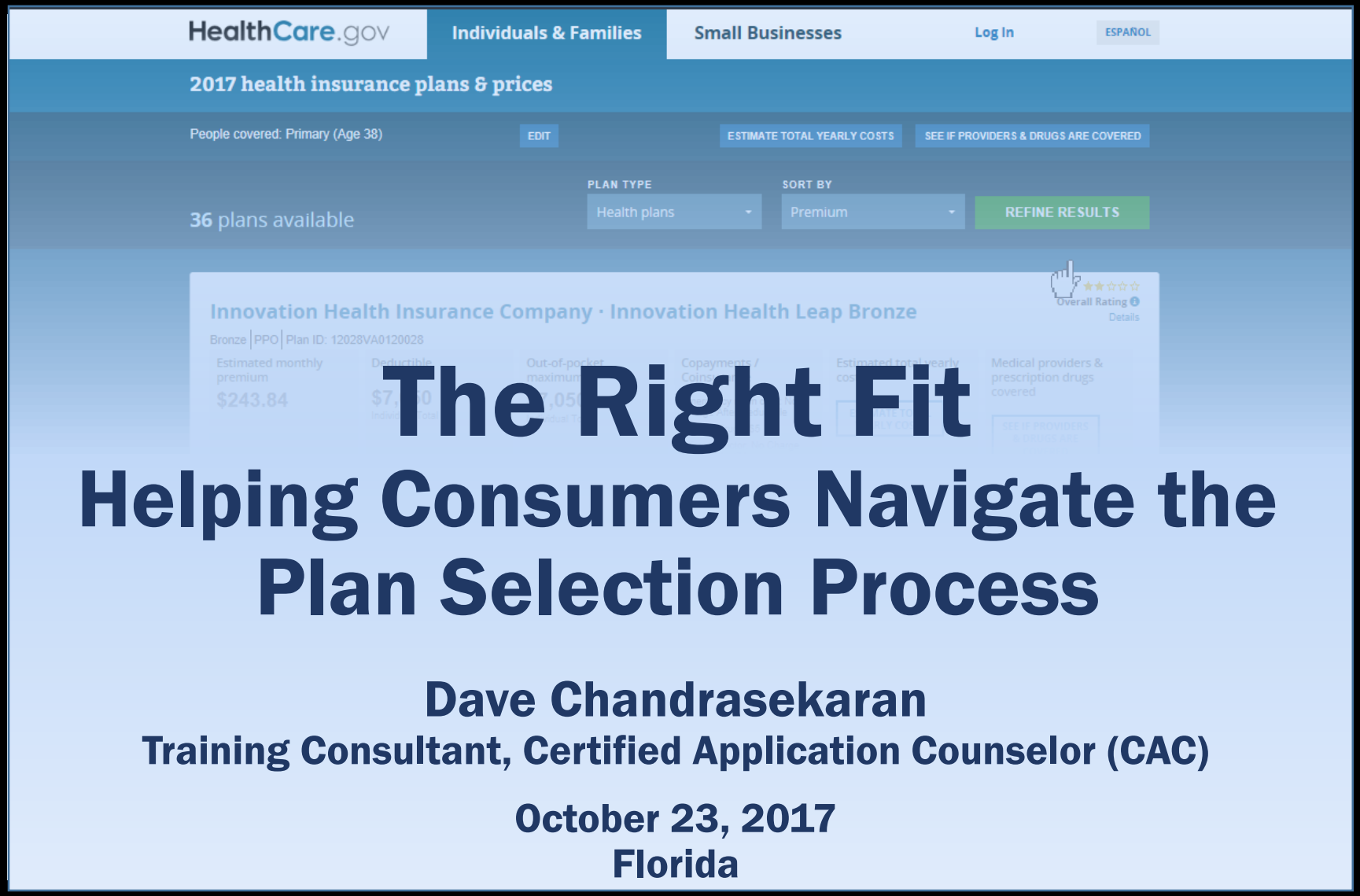


The Right Fit

Helping Consumers Navigate the Plan Selection Process

Dave Chandrasekaran

Training Consultant, Certified Application Counselor (CAC)

October 23, 2017

Florida

Initial Self-Assessment

QI: On a scale of 1 to 10, how confident are you in your ability to help consumers select a plan?

(1 = not confident, 10 = very confident)

Today's Presentation

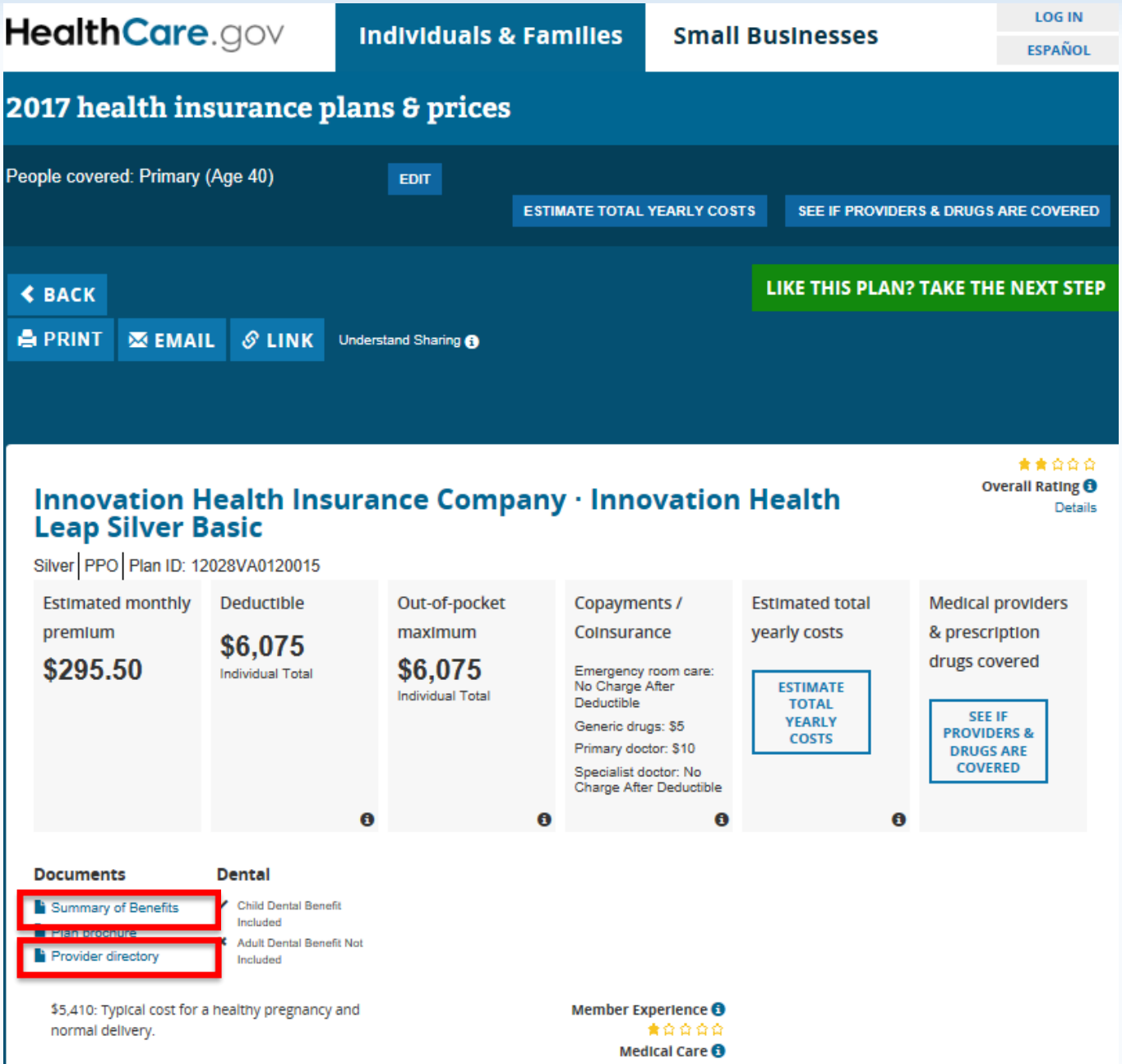
- Section 1: Overview of Marketplace QHPs
- Section 2: Trends in Marketplace plans
- Section 3: Strategies to Help Consumers
- Section 4: Plan Comparison & Selection Demo

Section 1:
Overview of Marketplace QHPs

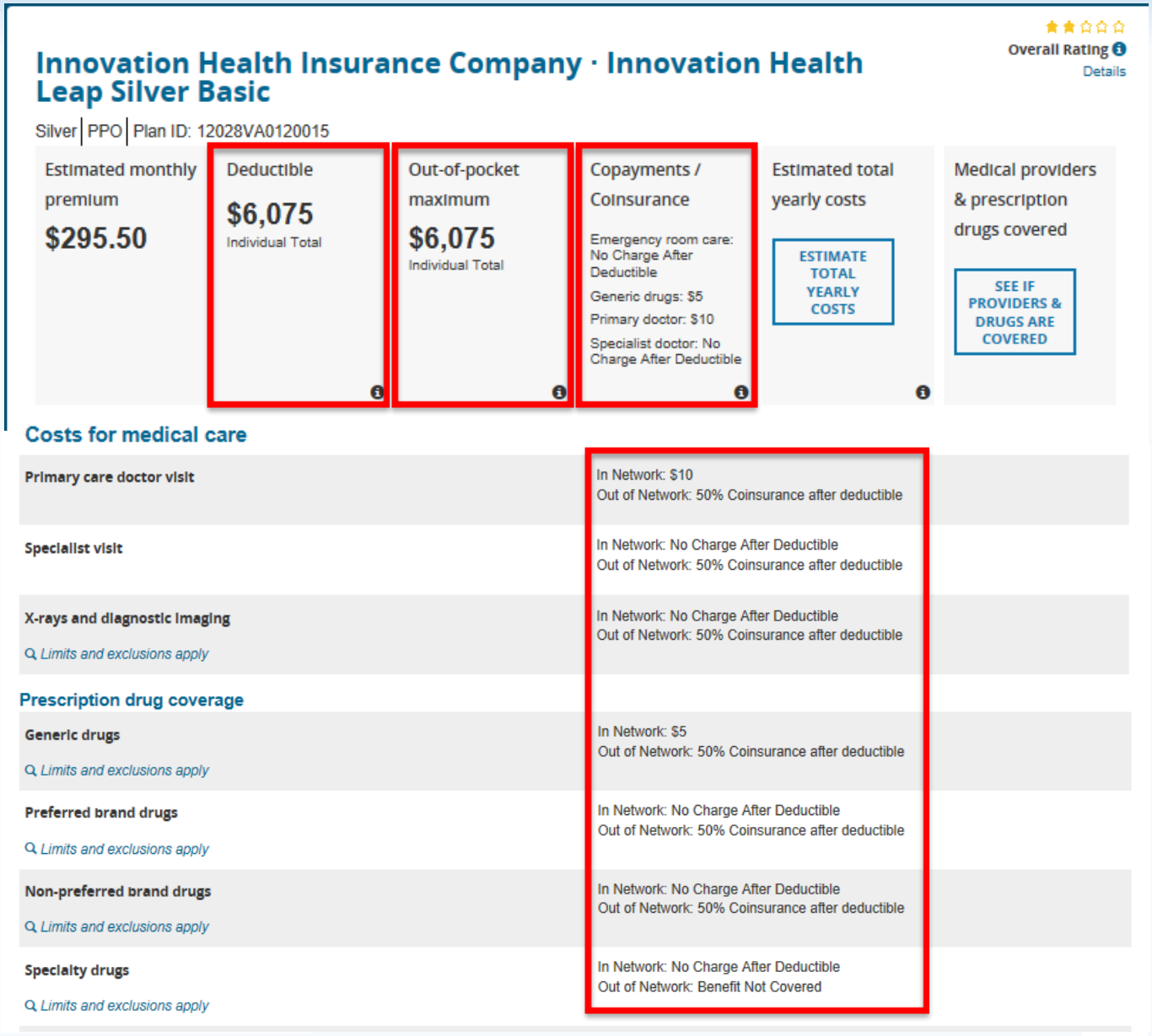
Elements of Marketplace Health Plans

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

healthcare.gov Plan Display



Overview of Cost Sharing



Innovation Health Insurance Company · Innovation Health Leap Silver Basic

Overall Rating
Details

Silver | PPO | Plan ID: 12028VA0120015

Estimated monthly premium	Deductible	Out-of-pocket maximum	Copayments / Coinsurance	Estimated total yearly costs	Medical providers & prescription drugs covered
$295.50	$6,075 Individual Total	$6,075 Individual Total	Emergency room care: No Charge After Deductible Generic drugs: $5 Primary doctor: $10 Specialist doctor: No Charge After Deductible	ESTIMATE TOTAL YEARLY COSTS	SEE IF PROVIDERS & DRUGS ARE COVERED

Costs for medical care

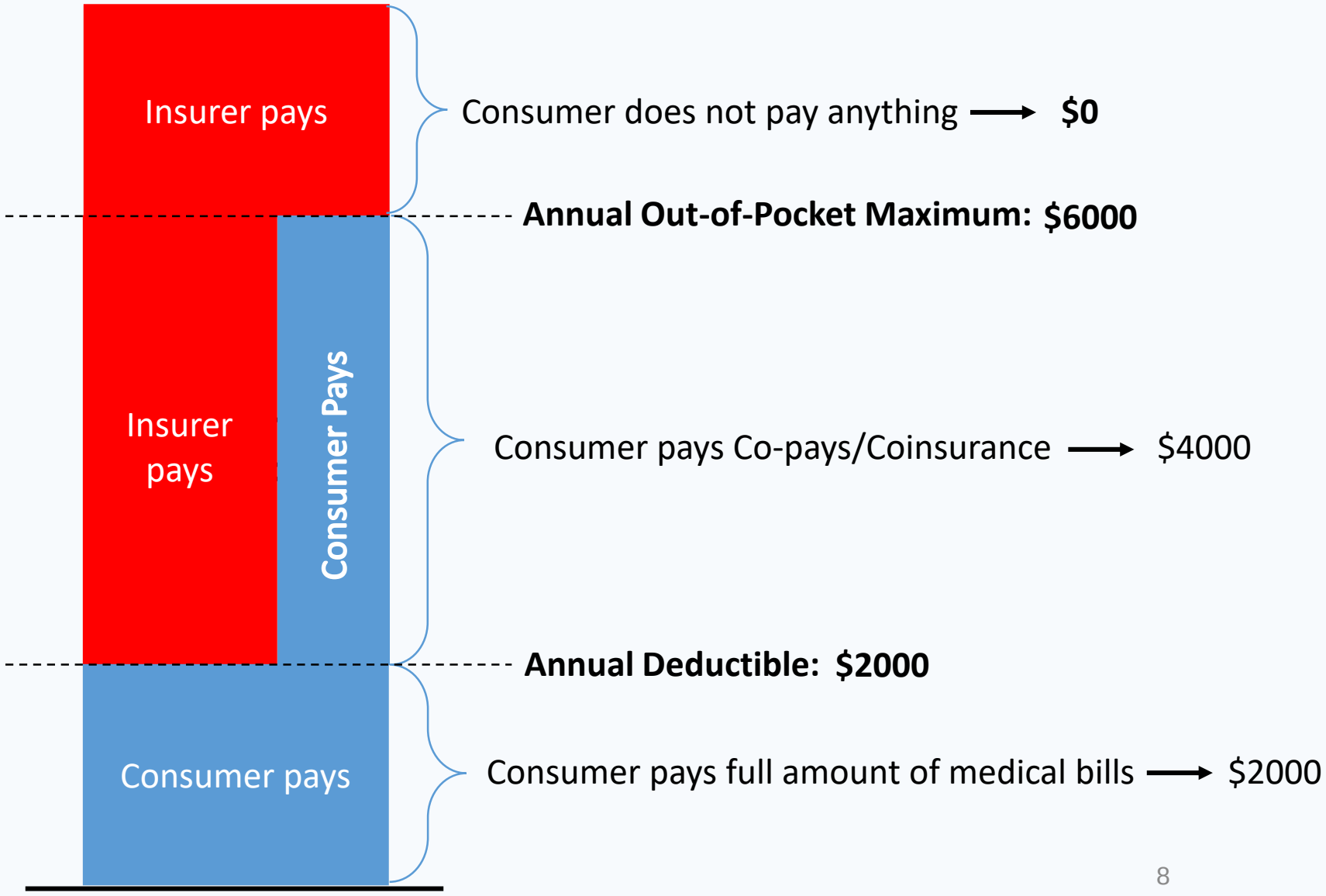
Primary care doctor visit	In Network: $10 Out of Network: 50% Coinsurance after deductible
Specialist visit	In Network: No Charge After Deductible Out of Network: 50% Coinsurance after deductible
X-rays and diagnostic imaging *Limits and exclusions apply*	In Network: No Charge After Deductible Out of Network: 50% Coinsurance after deductible

