Welcome!
Cover Arizona
Enrollment Assister Training

Open Enrollment 7

Welcome and Introductions
Arizona Department of Insurance
Topics:

- Arizona’s 2020 Individual Marketplace
- When & how to submit Complaints to ADOI
- Non-ACA products
- Renewing Navigator/CAC license with ADOI
Who’s in the Individual Market?

- Overall, rates in 2020 are **holding steady or decreasing** for the **five insurers** that will continue to offer Individual HMO plans in Arizona.
- ADOI is not yet at liberty to disclose which insurers are going to be in which counties.
- Health Insurance Rates FAQ on ADOI website

Marketplace Plans and Rates:

- We’ll publish plans by insurer, county and metal level in mid-October here:
  https://insurance.az.gov/consumers/help-health-insurance/information-about-health-insurance-rate-increases

- Look up the actual approved policy or the actual rate filings, using the SERFF tracking number in the charts above here:
  https://insurance.az.gov/sfa
Marketplace Questions?
Filing a Complaint

Examples of complaints to the ADOI related to health insurance:

- Delayed Claims
  - Denied claims disputes should be "appealed" to health insurer: [https://insurance.az.gov/complaint/health/appeal](https://insurance.az.gov/complaint/health/appeal)

- Access to care difficulties

- Deductible/cost-share Issues

- Balance or Surprise Billing
  - New dispute resolution process available for some surprise bill situations: Learn more at [https://insurance.az.gov/soonbdr](https://insurance.az.gov/soonbdr)

- Agent misrepresented the insurance or stole premium

Note: Consumer are urged to try to resolve complaints directly with their insurer; if unable to resolve, contact ADOI!
Who can submit a complaint to ADOI:

✓ Policyholders/Dependents
✓ Employees
✓ Claimants
✓ Authorized representatives
Reasons to complain to ADOI:

- Termination of coverage by the insurer
- Premium payments problems
- Cost-share issues: co-payments, deductibles
- Continuity of care
- Provider network adequacy
  - e.g., access to specialty care, such as Mental Health
- Provider Directory errors
- Agent misrepresentation or misappropriation

more...
ADOI Complaints Continued...

- Not providing Essential Health Benefits
- Qualified life event, e.g., *adding newborn*
- Claim problems
  - Insurer not processing claims per policy terms
- Refund Issues
  - Insurer fails to issue refund per Marketplace instruction or consumer request
When to complain to the Marketplace:

- Marketplace eligibility
- Special Enrollment Period (SEP) eligibility
- Premium tax credit and CSR eligibility
- Requests for cancellation of Marketplace coverage
  - If plan sold through marketplace, requests to cancel or make changes must be made through marketplace
- Refund Requests
  - Must be initiated with marketplace if plan sold through marketplace
- Requests for effective date changes
- Minimum Loss Ratio (MLR) Rebates
How to file a Complaint with ADOI:

https://insurance.az.gov/consumers/help-problem

- When filing a complaint on behalf of someone, submit a signed 3rd party authorization form:
  
Non-ACA insurance products:

- Pre-ACA plans (2013 and before)
- Limited benefit or “package” plans
- Short term limited duration plans (STP or STLD)
- “Association Plans”
Short Term Limited Duration Plans

[45 CFR § 144.103]

“This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. Also, this coverage is not ‘‘minimum essential coverage.’’
Navigator/CAC Licenses

Your license number is your National Producer Number (NPN).

- Renewing Navigator/CAC license with ADOI
  - Renew licenses at [www.nipr.com](http://www.nipr.com)
  - $5 transaction fee
  - After application is submitted to NIPR, email copy of your most recent Marketplace Training Certificate to [licensing@azinsurance.gov](mailto:licensing@azinsurance.gov). Reference the NIPR transaction number in the email.

- ADOI licensing webpage: [https://insurance.az.gov/producers/](http://https://insurance.az.gov/producers/)
Break

10 MIN
2019 Cover Arizona Scenario Workshop

Presenters: Livby Pearson & Claudia Maldonado
WE'RE BACK!!!
Kenia and Marcos are married and have three children. Pedro is 5 years old, Jose is 2 and Brenda just turned one. All three children require health care coverage. Marcos also has twins from his previous marriage who live with him 50 percent of the time. The mother of the twins will be claiming both of them on her income tax return for this year. Marco is self-employed and earned at net income of $57,562.
Case Scenario #1

Who will qualify for KidsCare?

A. Pedro and Jose
B. The twins
C. Pedro, Jose and Brenda
D. None of the above
Case Scenario #2

Angelina is a single mother of three children. Angelina works for a modeling agency and earns $2,950 every two weeks. Currently, Angelina and her children have insurance through her employer. She recently gained temporary custody of her two nephews Brian and Henry. Angelina is not sure whether she should add her two nephews to her insurance or if they will qualify for AHCCCS. Brian and Henry will not be claimed as dependents on her taxes.
Case Scenario #2

Who is eligible for AHCCCS

A. Angelina
B. Brian and Angelina
C. Brian and Henry
D. Non
Case Scenario #2

Angelina’s income is counted towards her nephews.

A. True
B. False
Case Scenario #3

Zack is 27 years old and a part-time firefighter who recently moved from Yuma to Phoenix. It is outside the Open Enrollment period and he wants to apply for the Marketplace. His gross income is $25,000 per year. He did not have qualifying health insurance in Yuma, but realizes that he might be able to get insurance because of his recent move.
Case Scenario #3

Does Zack qualify for an SEP in Phoenix?

A. Yes, he recently moved from Yuma County to Maricopa County.
B. Yes, his income increased.
C. No, he did not have qualifying health coverage and will not receive an SEP.
Case Scenario #3

CMS guidelines require that a consumer must have qualifying health coverage for how many days to receive a SEP?

A. 1 out of 60 days
B. 10 out of 90 days
C. 18 out of 45 days
D. Every day for 60 days
Frank is married to Sophia who is four months pregnant. They have three common children Mario (6 yrs.), Luigi (4 yrs.) and Bowser (2 yrs.). Frank has two children from his previous marriage that he claims on his tax return, Amber (11 yrs.) and Sally (10 yrs.). Frank’s children do not live in the household. They live with their mother and are insured through her. Frank is self-employed and earns $5,500 a month from his tile company. Frank would like to know how he can insure his wife and their children.
Case Scenario #4

Who is eligible for KidsCare?

A. All the children
B. Mario, Luigi, Bowser
C. Amber and Sally
D. None of the above
Case Scenario #4

Who is eligible for AHCCCS?

A. Amber and Sally
B. Sophia
C. Mario, Luigi, and Bowser
D. None of the above
Case Scenario #4

Who is eligible for the Marketplace? (Select all that apply)

A. Frank
B. Sophia
C. Mario, Luigi and Bowser
Case Scenario #5

Mary and Sam are married and have coverage through the Marketplace. Sam will be turning 65 in April and will be eligible for Medicare. Mary who is 62 will still need health coverage through the Marketplace. Sam needs to report that his Medicare Part A & B coverage will start on April 1, but he is not sure when he needs to inform the Marketplace.
Case Scenario #5

When should Sam report to the Marketplace that he is now eligible for Medicare Part B?

A. 30 days after new coverage starts
B. No need to let the Marketplace know
C. At least 14 days before you want the coverage to end
D. None of the above
Case Scenario #5

Medicare Part A counts as minimum essential coverage.

A. True
B. False
Case Scenario #6

Tom is a former employee of Hexcel LLC, but now receives long-term disability payments of $2,000 per month gross. He is enrolled in a COBRA plan that his former employer subsidizes. Tom pays $150 per month. He received a letter stating that his former employer will no longer be paying the subsidy for his COBRA plan. His plan will now be $560 per month. It is outside the Open Enrollment period and Tom is looking for assistance to enroll in new health coverage.
Case Scenario #6

Tom qualifies for a Special Enrollment Period (SEP) from Healthcare.gov.

A. True
B. False
Case Scenario #6

What special enrollment period status would he qualify under?

A. Loss of coverage
B. Medicaid Denial
C. Affordability
Case Scenario #6

Would he qualify for Advanced Premium Tax Credits (APTC)?

A. No, Tom will not receive APTC because he is enrolled in COBRA.
B. Yes, Tom’s former employer stopped contributing to his COBRA coverage, requiring him to pay the full cost.
C. No, Tom only qualifies for APTC during Open Enrollment.
Case Scenario #7

Jane has two children, Chris and Tony. Jane’s gross income is $2,500 per month. She applied for KidsCare in August and the kids were approved. Tony had a severe asthma attack and was hospitalized in June. Jane wants to have the outstanding hospital bill covered because neither child had health insurance at that time.
Case Scenario #7

Will KidsCare cover Tony’s hospital bill?

A. Yes, KidsCare is retroactive.
B. Yes, Tony has severe asthma and did not have coverage.
C. No, KidsCare is prospective and not retroactive.
Case Scenario #7

**Bonus question:** How do you make a KidsCare payment?
Case Scenario #8

Andres is a Lawful Permanent Resident of six years who is married to Amy who currently has an employment authorization card. They have three children. Antonio is 15 years old and currently under Deferred Action for Childhood Arrival (DACA), Manny who is an undocumented immigrant and is 12 years old, and Sara who is a U.S. citizen and is 2 years old. Amy is currently looking for employment and Andres is the sole provider for the family. Andres is a plumber and earns $3,000 a month in gross income.
Case Scenario #8

Who is eligible for full coverage from AHCCCS?

