | HMO | Plan ID: 89942GA0050020

Estimated monthly premium

**\$206.58**

Was: \$349.17

Deductible

**\$6,200**

Individual Total

Out-of-pocket maximum

**\$6,550**

Individual Total

**Primary care doctor visit** In Network: 40% Coinsurance after deductible  
Out of Network: Benefit Not Covered

**Specialist visit** In Network: 40% Coinsurance after deductible  
Out of Network: Benefit Not Covered

**X-rays and diagnostic imaging** In Network: 40% Coinsurance after deductible  
Out of Network: Benefit Not Covered

**Laboratory outpatient and pro** In Network: 40% Coinsurance after deductible  
Out of Network: Benefit Not Covered

### Prescription drug coverage

**Generic drugs** In Network: 40% Coinsurance after deductible  
Out of Network: Benefit Not Covered

[View limits and exclusions](#)

**Preferred brand drugs** In Network: 50% Coinsurance after deductible  
Out of Network: Benefit Not Covered

[View limits and exclusions](#)

**Non-preferred brand drugs** In Network: 50% Coinsurance after deductible  
Out of Network: Benefit Not Covered

[View limits and exclusions](#)

**Specialty drugs** In Network: 50% Coinsurance after deductible  
Out of Network: Benefit Not Covered

## Kaiser Permanente · KP GA Signature Silver 4700

Silver | HMO | Plan ID: 89942GA0050025

Estimated monthly premium

**\$231.36**

Was: \$373.95

Deductible

**\$4,700**

Individual Total

Out-of-pocket maximum

**\$7,350**

Individual Total

**Primary care doctor visit** In Network: \$35  
Out of Network: Benefit Not Covered

**Specialist visit** In Network: \$65  
Out of Network: Benefit Not Covered

**X-rays and diagnostic imaging** In Network: 30% Coinsurance after deductible  
Out of Network: Benefit Not Covered

**Laboratory outpatient and profi** In Network: 30% Coinsurance after deductible  
Out of Network: Benefit Not Covered

### Prescription drug coverage

**Generic drugs** In Network: \$15  
Out of Network: Benefit Not Covered

[View limits and exclusions](#)

**Preferred brand drugs** In Network: \$45 Copay after deductible  
Out of Network: Benefit Not Covered

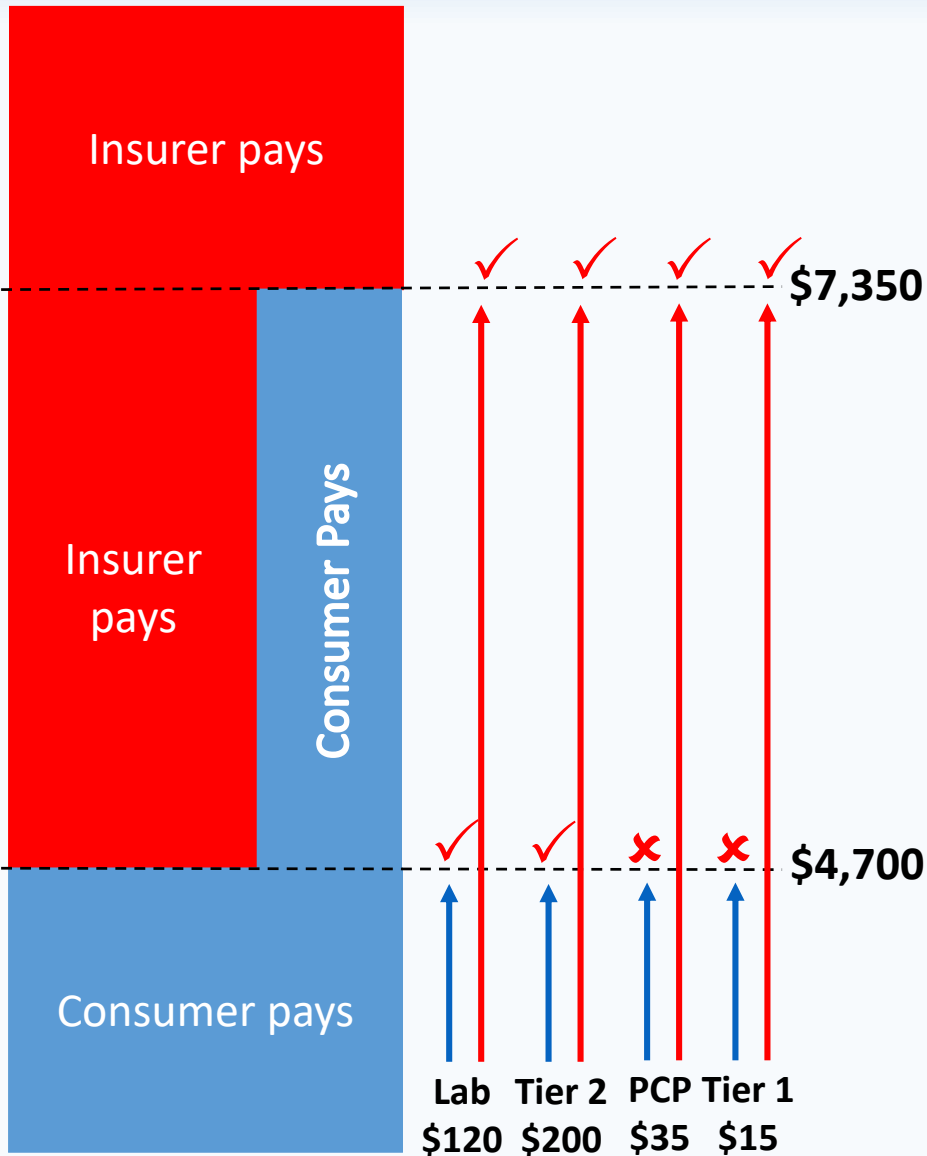
[View limits and exclusions](#)

**Non-preferred brand drugs** In Network: 50% Coinsurance after deductible  
Out of Network: Benefit Not Covered

[View limits and exclusions](#)

**Specialty drugs** In Network: 50% Coinsurance after deductible  
Out of Network: Benefit Not Covered

# Counting toward Deductible & OOP Max



**Kaiser Permanente · KP GA Signature Silver 4700/35**  
 Silver | HMO | Plan ID: 89942GA0050025

Estimated monthly premium	Deductible	Out-of-pocket maximum
<b>\$231.36</b> <small>Was: \$373.95</small>	<b>\$4,700</b> <small>Individual Total</small>	<b>\$7,350</b> <small>Individual Total</small>

<b>Primary care doctor visit</b>	In Network: \$35 Out of Network: Benefit Not Covered
<b>Specialist visit</b>	In Network: \$65 Out of Network: Benefit Not Covered
<b>X-rays and diagnostic imaging</b>	In Network: 30% Coinsurance after deductible Out of Network: Benefit Not Covered
<b>Laboratory outpatient and professional</b>	In Network: 30% Coinsurance after deductible Out of Network: Benefit Not Covered
<b>Prescription drug coverage</b>	
<b>Generic drugs</b>	In Network: \$15 Out of Network: Benefit Not Covered <a href="#">View limits and exclusions</a>
<b>Preferred brand drugs</b>	In Network: \$45 Copay after deductible Out of Network: Benefit Not Covered <a href="#">View limits and exclusions</a>
<b>Non-preferred brand drugs</b>	In Network: 50% Coinsurance after deductible Out of Network: Benefit Not Covered <a href="#">View limits and exclusions</a>
<b>Specialty drugs</b>	In Network: 50% Coinsurance after deductible Out of Network: Benefit Not Covered

# No Cost Sharing for Preventive Services



## 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 <b>deductible</b> ?	<p>Select In-network: <b>\$5,850</b> individual / <b>\$11,700</b> family</p> <p>In-network: <b>\$6,450</b> individual / <b>\$12,900</b> family</p> <p>Out-of-network: <b>\$12,900</b> individual / <b>\$25,800</b> family</p> <p><u>Does not apply to most preventive care.</u> Copayments and coinsurance don't count toward the <b>deductible</b>.</p>	<p>You must pay all the costs up to the <b>deductible</b> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <b>deductible</b> 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 <b>deductible</b>.</p>
Are there other <b>deductibles</b> for specific services?	No.	You don't have to meet <b>deductibles</b> for specific services, but see the chart starting on page 3 for other costs for services this plan covers.
Is there an <b>out-of-pocket limit</b> on my expenses?	<p>Yes.</p> <p>Select In-network: <b>\$5,850</b> individual / <b>\$11,700</b> family</p> <p>In-network: <b>\$6,450</b> individual / <b>\$12,900</b> family</p> <p>Out-of-network: <b>\$12,900</b> individual / <b>\$25,800</b> family</p>	<p>The <b>out-of-pocket limit</b> 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.</p>

# Paying Carrier Negotiated Rates



**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	Insurance Pays	You Owe
01/01/12	11	Office visit	11	\$220.00	\$85.00	\$0.00	\$0.00	\$85.00
01/02/12	11	Office visit	11	\$220.00	\$85.00	\$0.00	\$0.00	\$85.00
01/03/12	11	Laboratory	11	\$130.00	\$20.00	\$0.00	\$0.00	\$20.00
<b>TOTALS</b>				\$570.00	\$190.00	\$0.00	\$0.00	\$190.00

# Covered Benefits

## 10 Categories of Essential Health Benefits

-  **Ambulatory Patient Services**
-  **Emergency Services**
-  **Maternity and Newborn Care**
-  **Hospitalization**
-  **Mental Health and Substance Use Disorders**
-  **Preventive & Wellness Services**
-  **Laboratory Services**
-  **Prescription Drugs**
-  **Rehabilitation and Habilitative Services**
-  **Pediatric Oral and Vision Care**