Prescription drug coverage

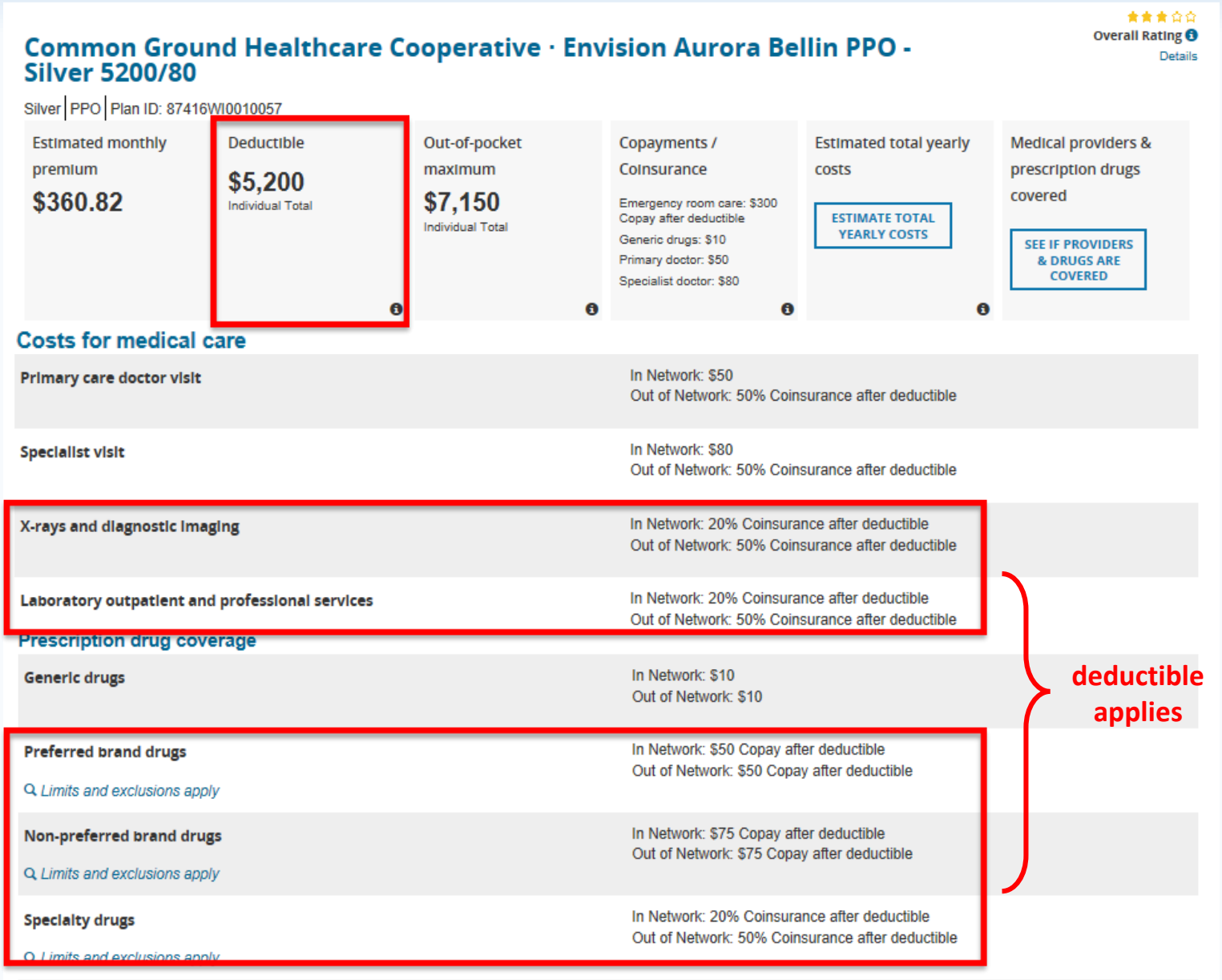
Generic drugs *Limits and exclusions apply*	In Network: $5 Out of Network: 50% Coinsurance after deductible
Preferred brand drugs *Limits and exclusions apply*	In Network: No Charge After Deductible Out of Network: 50% Coinsurance after deductible
Non-preferred brand drugs *Limits and exclusions apply*	In Network: No Charge After Deductible Out of Network: 50% Coinsurance after deductible
Specialty drugs *Limits and exclusions apply*	In Network: No Charge After Deductible Out of Network: Benefit Not Covered

***Source**: healthcare.gov, Innovation Health Leap Silver Basic Plan in Arlington, VA (2017)*

Explaining Cost-Sharing Terms



First Dollar Coverage



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

Overall Rating
Details

Silver | PPO | Plan ID: 87416WI0010057

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

Costs for medical care

Primary care doctor visit	In Network: $50 Out of Network: 50% Coinsurance after deductible
Specialist visit	In Network: $80 Out of Network: 50% Coinsurance after deductible
X-rays and diagnostic imaging	In Network: 20% Coinsurance after deductible Out of Network: 50% Coinsurance after deductible
Laboratory outpatient and professional services	In Network: 20% Coinsurance after deductible Out of Network: 50% Coinsurance after deductible

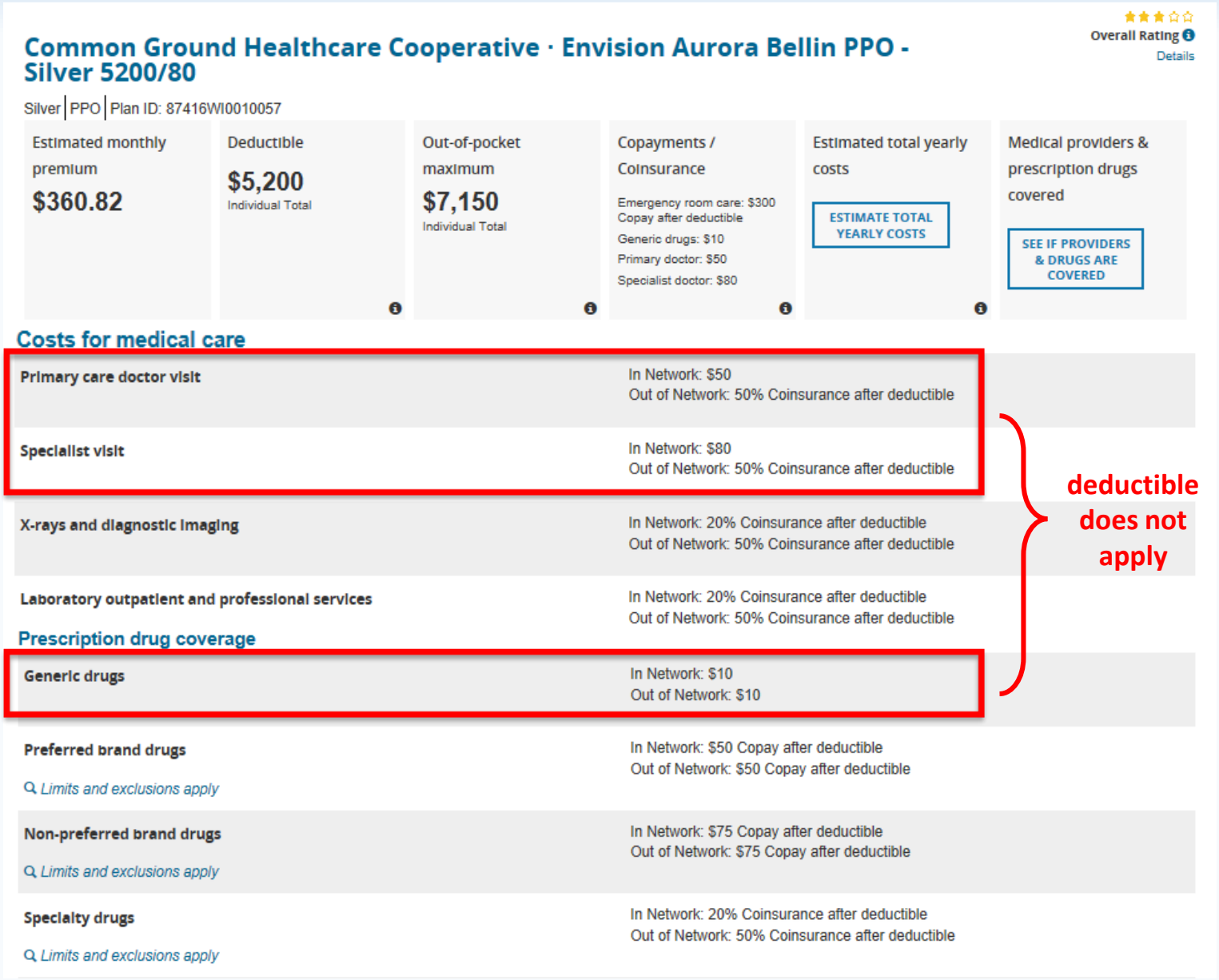
Prescription drug coverage

Generic drugs	In Network: $10 Out of Network: $10
Preferred brand drugs *Limits and exclusions apply*	In Network: $50 Copay after deductible Out of Network: $50 Copay after deductible
Non-preferred brand drugs *Limits and exclusions apply*	In Network: $75 Copay after deductible Out of Network: $75 Copay after deductible
Specialty drugs *Limits and exclusions apply*	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

Overall Rating
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Costs for medical care

Primary care doctor visit	In Network: $50 Out of Network: 50% Coinsurance after deductible
Specialist visit	In Network: $80 Out of Network: 50% Coinsurance after deductible
X-rays and diagnostic imaging	In Network: 20% Coinsurance after deductible Out of Network: 50% Coinsurance after deductible
Laboratory outpatient and professional services	In Network: 20% Coinsurance after deductible Out of Network: 50% Coinsurance after deductible

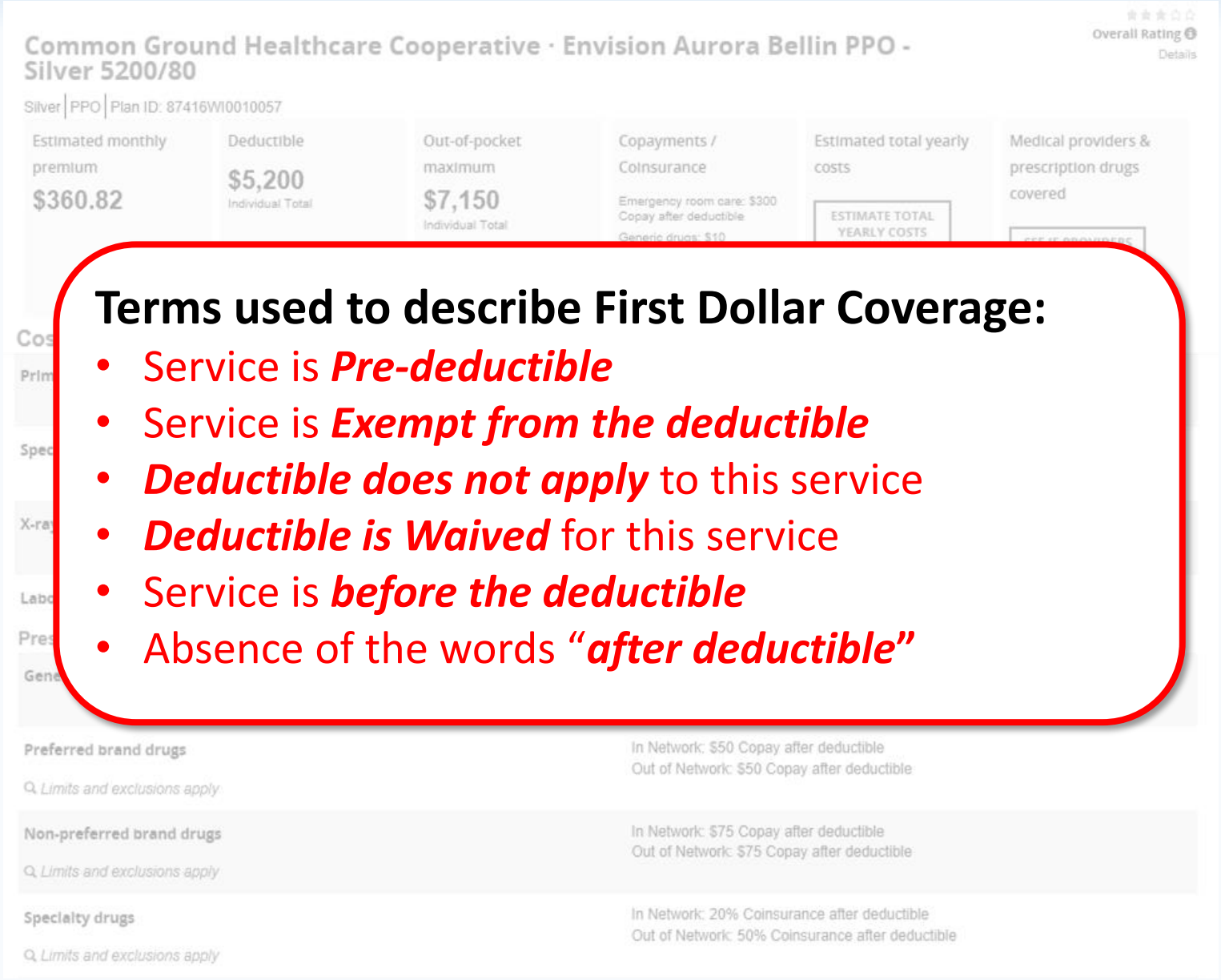
Prescription drug coverage

Generic drugs	In Network: $10 Out of Network: $10
Preferred brand drugs *Limits and exclusions apply*	In Network: $50 Copay after deductible Out of Network: $50 Copay after deductible
Non-preferred brand drugs *Limits and exclusions apply*	In Network: $75 Copay after deductible Out of Network: $75 Copay after deductible
Specialty drugs *Limits and exclusions apply*	In Network: 20% Coinsurance after deductible Out of Network: 50% Coinsurance after deductible

deductible does not apply

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

First Dollar Coverage



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***
- Absence of the words "***after deductible***"