A. Andres and Sara
B. The entire household
C. Antonio, Manny, and Sara
D. Andres and Amy
Case Scenario #8

Who is eligible for Federal Emergency Services (FES) though AHCCCS?

A. Andres and Manny
B. Amy, Sara and Antonio
C. Amy, Antonio and Manny
D. None of the above
Case Scenario #8

Who is eligible for Marketplace?

A. Andres and Amy
B. Amy
C. The entire household
D. Antonio, Manny, and Sara
Blaine has been receiving SSDI in the amount of $1,500 a month since January 1, 2019. Blaine’s AHCCCS coverage was terminated on January 31, 2019 for being over income. Blaine states that he was not worried because he knew that he would go into Medicare. Blaine has been feeling sick and went to see a doctor but when he got to his appointment he was charged $85. Blaine requested an explanation and was informed that his AHCCCS coverage had ended and he had no other health insurance. Blaine comes into your office on May 10, 2019 because he was under the impression that because he has been receiving SSDI he automatically qualifies for Medicare. He wants you to help him understand why he’s paying for his medication and doctor visits.
Case Scenario #9

Is Blaine eligible for Medicare?

A. Yes
B. No
Case Scenario #9

Does Blaine qualify for an SEP?

A. Yes
B. No
Case Scenario #9

What would you do next? Select all that apply.

A. Explain to Blaine when he would be eligible for Medicaid.
B. Provide him with the HealthCare.gov list of Brokers.
C. Give Blaine the information to a SHIP Counselor for Medicare.
D. Submit an application for Marketplace and Medicaid.
E. Provide the dates for OE7
Case Scenario #10

Edgar is 63 years old and retired. Edgar made an appointment during Open Enrollment to see a Navigator because he wanted assistance in reviewing his health coverage options. Edgar was previously covered under AHCCCS health insurance, but became ineligible due to a change in his income. Edgar currently receives $1,400 from Social Security and receives a monthly disbursement of $2,000 from his 401k. Edgar is not sure if he’ll qualify for subsidies through the Marketplace.
Case Scenario #10

Is Edgar eligible to enroll in the Marketplace?

A. Yes
B. No
Case Scenario #10

Edgar does not have to report the money he is retrieving from his 401k.

A. True
B. False
Case Scenario #11

Alisa and Mike are married with three kids. Alisa is a DACA recipient and her husband Mike is a Legal Permanent Resident of four years. They have two common children Nancy (6 years old) and Melissa (7 years old) who are both U.S citizens. Tony, the oldest of the three is 10 years old and a U.S citizen. Tony is from Mike’s previous relationship. Mike receives $500 a month in child support for Tony’s care. Mike is the sole provider of the family and earns $3,900 a month in gross income. Mike and Alisa plan on filing their taxes jointly and will claim all three children as dependents. They make an appointment to see if they can apply for AHCCCS.
Case Scenario #11

Do you include the $500 from child support in their application?

A. Yes
B. No
Case Scenario #11

Who is potentially eligible for KidsCare?

A. Nancy, Melissa and Tony
B. Nancy and Melissa
C. No one
Case Scenario #11

Alisa and Mike can apply for coverage through the Marketplace.

A. True  
B. False
Case Scenario #12

Diane, a 25 year-old college student, is self-employed. She grosses $42,000 per year, but her net income is $23,000 per year. She is also part of the Hopi tribe and sells her Native American art and grosses an additional $5,000 per year. She wants to apply for health insurance outside the Open Enrollment period. Please answer the following questions.
Case Scenario #12

Is Diane able to enroll in health insurance outside the Open Enrollment period?

A. Yes  
B. No
Case Scenario #12

When you are completing Diane’s application should you count her income from selling Native American art as part of her income?

A. Yes
B. No
Case Scenario #13

Denise, her husband, and her two children have coverage through the Marketplace. Denise was laid off from work and needed to report a change in her application. Her husband was now the sole provider and is working at the same company as a contractor. This was their first time reporting a change and wanted to know what steps to take. Denise also wanted to know how their premium would be affected. Denise submitted her change on April 1st. Denise wasn't happy with the eligibility results, she expected her premium to be less now that there was only one income in the household.
Case Scenario #13

Where can Denise report a change for her Marketplace application?

A. Marketplace Call Center
B. Healthcare.gov
C. In person assister (Navigator/CAC)
D. All of the above
Case Scenario #13

How long does Denise have to submit an eligibility appeal?

A. 60 Days
B. 90 Days
C. 120 Days
Case Scenario #13

How long does the Marketplace have to make a determination on Denise’s appeal?

A. 30 days
B. 60 days
C. 90 days
Case Scenario #14

Melanie is an undocumented immigrant who sells tamales to support her family. She earns $3,900 per month. Melanie has three children, Natalie 17 years old, who has a DACA status, Liliana 16 years old who is a Lawful Permanent Resident of three years. Natalie works at a local restaurant earning $150 twice a month. Melanie just had her third child, a boy named Derek. Melanie will receive an additional income from child support of $25 per week for just her newborn. Melanie needs to apply for coverage for her three children.
Case Scenario #14

Who will qualify for KidsCare?

A. Derek
B. Natalie and Derek
C. Natalie, Liliana and Derek
D. None of the above
Case Scenario #14

Liliana is not eligible to go to the Marketplace.

A. True
B. False
Case Scenario #15

John (Hopi) is married to Mary who is not native. They have three kids together, aged 6, 12, and 19, each enrolled with the Hopi tribe. They receive their primary care from the Hopi Indian Health Services and are uninsured. While playing outside, their youngest child Billy hit his head and became unconscious. John and Mary rush Billy to the Hopi Health Facility to treat Billy’s injury. His injury was too severe for Hopi IHS to treat due to the lack of resources. Hopi health providers recommended that Billy be transferred to an off-reservation facility for specialized treatment that they cannot provide. John does not feel comfortable with Billy being transferred to an off-reservation health facility because he fears the cost of treatment and trusts the Hopi providers he usually sees for his family’s health care needs.
Case Scenario #15

IHS does not meet the requirement of Minimum Essential Coverage?

A. True
B. False
Case Scenario #15

What options do John and his children have for healthcare coverage?

A. AHCCCS
B. Marketplace
C. File an exemption
D. All of the above
Case Scenario #15

Tribal Members have year round enrollment through Healthcare.gov. Does this apply to Mary?

A. Yes
B. No
Case Scenario #16

Ben and his wife Andrea come into the office on September 10, 2019 seeking help with their health insurance options. They had previously submitted a Marketplace application and were determined AHCCCS eligible. Ben doesn’t understand why they would be sent to AHCCCS when their coverage ended on August 31, 2019 when he started receiving his SSDI in the amount of $1,900 a month. Since he was confused he decided not to continue with the application. Ben also explained that Andrea is pregnant and only receives $1,000 a month in SSI.
Case Scenario #16

What are your next steps with Ben and Andrea? Select all that apply

A. Submit an application for AHCCCS like Marketplace asked.
B. Tell them there’s nothing you can do and that AHCCCS and the Marketplace will have to sort it out.
C. Explain to Ben that the SSI income his wife is receiving is not countable income for Marketplace which is why the Marketplace determined them AHCCCS eligible.
D. Inform Ben that you will help him review the application and upload the AHCCCS denial letter.
Case Scenario #16

Is Andrea potentially eligible for AHCCCS?

A. Yes
B. No
Case Scenario #17

Brad and Carrie are married and file taxes together. Brad is the sole provider of the household and is projected to make a gross income of $60,000 for 2019. Brad is offered employer sponsored insurance for him and his wife but he is not sure if he can afford it. He only has a couple more weeks until his employer’s open enrollment ends. Brad and Carrie are curious about what other options they may have so they make an appointment with a Navigator during the Marketplace Open Enrollment period. Brad brings the Employer Coverage Tool to his appointment. Brad’s employee only premium is $150 per month. If he adds his wife he’ll have to pay $700 a month.
Case Scenario #17

What percentage of the household annual income goes towards the employer sponsored insurance premium?

A. 3%
B. 14%
C. 25%
D. 2%
Case Scenario #17

How do you assist Brad and Carrie with their next steps? Select all that apply

A. You do nothing.
B. You submit the Marketplace application, view the plans and tell them that the QHP’s in the Marketplace are the better option.
C. You explain the affordability guidelines and its impact on subsidy eligibility.
D. You take them through the application and compare the Marketplace QHP’s with Brad’s employer sponsored insurance.
Case Scenario #17

What is the affordability threshold for 2019?

A. 10.1%
B. 9.75%
C. 8.96%
D. 9.86%
Case Scenario #18

On September 2, 2019 Jennifer comes into your office seeking health insurance for her family. Jennifer is a Lawful Permanent Resident of six years and is married to Marc who is a U.S citizen. They have two children. A three year old named Raul and eight year old name Rafaela. Both children are U.S citizens. Jennifer and Marc file taxes together and claim both children as dependents. Jennifer and Marc’s tax return for 2018 reflected a net income of $33,000 from her business. On August 28, 2019 Marc and Rafaela had to be hospitalized due to severe stomach pains. Jennifer is very worried about how she is going to pay for the hospital bills and asks for help.
Case Scenario #17

What programs is the family potentially eligible for?