# Dental Coverage for Children/Adults

Cigna Health And Life Insurance Company Cigna Connect 5750	Innovation Health Insurance Company Innovation Health Leap Bronze	Kaiser Permanente · KP VA Bronze 6500/50/Dental/Ped Dental															
Bronze   EPO   Plan ID: 41921VA0020011	Bronze   PPO   Plan ID: 12028VA0120028	Bronze   HMO   Plan ID: 95185VA0530011															
<table border="1"> <tr> <td>Estimated monthly premium <b>\$164.54</b> Was: \$230.86</td> <td>Deductible <b>\$5,750</b> Individual Total</td> <td>Out-of-pocket maximum <b>\$7,150</b> Individual Total</td> <td>Copayments / Coinsurance Emergency room care: 50% Coinsurance after deductible Generic drugs: 50% Coinsurance after deductible Primary doctor: 50% Coinsurance after deductible Specialist doctor: 50% Coinsurance after deductible</td> <td>Estimated total costs <b>ESTI TC YE, CC</b></td> </tr> </table>	Estimated monthly premium <b>\$164.54</b> Was: \$230.86	Deductible <b>\$5,750</b> Individual Total	Out-of-pocket maximum <b>\$7,150</b> Individual Total	Copayments / Coinsurance Emergency room care: 50% Coinsurance after deductible Generic drugs: 50% Coinsurance after deductible Primary doctor: 50% Coinsurance after deductible Specialist doctor: 50% Coinsurance after deductible	Estimated total costs <b>ESTI TC YE, CC</b>	<table border="1"> <tr> <td>Estimated monthly premium <b>\$155.80</b> Was: \$222.12</td> <td>Deductible <b>\$7,050</b> Individual Total</td> <td>Out-of-pocket maximum <b>\$7,050</b> Individual Total</td> <td>Copayments / Coinsurance Emergency room care: No Charge After Deductible Generic drugs: \$5 Primary doctor: No Charge After Deductible Specialist doctor: No Charge After Deductible</td> <td></td> </tr> </table>	Estimated monthly premium <b>\$155.80</b> Was: \$222.12	Deductible <b>\$7,050</b> Individual Total	Out-of-pocket maximum <b>\$7,050</b> Individual Total	Copayments / Coinsurance Emergency room care: No Charge After Deductible Generic drugs: \$5 Primary doctor: No Charge After Deductible Specialist doctor: No Charge After Deductible		<table border="1"> <tr> <td>Estimated monthly premium <b>\$164.40</b> Was: \$230.72</td> <td>Deductible <b>\$6,500</b> Individual Total</td> <td>Out-of-pocket maximum <b>\$7,150</b> Individual Total</td> <td>Copayments / Coinsurance Emergency room care: 40% Coinsurance after deductible Generic drugs: 40% Coinsurance after deductible Primary doctor: \$50/40% Coinsurance after deductible Specialist doctor: 40% Coinsurance after deductible</td> <td></td> </tr> </table>	Estimated monthly premium <b>\$164.40</b> Was: \$230.72	Deductible <b>\$6,500</b> Individual Total	Out-of-pocket maximum <b>\$7,150</b> Individual Total	Copayments / Coinsurance Emergency room care: 40% Coinsurance after deductible Generic drugs: 40% Coinsurance after deductible Primary doctor: \$50/40% Coinsurance after deductible Specialist doctor: 40% Coinsurance after deductible	
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# 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 <u>excluded services</u> .)		
<ul style="list-style-type: none"> <li>• Acupuncture</li> <li>• Cosmetic Surgery</li> <li>• Hearing Aids</li> </ul>	<ul style="list-style-type: none"> <li>• Long-Term/Custodial Nursing Home Care</li> <li>• Non-Emergency Care when Traveling Outside the U.S.</li> </ul>	<ul style="list-style-type: none"> <li>• Routine Foot Care</li> <li>• Weight Loss Programs</li> </ul>

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.)		
<ul style="list-style-type: none"> <li>• Bariatric Surgery</li> <li>• Chiropractic Care with limits</li> <li>• Infertility Treatment with limits</li> </ul>	<ul style="list-style-type: none"> <li>• Private-Duty Nursing with limits</li> <li>• Routine Dental Services (Adult) with limits</li> <li>• Routine Eye Exam (Adult)</li> </ul>	<ul style="list-style-type: none"> <li>• Routine Hearing Tests</li> <li>• Voluntary Termination of Pregnancy with limits</li> </ul>

## 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

# Other Covered Services

	CareFirst BCBS	Cigna	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					

# Prescription Drug Cost-Sharing

## Molina Marketplace · Molina Marketplace Silver 250

Silver | HMO | Plan ID: 54172FL0010002

Estimated monthly premium <b>\$319.52</b>	Deductible <b>\$2,400</b> Individual Total	Out-of-pocket maximum <b>\$7,150</b> Individual Total	Copayments / Coinsurance Emergency room care: \$400 Generic drugs: \$10 Primary doctor: \$20 Specialist doctor: \$55	Estimated total yearly costs <b>ESTIMATE TOTAL YEARLY COSTS</b>	Medical providers & prescription drugs covered <b>SEE IF PROVIDERS &amp; DRUGS ARE COVERED</b>
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### Costs for medical care

Primary care doctor visit	In Network: \$20 Out of Network: Benefit Not Covered
Specialist visit	In Network: \$55 Out of Network: Benefit Not Covered

<b>Prescription drug coverage</b>	
1 Generic drugs	In Network: \$10 Out of Network: Benefit Not Covered
2 Preferred brand drugs	In Network: \$55 Out of Network: Benefit Not Covered
3 Non-preferred brand drugs	In Network: 40% Out of Network: Benefit Not Covered
4 Specialty drugs	In Network: 40% Out of Network: Benefit Not Covered
List of covered drugs	<a href="#">View</a>
Three month in-network mail order pharmacy benefit	Yes
Prescription drug deductible	\$200
Prescription drug out-of-pocket maximum	Included in plan's out-of-pocket maximum

Source: healthcare.gov, Molina Marketplace Silver 250 plan in Miami, FL (2017)

# Prescription Drug Formulary

## Plan Differences in Cost-sharing/Drug Tiers



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\\*](#)

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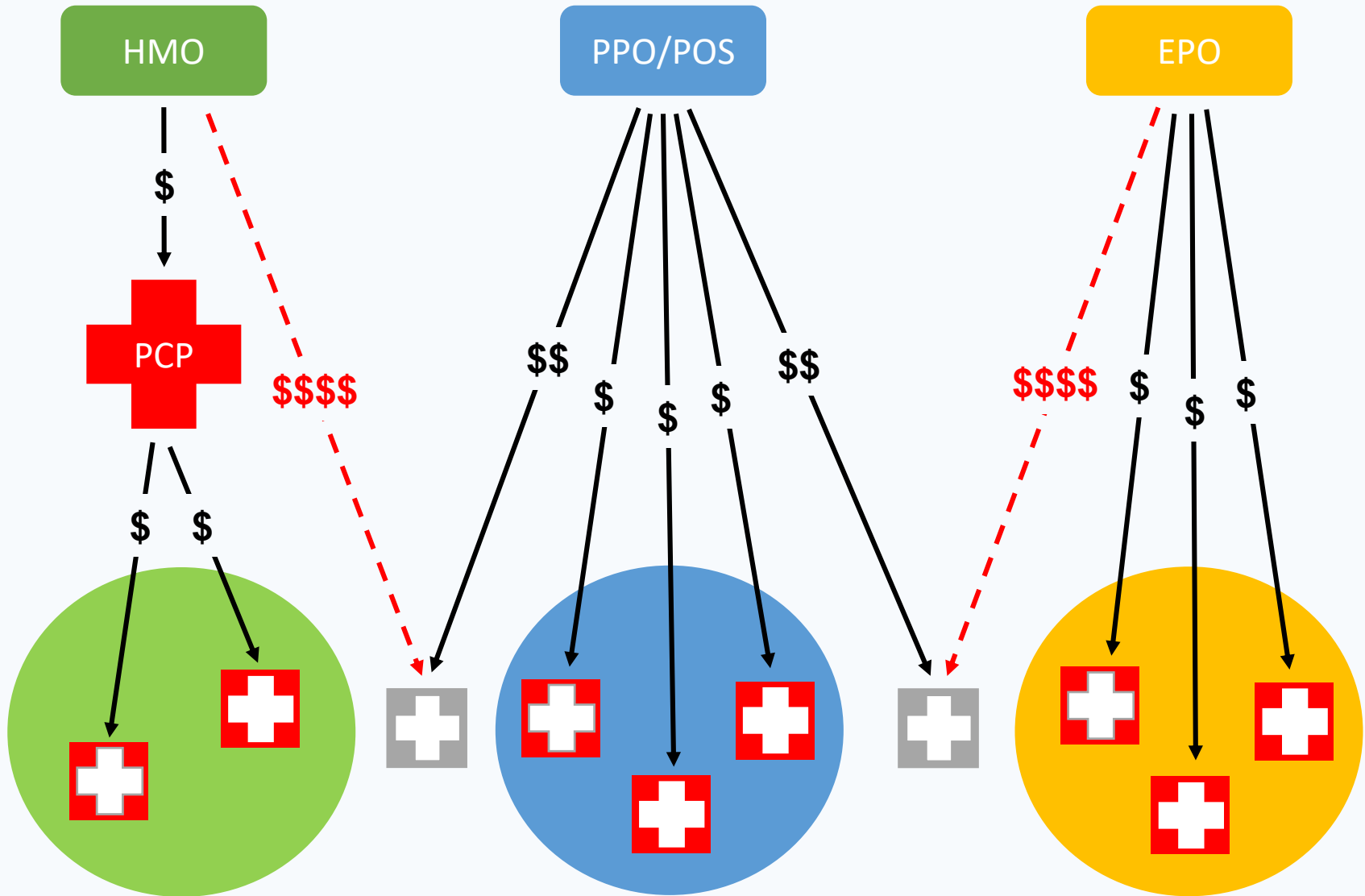
2016 CoventryOne Prescription Drug List: IA



BlueCross BlueShield  
of Illinois

Drug Name	Drug Tier	Prior Authorization	Step Therapy	Dispensing Limits	ACA	Limited Distribution
XIGDUO XR - dapagliflozin-metformin hcl tab sr 24hr 10-1000 mg	4			•		
<b>Rapid-Acting Insulins</b>						
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	•		•		

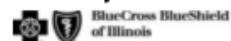
# Health Plan Network Types



# In-network vs Out-of-network Cost-sharing

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 01/01/2018-12/31/2018



: Blue Choice Preferred Gold PPO™ 204

Coverage for: Individual/Family | Plan Type: PPO

Important Questions	Answers	Why This Matters:
<b>What is the overall deductible?</b>	Individual: Participating \$750 Non-Participating \$15,000 Family: Participating \$2,250 Non-Participating \$45,000	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .
<b>What is the out-of-pocket limit for this plan?</b>	Individual: Participating \$7,350 Non-Participating Unlimited Family: Participating \$14,700 Non-Participating Unlimited	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$15/visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	Virtual visits may be available, please refer to your <u>plan</u> policy for more details.
	Specialist visit	\$50/visit, <u>deductible</u> does not apply	50% <u>coinsurance</u>	None.
	Preventive care/screening/immunization	No Charge, <u>deductible</u> does not apply	50% <u>coinsurance</u>	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. * Then check what your <u>plan</u> will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	Hospital - 30% <u>coinsurance</u> Non-Hospital - 20% <u>coinsurance</u>	50% <u>coinsurance</u>	None.
	Imaging (CT/PET scans, MRIs)	Hospital - 30% <u>coinsurance</u> Non-Hospital - 20% <u>coinsurance</u>	50% <u>coinsurance</u>	<u>Preauthorization</u> is required for certain services. *See benefit booklet for more details.