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

HSA vs. non-HSA Plans

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

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

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

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

Costs for Medical Care

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

Prescription drug coverage

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

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

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

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

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

Costs for Medical Care

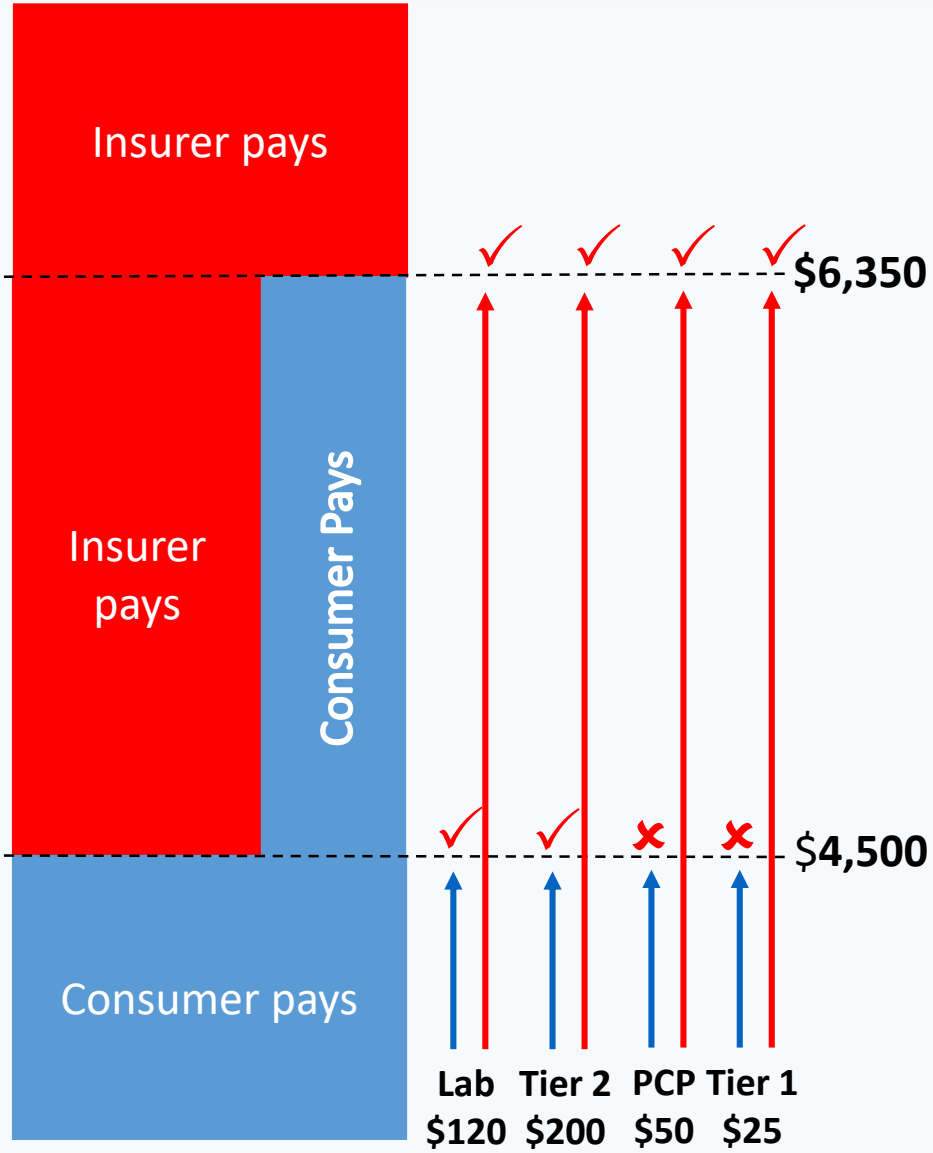
Primary Care Visit to Treat an Injury or Illness	*$50*
Specialist Visit	*$50*
Hearing Aids	*Benefit not covered*
Routine Eye Exam for Children	*$50*
Eye Glasses for Children	*No charge*
Laboratory Outpatient and Professional Services	*$50 Copay after deductible*
X-rays and Diagnostic Imaging	*$50 Copay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

Prescription drug coverage

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

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

Counting toward Deductible & OOP Max



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*

No Cost Sharing for Preventive Services

BlueCross BlueShield Nebraska

SelectBlue 5850 HSA Bronze

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

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

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

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

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

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

In-network Discount in Deductible Phase

Health Insurance Provider
1212 Main Street
Anytown, USA 000000

EXPLANATION OF BENEFITS

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

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

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

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

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

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 CSR variants, Gold and Platinum plans in Jefferson County, KY (2015)*

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

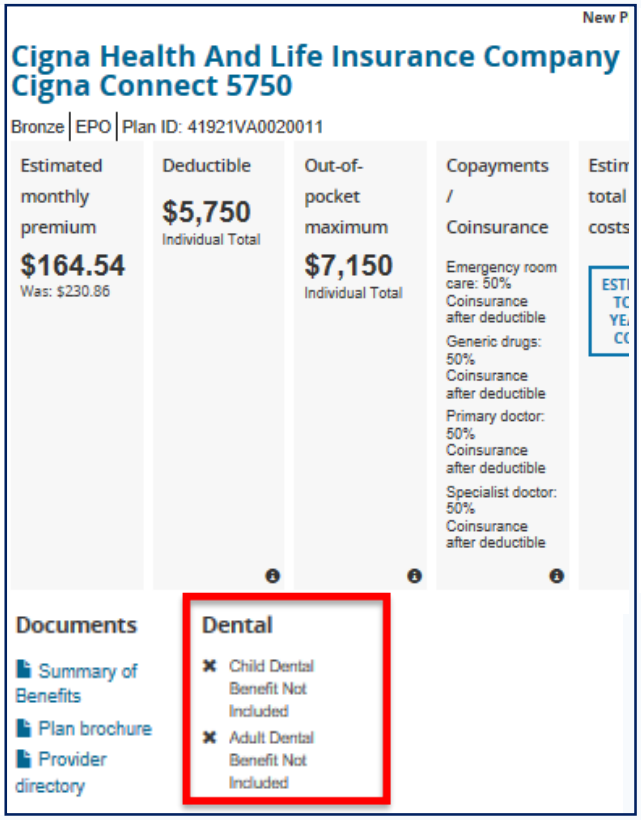

Laboratory Services

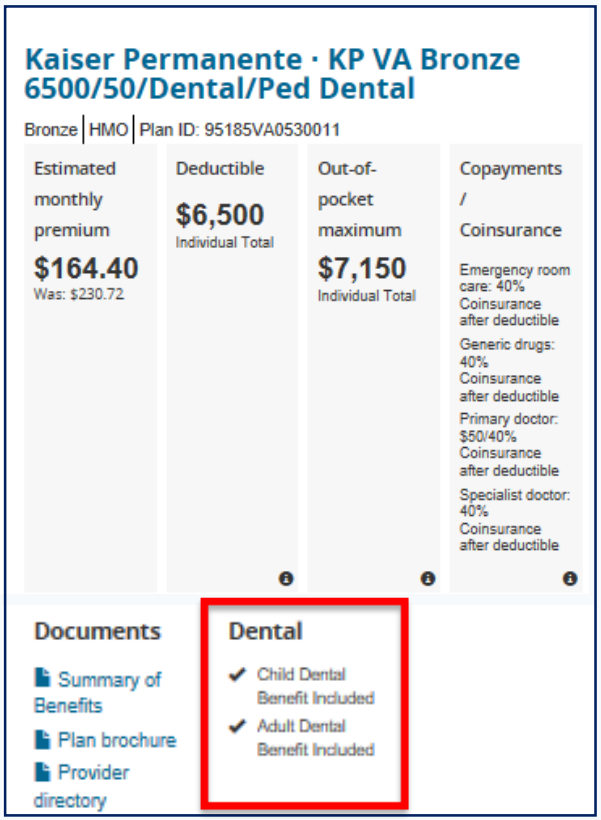

Prescription Drugs


Rehabilitation and Habilitative Services


Pediatric Oral and Vision Care

Dental Coverage for Children/Adults





***Source**: Healthcare.gov, Innovation Health Leap Bronze, Kaiser Permanente VA Bronze 6500/50/Dental/Ped Dental, and Cigna Connect 5750 plans in Arlington County, VA*

Other Covered Services

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

Excluded Services & Other Covered Services:

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

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

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

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

Your Rights to Continue Coverage:

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

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

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

Other Covered Services

	CareFirst BCBS	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					

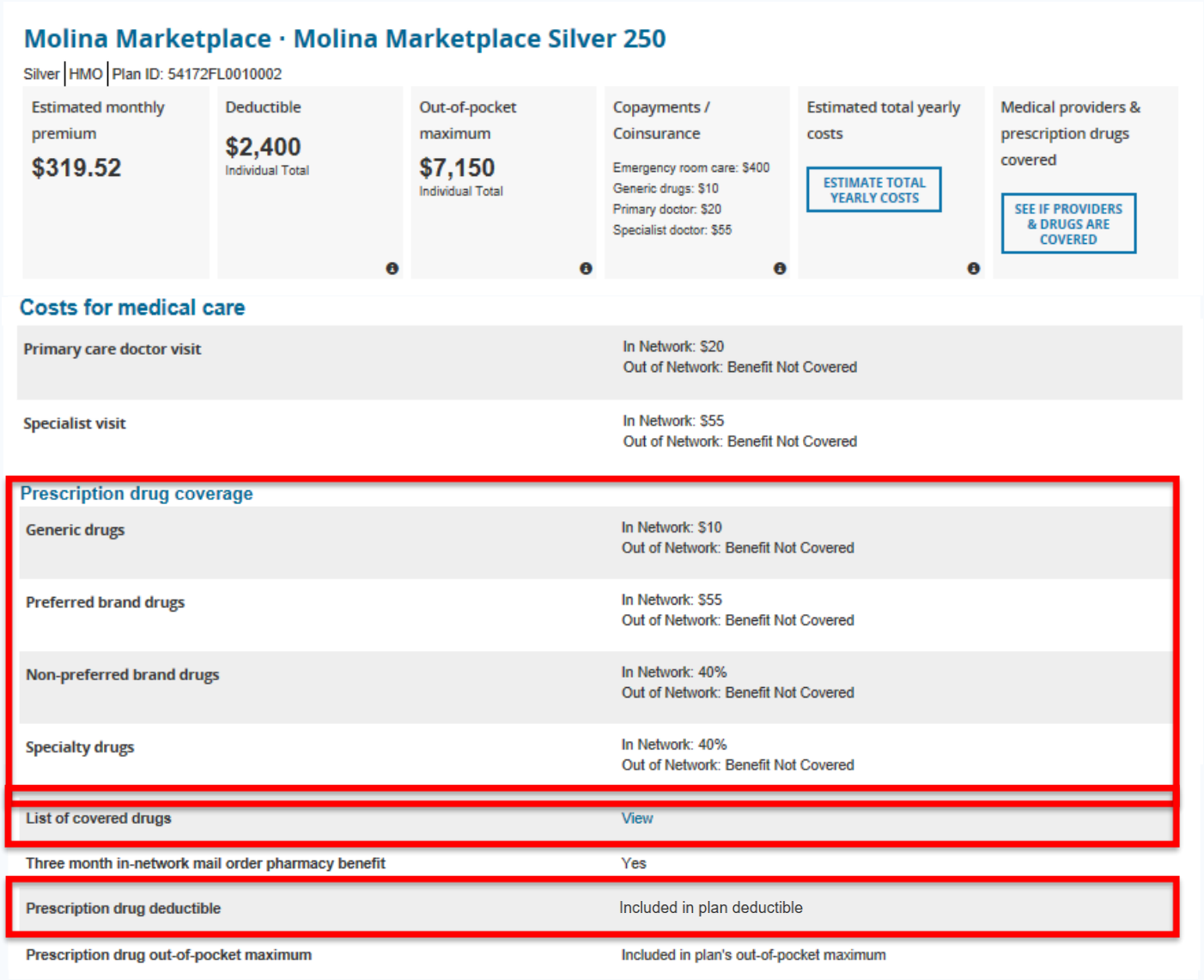
***Source**: Summary of Benefits and Coverage for CareFirst Blue Cross Blue Shield, Cigna, Innovation Health, Kaiser Permanente, and UnitedHealthcare plans in Arlington, VA (2017)*

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					

***Source**: Summary of Benefits and Coverage for CareFirst Blue Cross Blue Shield, Cigna, Innovation Health, Kaiser Permanente, and UnitedHealthcare plans in Arlington, VA (2017)*

Prescription Drug Cost-Sharing



Molina Marketplace · Molina Marketplace Silver 250

Silver | HMO | Plan ID: 54172FL0010002

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

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

Prescription drug coverage

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	View
	Three month in-network mail order pharmacy benefit	Yes
	Prescription drug deductible	Included in plan deductible
	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

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*

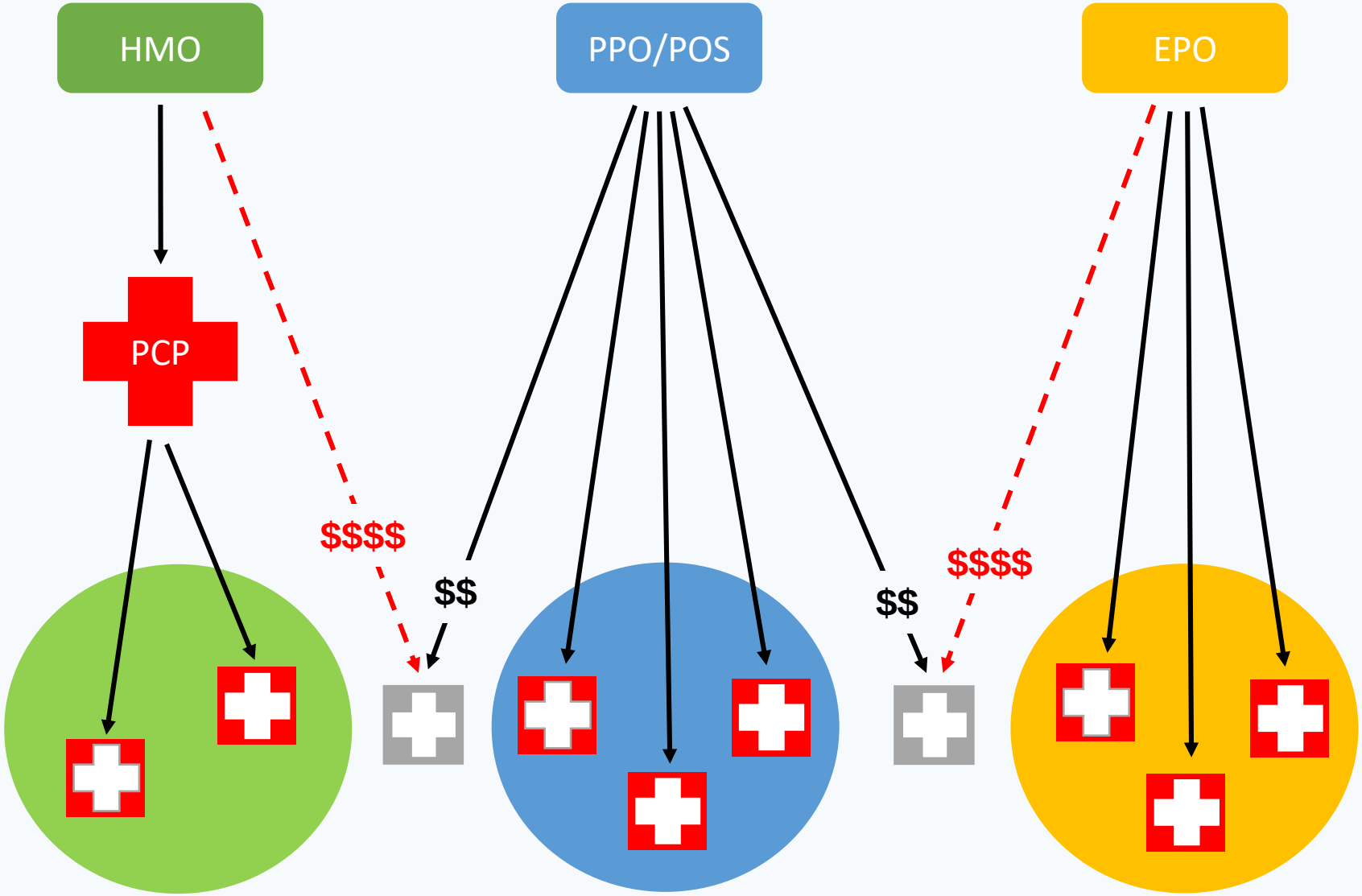
2016 CoventryOne Prescription Drug List: IA

BlueCross BlueShield of Illinois

Drug Name	Drug Tier	Prior Authorization	Step Therapy	Dispensing Limits	ACA	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 (2016)*

Health Plan Network Types



Provider Network Size

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

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

***Source**: Provider search sites BlueCross BlueShield of Nebraska, Coventry, Medica, and UnitedHealthcare in Omaha, NE (2016)*