A. AHCCCS
B. KidsCare
C. Marketplace
D. None of the above
Case Scenario #18

Are Marc and Rafaela eligible for prior quarter coverage?

A. Yes, based on their income and family size they are potentially eligible for prior quarter coverage.
B. No, only Marc would qualify for prior quarters.
C. Yes, because they had an emergency.
D. No, only Rafaela is potentially eligible for prior quarters because she is under the age of 19.
Nicolas and his family go for assistance to one of the Volunteer Income Tax Assistance (VITA) sites to file their taxes for the year. Nicolas, his wife, and his son had coverage through the Marketplace. The family received financial assistance that included APTC’s and CSR’s to help lower their premiums and out of pocket costs.
Case Scenario #19

Will Nicolas and his family have to do tax reconciliation?

A. Yes
B. No
Case Scenario #19

What will Nicolas have to reconcile?

A. APTC
B. CSR
C. A and B
D. None
Case Scenario #19

What forms will Nicolas need to do tax reconciliation?

A. 1095-A and 8962
B. 1095-B and 8962
C. 1095-C
D. None of the above
Case Scenario #20

Rosemary and Dominic are domestic partners and U.S. Citizens. Rosemary and Dominic have been living together in Arizona for the last five years. They file their taxes separately. They have two children: Mia, 5 years old, and Donovan, 2 years old. Dominic claims both children as dependents on his tax returns. Dominic works as a manager at a restaurant and earns $40,000 annually. Rosemary runs a child care service on her own (she has no employees) and earns $19,000 annually.
Case Scenario #20

How should Rosemary and Dominic apply for Marketplace health coverage?

A. Submit one application: List Dominic as an applicant and applying for coverage for Mia, and Donovan, and include Rosemary as a tax filer.
B. Submit one application: Rosemary is the applicant filer and applying for coverage for Dominic, Mia and Donovan.
C. Submit two applications: One application with Dominic as the application filer and applying for coverage for himself, Mia, and Donovan; include Rosemary as a non-applicant. One application with Rosemary as the application filer and applying for coverage; include Dominic, Mia, and Donovan as non-applicants.
D. None of the above
Case Scenario #20

Are Rosemary and Dominic both eligible for financial assistance to make health coverage more affordable?

A. No. Based on their incomes and respective household sizes, only the applicant who has tax dependents and applying for coverage for them should qualify for advance payments of the premium tax credit (APTC) because, assuming they meet all other eligibility criteria, their incomes are between 100% to 400% of the federal poverty level, and they aren’t eligible for Medicaid or the Children’s Health Insurance Program (CHIP).

B. Yes. Based on their incomes and respective household sizes, both Rosemary and Dominic could potentially qualify for advance premium tax credits (APTC) because, assuming they meet all other eligibility criteria, their incomes are between 100% to 400% of the federal poverty level, and they aren’t eligible for Medicaid or the Children’s Health Insurance Program (CHIP).

C. None of the above
Case Scenario #21

Juan and his wife Alejandra come in to your office to apply for Marketplace Health Insurance for their family. They have two daughters: Brittany (8 yrs) and Sofia (13 yrs) U.S. citizens. Juan is self employed and projected his income will be $29,000 in 2019, which is $10,000 less than 2018. Alejandra receives SSDI of $1650 monthly (not Medicare eligible); and Brittany receives SSI of $733 monthly. Juan and his wife will file taxes and claiming both of their daughters as dependents. During the process, Juan decided to apply for health coverage for himself, Alejandra, and Sofia. After Juan chooses a health plan the Marketplace is now requesting income verification.
Case Scenario #21

Whose income is the Marketplace requesting verification from?

A. Juan and Brittany
B. Juan, Alejandra, and Sofia
C. Juan and Alejandra
D. Juan
Case Scenario #21

Juan provides his 1040 tax forms for 2018, and other income verification. What other supportive document MUST Juan provide to the Marketplace?

A. Verification of residence
B. An explanation of any income discrepancies
C. Verification of Brittany’s SSI
D. No more is needed
Case Scenario #21

Does the Navigator include Brittany in the application, including her SSI payments?

A. Yes, Include everyone and all income.
B. Yes, but not her SSI payments.
C. No, because they are not applying for her.
D. Yes, only if Juan applies for her in his application.
Case Scenario #22

Ross comes into your office to apply for AHCCCS for his girlfriend Rachel and her children Monica and Chandler. During the interview, Ross explains that he works the third shift at Elite Warehouse earning a total of $1,200 a month. Rachel works the first shift at Elite Warehouse and earns the gross amount of $1,500 a month. Rachel also receives $100 a week in child support for the care of Monica and Chandler. Rachel works during the morning and has asked Ross to go in and apply for her. Ross states that even when they lived in New Mexico he was the one submitting the application. Ross has all the required documentation and is asking you to help him apply.
Case Scenario #22

What would be the best course of action?

A. **Submit the application** - Since he has all the documents with him he must be telling the truth.

B. **Reschedule the appointment** - Provide him with an Authorized Representative form and ask him to schedule another appointment to apply on Rachel and her children’s behalf.

C. **Submit the application** - Give him the forms after and ask him to bring it back to you at a different time.

D. **Submit an application and schedule another appointment** - Let him know that you can submit an application for him but will need to schedule another appointment to apply on Rachel and her children’s behalf. You provide him with the Authorized Representative form that needs to be filled out by Rachel.
Case Scenario #22

Who can be an Authorized Representative? Select all that apply.

A. Neighbor
B. Family member
C. Partner
D. Assistor Organization
E. All of the above
Case Scenario #23

Kassandra and Oscar are married and have a blended family. They each have a child from a previous relationship as well as one child from their current marriage. Oscar and Kassandra moved to Arizona five weeks ago and lost their employer sponsored coverage. Kassandra started a part time job as a waitress in a local restaurant earning $2,800 a month before taxes. Kassandra is also receiving $400 in child support from her ex-husband. Oscar works at Amazon earning a monthly gross amount of $3,000. Kassandra and Oscar plan to file 2019 taxes as married filing jointly and claiming all the children as dependents.
Case Scenario #23

Who is eligible to enroll in the Marketplace?

A. Kassandra and Oscar  
B. Only common children  
C. Step-children  
D. The entire household
Case Scenario #23

What SEP does family qualify under?

A. Change in household
B. Change in residency
C. Change in income
D. All of the above
Case Scenario #24

Lisa is 19 years old and attends Northern Arizona University on a full time basis. Every summer, Lisa comes back to Phoenix to stay with her parents and two younger siblings. Lisa’s parents claim her as a dependent on their taxes. They recently received their renewal letter from Health-e-Arizona Plus and are unsure of what to do. They schedule an appointment with an Assistor.
Case Scenario #24

Should Lisa still be included on their renewal application?

A. Yes, because her parents claim her as a dependent.
B. No, because she is attending college on a full time basis.
Case Scenario #24

Lisa’s parents need to obtain an Authorized Representative form in order for them to apply on her behalf.

A. True
B. False
Case Scenario #25

Tanya and Sean are married and have coverage through the Marketplace. They have a silver plan and are receiving APTCs and CSR. Tanya will be turning 65 on November 2nd of this year. Tanya makes an appointment with a Navigator to discuss the upcoming changes. Tanya explains that she spoke with a community representative at a health fair who stated that she can have both Marketplace and Medicare as long as she does not take Medicare Part B. Tanya knows that she will receive part A starting November 1, 2019 because she earned sufficient credits. Her husband who is 63 years old will continue to have coverage through the Marketplace but is also considering having Medicare and Marketplace coverage.
Case Scenario #25

Medicare part A counts as minimum essential coverage.

A. True
B. False
Case Scenario #25

If Tanya decides to keep her Marketplace coverage will she still be eligible to receive subsidies as long as she waives Medicare Part A and B.

A. Yes
B. No
CONGRATULATIONS
YOU DID IT!
Family Photo & Lunch
AHCCCS Updates
Who We Are

A managed care system that mainstreams recipients, allows members to select their providers, and encourages quality care and preventive services.

- Largest Insurer in AZ
  Covers 1.9 million individuals and families

- Covers 50% Of all Births

- Covers 2/3 of nursing facility days

- AHCCCS uses federal, state, and county funds to provide health care coverage to the State’s Acute and Long-Term Care Medicaid populations.

- $14,500,000+ Program

- 87,906 Registered Healthcare Providers

- Payments are made to 15 contracted health plans, known as Managed Care Organizations (MCOs), responsible for the delivery of care to members.

Reaching across Arizona to provide comprehensive quality health care for those in need.
Empower yourself... ONE-PAGERS

Info at a Glance
Download and print these handy one-page fliers to help you navigate behavioral health care needs and advocate for you and your family.