Source: Summary of Benefits and Coverage for Blue Cross Blue Shield of Illinois Blue Choice Preferred Gold PPO 204 in Chicago, IL (2018)

# Provider Network Size

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

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



# Provider Search

## 2018 health insurance plans & prices

People covered: Primary (Age 30) with estimated tax credit (not your premium) of \$130.44 per month

EDIT

ESTIMATE TOTAL YEARLY COSTS

SEE IF PROVIDERS & DRUGS ARE COVERED

### IdealCare By Sendero Health Plans · IdealCare Essential By Sendero Health Plans

Bronze | HMO | Plan ID: 71837TX0010003

Estimated monthly premium

**\$156.16**

Was: \$286.60

Deductible

**\$6,500**

Individual Total

Out-of-pocket maximum

**\$7,350**

Individual Total

Copayments / Coinsurance

Emergency room care: \$500  
Copay with Deductible  
Generic drugs: \$5  
Primary doctor: \$25  
Specialist doctor: \$50 Copay with Deductible

Estimated total yearly costs

ESTIMATE TOTAL YEARLY COSTS

Medical providers & prescription drugs covered

Coverage details below

SEE IF PROVIDERS & DRUGS ARE COVERED

#### Documents

- [Summary of Benefits](#)
- [Plan brochure](#)
- [Provider directory](#)

#### Dental

- ✘ Child Dental Benefit Not Included
- ✘ Adult Dental Benefit Not Included

\$8,275: Typical cost for a healthy pregnancy and normal delivery.

\$6,633: Typical yearly cost for managing type 2 diabetes for one person.

\$1,849: Typical cost for treatment of a simple fracture.

# Provider Search



IdealCare Members: 844.800.4693

[Click here for Member Portal](#)



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Doctor Search

Hospital Search

Ancillary Search

Find a Vision Care Provider

Find a Behavioral Care Provider

Map It

## Doctor Search Results

Last Updated: 2018-09-17

Quick search

[Back](#)

Provider	Medical Group Affiliation	Hospital Affiliations	Languages Spoken By Doctor Or Staff	Accepting New Patients
<b>Gonzales, Mary, MD</b> Physical Medicine & Rehabilitation Specialist	Mary A. Gonzales, M.D., P.A. 919 E. 32nd St. Suite 4 Austin, TX 78705 <a href="tel:5125445116">(512) 544-5116</a>	Cornerstone Hospital Austin St. David's South Austin Medical Center	English	Yes
<b>Gonzales, Migdalia (Micky), APRN</b> Physical Medicine & Rehabilitation Specialist	Institute of Reconstructive Plastic Surgery 601 E. 15th St. 4th Fl. W. Austin, TX 78665 <a href="tel:5123248300">(512) 324-8300</a>	None	English, Spanish	No

Go to

[First](#) [Previous](#)  [Next](#) [Last](#)

[1 to 2 of 2]

To reset the search criteria click the [Back](#) button

# **Section 2: Trends in Marketplace Plans**

# Partial Exemptions from the Deductible

Cigna Health and Life Insurance Company: Cigna US-VA Connect 6650

Coverage Period: 01/01/2017-12/31/2017

Summary of Benefits and Coverage: What this Plan Covers & What it Costs Coverage for: Individual & Family | Plan Type: EPO

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 visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$45 co-pay/visit	Not Covered	First 3 visits \$45 co-pay/visit, additional visits 50% co-insurance. Expanded Access Telehealth visit – \$40 co-pay/visit if from a provider in the expanded access telehealth network. Refer to the policy for more information.
	Specialist visit	50% co-insurance	Not Covered	-----None-----
	Other practitioner office visit	50% co-insurance	Not Covered	-----None-----
	Preventive care/screening/immunization	No Charge	Not Covered	-----None-----
If you have a test	Diagnostic test (x-ray, blood work)	50% co-insurance	Not Covered	-----None-----
	Imaging (CT/PET scans, MRIs)	50% co-insurance	Not Covered	-----None-----
If you need drugs to treat your illness or condition  More information about <b>prescription drug coverage</b> is available <a href="http://www.cigna.com/ifp-drug-list">www.cigna.com/ifp-drug-list</a>	Preferred generic drugs	\$30 co-pay (retail)/ \$75 co-pay (home delivery)	Not Covered	Coverage is limited up to a 90-day supply (retail/home delivery). You pay co-pay for each 30 day supply (retail).
	Non-preferred generic drugs	\$35 co-pay (retail)/ \$87 co-pay (home delivery)	Not Covered	Coverage is limited up to a 90-day supply (retail/home delivery). You pay co-pay for each 30 day supply (retail).
	Preferred brand drugs	35% co-insurance (retail/home delivery)	Not Covered	Coverage is limited up to a 90-day supply (retail/home delivery).
	Non-preferred brand drugs	40% co-insurance (retail/home delivery)	Not Covered	Coverage is limited up to a 90-day supply (retail/home delivery).
	Specialty drugs	45% co-insurance (retail)/35% co-insurance (home delivery)	Not Covered	Coverage is limited up to a 30-day supply (retail/home delivery).
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% co-insurance	Not Covered	-----None-----
	Physician/surgeon fees	50% co-insurance	Not Covered	-----None-----

# Partial Exemptions from the Deductible

Simple Choice

New Plan - Quality Ratings unavailable

[Details](#)

## Cigna Health And Life Insurance Company · Cigna US-VA Connect 6650

Bronze | EPO | Plan ID: 41921VA0020012

<p>Estimated monthly premium</p> <p><b>\$264.68</b></p>	<p>Deductible</p> <p><b>\$6,650</b></p> <p>Individual Total</p>	<p>Out-of-pocket maximum</p> <p><b>\$7,150</b></p> <p>Individual Total</p>	<p>Copayments / Coinsurance</p> <p>Emergency room care: 50% Coinsurance after deductible Generic drugs: \$35</p> <p><b>Primary doctor: \$45 Copay before deductible/50% Coinsurance after deductible</b></p> <p>Specialist doctor: 50% Coinsurance after deductible</p>	<p>Estimated total yearly costs</p> <p><b>ESTIMATE TOTAL YEARLY COSTS</b></p>	<p>Medical providers &amp; prescription drugs covered</p> <p><b>SEE IF PROVIDERS &amp; DRUGS ARE COVERED</b></p>
---	---	--	---	---	--

### Costs for medical care

Deductible	\$6,650 Individual Total
Out-of-pocket maximum	\$7,150 Individual Total
Primary care doctor visit	In Network: \$45 Copay before deductible/50% Coinsurance after deductible Out of Network: Benefit Not Covered
Specialist visit	In Network: 50% Coinsurance after deductible Out of Network: Benefit Not Covered
X-rays and diagnostic imaging	In Network: 50% Coinsurance after deductible Out of Network: Benefit Not Covered
Laboratory outpatient and professional services	In Network: 50% Coinsurance after deductible Out of Network: Benefit Not Covered

[Limits and exclusions apply](#)

# Partial Exemptions from the Deductible

Simple Choice

New Plan - Quality Ratings unavailable

Details

## Cigna Health And Life Insurance Company - Cigna US-VA Connect 6650

Bronze | EPO | Plan ID: 41921VA0020012

Estimated monthly premium  
**\$264.68**

Deductible  
**\$6,650**  
Individual Total

Out-of-pocket maximum  
**\$7,150**  
Individual Total

Copayments / Coinsurance  
Emergency room care: 50% Coinsurance after deductible  
Generic drugs: \$35  
Primary doctor: \$45 Copay before deductible/50% Coinsurance after deductible

Estimated total yearly costs

**ESTIMATE TOTAL YEARLY COSTS**

Medical providers & prescription drugs covered

**SEE IF PROVIDERS & DRUGS ARE COVERED**

CLOSE

### PRIMARY CARE DOCTOR VISIT

This health plan includes expanded access to telehealth visits. Refer to the policy for more information. Bronze Standardized Plans: The first 3 primary care doctor visits are not subject to the deductible or coinsurance. Each of the first 3 visits is subject to a copayment of \$45 only. Starting with the 4th visit, the deductible and coinsurance will apply.

### Costs for medical care

Deductible

Out-of-pocket maximum

Primary care doctor visit

Q Limits and exclusions apply

Specialist visit

X-rays and diagnostic imaging

Laboratory outpatient and professional services

In Network: \$45 Copay before deductible/50% Coinsurance after deductible  
Out of Network: Benefit Not Covered

In Network: 50% Coinsurance after deductible  
Out of Network: Benefit Not Covered

In Network: 50% Coinsurance after deductible  
Out of Network: Benefit Not Covered

In Network: 50% Coinsurance after deductible  
Out of Network: Benefit Not Covered

# Deductible-only Plans

## Florida Blue HMO (A BlueCross BlueShield FL Company) · MyBlue Bronze 1602

Bronze | HMO | Plan ID: 30252FL0070003

Estimated monthly premium <b>\$285.98</b>	Deductible <b>\$7,150</b> Individual Total	Out-of-pocket maximum <b>\$7,150</b> Individual Total	Copayments / Coinsurance  Emergency room care: No Charge After Deductible Generic drugs: No Charge After Deductible Primary doctor: No Charge After Deductible Specialist doctor: No Charge After Deductible	Estimated total yearly costs  <b>ESTIMATE TOTAL YEARLY COSTS</b>	Medical providers & prescription drugs covered  <b>SEE IF PROVIDERS &amp; DRUGS ARE COVERED</b>
--	--	---	---	--	---

### Costs for medical care

<b>Primary care doctor visit</b>	In Network: No Charge After Deductible Out of Network: Benefit Not Covered
<b>Specialist visit</b>	In Network: No Charge After Deductible Out of Network: Benefit Not Covered
<b>X-rays and diagnostic imaging</b>	In Network: No Charge After Deductible Out of Network: Benefit Not Covered
<b>Laboratory outpatient and professional services</b>	In Network: No Charge After Deductible Out of Network: Benefit Not Covered
<b>Outpatient facility</b>	In Network: No Charge After Deductible Out of Network: Benefit Not Covered
<b>Prescription drug coverage</b>	
<b>Generic drugs</b>	In Network: No Charge After Deductible Out of Network: Benefit Not Covered

[Limits and exclusions apply](#)

# Additional Prescription Drug Tiers

**Geisinger Health Plan: HMO Plan 20/40/3000**

**Coverage Period: 01/01/2017-12/31/2017**

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

**Coverage for: Individual + Family | 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.thehealthplan.com](http://www.thehealthplan.com) or by calling 1-866-379-4489.