Section 2:
Trends in Marketplace Plans

Partial Exemptions from the Deductible

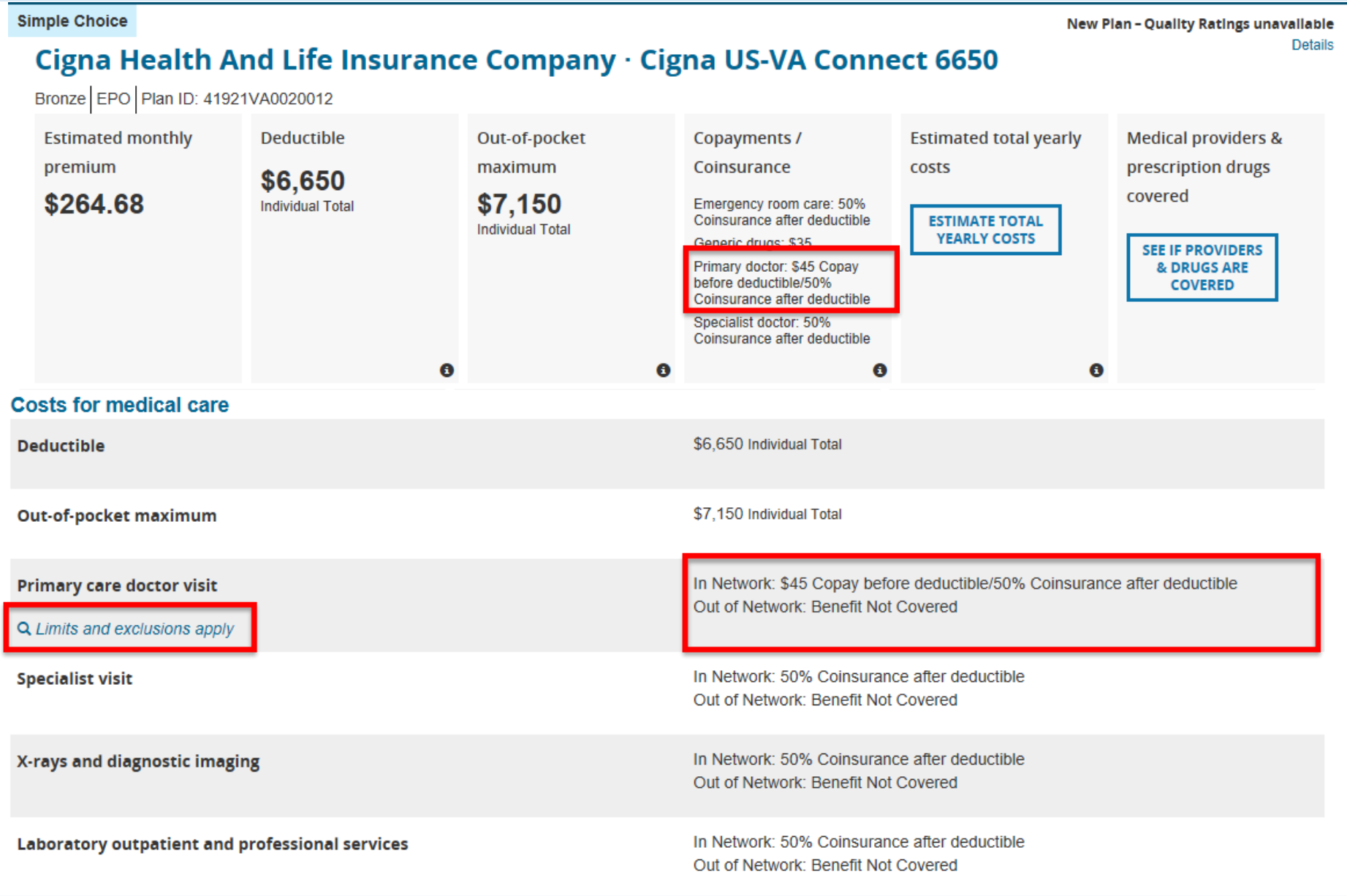
Cigna Health and Life Insurance Company: Cigna US-VA Connect 6650 Coverage Period: 01/01/2017-12/31/2017

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 prescription drug coverage is available www.cigna.com/ifp-drug-list .	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----------

***Source**: Summary of Benefits and Coverage for Cigna US-VA Connect 6650 in Fairfax County, VA (2017)*

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

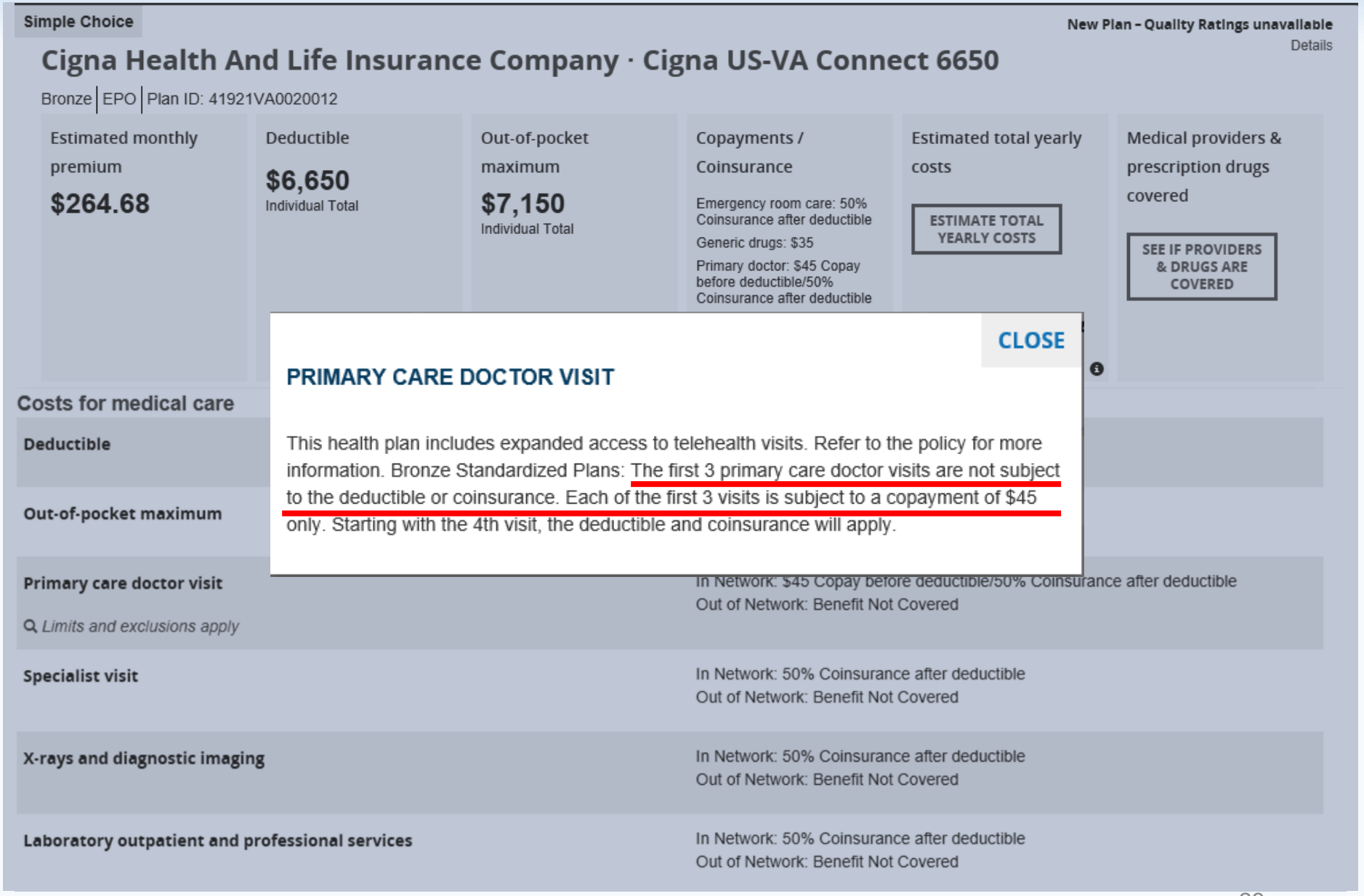
Estimated monthly premium	Deductible	Out-of-pocket maximum	Copayments / Coinsurance	Estimated total yearly costs	Medical providers & prescription drugs covered
$264.68	$6,650 Individual Total	$7,150 Individual Total	Emergency room care: 50% Coinsurance after deductible Generic drugs: $35 Primary doctor: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

Costs for medical care

Deductible	$6,650 Individual Total
Out-of-pocket maximum	$7,150 Individual Total
Primary care doctor visit *Limits and exclusions apply*	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

***Source**: healthcare.gov, Cigna US-VA Connect 6650 in Fairfax County, VA (2017)*

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	Deductible	Out-of-pocket maximum	Copayments / Coinsurance	Estimated total yearly costs	Medical providers & prescription drugs covered
$264.68	$6,650 Individual Total	$7,150 Individual Total	Emergency room care: 50% Coinsurance after deductible Generic drugs: $35 Primary doctor: $45 Copay before deductible/50% Coinsurance after deductible	ESTIMATE TOTAL YEARLY COSTS	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 *Limits and exclusions apply*	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

***Source**: healthcare.gov, Cigna US-VA Connect 6650 in Fairfax County, VA (2017)*

Deductible-only Plans

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

Bronze | HMO | Plan ID: 30252FL0070003

Estimated monthly premium	Deductible	Out-of-pocket maximum	Copayments / Coinsurance	Estimated total yearly costs	Medical providers & prescription drugs covered
$285.98	$7,150 Individual Total	$7,150 Individual Total	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	ESTIMATE TOTAL YEARLY COSTS	SEE IF PROVIDERS & DRUGS ARE COVERED

Costs for medical care

Primary care doctor visit	In Network: No Charge After Deductible Out of Network: Benefit Not Covered
Specialist visit	In Network: No Charge After Deductible Out of Network: Benefit Not Covered
X-rays and diagnostic imaging	In Network: No Charge After Deductible Out of Network: Benefit Not Covered
Laboratory outpatient and professional services	In Network: No Charge After Deductible Out of Network: Benefit Not Covered
Outpatient facility	In Network: No Charge After Deductible Out of Network: Benefit Not Covered

Prescription drug coverage

Generic drugs *Limits and exclusions apply*	In Network: No Charge After Deductible Out of Network: Benefit Not Covered
Preferred brand drugs *Limits and exclusions apply*	In Network: No Charge After Deductible Out of Network: Benefit Not Covered

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 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 provider's 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 More information about prescription drug coverage is available at www.thehealthplan.com	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
	$0 Tier	No Charge	Not covered	MediBenNC vaccines (flu and zostavax)

***Source**: Summary of Benefits and Coverage, Geisinger Health Plan HMO Plan 20/40/3000 in Cambria County, PA (2017)*

Additional Prescription Drug Tiers

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

Gold | HMO | Plan ID: 22444PA0010006

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

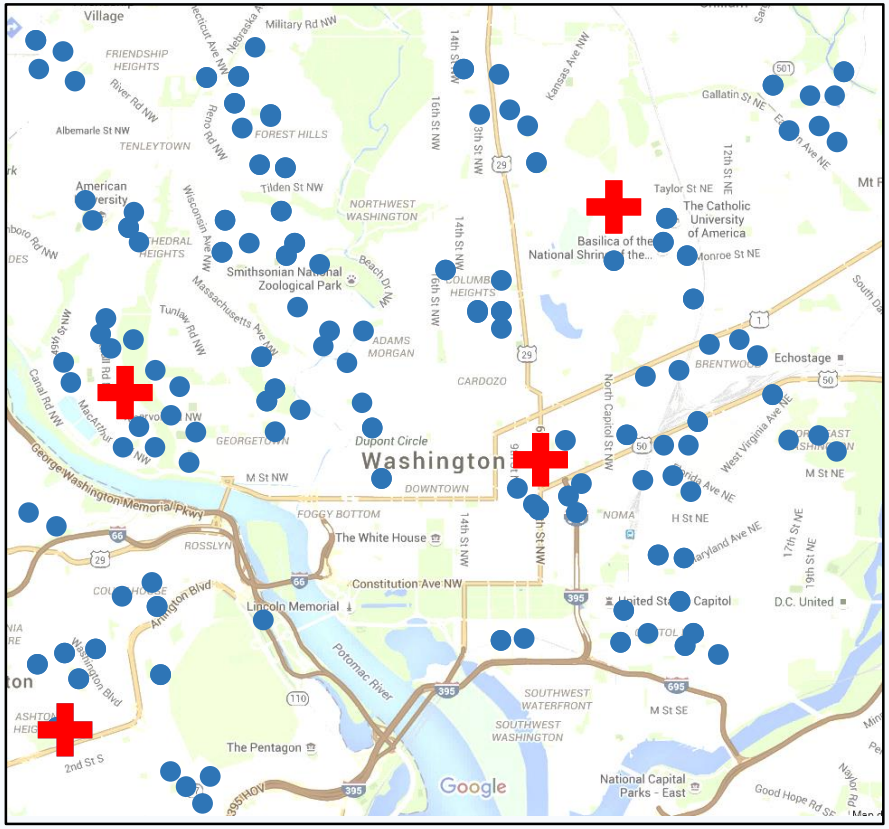
Prescription drug coverage

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

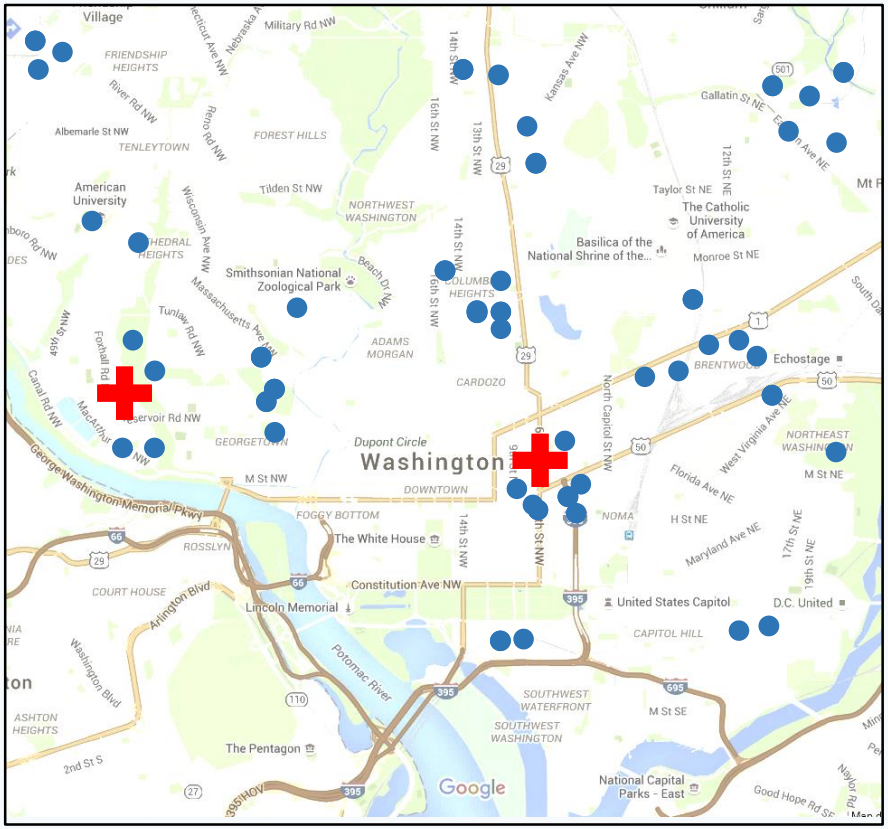
***Source**: healthcare.gov, Geisinger Health Plan HMO Plan 20/40/3000 in Cambria County, PA (2017)*