**Your Health Care Rights**
You have a voice and a choice in your health care decisions. Learn how to be your own advocate.
- No Wait Lists
- You Have a Voice and Choice
- Sharing Health Information With Family and Friends Of Adult Members
- Services for AHCCCS Members Without a Serious Mental Illness
- Hospital Discharge Plan
- Standards Appointment Availability

**Foster Care, Kinship and Adoptive Families**
If you are a foster parent or kinship/adoptive caregiver, learn more about your health care choices.
- Foster Caregiver FAQs - English
- Spanish
- Crisis Services for Children in Foster Care Bilingual
- BHS Children in Foster Care Bilingual

**Peer and Family-Run Organizations**
Familiarize yourself with the family support services available to you from family-run organizations.
- Family-run Organizations
- Peer and Family-Run Organizations

There are more than this but this just gives a glance...
You can also sign up for OIFA’s weekly newsletter

Office of Individual and Family Affairs
Subscribe to our Friday Newsletter
Timeline for Integration

Reaching across Arizona to provide comprehensive quality health care for those in need
More changes to come....
AHCCCS Contract Timeline

**2016**
- 10/16: Release ALTCS RFP

**2017**
- 3/17: Award ALTCS
- 10/1/17: Transition ALTCS

**2018**
- 4/1/18: Award DDD Acute/BH
- 10/1/19: DDD Acute/BH

**2019**
- 9/30/21: 5 years Greater AZ Mercy Care RBHA Contract Expires

**2020**
- 10/1/20: CMDP Integrated Care

**2021**
- 10/1/21: Expanded ACC Contracts with RBHA Services
RBHA Services Transfer RFI

Requests for Information (RFIs)

YH13-0084 RBHA Services Transfer

- Due Date: March 14, 2019, 3:00 P.M. Arizona Time
- Deadline for Questions: February 21, 2019 5:00 P.M. Arizona Time
- Notice of Request for Information
  - Questions and Answers Form
  - Solicitation Amendment 1
  - Appendix
  - Revised Appendix 3/8/19
  - Solicitation Amendment 2
What is an RFI?

- A request for information allows AHCCCS to engage stakeholders and gain feedback on a path forward continuing the journey of integrated health care in Arizona.
- Responding to an RFI allows you the chance to inform AHCCCS of opinions and matters to be considered in next steps.
Current status with RBHA services

Regional Behavioral Health Authorities (RBHAs) currently continue to provide and serve:

- Foster children enrolled in CMDP
- Members enrolled with DES/DD;
- Individuals determined to have a serious mental illness (SMI)
- Crisis services, grant funded, and state-only funded services
  - Populations:
    - Northern GSA Enrollment 5,725
    - Central GSA Enrollment 21,597
    - South GSA Enrollment 13,352
Note: Zip codes 85542, 85192, 85550 representing San Carlos Tribal area are included in the South GSA.
Next steps

- In ACC RFP it announced AHCCCS sole discretion to allow at least one ACC plan in each GSA to expand services to those served by a RBHA
- No sooner than 10-1-20
SMI Specific Responsibilities

• What should AHCCCS consider to maintain focus on the needs of individuals with an SMI as the responsibilities are blended within one plan?
Telehealth Policy

Out for public comment
Telehealth

• Revision to telehealth policy scheduled for 10/1/19
  o Broadening of POS allowable for distant and originating sites (including home)
  o Broadening of disciplines able to offer telehealth services, generally, to any AHCCCS enrolled provider
  o Broadening of coverage for telemedicine (real time, remote patient monitoring)
  o No rural vs. metro limitations
  o MCOs retain their ability to manage network and leverage telehealth strategies as they determine appropriate
What is a Waiver and State Plan?
1115 Waiver & State Plan Overview

• States have flexibility in designing the their Medicaid program, and they can change aspects of their program at any time

• However, states must apply for and receive approval from the Centers for Medicare and Medicaid Services (CMS) before making changes to the program

• Two ways a state can go about changing their program:
  o A State Plan Amendment (SPA)
  o A Waiver
# State Plan & 1115 Waiver Comparison

<table>
<thead>
<tr>
<th></th>
<th>State Plan Amendment</th>
<th>1115 Waiver</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Submission to CMS</strong></td>
<td>Proposed changes to Medicaid State Plan. Changes must comply with federal Medicaid requirements.</td>
<td>Formal request to have certain federal Medicaid requirements waived</td>
</tr>
<tr>
<td><strong>What States Can Request</strong></td>
<td>Can address any aspect of Medicaid program administration—e.g. eligibility, benefits, services, provider payments, etc.</td>
<td>Seek changes that cannot be implemented through state plan amendments.</td>
</tr>
<tr>
<td><strong>Budget Requirements</strong></td>
<td>No cost or budget requirements</td>
<td>Cost neutral to the federal government</td>
</tr>
<tr>
<td><strong>Approval Process</strong></td>
<td>90 day clock that can be suspended if CMS request information from state.</td>
<td>Approval process includes robust public notice process and extensive negotiations with CMS.</td>
</tr>
<tr>
<td><strong>Duration of Approval</strong></td>
<td>Permanent</td>
<td>Time limited. Must be renewed every 5-years.</td>
</tr>
</tbody>
</table>
Section 1115 Community Engagement Demonstration Implementation Plan
Background on Arizona’s CE Demonstration

2015
AZ statute enacted which required AHCCCS to request work requirements & 5-year lifetime limit for AHCCCS members

January - March 2017
AHCCCS Works Public Comment Period

December 19, 2017
AHCCCS Works Waiver submitted to CMS

2016

January 2018
Inception of AHCCCS Works Workgroups

April 2018
Expanded AHCCCS Works Workgroups

2017

January 18, 2019
CMS Approves AHCCCS Works

WAIVER NEGOTIATIONS
February 2018 – January 2019

Reaching across Arizona to provide comprehensive quality health care for those in need
Stakeholder Engagement and Education

- AHCCCS leveraged an in-house peer and family group as well as community-based organizations to obtain members’ perspective regarding critical aspects of the implementation plan.

- Staff also hosted several community and tribal specific forums around the state to obtain member and stakeholder perspective regarding implementation of CE requirements in their particular geographic area.
National Landscape: Community Engagement Waivers
AHCCCS Works Unique Program Features

• First in the nation to exempt members of federally recognized tribes

• First in the nation to allow members who are suspended to automatically re-enrolled at the expiration of the Suspension Period as long as they meet all other eligibility criteria
AHCCCS Works Requirements

• No sooner than **Summer 2020**, able-bodied adults* 19-49 who do not qualify for an exemption must, for at least 80 hours per month:
  o Be employed (including self-employment);
  o Actively seek employment;
  o Attend school (less than full time);
  o Participate in other employment readiness activities, i.e., job skills training, life skills training & health education;
  or
  o Engage in Community Service.

* Adults = SSA Group VIII expansion population, a.k.a, Adult group
Who is Exempt

- Members of federally recognized tribes
- Former Arizona foster youth up to age 26
- Members determined to have a serious mental illness (SMI)
- Members with a disability recognized under federal law and individuals receiving long term disability benefits
- Individuals who are homeless
- Individuals who receive assistance through SNAP, Cash Assistance or Unemployment Insurance or who participate in another AHCCCS-approved work program
- Pregnant women up to the 60th day post-pregnancy
- Members who are medically frail
- Caregivers who are responsible for the care of an individual with a disability
- Members who are in active treatment for a substance use disorder
- Members who have an acute medical condition
- Survivors of domestic violence
- Full-time high school, college, or trade school students
- Designated caretakers of a child under age 18
In this example, January represents the first month any new AHCCCS member is required to comply.
Reporting Requirement

• Must complete at least 80 hours of qualifying activities each month and report these hours by the 10th day of the following month

• Members will be allowed report AW activities through several methods including in a state portal, by phone, and in person
Reactivation of Eligibility During Suspension Period

- Member is automatically reinstated immediately following the 2 month suspension period
- Member who is suspended will have eligibility reactivated immediately during the suspension period if:
  - Member is found eligible for another eligibility category
  - Verifies that he or she currently qualifies for an AW exemption
AHCCCS Works Geographic Phase-in Recommendation

• Gradually phase-in AHCCCS Works program by geographic areas.

• If approved, the AW program will be implemented in three phases:
  
  o **Phase 1:** Most Urbanized Counties: Maricopa, Pima, and Yuma
  
  o **Phase 2:** Semi-Urbanized Counties: Cochise, Coconino, Mohave, Pinal, Santa Cruz, & Yavapai
  
  o **Phase 3:** Least Urbanized Counties: Apache, Gila, Graham, Greenlee, La Paz, & Navajo
Why:

• Need time to establish community engagement supports for members in regions with limited employment, educational and training opportunities, accessible transportation, and child care services.

• Phase-in approach will give the State time to assess the availability of community engagement resources in rural areas and address gaps.