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 visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 copay/visit	Not covered	None
	Specialist visit	\$40 copay/visit	Not covered	None
	Other practitioner office visit	\$20 copay/visit	Not covered	Chiropractor, In-network only: 20 visits/member/benefit period
	Preventive care/screening/immunization	No charge	Not covered	Adults (22+): Limited to 1 routine exam per year, PCP copay applies thereafter
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Precert / prior auth required.
If you need drugs to treat your illness or condition	1 Generic (preferred) drugs	\$3	Not covered	Covers up to a 34-day supply. Mail order 2x copayment.
	2 Generic (non-preferred) drugs	\$15	Not covered	
	3 Brand (preferred) drugs	\$35	Not covered	
	4 Brand (non-preferred) drugs	\$55	Not covered	
	5 Specialty (preferred)	40% up to \$150	Not covered	No mail order option
More information about <u>prescription drug coverage</u> is available at <a href="http://www.thehealthplan.com">www.thehealthplan.com</a>	\$0 Tier	No Charge	Not covered	MediBenNC vaccines (flu and zostavax)



# Additional Prescription Drug Tiers

## Geisinger Health Plan · Geisinger Marketplace HMO 20/40/3000

Gold | HMO | Plan ID: 22444PA0010006

Estimated monthly premium <b>\$516.09</b>	Deductible <b>\$3,000</b> Individual Total	Out-of-pocket maximum <b>\$4,000</b> Individual Total	Copayments / Coinsurance Emergency room care: \$250 Generic drugs: \$15 Primary doctor: \$20 Specialist doctor: \$40	Estimated total yearly costs <a href="#">ESTIMATE TOTAL YEARLY COSTS</a>	Medical providers & prescription drugs covered <a href="#">SEE IF PROVIDERS &amp; DRUGS ARE COVERED</a>
--	--	---	--	---	--

### Prescription drug coverage

#### Generic drugs

[Limits and exclusions apply](#)

In Network: \$15  
Out of Network: Benefit Not Covered

#### Preferred brand drugs

[Limits and exclusions apply](#)

In Network: \$35  
Out of Network: Benefit Not Covered

#### Non-preferred brand drugs

[Limits and exclusions apply](#)

In Network: \$55  
Out of Network: Benefit Not Covered

#### Specialty drugs

[Limits and exclusions apply](#)

In Network: 40%  
Out of Network: Benefit Not Covered

#### List of covered drugs

[View](#)

#### Three month in-network mail order pharmacy benefit

Yes

#### Prescription drug deductible

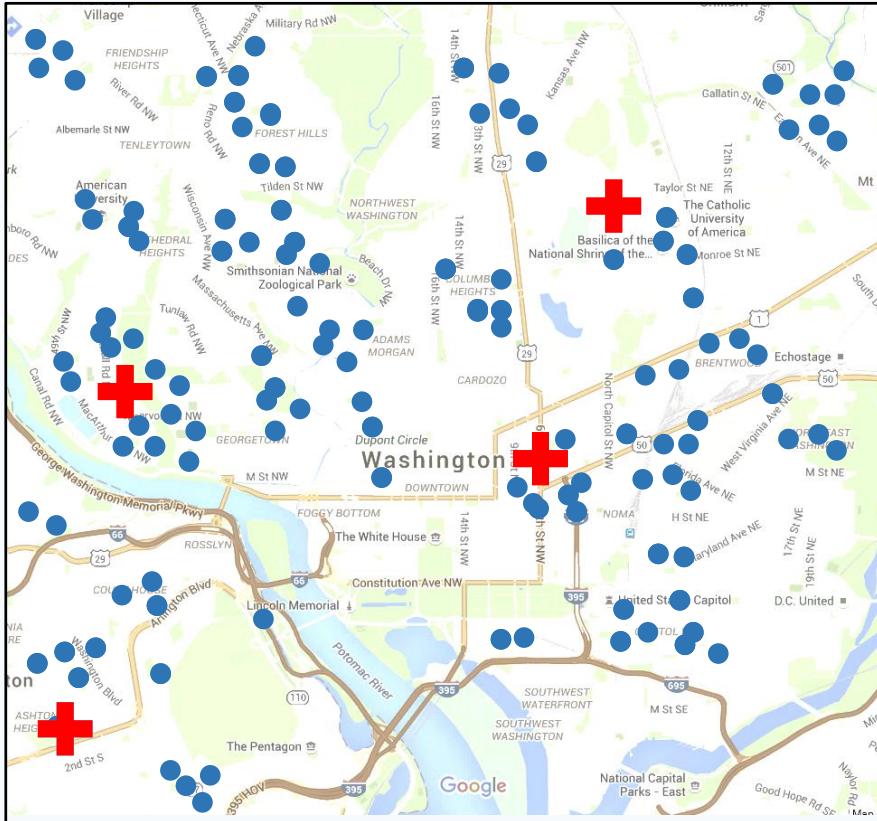
\$0

#### Prescription drug out-of-pocket maximum

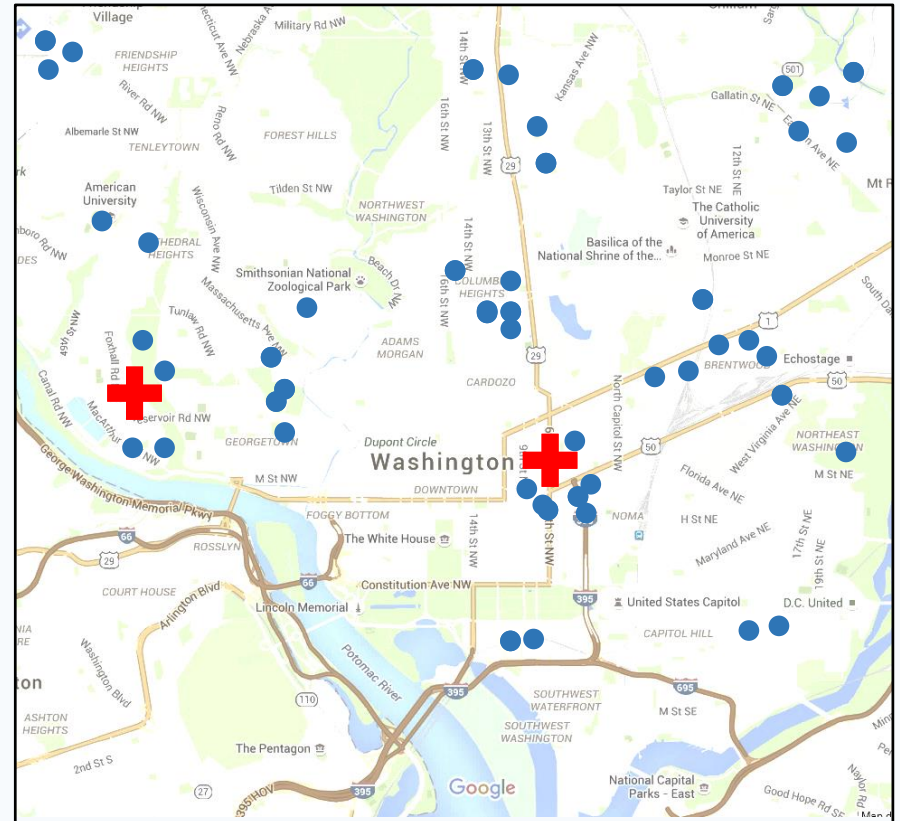
Included in plan's out-of-pocket maximum