Narrow Provider Networks

Off-Exchange Provider Network



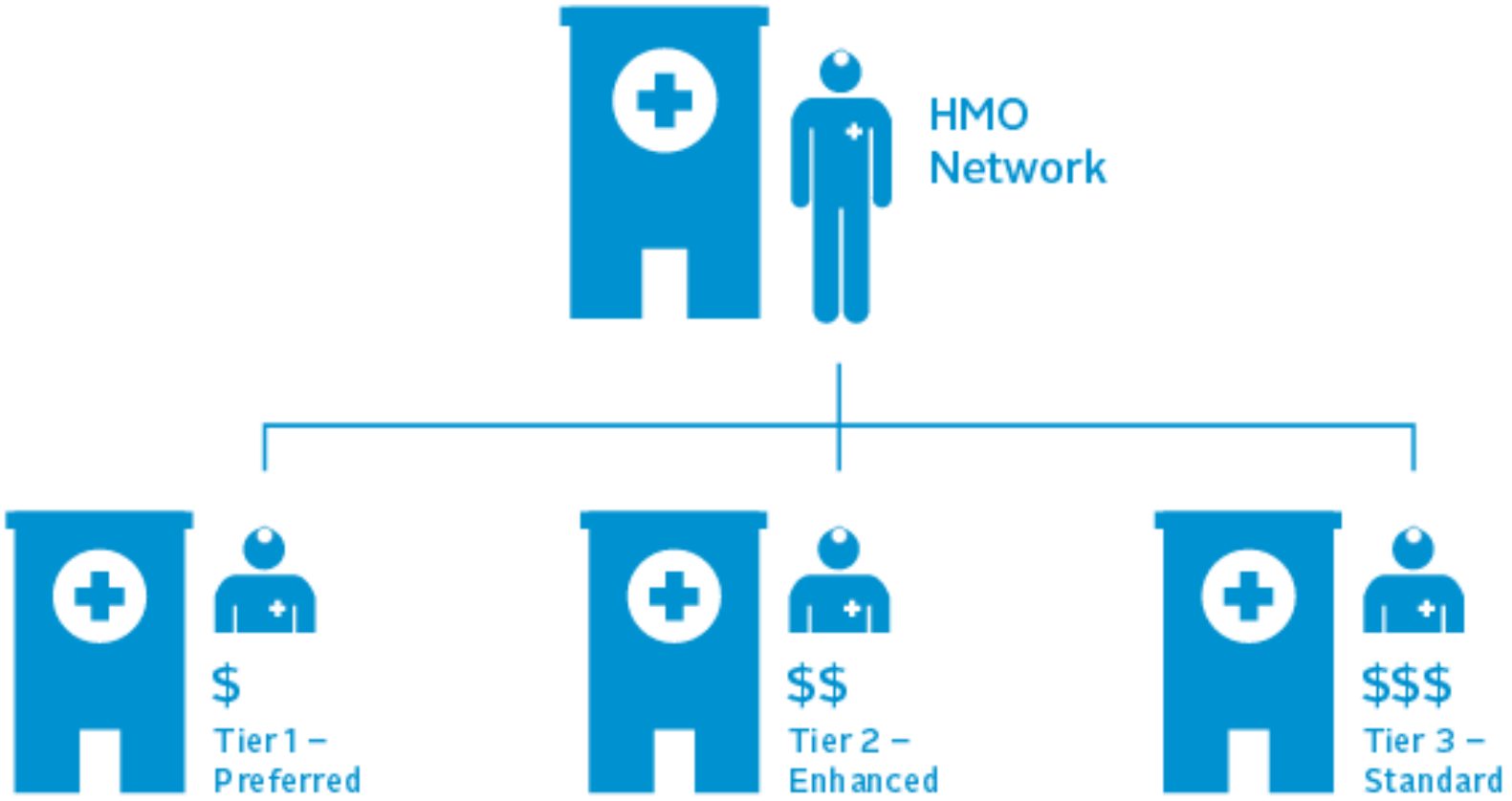
Marketplace Provider Network



● Primary Care Providers ✚ Hospitals

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

Tiered Provider Networks



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

Tiered Provider Networks

Independence **HMO Silver Proactive**

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

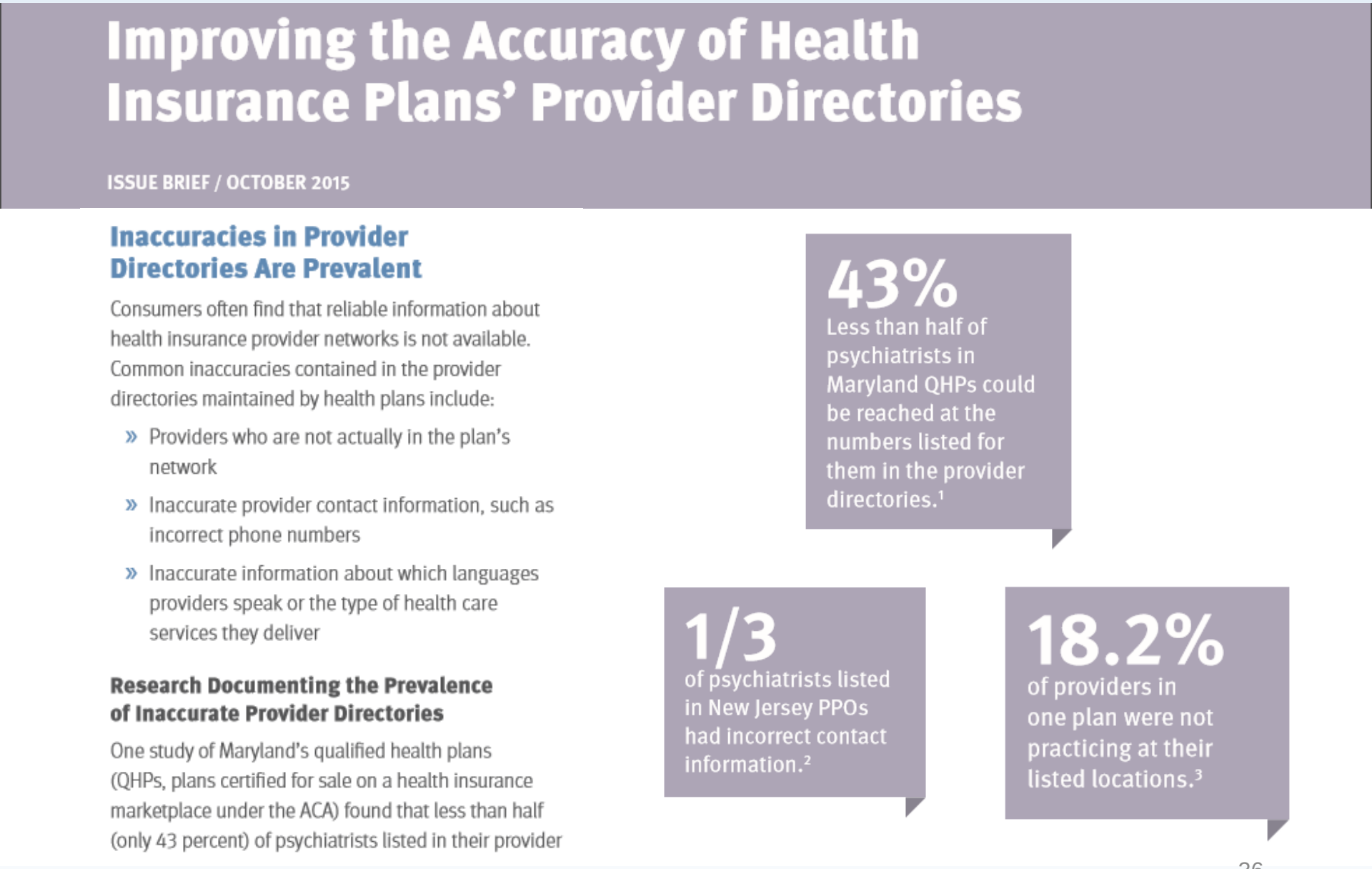
Coverage Period: Beginning on or after 01/01/2017

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.

***Source**: Summary of Benefits and Coverage for Independence Blue Cross HMO Silver Proactive Plan in Philadelphia, PA (2017)*

Inaccurate Provider Directories



Improving the Accuracy of Health Insurance Plans' Provider Directories

ISSUE BRIEF / OCTOBER 2015

Inaccuracies in Provider Directories Are Prevalent

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

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

Research Documenting the Prevalence of Inaccurate Provider Directories

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

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

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

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

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

Section 3:
Strategies to Help Consumers

Preparing for Open Enrollment

1. Monitoring annual changes in lowest-cost options

Rank	2015		2016		2017	
	Plan	Price	Plan	Price	Plan	Price
1	Kaiser Permanente 1750/25%/HSA/ Dental	$239	Innovation Health Leap Silver Basic	$237	Innovation Health Leap Silver Basic	$259
2	Innovation Silver $10 Copay	$247	Kaiser Permanente VA Silver 2750/20/ HSA/Dental/ Ped dental	$248	Innovation Health Leap Silver Diabetes	$271
3	Kaiser Permanente 2500/30/Dental	$251	United HealthCare, Silver Compass HSA 2000	$253	Cigna Connect 4500	$274
4	Kaiser Permanente 1500/30/Dental	$261	Innovation Health Leap Silver Plus	$254	UnitedHealthcare Compass Silver 5200	$279
5	Innovation Silver $5 Copay 2750	$265	Kaiser Permanente VA Silver 2500/30/ Dental/Ped Dental	$262	Innovation Health Leap Silver Plus	$281
6	CareFirst BlueChoice Plus Silver $2500	$283	United Healthcare, Silver Compass 4500-1	$264	UnitedHealthcare Compass HSA Silver 2800	$282
7	CareFirst BlueChoice Plus Silver $2000	$288	Kaiser Permanente VA Silver 1500/30/ Dental/Ped Dental	$276	Innovation Health Leap Silver Healthy Minds	$287
8	CareFirst BlueChoice Silver $1300	$288	CareFirst BlueChoice HMO HSA Silver $1,350	$312	Kaiser Permanente VA Silver 6000/30/Dental/Ped Dental	$288
9	GHMSI BCBS Preferred 1500 (MSP)	$304	CareFirst BlueChoice HMO Silver $2,000	$345	Cigna Connect 2500	$288
10			CareFirst BlueChoice Plus Silver $2500	$345	Kaiser Permanente VA Silver 2750/20%/HSA/Dental/Ped Dental	$315

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

Preparing for Open Enrollment

2. Understanding annual changes in plan design

	2017		2018	
Insurance company	Cigna		Cigna	
Health plan name	Cigna Connect 4500		Cigna Connect 4500	
Metal level/Network Type	Silver		Silver	
Monthly premium	$313.29		$356.07	
Deductible	$4,500		$4,500	
OOP Maximum	$7,150		$7,350	
Copay	**Deductible applies?**		**Deductible applies?**	
Primary Care Provider	$20		$20	
Specialist Visit	15%	✓	20%	✓
X-rays and Diagnostic Imaging	15%	✓	20%	✓
Rx Tier 1	Preferred: $4/Non-preferred: $20		Preferred: $4, Non-preferred: $20	
Rx Tier 2	$55	✓	$55	✓
Rx Tier 3	50%	✓	50%	✓
Rx Tier 4	30%	✓	30%	✓
Outpatient Facility Fee	15%	✓	20%	✓
Emergency Room Visit	15%	✓	20%	✓
Inpatient Hospital Stay	15%	✓	20%	✓

***Source**: healthcare.gov, plan information for 2017 and 2018 Cigna Connect 4500 Silver plan in Arlington VA*

Preparing for Open Enrollment

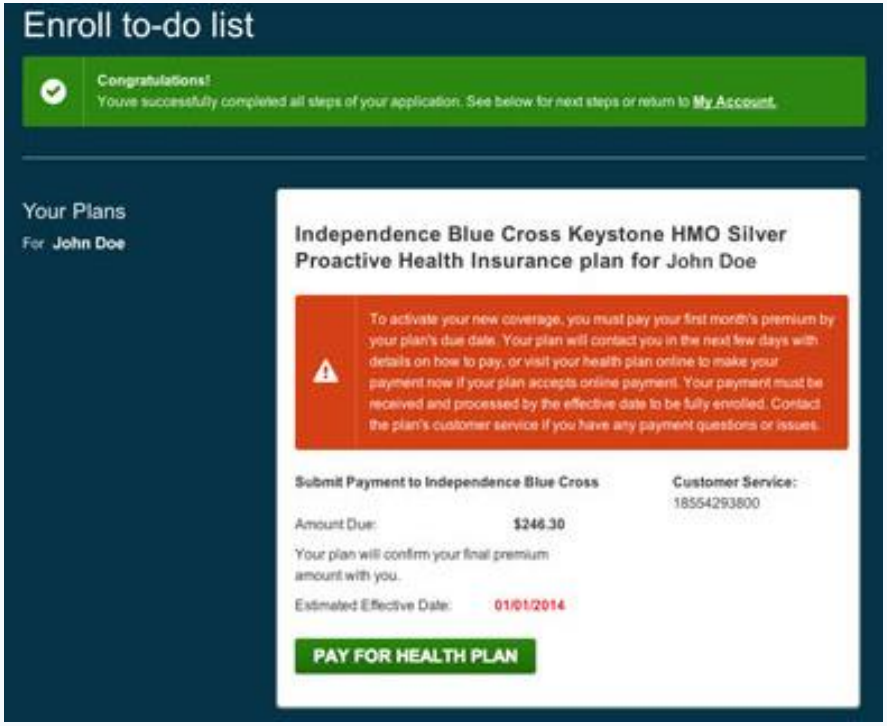
2. Understanding annual changes in plan design

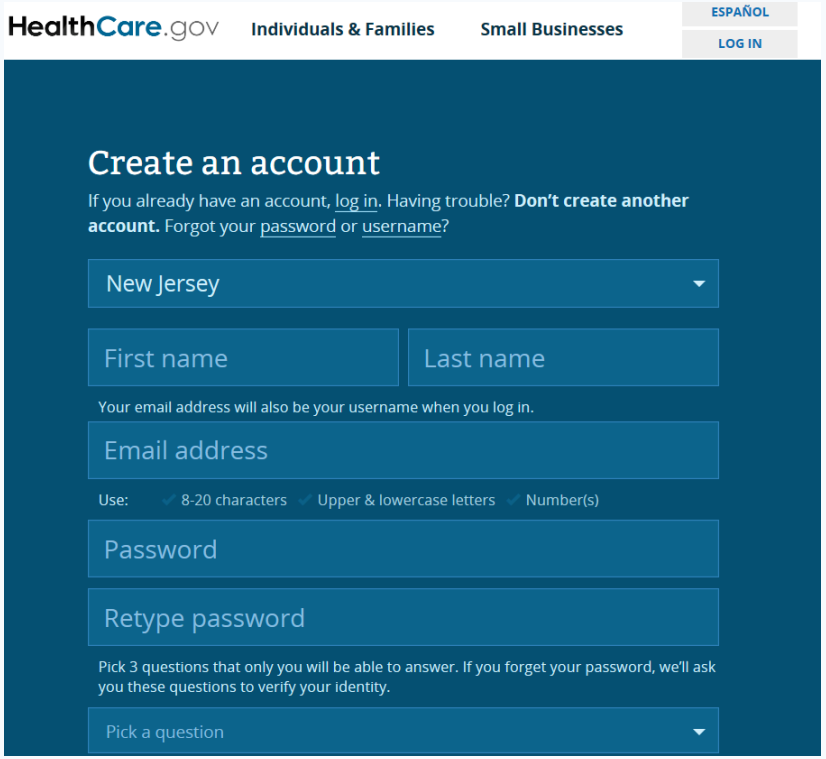
	2017		2018	
Insurance company	Cigna		Cigna	
Health plan name	Cigna Connect 4500		Cigna Connect 4500	
Metal level/Network Type	Silver		Silver	
Monthly premium	$313.29		$356.07	
Deductible	$4,500		$4,500	
OOP Maximum	$7,150		$7,350	
Copay	**Deductible applies?**		**Deductible applies?**	
Primary Care Provider	$20		$20	
Specialist Visit	15%	✓	20%	✓
X-rays and Diagnostic Imaging	15%	✓	20%	✓
Rx Tier 1	Preferred: $4/Non-preferred: $20		Preferred: $4, Non-preferred: $20	
Rx Tier 2	$55	✓	$55	✓
Rx Tier 3	50%	✓	50%	✓
Rx Tier 4	30%	✓	30%	✓
Outpatient Facility Fee	15%	✓	20%	✓
Emergency Room Visit	15%	✓	20%	✓
Inpatient Hospital Stay	15%	✓	20%	✓