• Counties with a higher percentage of urban populations are likely to have sufficient community engagement supports compared to counties with a higher percentage of rural populations.
## AHCCCS Works Geographic Phase-in Recommendation

<table>
<thead>
<tr>
<th>Counties</th>
<th>Percentage of the County Population Residing in Rural Areas as of the 2010 Census.</th>
<th>Percentage of AW Members Residing in the County</th>
<th>AW Implementation Phases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maricopa</td>
<td>2.4</td>
<td>56.9</td>
<td>Phase I</td>
</tr>
<tr>
<td>Pima</td>
<td>7.5</td>
<td>17.6</td>
<td>Phase I</td>
</tr>
<tr>
<td>Yuma</td>
<td>10.4</td>
<td>4.1</td>
<td>Phase I</td>
</tr>
<tr>
<td>Total Phase I</td>
<td>-</td>
<td><strong>78.6</strong></td>
<td></td>
</tr>
<tr>
<td>Pinal</td>
<td>21.9</td>
<td>4.7</td>
<td>Phase II</td>
</tr>
<tr>
<td>Mohave</td>
<td>23</td>
<td>5</td>
<td>Phase II</td>
</tr>
<tr>
<td>Santa Cruz</td>
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<td>1</td>
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<tr>
<td>Coconino</td>
<td>31.5</td>
<td>1.5</td>
<td>Phase II</td>
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<td>Yavapai</td>
<td>33.2</td>
<td>3.3</td>
<td>Phase II</td>
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<tr>
<td>Cochise</td>
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<td>Phase II</td>
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<tr>
<td>Total Phase II</td>
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<td><strong>18.1</strong></td>
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<tr>
<td>Gila</td>
<td>41.1</td>
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<td>Phase III</td>
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<tr>
<td>Graham</td>
<td>46.4</td>
<td>0.6</td>
<td>Phase III</td>
</tr>
<tr>
<td>Greenlee</td>
<td>46.6</td>
<td>0.1</td>
<td>Phase III</td>
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<tr>
<td>Navajo</td>
<td>54.1</td>
<td>1</td>
<td>Phase III</td>
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<tr>
<td>La Paz</td>
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<td>0.3</td>
<td>Phase III</td>
</tr>
<tr>
<td>Apache</td>
<td>74.1</td>
<td>0.4</td>
<td>Phase III</td>
</tr>
<tr>
<td>Total Phase III</td>
<td>-</td>
<td><strong>3.3</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Key:**
- < 20% Low Rural Population
- 40% - 20% Moderate Rural Population
- > 40% High Rural Population
Next Steps: AHCCCS Works

February 18, 2019
Waiver Acceptance Letter and Technical Corrections

July 17, 2019
Waiver Evaluation Design Plan

July 1, 2019
Implementation Plan

August 16, 2019
Monitoring Protocol

No sooner than Summer 2020
AHCCCS Works program begins

Reaching across Arizona to provide comprehensive quality health care for those in need
Implementation Plan

• Describes the state’s approach to implementing the AHCCCS Works program, including exemptions, coordination with other agencies, member protections, and outreach.
Evaluation Design Plan

- Specifies the state’s plan for evaluating the success of the AHCCCS Works and Retroactive Coverage Waivers
- The Evaluation Design Plan includes research questions, hypotheses, and proposed measures, and method for conducting evaluation.
- The Evaluation Design Plan must be developed by an independent party.
Monitoring Protocol

• Specifies the state’s plan for reporting required monitoring metrics and implementation updates to CMS.

• CMS will provide the state with a set of required metrics including:
  o Total members exempted from AHCCCS Works requirement in the month
  o Members with approved good cause circumstances
  o Total members whose benefits were reinstated after being in suspended status for non-compliance
Questions?

Reaching across Arizona to provide comprehensive quality health care for those in need
Your Marketplace
Insurance Companies
About Ambetter

• Ambetter health insurance plans are designed to deliver high quality, locally-based healthcare services to our members

• Established to deliver quality health insurance through local, regional and community-based resources, our Ambetter products are offered by the Centene Corporation. Centene is a Fortune 100 company with over 30 years in the managed care industry

• Ambetter is certified as a Qualified Health Plan issuer on the Health Insurance Marketplace
Local, Helpful, Affordable

• Local presence of the health plan – customer service by people that live and work in the community
• Easy to understand and helpful from enrollment through membership
• Ambetter helps our members navigate their healthcare
• Medical management programs
• Ambetter Telehealth
• My Health Pays
Plan Design Philosophy

- Focus on offering plans with affordable premiums that will also keep your clients out of pocket costs down
- Maximize cost sharing reductions; Low deductible and copays
- Ambetter’s exclusive provider network has strong discounts with select providers
Arizona Complete Health Plan

• **Focus on individuals:** We believe treating people with kindness, respect and dignity empowers healthy decisions and that healthier individuals create more vibrant families and communities

• **Whole health:** We believe in treating the whole person, not just the physical body

• **Active local involvement:** We believe local partnerships enable meaningful, accessible healthcare with local provider relations, medical management and member services staff
2020 County Roster

Gila
Graham
Greenlee
Maricopa
Pima
Pinal
Santa Cruz
Plan Tiers

Essential Care
Bronze Plans
• Lower monthly premiums, with high deductibles

Secure Care
Gold Plans
• Higher monthly premiums, but comes with a low deductible

Balanced Care
Silver Plans
• Best balance of premium and out-of-pocket costs
  • Most office visits are covered by a copay
  • Available on all plan tiers

Advanced Premium Tax Credits
(Lower cost in Silver Plans)
• Easier to access, reduces monthly premiums
• Most office visits are covered by copay

Cost Sharing Reductions
(Greatest amount in Silver Plans)
• Only available on Balanced Care (Silver Plans)
# 2020 Portfolio Overview

## Product I
**Medical EHB**

<table>
<thead>
<tr>
<th>Secure Care (Gold)</th>
<th>Balanced Care (Silver)</th>
<th>Essential Care (Bronze)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC 5</td>
<td>BC 4 SC 5 BC 11 BC 12 BC 14 BC 15</td>
<td>EC 1 EC 2 HSA</td>
</tr>
<tr>
<td></td>
<td>BC 9</td>
<td></td>
</tr>
</tbody>
</table>

- **Deductible**: $0
- **Coverage**: 87% & 94%

## Product II
**Medical EHB**
**Plus Adult Vision**
**Plus Adult Dental**

<table>
<thead>
<tr>
<th>Secure Care (Gold)</th>
<th>Balanced Care (Silver)</th>
<th>Essential Care (Bronze)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SC 5</td>
<td>BC 4 SC 5 BC 11 BC 12 BC 14 BC 15</td>
<td>EC 1</td>
</tr>
<tr>
<td></td>
<td>BC 9</td>
<td></td>
</tr>
</tbody>
</table>

- **Deductible**: $0
- **Coverage**: 87% & 94%

*Bold outline denotes new plan for state*
### Essential Care 2 HSA (2020)

<table>
<thead>
<tr>
<th></th>
<th>Essential Care 2 HSA (2020)</th>
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</thead>
<tbody>
<tr>
<td><strong>Medical Deductible</strong></td>
<td>$6,750</td>
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<tr>
<td>Medical Coinsurance</td>
<td>0%</td>
</tr>
<tr>
<td>Rx Drug Deductible</td>
<td>INT</td>
</tr>
<tr>
<td>Rx Coinsurance</td>
<td>INT</td>
</tr>
<tr>
<td><strong>MOOP</strong></td>
<td>$6,750</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>NCAD</td>
</tr>
<tr>
<td>All Inpatient Hospital Services (inc. MHSA)</td>
<td>NCAD</td>
</tr>
</tbody>
</table>

### Essential Care 2 HSA (2020)

<table>
<thead>
<tr>
<th>Medical Deductible</th>
<th>MOOP</th>
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<tbody>
<tr>
<td>$6,750</td>
<td>$6,750</td>
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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Rehabilitative Speech Therapy</td>
<td>NCAD</td>
</tr>
<tr>
<td>Rehabilitative OT/PT</td>
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</tr>
<tr>
<td>Preventive Care/Screening/Immunization</td>
<td>No Charge</td>
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<tr>
<td>Labs</td>
<td>NCAD</td>
</tr>
<tr>
<td>X-rays and Diagnostic Imaging</td>
<td>NCAD</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>NCAD</td>
</tr>
<tr>
<td>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</td>
<td>NCAD</td>
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<tr>
<td>Outpatient Surgery Physician/Surgical Services</td>
<td>NCAD</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Essential Care 2 HSA (2020)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generics</td>
<td>NCAD</td>
</tr>
<tr>
<td>Preferred Brand Drugs</td>
<td>NCAD</td>
</tr>
<tr>
<td>Non-Preferred Brand Drugs</td>
<td>NCAD</td>
</tr>
<tr>
<td>Specialty Drugs (i.e. high-cost)</td>
<td>NCAD</td>
</tr>
</tbody>
</table>
## Balanced Care 11 (2020)

<table>
<thead>
<tr>
<th>Medical Deductible</th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rx Drug Deductible</td>
<td>$6,000</td>
<td>$3,250</td>
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<td>$0</td>
</tr>
<tr>
<td>Rx Coinsurance</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
<td>25%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MOOP</th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
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</thead>
<tbody>
<tr>
<td>$8,100</td>
<td>$6,500</td>
<td>$2,700</td>
<td>$1,050</td>
<td></td>
</tr>
</tbody>
</table>

### Generics
- Base Silver: $20
- 73% CSR: $20
- 87% CSR: $8
- 94% CSR: No Charge

### Preferred Brand Drugs
- Base Silver: $50
- 73% CSR: $50
- 87% CSR: $30
- 94% CSR: $25

#### Mental/BH and Substance Abuse Disorder Outpatient Services
- $30 Copay/Office Visit; 40% AD for all other outpatient services
- $20 Copay/Office Visit; 40% AD for all other outpatient services
- $8 Copay/Office Visit; 40% AD for all other outpatient services
- No charge/Office Visit; 25% for all other outpatient services