# Narrow Provider Networks

## Off-Exchange Provider Network



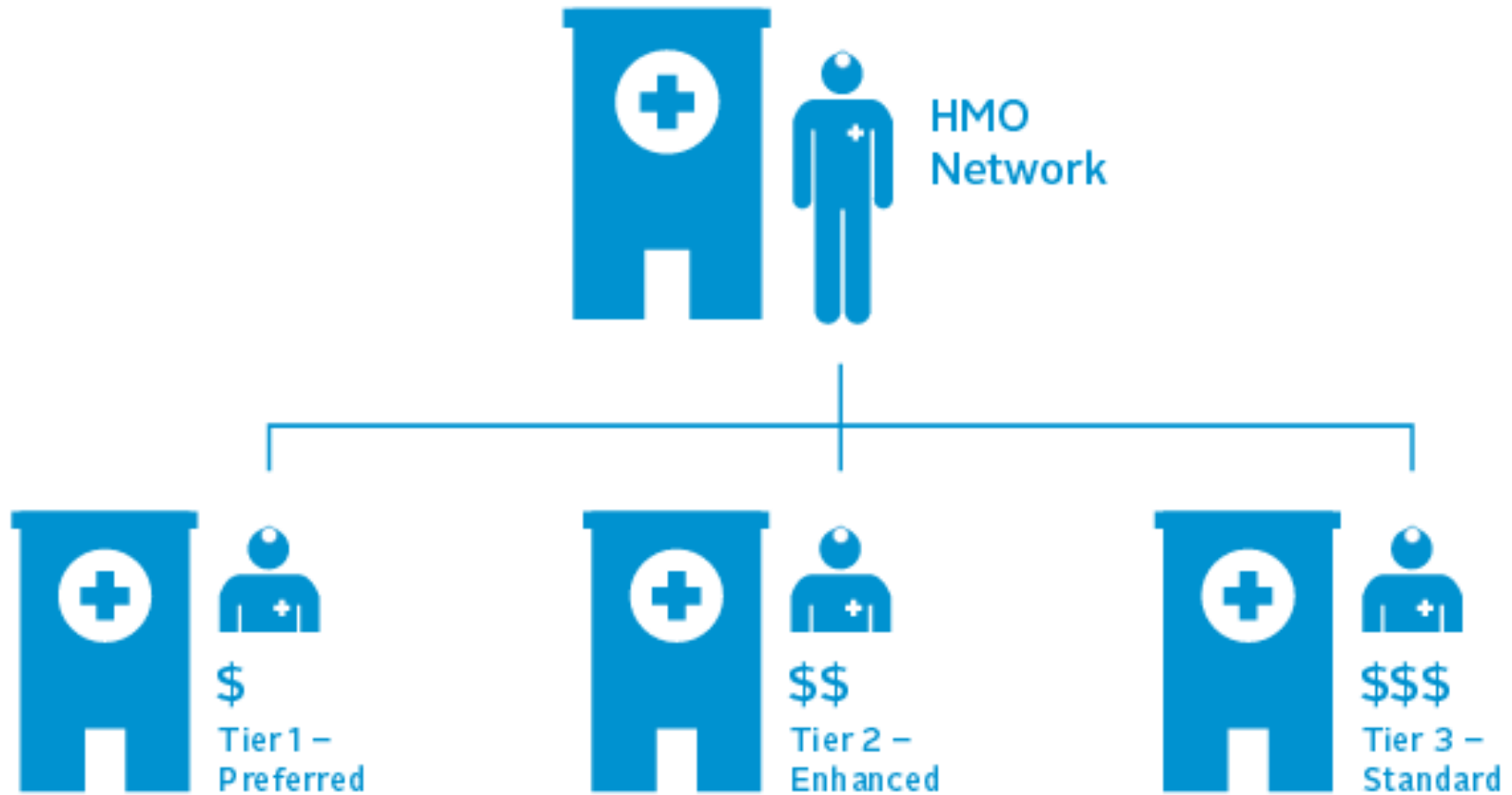
## Marketplace Provider Network



● Primary Care Providers    + Hospitals

*Note: data is fictitious and is used in this example for illustrative purposes only*

# Tiered Provider Networks



# Tiered Provider Networks



## HMO Silver Proactive

Coverage Period: Beginning on or after 01/01/2017

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

Coverage for: FAMILY | PlanType: HMO

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 Copayment (copay)	\$40 copay, no Deductible (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 a test	Diagnostic test (x-ray, blood work)	\$60 copay(X-Ray)/ No Charge(Blood Work)	\$60 copay, no ded(X-Ray)/ No Charge no ded(Blood Work)	\$60 copay, no ded(X-Ray)/ No Charge no ded(Blood Work)	PCP referral required for x-rays. Requisition form required for lab work.
	Imaging (CT/PET scans, MRIs)	\$250 copay	\$250 copay, no ded	\$250 copay, no ded	Precertification required for certain services. See benefit booklet.
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.

# 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.<sup>1</sup>

1/3

of psychiatrists listed in New Jersey PPOs had incorrect contact information.<sup>2</sup>

18.2%

of providers in one plan were not practicing at their listed locations.<sup>3</sup>

# healthcare.gov Provider/Rx Search Tool

HealthCare.gov

ESPAÑOL

Log in

## 2018 health insurance plans & prices

People covered: Primary (Age 40) with **estimated tax credit** (not your premium) of \$236.17 per month

EDIT

ESTIMATE TOTAL YEARLY COSTS

SEE IF PROVIDERS & DRUGS ARE COVERED

25 plans available

PLAN TYPE

Health plans

SORT BY

Premium

REFINE RESULTS

### Cigna Healthcare · Cigna Connect 7150

Bronze | HMO | Plan ID: 53882IL0040009

Estimated monthly premium

**\$68.65**

Was: \$304.82

Deductible

**\$7,150**

Individual Total

Out-of-pocket maximum

**\$7,350**

Individual Total

Copayments / Coinsurance

Emergency room care: 50%  
Coinsurance after deductible  
Generic drugs: 50%  
Coinsurance after deductible  
Primary doctor: 50%  
Coinsurance after deductible  
Specialist doctor: 50%  
Coinsurance after deductible

Estimated total yearly costs

ESTIMATE TOTAL YEARLY COSTS

Medical providers & prescription drugs covered

SEE IF PROVIDERS & DRUGS ARE COVERED

QUICK VIEW

DETAILS

COMPARE


LIKE THIS PLAN

# healthcare.gov Provider Search Tool

## 2018 health insurance plans & prices

### See if your providers and prescription drugs are covered.

**What's a "medical provider?"**  
A person (like a doctor or a nurse) or facility (a hospital) that provides health care.

Enter your preferred medical providers and prescription drugs. We'll show you which plans cover them when you review plans and prices. 

**Medical providers** Prescription drugs

Type the name of a medical provider, like a doctor or facility

nancy zamora  **SEARCH**

Matches for **MEDICAL PROVIDERS** called **NANCY ZAMORA**

**Dr. Nancy A Zamora** Select

Internal Medicine  
Internal Medicine (Primary Care Provider)  
Chicago, IL (3.05 mi away)

**Nancy V Zamora-Miller** Select

Counselor  
Counselor  
Atlanta, GA (589.98 mi away)

**BACK TO PLANS**

# healthcare.gov Provider Search Tool

HealthCare.gov

ESPAÑOL

Log in

## 2018 health insurance plans & prices

People covered: Primary (Age 40) with **estimated tax credit** (not your premium) of \$236.17 per month

EDIT

ESTIMATE TOTAL YEARLY COSTS

SEE IF PROVIDERS & DRUGS ARE COVERED

25 plans available

PLAN TYPE

Health plans

SORT BY

Premium

REFINE RESULTS

### Cigna Healthcare · Cigna Connect 7150

Bronze | HMO | Plan ID: 53882IL0040009

Estimated monthly premium

**\$68.65**

Was: \$304.82

Deductible

**\$7,150**

Individual Total

Out-of-pocket maximum

**\$7,350**

Individual Total

Copayments / Coinsurance

Emergency room care: 50%  
Coinsurance after deductible  
Generic drugs: 50%  
Coinsurance after deductible  
Primary doctor: 50%  
Coinsurance after deductible  
Specialist doctor: 50%  
Coinsurance after deductible

Estimated total yearly costs

ESTIMATE TOTAL YEARLY COSTS

Medical providers & prescription drugs covered

1 prescription drugs covered

1 medical providers covered

EDIT

QUICK VIEW

DETAILS

COMPARE

LIKE THIS PLAN



# Major Cuts to Federal Navigator Funding



ABOUT ▾

RESEARCH ▾

EXPERTS

**BLOG**

DONATE

off the charts

POLICY INSIGHT  
BEYOND THE NUMBERS



Halley Cloud  
Health Outreach Manager

SHARE



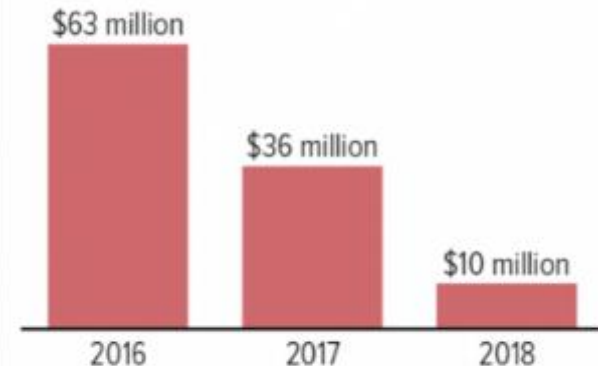
Leave a comment

The Department of Health and Human Services (HHS) announced yesterday which groups will receive navigator funds in the 34 states where the federal government runs the Affordable Care Act (ACA) marketplace. But the Trump Administration's sharp cuts in overall navigator funding in the last two years mean that many consumers who buy insurance through HealthCare.gov will be on their own to complete the complex application and enrollment process to get affordable health coverage. The defunding of navigator programs erects another obstacle to enrollment in the ACA marketplaces, even as new Census figures show that progress in reducing the uninsured rate stalled in 2017, likely due in part to other Administration efforts to undermine the ACA.

HHS has slashed navigator funding by over 80 percent since 2016, leaving only \$10 million to thinly spread

## Trump Administration Has Cut Navigator Funding by Over 80 Percent Since 2016

Funding for programs in 34 states using federal marketplace



Source: Centers for Medicare & Medicaid Services (CMS)

# **Section 3: Strategies to Help Consumers**

# Preparing for Open Enrollment

## 1. Tracking changes in the lowest-cost plan options

Rank	2016		2017		2018	
	Plan	Price	Plan	Price	Plan	Price
1	Innovation Health Leap Silver Basic	\$237	Innovation Health Leap Silver Basic	\$259	Kaiser Permanente Silver 6000/35/ Dental	\$392
2	Kaiser Permanente VA Silver 2750/20/ HSA/Dental/ Ped dental	\$248	Innovation Health Leap Silver Diabetes	\$271	Cigna Connect 6500	\$401
3	United HealthCare, Silver Compass HSA 2000	\$253	Cigna Connect 4500	\$274	Kaiser Permanente Silver 2750/20%/ HSA/Dental	\$421
4	Innovation Health Leap Silver Plus	\$254	UnitedHealthcare Compass Silver 5200	\$279	Kaiser Permanente Silver 3000/30/ Dental	\$427
5	Kaiser Permanente VA Silver 2500/30/ Dental/Ped Dental	\$262	Innovation Health Leap Silver Plus	\$281	Kaiser Permanente Silver 2000/30/ Dental	\$437
6	United Healthcare, Silver Compass 4500-1	\$264	UnitedHealthcare Compass HSA Silver 2800	\$282	Cigna Connect 4500	\$441
7	Kaiser Permanente VA Silver 1500/30/ Dental/Ped Dental	\$276	Innovation Health Leap Silver Healthy Minds	\$287	Kaiser Permanente Standard Silver 3500/30/Dental	\$452
8	CareFirst BlueChoice HMO HSA Silver \$1,350	\$312	Kaiser Permanente VA Silver 6000/30/Dental/Ped Dental	\$288	CareFirst BlueChoice HMO Silver \$3,500	\$631
9	CareFirst BlueChoice HMO Silver \$2,000	\$345	Cigna Connect 2500	\$288	CareFirst BluePreferred Silver \$3,500	\$812
10	CareFirst BlueChoice Plus Silver \$2500	\$345	Kaiser Permanente VA Silver 2750/20%/HSA/Dental/Ped Dental	\$315		
			(9 other plans)			

# Preparing for Open Enrollment

## 2. Comparing differences in provider networks

	CareFirst BCBS PPO	CareFirst BCBS HMO	Cigna	Kaiser Permanente
Primary Care Physicians	500+	500+	398	8
Cardiologists	222	222	110	0 (3 in 10 mi.)
OB/GYN	312	309	151	4
Pediatricians	177	147	200	1
Hospitals	6	6	13	0 (5 in 10 mi.)