***Source**: healthcare.gov, plan information for 2017 and 2018 Cigna Connect 4500 Silver plan in Arlington VA*

Tailoring Search Based on Consumer Needs

1. Renewal or new applicant?

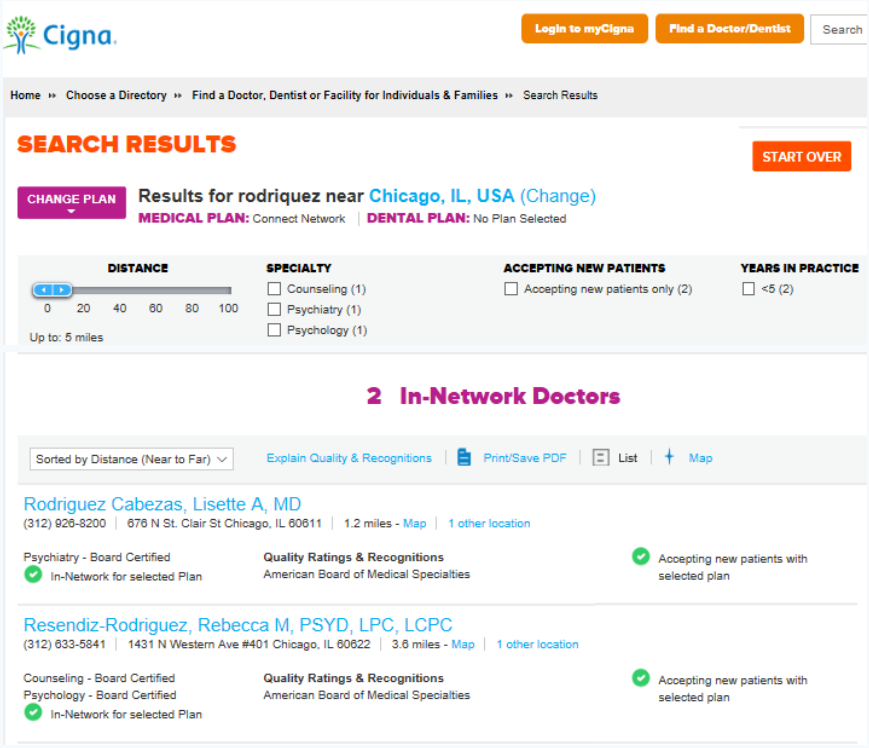




***Source**: healthcare.gov*

Tailoring Search Based on Consumer Needs

2. Any prescription drugs or current doctors?



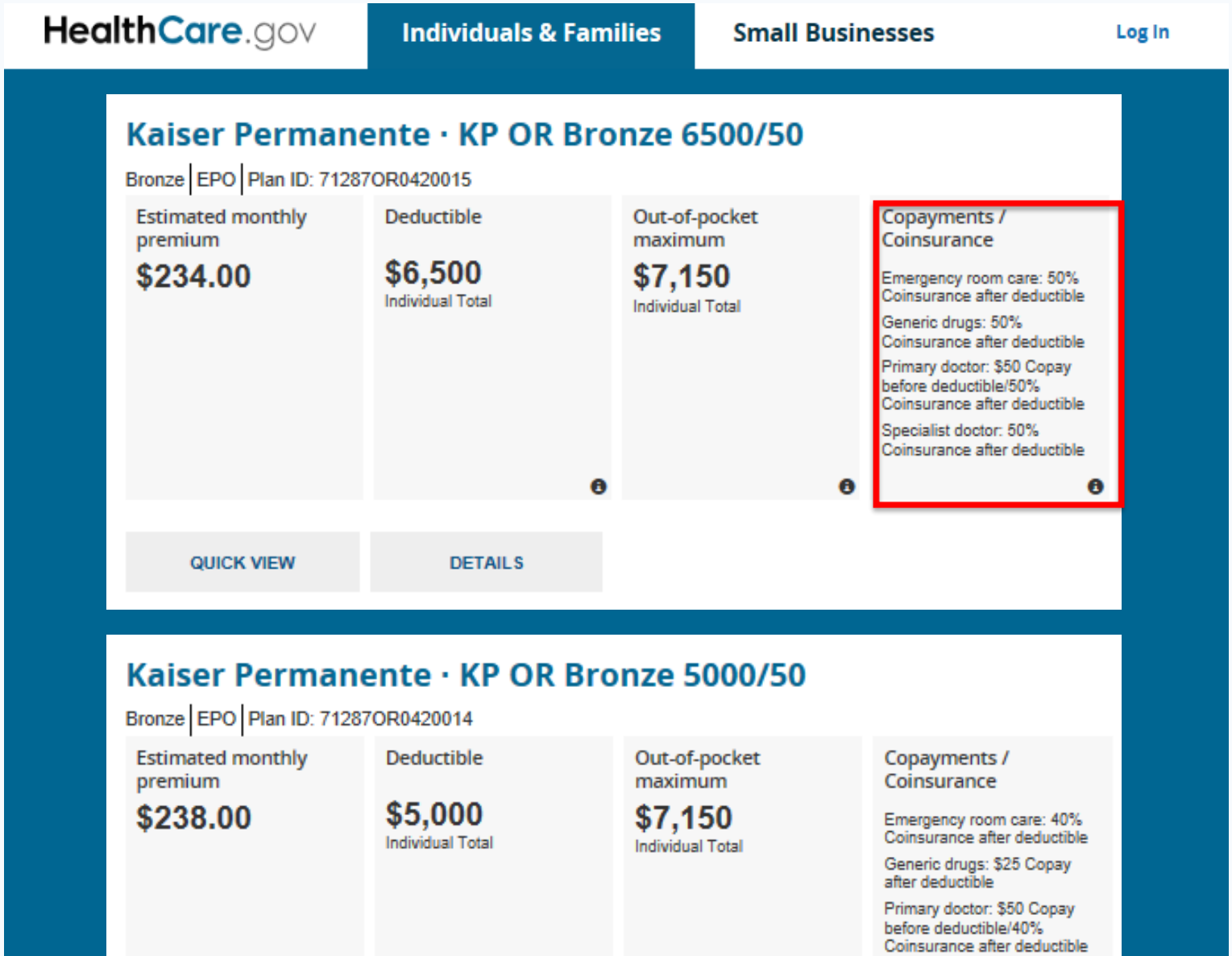
***Source**: Cigna prescription drug search and provider search websites*

Tailoring Search Based on Consumer Needs

3. Major health heeds or anticipated procedures?

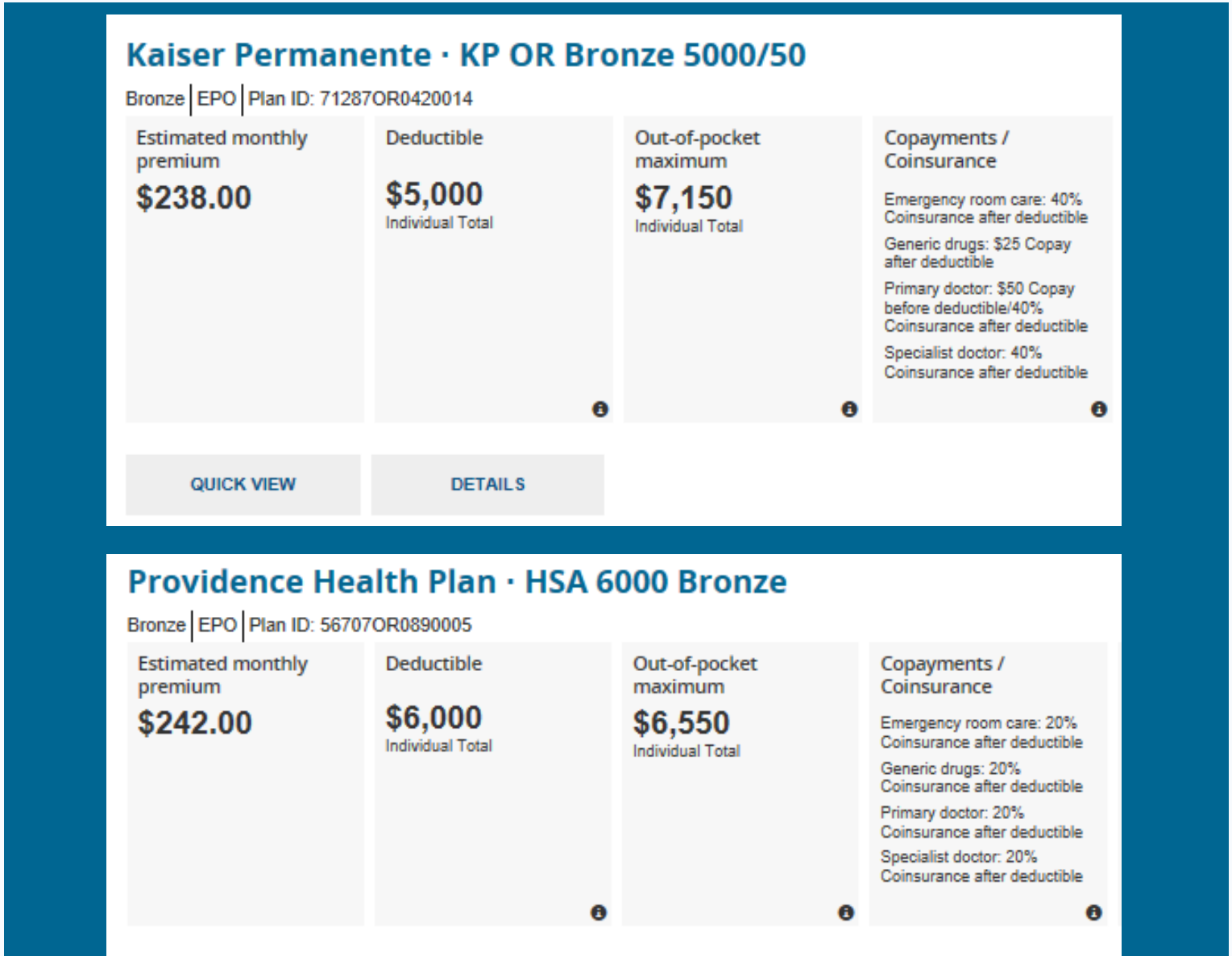
Tailoring Search Based on Consumer Needs

4. Finding options for First Dollar Coverage



Tailoring Search Based on Consumer Needs

4. Finding options for First Dollar Coverage



Understanding Consumers Tradeoffs

1. Cheaper Bronze vs. Expensive Silver

vs

***Source**: healthcare.gov, HMO Louisiana Blue POS 60/40 $6500 Bronze and HMO Louisiana Blue POS Copay 70/50 $3100 Silver plans in New Orleans, LA*

Understanding Consumers Tradeoffs

1. Cheaper Bronze vs. Expensive Silver

HMO Louisiana · Blue POS 60/40 $6500

Bronze | POS | Plan ID: 19636LA0220012

Estimated monthly premium
$130.31
Was: $339.63

Deductible
$6,500
Individual Total

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

Copayments / Coinsurance

Emergency room care: 40% Coinsurance after deductible

Generic drugs: 40% Coinsurance after deductible

Primary doctor: 40% Coinsurance after deductible

Specialist doctor: 40% Coinsurance after deductible

+

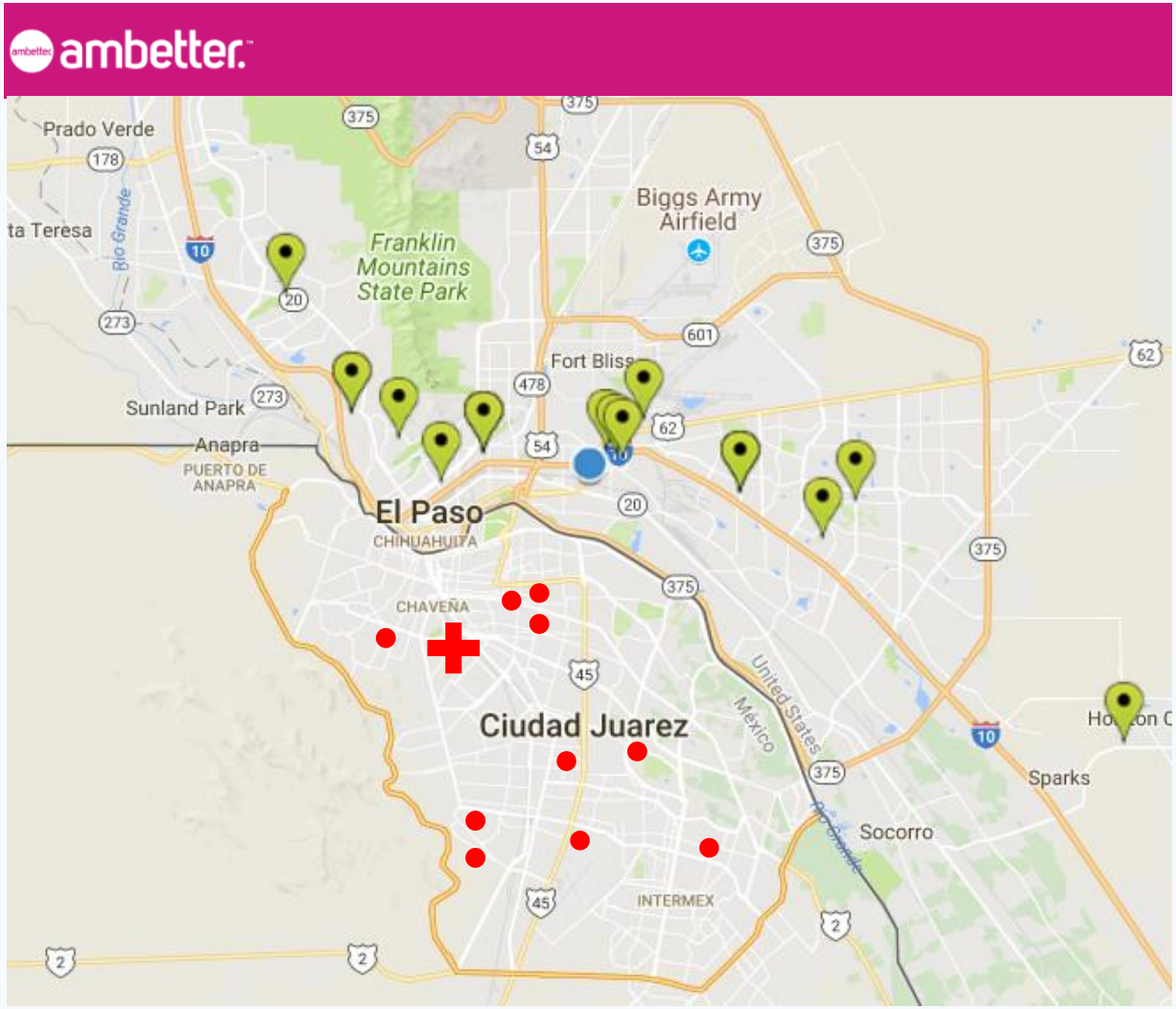
afc | arlington freeclinic

Together Rx Access. Prescription Savings Program
00000 0000
MEMBER NAME

Source: healthcare.gov, HMO Louisiana Blue POS 60/40 $6500 Bronze plan in New Orleans, LA