### Specialist Visit
- Base Silver: $60
- 73% CSR: $50
- 87% CSR: $15
- 94% CSR: $5

### Injury or Illness
- Labs: No Charge
- X-rays and Diagnostic Imaging: $25
- Skilled Nursing Facility: 40% AD
- Outpatient Facility Fee (e.g., Ambulatory Surgery Center): 40% AD
- Outpatient Surgery Physician/Surgical Services: 40% AD

### Drugs
<table>
<thead>
<tr>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generics</td>
<td>$20</td>
<td>$20</td>
<td>$8</td>
</tr>
<tr>
<td>Preferred Brand Drugs</td>
<td>$50</td>
<td>$50</td>
<td>$30</td>
</tr>
<tr>
<td>Non-Preferred Brand Drugs</td>
<td>50% AD</td>
<td>50% AD</td>
<td>50%</td>
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<tr>
<td>Specialty Drugs (i.e., high-cost)</td>
<td>50% AD</td>
<td>50% AD</td>
<td>50%</td>
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</tbody>
</table>
## Balanced Care 12 (2020)

<table>
<thead>
<tr>
<th></th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
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<tbody>
<tr>
<td><strong>Medical Deductible</strong></td>
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<td><strong>Medical Coinsurance</strong></td>
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</tr>
<tr>
<td></td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>INT</td>
<td>INT</td>
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<td>INT</td>
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<tr>
<td><strong>Rx Deductible</strong></td>
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<tr>
<td></td>
<td>40% AD</td>
<td>40% AD</td>
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<td>25%</td>
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<tr>
<td><strong>All Inpatient Hospital Services (inc. MHSA)</strong></td>
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<td></td>
<td></td>
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<tr>
<td></td>
<td>40% AD</td>
<td>40% AD</td>
<td>40% AD</td>
<td>25%</td>
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<tr>
<td><strong>Urgent Care</strong></td>
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<td>$55</td>
<td>$20</td>
<td>$10</td>
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<tr>
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<td><strong>Primary Care Visit to Treat an Injury or Illness</strong></td>
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<td>No Charge</td>
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<td><strong>Specialist Visit</strong></td>
<td>$70</td>
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<td>$30</td>
<td>$10</td>
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</table>

### Drugs

<table>
<thead>
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<th>94% CSR</th>
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</thead>
<tbody>
<tr>
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<td>$25</td>
<td>$10</td>
<td>No Charge</td>
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<tr>
<td><strong>Primary Care Visit to Treat an Injury or Illness</strong></td>
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<td>$25</td>
<td>$10</td>
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<td><strong>Specialist Visit</strong></td>
<td>$70</td>
<td>$60</td>
<td>$30</td>
<td>$10</td>
</tr>
</tbody>
</table>

### Outpatient Facility Fee (e.g., Ambulatory Surgery Center)

<table>
<thead>
<tr>
<th></th>
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<tr>
<td><strong>Generics</strong></td>
<td>$25</td>
<td>$25</td>
<td>$10</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

### Preferred Brand Drugs

<table>
<thead>
<tr>
<th></th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generics</strong></td>
<td>$25</td>
<td>$25</td>
<td>$10</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

### Non-Preferred Brand Drugs

<table>
<thead>
<tr>
<th></th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generics</strong></td>
<td>$25</td>
<td>$25</td>
<td>$10</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

### Specialty Drugs (i.e. high-cost)

<table>
<thead>
<tr>
<th></th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generics</strong></td>
<td>$25</td>
<td>$25</td>
<td>$10</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

### Outpatient Surgery Physician/Surgical Services

<table>
<thead>
<tr>
<th></th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generics</strong></td>
<td>$25</td>
<td>$25</td>
<td>$10</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

### Labs

<table>
<thead>
<tr>
<th></th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generics</strong></td>
<td>$25</td>
<td>$25</td>
<td>$10</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

### Imaging (CT/PET Scans, MRIs)

<table>
<thead>
<tr>
<th></th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generics</strong></td>
<td>$25</td>
<td>$25</td>
<td>$10</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

### Rehabilitative Speech Therapy

<table>
<thead>
<tr>
<th></th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generics</strong></td>
<td>$25</td>
<td>$25</td>
<td>$10</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

### Rehabilitative OT/PT

<table>
<thead>
<tr>
<th></th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generics</strong></td>
<td>$25</td>
<td>$25</td>
<td>$10</td>
<td>No Charge</td>
</tr>
</tbody>
</table>

**Note:** CSR percentages represent cost-sharing responsibility for the plan year. Costs listed include both medical and pharmacy costs. MOOP (Medical Out-of-Pocket) limits are annual.
## Balanced Care 14 (2020)

<table>
<thead>
<tr>
<th>Medical Deductible</th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Coinsurance</th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>50%</td>
<td>50%</td>
<td>40%</td>
<td>30%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rx Drug Deductible</th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>INT</td>
<td>INT</td>
<td>INT</td>
<td>INT</td>
<td>INT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Rx Coinsurance</th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>50%</td>
<td>INT</td>
<td>INT</td>
<td>INT</td>
<td>INT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MOOP</th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>$8,150</td>
<td>$6,500</td>
<td>$2,700</td>
<td>$1,400</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Room Services</th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>50%</td>
<td>50%</td>
<td>40%</td>
<td>30%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>All Inpatient Hospital Services (inc. MHSA)</th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>50%</td>
<td>50%</td>
<td>40%</td>
<td>30%</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Urgent Care</th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>$60</td>
<td>$60</td>
<td>$20</td>
<td>$10</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospital Physician</th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>50%</td>
<td>50%</td>
<td>40%</td>
<td>30%</td>
<td></td>
</tr>
</tbody>
</table>

### Primary Care Visit to Treat an Injury or Illness

<table>
<thead>
<tr>
<th>Primary Care Visit to Treat an Injury or Illness</th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>$45</td>
<td>$45</td>
<td>$15</td>
<td>No charge</td>
<td></td>
</tr>
</tbody>
</table>

### Drugs

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generics</td>
<td>$36</td>
<td>$36</td>
<td>$15</td>
<td>No charge</td>
</tr>
<tr>
<td>Preferred Brand Drugs</td>
<td>50%</td>
<td>50%</td>
<td>40%</td>
<td>30%</td>
</tr>
<tr>
<td>Non-Preferred Brand Drugs</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td>Specialty Drugs (i.e. high-cost)</td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>40%</td>
</tr>
</tbody>
</table>

### Preventive Care/Screening/Immunization

<table>
<thead>
<tr>
<th>Preventive Care/Screening/Immunization</th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Charge</td>
<td>$45</td>
<td>$45</td>
<td>$15</td>
<td>No charge</td>
</tr>
</tbody>
</table>

### Labs

<table>
<thead>
<tr>
<th>Labs</th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>$45</td>
<td>$45</td>
<td>$15</td>
<td>No charge</td>
<td></td>
</tr>
</tbody>
</table>

### X-rays and Diagnostic Imaging

<table>
<thead>
<tr>
<th>X-rays and Diagnostic Imaging</th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>50%</td>
<td>50%</td>
<td>40%</td>
<td>30%</td>
<td></td>
</tr>
</tbody>
</table>

### Skilled Nursing Facility

<table>
<thead>
<tr>
<th>Skilled Nursing Facility</th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>50%</td>
<td>50%</td>
<td>40%</td>
<td>30%</td>
<td></td>
</tr>
</tbody>
</table>

### Outpatient Facility Fee (e.g., Ambulatory Surgery Center)

<table>
<thead>
<tr>
<th>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>50%</td>
<td>50%</td>
<td>40%</td>
<td>30%</td>
<td></td>
</tr>
</tbody>
</table>

### Outpatient Surgery Physician/Surgical Services

<table>
<thead>
<tr>
<th>Outpatient Surgery Physician/Surgical Services</th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td>50%</td>
<td>50%</td>
<td>40%</td>
<td>30%</td>
<td></td>
</tr>
</tbody>
</table>
## Balanced Care 15 (2020)