**Providers in a 5 mile radius of 22202 Zip Code (Arlington, VA)**

# Preparing for Open Enrollment

## 3. Studying all plans in your area



Plan Info	Insurance Company	Cigna	Kaiser Permanente	Cigna	Kaiser Permanente	Kaiser Permanente	Kaiser Permanente	Cigna	Cigna	Carefirst
	Plan Name	Connect 6500	KP VA Silver 6000/35/Dental	Connect 4000	KP VA Silver 2750/20%/HSA/Dental	KP VA Silver 3000/30/Dental	KP VA Standard Silver 3500/30/Dental	Connect 3000	Connect HSA 2600	BlueChoice HMO Silver \$3,500
	Metal Tier	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver	Silver
	Plan Type	EPO	HMO	EPO	HMO	HMO	HMO	EPO	EPO	HMO
	Premium Adult Age 40	\$395.64	\$398.21	\$411.78	\$427.61	\$434.05	\$459.33	\$479.89	\$501.35	\$514.47
	Summary of Benefits	<a href="#">SBC Link</a>	<a href="#">SBC Link</a>	<a href="#">SBC Link</a>	<a href="#">SBC Link</a>	<a href="#">SBC Link</a>	<a href="#">SBC Link</a>	<a href="#">SBC Link</a>	<a href="#">SBC Link</a>	<a href="#">SBC Link</a>
	Provider Directory	<a href="#">Provider Dir Link</a>	<a href="#">Provider Dir Link</a>	<a href="#">Provider Dir Link</a>	<a href="#">Provider Dir Link</a>	<a href="#">Provider Dir Link</a>	<a href="#">Provider Dir Link</a>	<a href="#">Provider Dir Link</a>	<a href="#">Provider Dir Link</a>	<a href="#">Provider Dir Link</a>
	List of Covered Drugs	<a href="#">Rx List Link</a>	<a href="#">Rx List Link</a>	<a href="#">Rx List Link</a>	<a href="#">Rx List Link</a>	<a href="#">Rx List Link</a>	<a href="#">Rx List Link</a>	<a href="#">Rx List Link</a>	<a href="#">Rx List Link</a>	<a href="#">Rx List Link</a>
Deductible and OOP	Medical Deductible - individual	\$6,500	\$6,000	\$4,000	\$2,750	\$3,000	\$3,500	\$3,000	\$2,600	\$3,500
	Drug Deductible - individual	Included in Medical	\$750	Included in Medical	Included in Medical	\$750	\$500	Included in Medical	in Medical	\$150
	Medical Deductible -family	\$13000	\$12000	\$8000	\$5500	\$6000	\$7000	\$6000	\$5200	\$7000
	Drug Deductible - family	Included in Medical	\$750/person	Included in Medical	Included in Medical	\$750/person	\$1000	Included in Medical	Included in Medical	\$150/per son
	Out Of Pocket Max - individual	\$7,350	\$7,350	\$7,350	\$5,000	\$7,350	\$7,350	\$7,350	\$7,000	\$6,850
	Out of Pocket Max - family	\$14700	\$14700	\$14700	\$10000	\$14700	\$14700	\$14700	\$14000	\$13700
Office Visits	Primary Care Physician	\$15 !	\$35 !	\$5 !+20% after ded	20% after ded	\$30 !	\$30 !	\$20 !+20% after ded	\$20 after ded	No Charge
	Specialist	30% after ded	\$55 !	20% after ded	20% after ded	\$50 !	\$65 !	20% after ded	\$50 after ded	\$50 !+0% !
Tests	Diagnostic Test	30% after ded	\$35 !	20% after ded	20% after ded	\$30 !	20% after ded	20% after ded	20% after ded	\$25 !+0% !
	Imaging	30% after ded	35% after ded	20% after ded	20% after ded	35% after ded	20% after ded	20% after ded	20% after ded	\$250 !+0% !
in Drugs	Generic Drugs	\$4 !	\$20 !	\$4 !	\$15 after ded	\$15 !	\$15 !	\$4 !	20% after ded	\$10 !+0% !
	Preferred Brand Drugs	\$60 !	\$60 after ded	\$55 !	\$55 after ded	\$55 after ded	\$50 !	20% after ded	20% after ded	ded+0% after ded

◀ ▶
Catastrophic On
Bronze On
Silver On
73% AV Silver
87% /er
Gold C ...
⊕
⋮
◀

# Tailoring Search Based on Consumer Needs

## 1. Renewal or new applicant?

**Enroll to-do list**

**Congratulations!**  
You've successfully completed all steps of your application. See below for next steps or return to [My Account](#).

**Your Plans**  
For **John Doe**

**Independence Blue Cross Keystone HMO Silver Proactive Health Insurance plan for John Doe**

To activate your new coverage, you must pay your first month's premium by your plan's due date. Your plan will contact you in the next few days with details on how to pay, or visit your health plan online to make your payment now if your plan accepts online payment. Your payment must be received and processed by the effective date to be fully enrolled. Contact the plan's customer service if you have any payment questions or issues.

**Submit Payment to Independence Blue Cross**      **Customer Service:** 18554293800

Amount Due: **\$246.30**

Your plan will confirm your final premium amount with you.

Estimated Effective Date: **01/01/2014**

**PAY FOR HEALTH PLAN**

HealthCare.gov    Individuals & Families    Small Businesses    ESPAÑOL

LOG IN

### Create an account

If you already have an account, [log in](#). Having trouble? **Don't create another account.** Forgot your [password](#) or [username](#)?

New Jersey

First name      Last name

Your email address will also be your username when you log in.

Email address

Use:    ✓ 8-20 characters    ✓ Upper & lowercase letters    ✓ Number(s)

Password

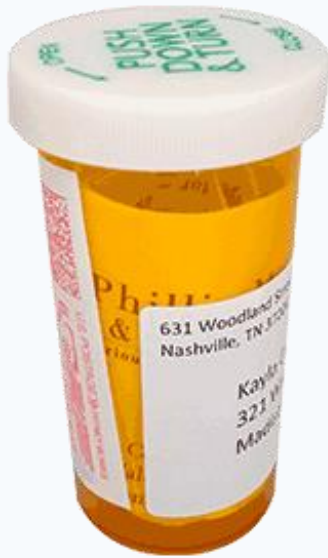
Retype password

Pick 3 questions that only you will be able to answer. If you forget your password, we'll ask you these questions to verify your identity.

Pick a question

# Tailoring Search Based on Consumer Needs

## 2. Any prescription drugs or current doctors?



**Cigna** [Login to myCigna](#) [Find a Doctor/Dentist](#)

Home » Choose a Directory » Find a Doctor, Dentist or Facility for Individuals & Families » Search Results

### SEARCH RESULTS

[START OVER](#)

[CHANGE PLAN](#) Results for **rodriguez** near **Chicago, IL, USA** (Change)  
**MEDICAL PLAN:** Connect Network | **DENTAL PLAN:** No Plan Selected

**DISTANCE**  0 20 40 60 80 100 Up to: 5 miles

**SPECIALTY**  
 Counseling (1)  
 Psychiatry (1)  
 Psychology (1)

**ACCEPTING NEW PATIENTS**  
 Accepting new patients only (2)

**YEARS IN PRACTICE**  
 <5 (2)

### 2 In-Network Doctors

Sorted by Distance (Near to Far) [Explain Quality & Recognitions](#) [Print/Save PDF](#) [List](#) [Map](#)

**Rodriguez Cabezas, Lisette A, MD**  
(312) 926-8200 | 676 N St. Clair St Chicago, IL 60611 | 1.2 miles - [Map](#) | 1 other location

Psychiatry - Board Certified  
 In-Network for selected Plan

Quality Ratings & Recognitions  
American Board of Medical Specialties

Accepting new patients with selected plan

**Resendiz-Rodriguez, Rebecca M, PSYD, LPC, LCPC**  
(312) 633-5841 | 1431 N Western Ave #401 Chicago, IL 60622 | 3.6 miles - [Map](#) | 1 other location

Counseling - Board Certified  
Psychology - Board Certified  
 In-Network for selected Plan

Quality Ratings & Recognitions  
American Board of Medical Specialties

Accepting new patients with selected plan

# Tailoring Search Based on Consumer Needs

## 3. Major health needs or anticipated procedures?





# Tailoring Search Based on Consumer Needs

## 4. Finding options for First Dollar Coverage

HealthCare.gov **Individuals & Families** Small Businesses Log in ESPAÑOL

### Cigna Healthcare · Cigna Connect 7150

Bronze | HMO | Plan ID: 53882IL0040009

Estimated monthly premium <b>\$134.05</b> <small>Was: \$270.71</small>	Deductible <b>\$7,150</b> <small>Individual Total</small>	Out-of-pocket maximum <b>\$7,350</b> <small>Individual Total</small>	<b>Copayments / Coinsurance</b> Emergency room care: 50% Coinsurance after deductible Generic drugs: 50% Coinsurance after deductible Primary doctor: 50% Coinsurance after deductible Specialist doctor: 50% Coinsurance after deductible	Estimated total yearly costs <b>ESTIMATE TOTAL YEARLY COSTS</b>	Medical providers & prescription drugs covered <b>SEE IF PROVIDERS &amp; DRUGS ARE COVERED</b>
--	---	--	--	--	---

QUICK VIEW DETAILS COMPARE LIKE THIS PLAN

### Cigna Healthcare · Cigna Connect 6650

Bronze | HMO | Plan ID: 53882IL0040002

Estimated monthly premium <b>\$159.92</b> <small>Was: \$296.58</small>	Deductible <b>\$6,650</b> <small>Individual Total</small>	Out-of-pocket maximum <b>\$7,350</b> <small>Individual Total</small>	<b>Copayments / Coinsurance</b> Emergency room care: 50% Coinsurance after deductible Generic drugs: \$10 Primary doctor: \$25/50% Coinsurance after deductible Specialist doctor: 50% Coinsurance after deductible	Estimated total yearly costs <b>ESTIMATE TOTAL YEARLY COSTS</b>	Medical providers & prescription drugs covered <b>SEE IF PROVIDERS &amp; DRUGS ARE COVERED</b>
--	---	--	---	--	---