Understanding Consumers Tradeoffs

2. Alternate sources of care



***Source**: provider search for Ambetter Essential Care 1 (2017) in El Paso, TX (2017)*

Understanding Consumers Tradeoffs

3. Buying coverage vs. going uninsured

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

Bronze | EPO | Plan ID: 29418TX0140006

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

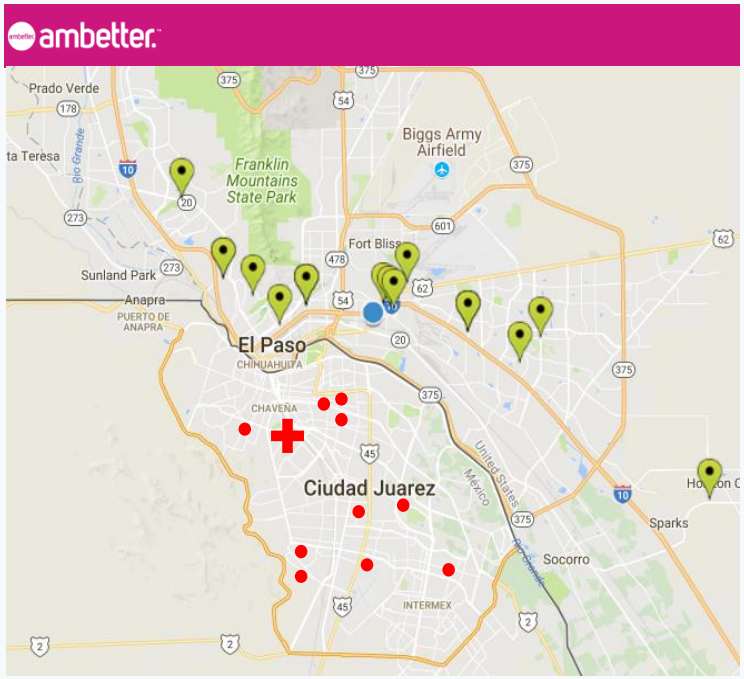
vs

Understanding Consumers Tradeoffs

3. Buying coverage vs. going uninsured

afc arlington freeclinic

Together Rx Access. Prescription Savings Program
00000 0000
MEMBER NAME



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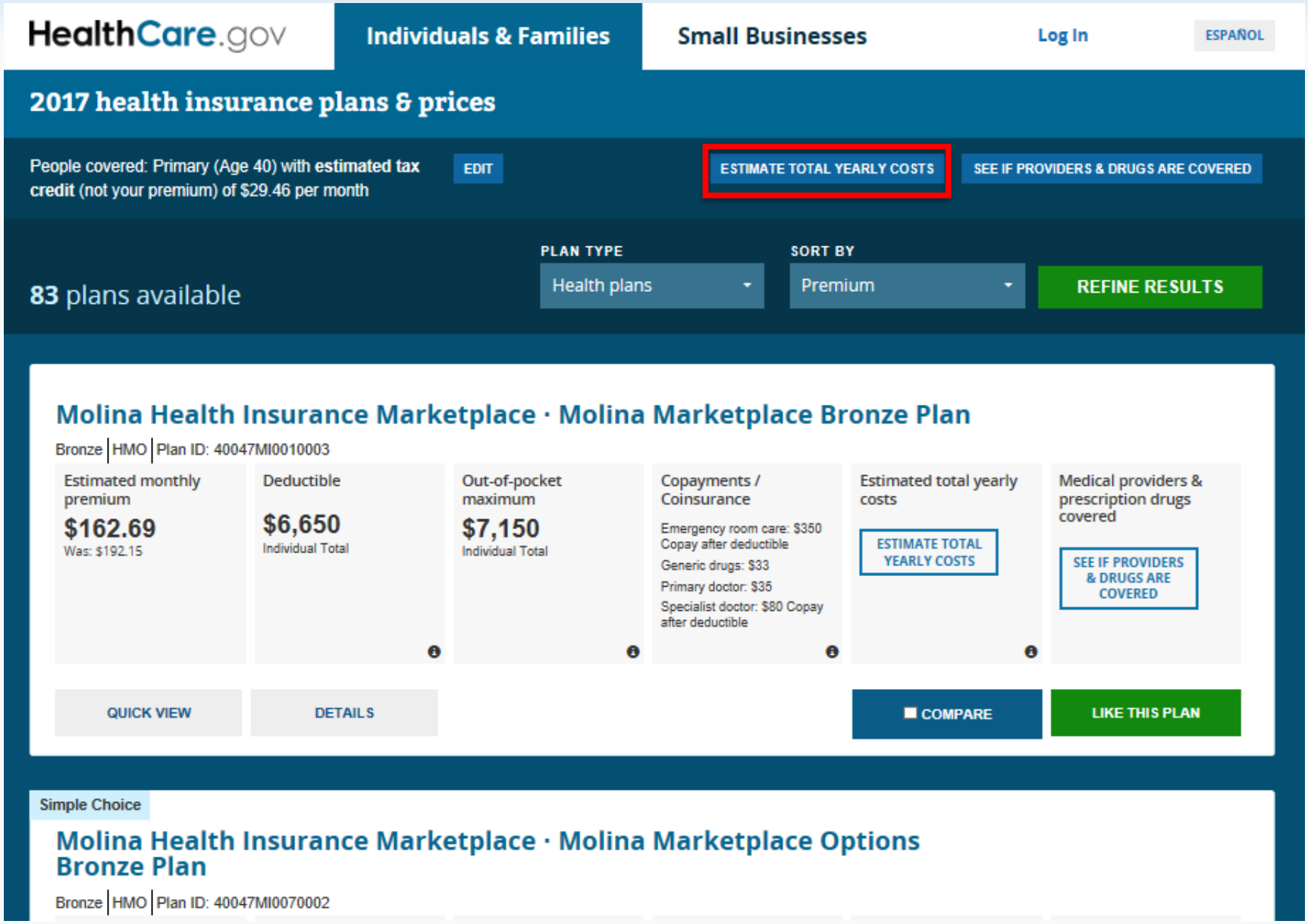
Q & A Session 1

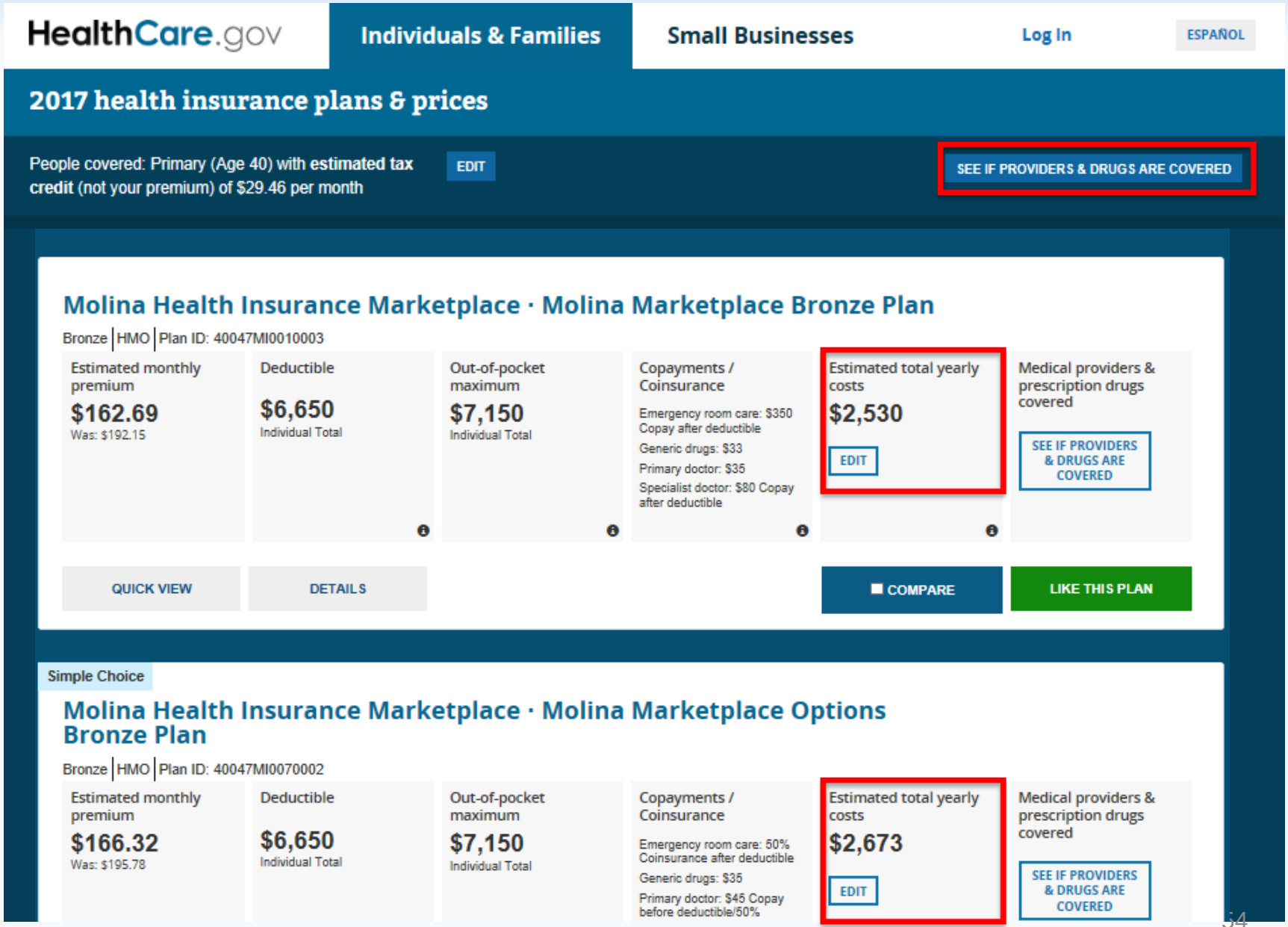
Section 4:
Plan Comparison & Selection

healthcare.gov Decision Support Tools



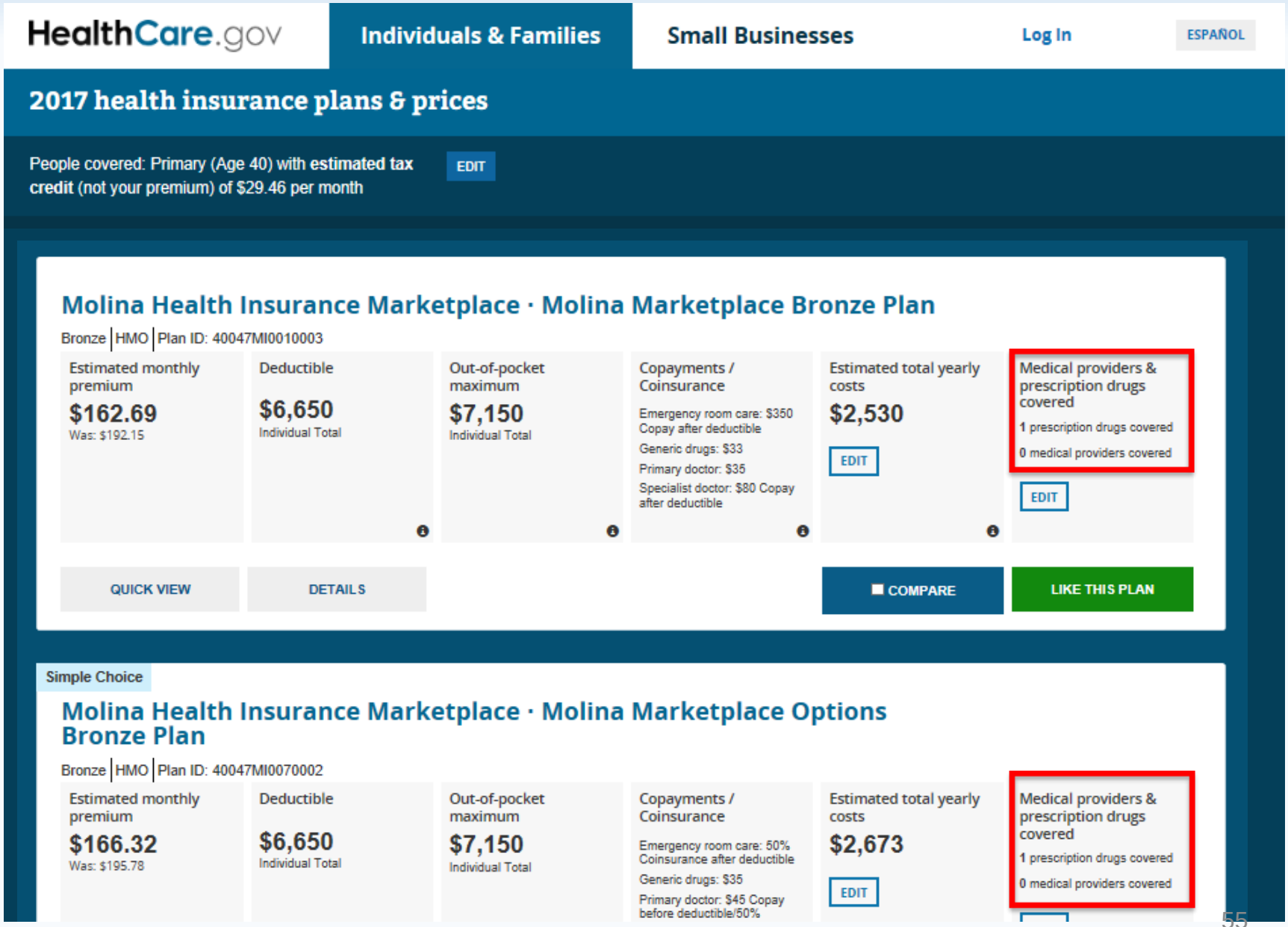
***Source**: healthcare.gov, plans in Detroit, MI (2017)*

Out-of-Pocket Cost Calculator

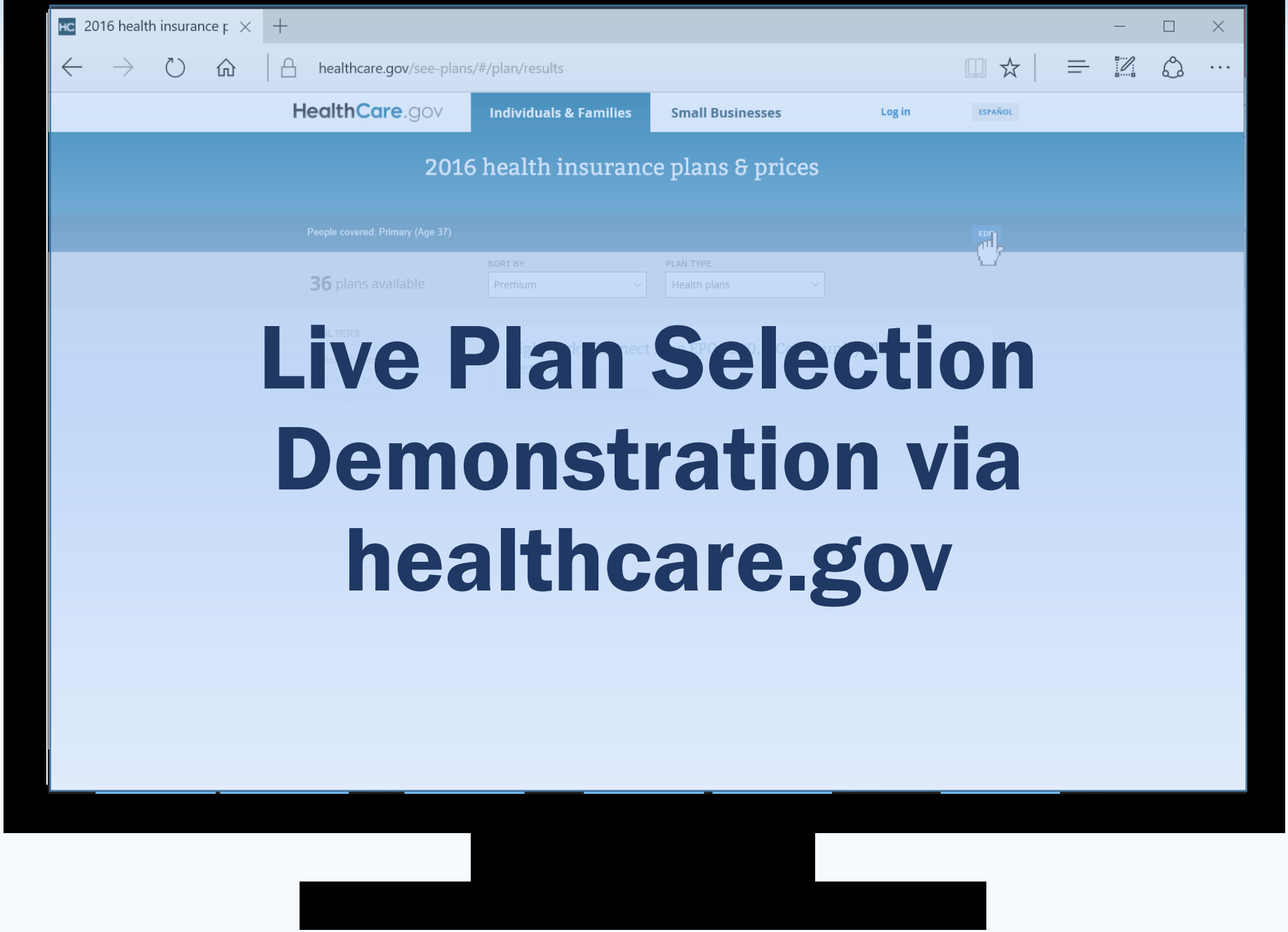


***Source**: healthcare.gov, plans in Detroit, MI (2017)*

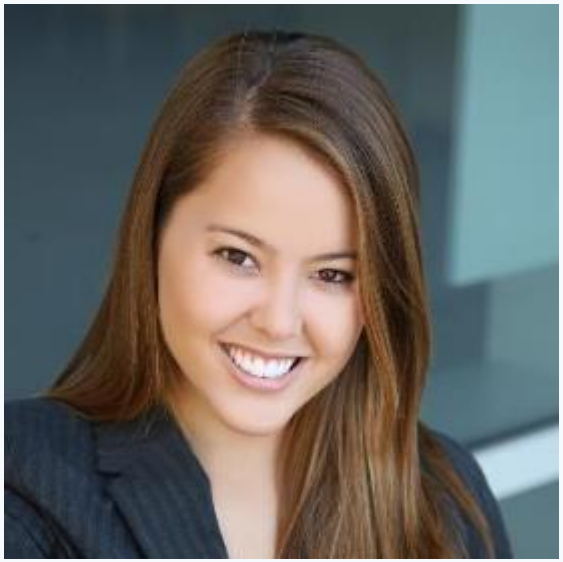
Provider and Rx Search Tool



***Source**: healthcare.gov, plans in Detroit, MI (2017)*


2016 health insurance p
healthcare.gov/see-plans/#/plan/results
HealthCare.gov
Individuals & Families
Small Businesses
Log in
ESPAÑOL
2016 health insurance plans & prices
People covered: Primary (Age 37)
EDIT
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: Orlando, FL
Orange County