<table>
<thead>
<tr>
<th></th>
<th>Base Silver</th>
<th>73% CSR</th>
<th>87% CSR</th>
<th>94% CSR</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Deductible</strong></td>
<td>$2,950</td>
<td>$2,875</td>
<td>$1,000</td>
<td>$200</td>
</tr>
<tr>
<td><strong>Medical Coinsurance</strong></td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
<td>30%</td>
</tr>
<tr>
<td><strong>Rx Drug Deductible</strong></td>
<td>INT</td>
<td>INT</td>
<td>INT</td>
<td>INT</td>
</tr>
<tr>
<td><strong>Rx Coinsurance</strong></td>
<td>50%</td>
<td>50%</td>
<td>50%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>MOOP</strong></td>
<td>$8,150</td>
<td>$6,500</td>
<td>$2,400</td>
<td>$1,350</td>
</tr>
<tr>
<td><strong>Emergency Room Services</strong></td>
<td>40% AD</td>
<td>40% AD</td>
<td>40% AD</td>
<td>30% AD</td>
</tr>
<tr>
<td><strong>All Inpatient Hospital Services (inc. MHSA)</strong></td>
<td>40% AD</td>
<td>40% AD</td>
<td>40% AD</td>
<td>30% AD</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>$65</td>
<td>$65</td>
<td>$20</td>
<td>$10</td>
</tr>
<tr>
<td><strong>Hospital Physician</strong></td>
<td>40% AD</td>
<td>40% AD</td>
<td>40% AD</td>
<td>30% AD</td>
</tr>
<tr>
<td>Primary Care Visit to Treat an Injury or Illness</td>
<td>$30</td>
<td>$30</td>
<td>$15</td>
<td>No Charge</td>
</tr>
<tr>
<td><strong>Specialist Visit</strong></td>
<td>$65</td>
<td>$65</td>
<td>$30</td>
<td>$10</td>
</tr>
<tr>
<td><strong>Mental/BH and Substance Abuse Disorder Outpatient Services</strong></td>
<td>$30 Copay/Office Visit; 40% AD for all other outpatient services</td>
<td>$30 Copay/Office Visit; 40% AD for all other outpatient services</td>
<td>$15 Copay/Office Visit; 40% AD for all other outpatient services</td>
<td>No charge/Office Visit; 30% AD for all other outpatient services</td>
</tr>
<tr>
<td><strong>Generics</strong></td>
<td>$15</td>
<td>$15</td>
<td>$10</td>
<td>No Charge</td>
</tr>
<tr>
<td><strong>Preferred Brand Drugs</strong></td>
<td>$60</td>
<td>$60</td>
<td>$35</td>
<td>$25</td>
</tr>
<tr>
<td><strong>Laboratory Services</strong></td>
<td>$30</td>
<td>$30</td>
<td>$15</td>
<td>No Charge</td>
</tr>
<tr>
<td><strong>X-rays and Diagnostic Imaging</strong></td>
<td>40% AD</td>
<td>40% AD</td>
<td>40% AD</td>
<td>30% AD</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>40% AD</td>
<td>40% AD</td>
<td>40% AD</td>
<td>30% AD</td>
</tr>
<tr>
<td><strong>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</strong></td>
<td>40% AD</td>
<td>40% AD</td>
<td>40% AD</td>
<td>30% AD</td>
</tr>
<tr>
<td><strong>Outpatient Surgery Physician/Surgical Services</strong></td>
<td>40% AD</td>
<td>40% AD</td>
<td>40% AD</td>
<td>30% AD</td>
</tr>
<tr>
<td><strong>Non-Preferred Brand Drugs</strong></td>
<td>50% AD</td>
<td>50% AD</td>
<td>50% AD</td>
<td>40% AD</td>
</tr>
<tr>
<td><strong>Specialty Drugs (i.e. high-cost)</strong></td>
<td>50% AD</td>
<td>50% AD</td>
<td>50% AD</td>
<td>40% AD</td>
</tr>
</tbody>
</table>
## Secure Care 5 (2020)

<table>
<thead>
<tr>
<th>Service</th>
<th>Secure Care 5 (New 2020)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Deductible</strong></td>
<td>$1,250</td>
</tr>
<tr>
<td>Medical Coinsurance</td>
<td>20%</td>
</tr>
<tr>
<td>Rx Drug Deductible</td>
<td>INT</td>
</tr>
<tr>
<td>Rx Coinsurance</td>
<td>30%</td>
</tr>
<tr>
<td><strong>MOOP</strong></td>
<td>$5,900</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>20% AD</td>
</tr>
<tr>
<td>All Inpatient Hospital Services (inc. MHSA)</td>
<td>20% AD</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$35</td>
</tr>
<tr>
<td>Hospital Physician</td>
<td>20% AD</td>
</tr>
<tr>
<td><strong>Primary Care Visit to Treat an Injury or Illness</strong></td>
<td>$15</td>
</tr>
<tr>
<td><strong>Specialist Visit</strong></td>
<td>$35</td>
</tr>
<tr>
<td><strong>Labs</strong></td>
<td>$15</td>
</tr>
<tr>
<td>X-rays and Diagnostic Imaging</td>
<td>20% AD</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>20% AD</td>
</tr>
<tr>
<td>Outpatient Facility Fee (e.g., Ambulatory Surgery Center)</td>
<td>20% AD</td>
</tr>
<tr>
<td>Outpatient Surgery Physician/Surgical Services</td>
<td>20% AD</td>
</tr>
<tr>
<td><strong>Drugs</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Generics</strong></td>
<td>$15</td>
</tr>
<tr>
<td>Preferred Brand Drugs</td>
<td>$30</td>
</tr>
<tr>
<td>Non-Preferred Brand Drugs</td>
<td>30% AD</td>
</tr>
<tr>
<td>Specialty Drugs (i.e. high-cost)</td>
<td>30% AD</td>
</tr>
</tbody>
</table>
# Pediatric Vision

## Up to 19 years of age

<table>
<thead>
<tr>
<th>Service</th>
<th>Subj. to Ded.</th>
<th>In-network Providers Only</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exams and Eyewear</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Eye Exam (1 visit per year)</td>
<td>N</td>
<td>100% Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Eyeglasses (frames) and contacts (1 item per</td>
<td>N</td>
<td>100% Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>year)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Lenses (per pair)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>N</td>
<td>100% Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Bifocal</td>
<td>N</td>
<td>100% Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Trifocal</td>
<td>N</td>
<td>100% Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Lenticular</td>
<td>N</td>
<td>100% Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Contact Lenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contact lenses (in lieu of glasses)</td>
<td>N</td>
<td>100% Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Contact Lens Fitting</td>
<td>N</td>
<td>100% Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Specialty Lens Fitting</td>
<td>N</td>
<td>100% Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
**Adult Vision Buy-up**

Ages 19 years of age and older

<table>
<thead>
<tr>
<th>Exams and Eyewear</th>
<th>In-Network Providers Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Eye Exam - 1 visit per year</td>
<td>$0 copay</td>
</tr>
</tbody>
</table>

**Contact Lenses**

<table>
<thead>
<tr>
<th>Contact Lenses</th>
<th>Covered up to $130</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact lenses (in lieu of glasses)</td>
<td></td>
</tr>
<tr>
<td>Eyeglasses (frames) - 1 item per year</td>
<td>Covered up to $130</td>
</tr>
</tbody>
</table>

**Trifocal**

<table>
<thead>
<tr>
<th>Lenticular</th>
</tr>
</thead>
</table>

**Contact Lenses**

<table>
<thead>
<tr>
<th>Contact Lenses</th>
<th>Covered up to $130</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact lenses (in lieu of glasses)</td>
<td></td>
</tr>
<tr>
<td>Contact Lens Fitting</td>
<td>100% Covered</td>
</tr>
<tr>
<td>Specialty Lens Fitting</td>
<td>Covered up to $50</td>
</tr>
</tbody>
</table>
# Adult Dental Buy-up

- Ages 19 years of age and older

<table>
<thead>
<tr>
<th></th>
<th>Subj. to Ded.</th>
<th>Cost for In-network Providers Only</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Maximum</strong> (Dental out-of-pocket maximum does not apply toward any other maximums)</td>
<td>NA</td>
<td>$1,000 per covered person, per calendar year</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Routine Dental</strong> (Class 1)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Oral Exam</td>
<td>N</td>
<td>$0 copay, subject to annual maximum</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Cleaning</td>
<td>N</td>
<td>$0 copay, subject to annual maximum</td>
<td>Not Covered</td>
</tr>
<tr>
<td>X-rays, bite-wings, full-mouth and panoramic film</td>
<td>N</td>
<td>$0 copay, subject to annual maximum</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Basic Dental</strong> (Class 2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minor restorative – metal and resin based fillings</td>
<td>N</td>
<td>50% coinsurance, subject to annual maximum</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Endodontic therapy</td>
<td>N</td>
<td>50% coinsurance, subject to annual maximum</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Periodontics:</td>
<td>N</td>
<td>50% coinsurance, subject to annual maximum</td>
<td>Not Covered</td>
</tr>
<tr>
<td>- Scaling and root planing and Periodontal Maintenance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Simple Extractions</td>
<td>N</td>
<td>50% coinsurance, subject to annual maximum</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Prosthodontics:</td>
<td>N</td>
<td>50% coinsurance, subject to annual maximum</td>
<td>Not Covered</td>
</tr>
<tr>
<td>- Relines, Rebase, Adjustments &amp; Repairs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Major Restorative</strong> (Class 3)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crowns &amp; Bridges</td>
<td>N</td>
<td>50% coinsurance, subject to annual maximum</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Dentures</td>
<td>N</td>
<td>50% coinsurance, subject to annual maximum</td>
<td>Not Covered</td>
</tr>
<tr>
<td>More complex extractions and surgical services</td>
<td>N</td>
<td>50% coinsurance, subject to annual maximum</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
Post Application

• After submitting an application an 834 Enrollment File is sent by the Marketplace to Ambetter

• After we receive the 834 File an applicant can expect to receive a welcome letter and billing statement in about 7 days

• After first payment, members will receive their ID cards in about 7 days
Welcome Packet

**Welcome Brochure:** Information about our My Health Pays program, a premium rate letter and plan brochure

**Start Guide Card:** Check list that helps the member with “what’s next” now that they are enrolled with Ambetter

**Tip Sheet:** Information about a members rights and responsibilities
A policy is not effective until the first months premium is received!