Source: healthcare.gov bronze plans in Arlington, VA (2018)

# Understanding Consumers Tradeoffs

## 1. Bronze vs. Silver

### Total Health Care USA, Inc. - Total Saver Complete

Bronze | HMO | Plan ID: 67183MI0030006

<b>Estimated monthly premium</b> <b>\$60.89</b> <small>Was: \$194.11</small>	<b>Deductible</b> <b>\$7,150</b> <small>Individual Total</small>	<b>Out-of-pocket maximum</b> <b>\$7,150</b> <small>Individual Total</small>	<b>Copayments / Coinsurance</b> Emergency room care: No Charge After Deductible Generic drugs: No Charge After Deductible Primary doctor: No Charge After Deductible Specialist doctor: No Charge After Deductible	<b>Medical providers &amp; prescription drugs covered</b> 0 medical providers covered <a href="#">EDIT</a>
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VS

### Total Health Care USA, Inc. - Totally You - Value

Silver | HMO | Plan ID: 67183MI0030007

<b>Estimated monthly premium</b> <b>\$107.38</b> <small>Was: \$264.73</small>	<b>Deductible</b> <b>\$3,000</b> <small>Individual Total</small>	<b>Out-of-pocket maximum</b> <b>\$5,000</b> <small>Individual Total</small>	<b>Copayments / Coinsurance</b> Emergency room care: 20% Coinsurance after deductible Generic drugs: \$10 Primary doctor: \$20 Specialist doctor: 20% Coinsurance after deductible	<b>Medical providers &amp; prescription drugs covered</b> <a href="#">SEE IF PROVIDERS &amp; DRUGS ARE COVERED</a>
---	--	---	--	---

# Understanding Consumers Tradeoffs

## 2. Paying more to preserve access to providers/Rx

### Total Health Care USA, Inc. - Total Saver Complete

Bronze | HMO | Plan ID: 67183MI0030006

<b>Estimated monthly premium</b> <b>\$60.89</b> Was: \$194.11	<b>Deductible</b> <b>\$7,150</b> Individual Total	<b>Out-of-pocket maximum</b> <b>\$7,150</b> Individual Total	<b>Copayments / Coinsurance</b> Emergency room care: No Charge After Deductible Generic drugs: No Charge After Deductible Primary doctor: No Charge After Deductible Specialist doctor: No Charge After Deductible	<b>Medical providers &amp; prescription drugs covered</b> 0 medical providers covered <a href="#">EDIT</a>
---	---	--	--	--

VS

### McLaren Health Plan Community - McLaren Bronze

Bronze | HMO | Plan ID: 74917MI0020011

<b>Estimated monthly premium</b> <b>\$102.06</b> Was: \$235.28	<b>Deductible</b> <b>\$5,500</b> Individual Total	<b>Out-of-pocket maximum</b> <b>\$7,350</b> Individual Total	<b>Copayments / Coinsurance</b> Emergency room care: 50% Coinsurance after deductible Generic drugs: \$30 Primary doctor: 50% Coinsurance after deductible Specialist doctor: 50% Coinsurance after deductible	<b>Medical providers &amp; prescription drugs covered</b> 1 medical providers covered <a href="#">EDIT</a>
--	---	--	--	--

# Understanding Consumers Tradeoffs

## 3. Bronze + community-based providers

### Total Health Care USA, Inc. - Total Saver Complete

Bronze | HMO | Plan ID: 67183MI0030006

Estimated monthly premium

**\$60.89**

Was: \$194.11

Deductible

**\$7,150**

Individual Total

Out-of-pocket maximum

**\$7,150**

Individual Total

Copayments / Coinsurance

Emergency room care: No Charge After Deductible

Generic drugs: No Charge After Deductible

Primary doctor: No Charge After Deductible

Specialist doctor: No Charge After Deductible

Medical providers & prescription drugs covered

0 medical providers covered

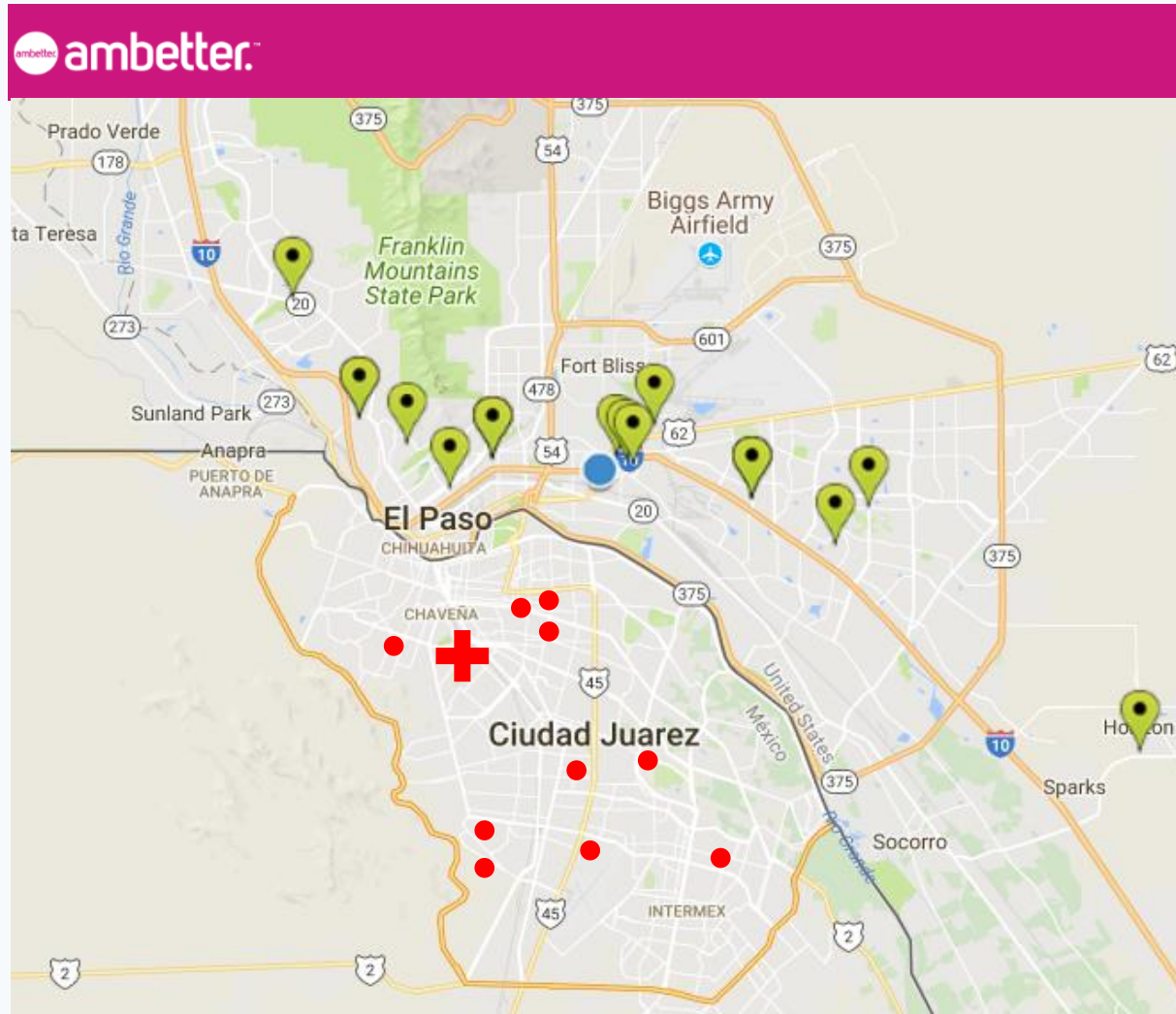
[EDIT](#)

+



# Understanding Consumers Tradeoffs

## 4. Alternate sources of care



# Understanding Consumers Tradeoffs

## 5. Benefits of coverage vs. going uninsured

### Ambetter From Superior HealthPlan · Ambetter Essential Care 1 (2017)

Bronze | EPO | Plan ID: 29418TX0140006

Estimated monthly premium <b>\$184.96</b>	Deductible <b>\$6,800</b> Individual Total	Out-of-pocket maximum <b>\$6,800</b> Individual Total	Copayments / Coinsurance  Emergency room care: No Charge After Deductible Generic drugs: \$20 Primary doctor: No Charge After Deductible Specialist doctor: No Charge After Deductible
--	--	---	---

### Preventive Services

Does not apply to most preventive care. Copayments and coinsurance don't count toward the **deductible**.

### Negotiated Rates

SERVICE CODE	BB	SUBMITTED CHARGES	ALLOWED AMOUNT
Office visit		\$150.00	\$85.00
Office visit		\$150.00	\$85.00
Laboratory		\$85.00	\$20.00
		<b>\$385.00</b>	<b>\$190.00</b>

=

Risk for Accidents



## 2016 health insurance plans & prices

People covered: Primary (Age 37)



36 plans available

SORT BY

Premium

PLAN TYPE

Health plans

# Live Plan Selection Demonstration via healthcare.gov

# SCENARIO 1: Jennifer



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

**Location:** Austin, TX  
Travis County

**Zip Code:** 78724

**Annual Income:** \$30,000

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



# SCENARIO 1: Jennifer

	Plan 1		Plan 2		Plan 3	
Insurance company	Oscar		IdealCare (Sendero Health)		Oscar	
Health plan name	Simple Bronze		IdealCare Essential		Classic Silver	
Metal level/Network Type	Bronze EPO		Bronze HMO		Silver EPO	
Monthly premium <i>(after tax credit)</i>	\$87.07		\$126.59		\$204.89	
Deductible (in-network/out-of-network)	\$7,350		\$6,500		\$3,000	
OOP Maximum (in-network/out-of-network)	\$7,350		\$7,350		\$5,850	
<b>Copay</b>	<b>Deductible applies?</b>		<b>Deductible applies?</b>		<b>Deductible applies?</b>	
Primary Care Provider	No charge	✓	\$25		\$10	
Specialist Visit	No charge	✓	\$50	✓	\$50	
Rx Tier 1	No charge	✓	\$5		\$10	
Rx Tier 2	No charge	✓	\$40	✓	\$50	
Rx Tier 3	No charge	✓	\$80	✓	30%	✓
Rx Tier 4	No charge	✓	30%	✓	30%	✓
Emergency Room Visit	No charge	✓	\$500	✓	30%	✓
Inpatient Hospital Stay	No charge	✓	\$500	✓	30%	✓
Other Service:						
Other Service:						
<b>Health Care Providers</b>	<b>In Network/Covered?</b>		<b>In Network/Covered?</b>		<b>In Network/Covered?</b>	
Provider/Rx:						
Provider/Rx:						
Provider/Rx:					59	

# SCENARIO 1: Jennifer

Identifying Jennifer's priorities:

- Cheapest monthly payment?
- Manageable deductible/copays
- Having first dollar coverage?