Zip Code: 32810

Annual Income: $30,000

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

SCENARIO 1: Jennifer

SCENARIO 1: Jennifer

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

SCENARIO 1: Jennifer

	Plan 1		Plan 2		Plan 3	
Insurance company	Florida Blue HMO					
Health plan name	MyBlue Bronze 1602					
Metal level/Network Type	Bronze HMO					
Monthly premium *(after tax credit)*	$154.54					
Deductible (in-network/out-of-network)	$7,150					
OOP Maximum (in-network/out-of-network)	$7,150					
Copay	**Deductible applies?**		**Deductible applies?**		**Deductible applies?**	
Primary Care Provider	No charge	✓				
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:						
Other Service:						
Health Care Providers	**In Network/Covered?**		**In Network/Covered?**		**In Network/Covered?**	
Provider/Rx:						
Provider/Rx:						
Provider/Rx:						

SCENARIO 1: Jennifer

	Plan 1		Plan 2		Plan 3	
Insurance company	Florida Blue HMO		Florida Blue HMO			
Health plan name	MyBlue Bronze 1602		MyBlue Bronze 1711S			
Metal level/Network Type	Bronze HMO		Bronze HMO			
Monthly premium *(after tax credit)*	$154.54		$159.34			
Deductible (in-network/out-of-network)	$7,150		$6,650			
OOP Maximum (in-network/out-of-network)	$7,150		$7,150			
Copay	**Deductible applies?**		**Deductible applies?**		**Deductible applies?**	
Primary Care Provider	No charge	✓	$45 for 3 visits/50%	~		
Specialist Visit	No charge	✓	50%	✓		
Rx Tier 1	No charge	✓	$35			
Rx Tier 2	No charge	✓	35%	✓		
Rx Tier 3	No charge	✓	40%	✓		
Rx Tier 4	No charge	✓	45%	✓		
Emergency Room Visit	No charge	✓	50%	✓		
Inpatient Hospital Stay	No charge	✓	50%	✓		
Other Service:						
Other Service:						
Health Care Providers	**In Network/Covered?**		**In Network/Covered?**		**In Network/Covered?**	
Provider/Rx:						
Provider/Rx:						
Provider/Rx:						

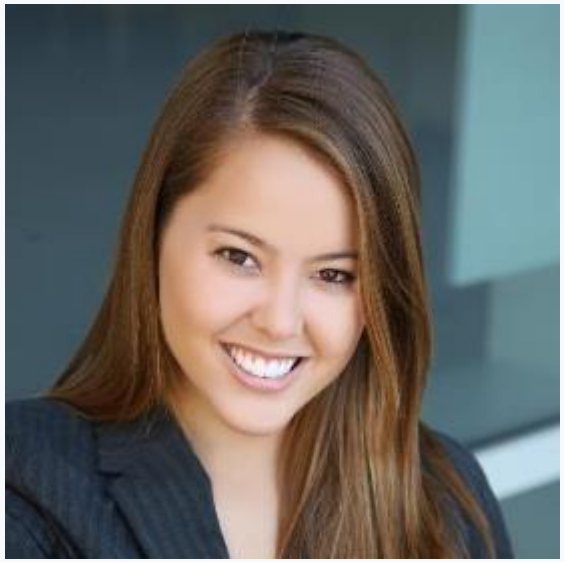
SCENARIO 1: Jennifer

	Plan 1		Plan 2		Plan 3	
Insurance company	Florida Blue HMO		Florida Blue HMO		Florida Blue HMO	
Health plan name	MyBlue Bronze 1602		MyBlue Bronze 1711S		MyBlue Silver 1603	
Metal level/Network Type	Bronze HMO		Bronze HMO		Silver HMO	
Monthly premium *(after tax credit)*	$154.54		$159.34		$207.12	
Deductible (in-network/out-of-network)	$7,150		$6,650		$5,950	
OOP Maximum (in-network/out-of-network)	$7,150		$7,150		$7,150	
Copay	**Deductible applies?**		**Deductible applies?**		**Deductible applies?**	
Primary Care Provider	No charge	✓	$45 for 3 visits/50%	~	$50	
Specialist Visit	No charge	✓	50%	✓	$100	
Rx Tier 1	No charge	✓	$35		$15	
Rx Tier 2	No charge	✓	35%	✓	$67	✓
Rx Tier 3	No charge	✓	40%	✓	50%	✓
Rx Tier 4	No charge	✓	45%	✓	50%	✓
Emergency Room Visit	No charge	✓	50%	✓	$400	✓
Inpatient Hospital Stay	No charge	✓	50%	✓	$600 per stay	✓
Other Service:						
Other Service:						
Health Care Providers	**In Network/Covered?**		**In Network/Covered?**		**In Network/Covered?**	
Provider/Rx:						
Provider/Rx:						
Provider/Rx:						

SCENARIO 1: Jennifer

Identifying Jennifer's priorities:

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



SCENARIO 2: Jim and Michelle

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

Location: Miami, FL
Miami-Dade County

Zip Code: 33142

Annual Income: $24,000

Health Status?	Jim has diabetes
Prescription Drugs?	Jim takes Metformin 1000 mg
Doctors/Providers?	Michelle sees Dr. Olga Tudela (OB/GYN)
Other considerations?	Jim gets frequent lab work

SCENARIO 2: Jim and Michelle

	Plan 1	Plan 2	Plan 3
Insurance company			
Health plan name			
Metal level/Network Type			
Monthly premium *(after tax credit)*			
Deductible (in-network/out-of-network)			
OOP Maximum (in-network/out-of-network)			
Copay	**Deductible applies?**	**Deductible applies?**	**Deductible applies?**
Primary Care Provider			
Specialist Visit			
Rx Tier 1			
Rx Tier 2			
Rx Tier 3			
Rx Tier 4			
Emergency Room Visit			
Inpatient Hospital Stay			
Other Service: **Laboratory Services**			
Other Service:			
Health Care Providers	**In Network/Covered?**	**In Network/Covered?**	**In Network/Covered?**
Provider/Rx: **Dr. Olga Tudela**			
Provider/Rx: **metformin 1000 mg**			
Provider/Rx:			

SCENARIO 2: Jim and Michelle

	Plan 1		Plan 2		Plan 3	
Insurance company	Ambetter		Ambetter		Florida Blue HMO	
Health plan name	Ambetter Balanced Care 4		Ambetter Balanced Care 1		MyBlue Silver 1604C	
Metal level/Network Type	Silver EPO		Silver EPO		Silver HMO	
Monthly premium *(after tax credit)*	$54.52		$94.40		$112.94	
Deductible (in-network/out-of-network)	$1,200		$0		$0	
OOP Maximum (in-network/out-of-network)	$1,200		$1,400		$1,900	
Copay	**Deductible applies?**		**Deductible applies?**		**Deductible applies?**	
Primary Care Provider	No charge		$1		$0 for 3 visits/ $1	
Specialist Visit	$5		$10		$3	
Rx Tier 1	No charge		$1		$2	
Rx Tier 2	$25		$25		$10	
Rx Tier 3	No charge	✓	20%		50%	
Rx Tier 4	No charge	✓	20%		50%	
Emergency Room Visit	No charge	✓	20%		$100	
Inpatient Hospital Stay	No charge	✓	20%		25%	
Other Service: **Laboratory Services**	No charge	✓	20%		25%	
Other Service:						
Health Care Providers	**In Network/Covered?**		**In Network/Covered?**		**In Network/Covered?**	
Provider/Rx: **Dr. Olga Tudela**	×		×		✓	
Provider/Rx: **metformin 1000 mg**	Yes (Tier 1)		Yes (Tier 1)		Yes (Tier 2)	
Provider/Rx:						

SCENARIO 2: Jim and Michelle

Identifying Jim and Michelle's priorities:

- Cheapest monthly payment?
- Manageable deductible/copays
- Having "first dollar" coverage? (i.e. some services exempt from the deductible)?
- 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: Jacksonville, FL
Duval County

Zip Code: 32206

Annual Income: $36,000

Health Status?	Mariela has asthma
Doctors/Providers?	Mariela sees Dr. Jean Go (Pulmonologist)
Prescription Drugs?	Mariela takes Advair (0.5 MG inhaler)
Other Health Needs/Issues?	Marco is considering procedure at Jacksonville Memorial Hospital

SCENARIO 3: Rodriguez Family

	Plan 1		Plan 2		Plan 3	
Insurance company						
Health plan name						
Metal level/Network Type						
Monthly premium *(after tax credit)*						
Deductible (in-network/out-of-network)						
OOP Maximum (in-network/out-of-network)						
Copay	**Deductible applies?**		**Deductible applies?**		**Deductible applies?**	
Primary Care Provider						
Specialist Visit						
Rx Tier 1						
Rx Tier 2						
Rx Tier 3						
Rx Tier 4						
Emergency Room Visit						
Inpatient Hospital Stay						
Other Service:						
Other Service:						
Health Care Providers	**In Network/Covered?**		**In Network/Covered?**		**In Network/Covered?**	
Provider/Rx: **Dr. Jean Go**						
Provider/Rx: **Jacksonville Memorial**						
Provider/Rx: **Advair 14 0.1mg/0.05**						

SCENARIO 3: Rodriguez Family

	Plan 1		Plan 2		Plan 3	
Insurance company	Molina Marketplace		Molina Marketplace		Florida Blue HMO	
Health plan name	Molina Marketplace Bronze		Molina Marketplace Silver		MyBlue Silver 160B	
Metal level/Network Type	Bronze HMO		Silver HMO		Silver HMO	
Monthly premium *(after tax credit)*	$44.41		$153.19		$207.47	
Deductible (in-network/out-of-network)	$13,300		$1,000		$0	
OOP Maximum (in-network/out-of-network)	$14,300		$4,500		$4,500	
Copay	**Deductible applies?**		**Deductible applies?**		**Deductible applies?**	
Primary Care Provider	$35		$10		$2	
Specialist Visit	$80	✓	$30		$15	
Rx Tier 1	$33		$5		$10	
Rx Tier 2	$65	✓	$30		$45	
Rx Tier 3	50%	✓	30%		50%	
Rx Tier 4	50%	✓	30%		50%	
Emergency Room Visit	$350	✓	$205		$500	
Inpatient Hospital Stay	40%	✓	20%	✓	40%	
Other Service:						
Other Service:						
Health Care Providers	**In Network/Covered?**		**In Network/Covered?**		**In Network/Covered?**	
Provider/Rx: **Dr. Jean Go**	×		×		✓	
Provider/Rx: **Jacksonville Memorial**	×		×		✓	
Provider/Rx: **Advair 14 0.1mg/0.05**	×		×		Yes (Tier 2)	

SCENARIO 3: Rodriguez Family

	Plan 1		Plan 3	
Insurance company	Molina Marketplace		Florida Blue HMO	
Health plan name	Molina Marketplace Bronze		MyBlue Silver 160B	
Metal level/Network Type	Bronze HMO		Silver HMO	
Monthly premium *(after tax credit)*	$44.41		$207.47	
Deductible (in-network/out-of-network)	$13,300		$0	
OOP Maximum (in-network/out-of-network)	$14,300		$4,500	
Copay	**Deductible applies?**		**Deductible applies?**	
Primary Care Provider	$35		$2	
Specialist Visit	$80	✓	$15	
Rx Tier 1	$33		$10	
Rx Tier 2	$65	✓	$45	
Rx Tier 3	50%	✓	50%	
Rx Tier 4	50%	✓	50%	
Emergency Room Visit	$350	✓	$500	
Inpatient Hospital Stay	40%	✓	40%	
Other Service:				
Other Service:				
Health Care Providers	**In Network/Covered?**		**In Network/Covered?**	
Provider/Rx: **Dr. Jean Go**	×		✓	
Provider/Rx: **Jacksonville Memorial**	×		✓	
Provider/Rx: **Advair 14 0.1mg/0.05**	×		Yes (Tier 2)	

SCENARIO 3: Rodriguez Family

	Plan 1				Plan 2	
Insurance company	Molina Marketplace				Florida Blue HMO	
Health plan name	Molina Marketplace Bronze				MyBlue Silver 160B	
Metal level/Network Type	Bronze HMO		**Annual Cost**	**Annual Cost**	Silver HMO	
Monthly premium *(after tax credit)*	$44.41		$533	$2,143	$207.47	
Deductible (in-network/out-of-network)	$13,300				$0	
OOP Maximum (in-network/out-of-network)	$14,300				$4,500	
Copay	**Deductible applies?**				**Deductible applies?**	
Primary Care Provider	$35		$175	$10	$2	
Specialist Visit	$80	✓	$750	$75	$15	
Rx Tier 1	$33				$10	
Rx Tier 2	$65	✓	$1,050	$135	$45	
Rx Tier 3	50%	✓			50%	
Rx Tier 4	50%	✓			50%	
Emergency Room Visit	$350	✓			$500	
Inpatient Hospital Stay	40%	✓	$5,000	$2,000	40%	
Other Service:						
Other Service:						
	twork/Covered?		**$7,508**	**$4,363**	**In Network/Covered?**	
	×				✓	
	×				✓	
	×				Yes (Tier 2)	

5 primary care visits ($100 each)
5 specialist visits ($150 each)
3 prescriptions ($350 each)
1 hospital stay for surgery ($5000 bill)

SCENARIO 3: Rodriguez Family

Identifying Jim and Michelle's priorities:

- Cheapest monthly payment?
- Manageable deductible/copays
- Having "first dollar" coverage? (i.e. some services exempt from the deductible)?
- Current doctor in network?
- Prescription drug(s) covered/cost?
- Best plan for health needs/condition?
- Hospital or facility in network?
- Lowest annual OOP cost (premiums + estimated cost-sharing)

Q & A Session 2

The Right Fit: Evaluation

https://tinyurl.com/PlanSelectionPresentationEval

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/PlanSelectionPresentationEval

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/PlanSelectionPresentationEval

The Right Fit: Evaluation

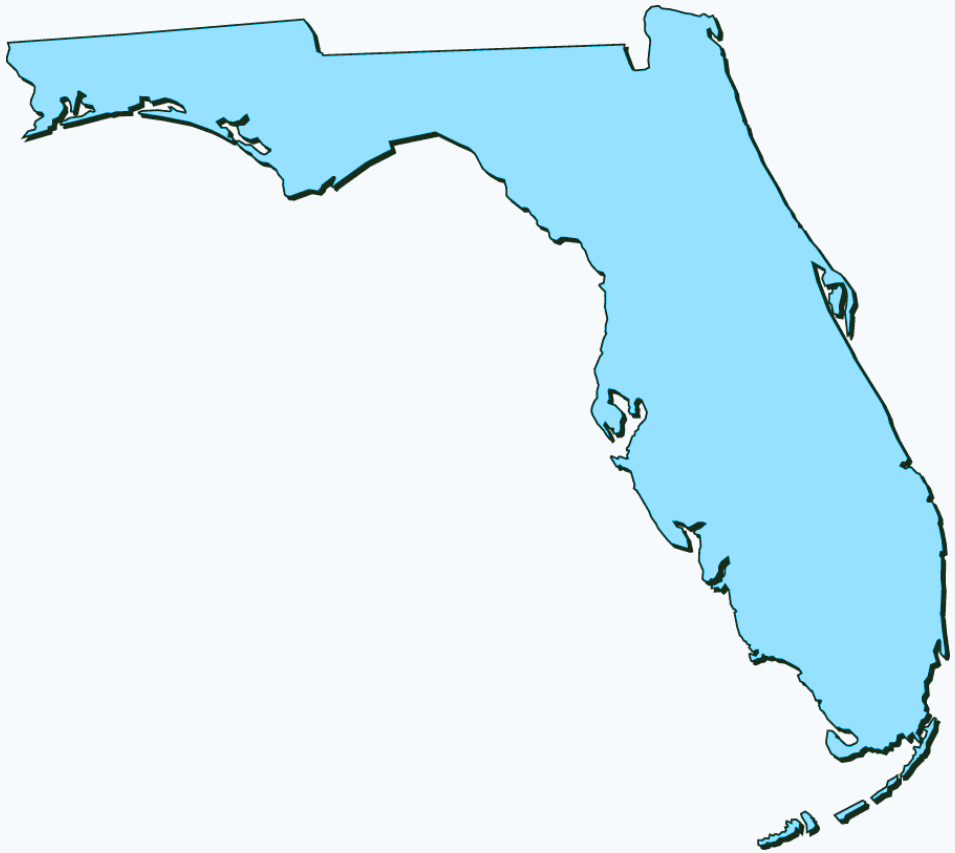
Q3: What plan selection topics do you think were missing and should be added to the presentation?

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/PlanSelectionPresentationEval

GOOD LUCK IN OEP 5!!!



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