# SCENARIO 2: Jim and Michelle



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

**Location:** Jacksonville, FL  
Duval County

**Zip Code:** 32214

**Annual Income:** \$24,000

<b>Health Status?</b>	Jim has diabetes
<b>Prescription Drugs?</b>	Jim takes Metformin 500 mg
<b>Doctors/Providers?</b>	Michelle sees Dr. Nikita Wilkes (OB/GYN)
<b>Other considerations?</b>	Jim gets frequent lab work

# SCENARIO 2: Jim and Michelle

	Plan 1		Plan 2		Plan 3	
Insurance company	Ambetter from Sunshine		Ambetter from Sunshine		Florida Blue HMO	
Health plan name	Ambetter Balanced Care 5		Ambetter Balanced Care 4		MyBlue Silver 1604	
Metal level/Network Type	Silver EPO		Silver EPO		Silver HMO	
Monthly premium <i>(after tax credit)</i>	\$47.70		\$77.97		\$146.10	
Deductible (in-network/out-of-network)	\$1,350		\$1,200		\$0	
OOP Maximum (in-network/out-of-network)	\$1,350		\$1,200		\$2,500	
<b>Copay</b>	<b>Deductible applies?</b>		<b>Deductible applies?</b>		<b>Deductible applies?</b>	
Primary Care Provider	No charge		No charge		\$1	
Specialist Visit	\$5		\$5		\$10	
Rx Tier 1	No charge		No charge		\$2	
Rx Tier 2	\$25		\$25		\$15	
Rx Tier 3	No charge	✓	No charge	✓	50%	
Rx Tier 4	No charge	✓	No charge	✓	50%	
Emergency Room Visit	No charge	✓	No charge	✓	\$125	
Inpatient Hospital Stay	No charge	✓	No charge	✓	25%	
Other Service: <b>Laboratory Services</b>	No charge	✓	No charge	✓	No charge	
Other Service:						
<b>Health Care Providers</b>	<b>In Network/Covered?</b>		<b>In Network/Covered?</b>		<b>In Network/Covered?</b>	
Provider/Rx: <b>Dr. Wilkes</b>	✘		✘		✓	
Provider/Rx: <b>metformin 500 mg</b>	Yes (Tier 1)		Yes (Tier 1)		Yes (Tier 2)	
Provider/Rx:					62	

# SCENARIO 2: Jim and Michelle

Identifying Jim and Michelle's priorities:

- Cheapest monthly payment?
- Manageable deductible/copays
- Having first dollar coverage?
- **Current doctor in network?**
- **Prescription drug(s) covered/cost?**
- **Best plan for health needs/condition?**



# SCENARIO 3: Rodriguez Family



**Applicant(s) (age):** Marco (43), Maria (43),  
Mariela (19)

**Location:** Milwaukee, WI  
Milwaukee County

**Zip Code:** 53218

**Annual Income:** \$36,000

<b>Health Status?</b>	Mariela has asthma
<b>Doctors/Providers?</b>	Mariela sees Dr. Lauren Lopez (Pulmonologist)
<b>Prescription Drugs?</b>	Mariela takes Advair (0.5 MG inhaler)
<b>Other Health Needs/Issues?</b>	Marco is considering procedure at Aurora Health Care Metro, Inc.

# SCENARIO 3: Rodriguez Family

	Plan 1		Plan 2		Plan 3	
Insurance company	Common Ground		Together with CCHP		Common Ground	
Health plan name	Envision Aurora Bellin, 7350/100		Together Silver 150		Envision Aurora Bellin, 50/25	
Metal level/Network Type	Bronze EPO		Silver EPO		Silver EPO	
Monthly premium <i>(after tax credit)</i>	\$0.52		\$102.01		\$158.00	
Deductible (in-network/out-of-network)	\$14,700		\$1,000		\$100	
OOP Maximum (in-network/out-of-network)	\$14,700		\$4,600		\$4,900	
<b>Copay</b>	<b>Deductible applies?</b>		<b>Deductible applies?</b>		<b>Deductible applies?</b>	
Primary Care Provider	\$35	✓	\$10		\$25	
Specialist Visit	No charge	✓	\$20		\$50	
Rx Tier 1	No charge	✓	\$5		\$10	
Rx Tier 2	No charge	✓	20%	✓	\$55	
Rx Tier 3	No charge	✓	20%	✓	20%	✓
Rx Tier 4	No charge	✓	20%	✓	20%	✓
Emergency Room Visit	No charge	✓	20%	✓	\$350	
Inpatient Hospital Stay	No charge	✓	20%	✓	20%	✓
Other Service:						
Other Service:						
<b>Health Care Providers</b>	<b>In Network/Covered?</b>		<b>In Network/Covered?</b>		<b>In Network/Covered?</b>	
Provider/Rx: <b>Dr. Lauren Lopez</b>	✓		✘		✓	
Provider/Rx: <b>Aurora Health Care Metro, Inc.</b>	✓		✘		✓	
Provider/Rx: <b>Advair 60 0.1mg/0.05</b>	Yes (Tier 2)		Yes (Tier 2)		Yes (Tier 2)	

# SCENARIO 3: Rodriguez Family

Plan 1		
Insurance company	Common Ground	
Health plan name	Envision Aurora Bellin, 7350/100	
Metal level/Network Type	Bronze EPO	
Monthly premium <i>(after tax credit)</i>	\$0.52	
Deductible (in-network/out-of-network)	\$14,700	
OOP Maximum (in-network/out-of-network)	\$14,700	
Copay	Deductible applies?	
Primary Care Provider	\$35	✓
Specialist Visit	No charge	✓
Rx Tier 1	No charge	✓
Rx Tier 2	No charge	✓
Rx Tier 3	No charge	✓
Rx Tier 4	No charge	✓
Emergency Room Visit	No charge	✓
Inpatient Hospital Stay	No charge	✓
Other Service:		
In Network/Covered?		
	✓	
	✓	
	Yes (Tier 2)	

**5 primary care visits (\$100 each)**

**5 specialist visits (\$150 each)**

**3 prescriptions (\$350 each)**

**4-day hospital stay for surgery (\$5000)**

Annual Cost	Annual Cost
\$6.24	\$1,896
\$500	\$125
\$750	\$250
\$1,050	\$165
\$5,000	\$1,080
<b>\$7,306</b>	<b>\$3,516</b>

Plan 3		
Common Ground		
Envision Aurora Bellin, 50/25		
Silver EPO		
\$158.00		
\$100		
\$4,900		
Deductible applies?		
\$25		
\$50		
\$10		
\$55		
20%		✓
20%		✓
\$350		
20%		✓
In Network/Covered?		
	✓	
	✓	
	Yes (Tier 2)	



# SCENARIO 3: Rodriguez Family

Identifying the Rodriguez family's priorities:

- Cheapest monthly payment?
- Manageable deductible/copays
- Having first dollar coverage?
- Current doctor in network?
- Prescription drug(s) covered/cost?
- Best plan for health needs/condition?
- **Hospital or facility in network?**
- **Lowest estimated annual OOP cost based on consumer's needs**



## The Right Fit Presentation Evaluation

Thank you for participating in The Right Fit: Helping Consumers Navigate the Plan Selection Process. We welcome your feedback to help us improve these presentations in the future.

\* Required

Your State \*

Choose ▼

How confident were you in your ability to help consumers select a plan (BEFORE the presentation)? \*

2 3 4 5 6 7 8 9  
Not Confident ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ Very Confident

How confident are you in your ability to help consumers select a plan (AFTER the presentation)? \*

2 3 4 5 6 7 8 9 10

# The Right Fit: Evaluation

<https://tinyurl.com/2018RightFitEval>

# The Right Fit: Evaluation

**Q1: On a scale of 1 to 10, how confident were you in your ability to assist consumers in selecting a plan (**BEFORE** the presentation?)**

**(1 = not confident, 10 = very confident)**

<https://tinyurl.com/2018RightFitEval>

# The Right Fit: Evaluation

**Q2: On a scale of 1 to 10, how confident are you in your ability to assist consumers in selecting a plan (**AFTER** the presentation?)**

**(1 = not confident, 10 = very confident)**

<https://tinyurl.com/2018RightFitEval>

# The Right Fit: Evaluation

Q3: What plan selection topics do you think were **missing** and **should be added** to the presentation?

Q4: What topics were **not useful** and **should be removed** from the presentation?

Q5: What topics were **not explained well** enough and needed more time/focus?

<https://tinyurl.com/2018RightFitEval>

# The Right Fit: Evaluation

Q6: On a scale of 1 to 10, how would you rate the **CONTENT** of the training?

Q7: On a scale of 1 to 10, how would you rate the presenter's **DELIVERY** of the training?

<https://tinyurl.com/2018RightFitEval>

# GOOD LUCK IN OEP 6!!!

## Contact Information

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Washington, DC

<https://tinyurl.com/2018RightFitEval>

- Worksheet: [Marketplace Plan Comparison Worksheet](#)
    - [English \(PDF\)](#)
    - [Spanish \(PDF\)](#)
  - Key Facts:
    - [Cost-Sharing Charges](#)
    - [Cost-Sharing Reductions](#)
- 
- Healthcare.gov: [Browse plans and prices tool](#)



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- Halley Cloud, [cloud@cbpp.org](mailto:cloud@cbpp.org)
- General inquiries: [beyondthebasics@cbpp.org](mailto:beyondthebasics@cbpp.org)

For more information and resources, please visit:

[www.healthreformbeyondthebasics.org](http://www.healthreformbeyondthebasics.org)

*This is a project of the Center on Budget and Policy Priorities, [www.cbpp.org](http://www.cbpp.org)*