- Pay Online
- Pay by Phone
- Pay by Mail
- Pay by MoneyGram®
Ambetter’s Value Added Benefits

• My Health Pays Program

• Ambetter Telehealth

• Health Management Programs
My Health Pays®

- Visit member portal to log in
- Earn points on healthy activities and behaviors
- Use points to shop our online rewards store
- Convert points into dollars to pay healthcare-related costs
- Starting in 2020, members can earn up to $500 in rewards!

Funds expire 90 days after termination of insurance coverage. Rewards program is subject to change. My Health Pays rewards can’t be used for pharmacy copays.

This card is issued by The Bancorp Bank pursuant to a license from Visa U.S.A. Inc. The Bancorp Bank; Member FDIC. Card cannot be used everywhere Visa debit cards are accepted. See Cardholder Agreement for complete usage restrictions.
Ambetter Telehealth

24-Hour help for non-emergency issues

Connect to experts regardless of physical location

Avoid long wait times at physician offices

Reduce cost of health care when a member's PCP or clinic is not available

Good for outlying or rural areas

New for 2020! $0 PCP copay
*except HSA plans
How to Register

Online at www.teladoc.com/ambetter

By phone at 1-800-Teladoc (1-800-835-2362)

Have ID card ready, will need to give agent first/last name and DOB
Health Management Programs

Ambetter offers a Health Management Program for these conditions:

- Asthma
- Coronary Artery Disease (Adult Only)
- Depression
- Diabetes
- Hypertension (high blood pressure)
- High Cholesterol
- Low Back Pain
- Tobacco Cessation
Member Portal Overview

Hi, Miranda!

Status: Active

My Health Pays
- You can earn up to $1,000 rewards points this year.

Pay your premium
- Your total balance is $50.
- Your monthly premium is due at the end of the month.

Find a Provider
- Use our search tool to find in-network doctors and specialists in your area.

ID Cards
- Member ID: 00000000-01
- Plan Name: Balanced Care Plan 1
- Effective Date of Coverage: 1/1/2020
- View All ID Cards

Your 2020 plan has more ways to earn rewards!

2019 Coverage At-A-Glance
- Maximum Out-of-Pocket: $8,000/year
- Deductible: $6,000/year
- PCP Copay: $10/visit

View your 2020 plan

Plan details
Find a Provider & Formulary
Finding a Provider

Don’t Miss Out on Affordable Coverage

ENROLL NOW  RENEW TODAY
Location and Search

Find a HealthCare Provider

Quick Name Search
Detailed Search
My Favorites

Click here for information about out-of-network providers (for example, physicians within the emergency service department) who may treat you at Ambetter participating hospitals, and for information on member financial responsibility at out-of-network providers.
2825 results within 200 miles

Updated: 09/18/2019

1. Nancy E Fuegner, PNP
   Practitioner
   23.86 miles
   Mercy Clinic East Communities
   107 Piper Hill Drive Suite 130
   Saint Peters, MO 63376
   (636) 928-8950

2. Bachar Malek, MD
   Practitioner
   153.76 miles
   Indiana Exceptional Medical Care, LLC
   4972 Lincoln Avenue Suite 101
   Evansville, IN 47715
   (812) 462-3700

3. Matthew A Broom, MD
   Practitioner
   2.12 miles
   SLU Care Dept of Pediatric Endocrinology
   1465 South Grand Boulevard
   Saint Louis, MO 63104
   (314) 268-8492

4. Isam S Hawatmeh, MD
   Practitioner
   6.27 miles
   Sam Hawatmeh MD
   6651 Chippewa Street Suite 202
   Saint Louis, MO 63110
   (314) 645-8200

5. Robert Parker Pierce, MD
   Practitioner
   98.80 miles
   Fulton Family Health Associates PC
   2613 Fairway Drive Suite C
   Fulton, MO 65251
   (573) 642-1990
Provider Details

Network: Missouri

Matthew Broom, MD
Practitioner
(314) 268-6492

Practice Details
Location Hours: Sun, Sat (Closed)
Mon, Tue, Wed, Thu, Fri (8:00 AM - 5:00 PM)
Open Weekends: No
Fax: (314) 268-6116
After-hours Phone: (314) 577-5668
County: Saint Louis City
Accessible to People with Disabilities: Yes

Patient Types
Accepting New Patients: Yes
Age Limitations: 0 yr(0) - 18 yr(0)
Gender Limitation: None

Provider Details
Gender: Male
Specialties:
- Pediatrics
Board Status: Not Certified View Details

Hospital Affiliations:
- SSM Cardinal Glennon Childrens Hospital
- SSM ST Marys Health Center
- SSM St Marys Health Center

Additional Practitioner Languages: None
National Provider Identifier: 1114967767

Location: Click to Update
Driving Directions
Add / Remove Favorite
Finding a Medication
Searching on the Formulary List

Control + F

Medication here
Prescription Tiers

**Tier 0** - No copayment for those drugs that are used for prevention and are mandated by the Affordable Care Act. Select oral contraceptives, vitamin D, folic acid for women of child bearing age, over-the-counter (OTC) aspirin, and smoking cessation products may be covered under this tier. Certain age or gender limits apply.

**Tier 1** - Lowest copayment for those drugs that offer the greatest value compared to other drugs used to treat similar conditions. Select over-the-counter (OTC), generic or brand name drugs may be covered under this tier.

**Tier 2** - Medium copayment covers brand name drugs that are generally more affordable, or may be preferred compared to other drugs to treat the same conditions.

**Tier 3** - Highest copayment covers higher cost brand name drugs. This tier may also cover non-specialty drugs that are not on the Preferred Drug List but approval has been granted for coverage.

**Tier 4** - Coverage for this tier is for “specialty” drugs used to treat complex, chronic conditions that may require special handling, storage or clinical management. For members who do not have a Tier 4 plan, these drugs may be covered under Tier 3.
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Term</th>
<th>What it means</th>
</tr>
</thead>
<tbody>
<tr>
<td>AL</td>
<td>Age Limit</td>
<td>Some drugs are only covered for certain ages.</td>
</tr>
<tr>
<td>QL</td>
<td>Quantity Limit</td>
<td>Some drugs are only covered for a certain amount.</td>
</tr>
<tr>
<td>PA</td>
<td>Prior Authorization</td>
<td>Your doctor must ask for approval from Ambetter before some drugs will be covered.</td>
</tr>
<tr>
<td>ST</td>
<td>Step Therapy</td>
<td>In some cases, you must first try certain drugs before Ambetter covers another drug for your medical condition. For example, if Drug A and Drug B both treat your medical condition, Ambetter may not cover Drug B unless you try Drug A first.</td>
</tr>
<tr>
<td>NF</td>
<td>Non-formulary</td>
<td>This product is not covered unless you or your provider request an exception. Alternative medications are listed next to non-covered product</td>
</tr>
<tr>
<td>RX/OTC</td>
<td>Prescription and OTC</td>
<td>These drugs are made in both prescription form and Over-the-counter (OTC) form.</td>
</tr>
<tr>
<td>Drug Name</td>
<td>Drug Tier</td>
<td>Requirements/Limits</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>zileuton 1b12</td>
<td>1</td>
<td>QL (4 ea daily)</td>
</tr>
<tr>
<td>ZYFLO CR TB12 (Use Zileuton)</td>
<td>3</td>
<td>QL (4 ea daily)</td>
</tr>
<tr>
<td>Selective Phosphodiesterase 4 (PDE4) Inhibitors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DALIRESP TABS 250 MCG</td>
<td>3</td>
<td>QL (1 ea daily) 30 rtd MAX day(s) supply, 180 rtd limt day(s), 30 mail MAX day(s) supply, 180 mail limt day(s).</td>
</tr>
<tr>
<td>DALIRESP TABS 500 MCG</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Steroid Inhalants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ALVESCO AERS</td>
<td>3</td>
<td>PA</td>
</tr>
<tr>
<td>ASMANEX TWISTHALER 120 METERED DOSES AEPB</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>ASMANEX TWISTHALER 14 METERED DOSES AEPB</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>ASMANEX TWISTHALER 30 METERED DOSES AEPB</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>ASMANEX TWISTHALER 60 METERED DOSES AEPB</td>
<td>2</td>
<td></td>
</tr>
</tbody>
</table>
Thank you!
inspiring health for All Arizonans

BlueCross BlueShield Arizona

2020 AFFORDABLE CARE ACT HEALTH PLANS
Agenda

- Why Blue
- 2020 Plan Portfolio
- Q&A
Starting on January 1\textsuperscript{st} 2020 we are excited to serve **ALL ARIZONA COUNTIES** including Maricopa County.
Why Our Plans Are Unique

Care designed for you

- A doctor who understands you
- Save money while getting healthy
- Local support when you need it
Why Our Plans Are Unique

Care designed for you

- A doctor who understands you
- Save money while getting healthy
- Local support when you need it
**Patient-Provider Experience is Important**

75% of consumers want to work in *partnership* with their provider to make treatment decisions.

---

**Personalization Expected via Providers**

<table>
<thead>
<tr>
<th>Interaction</th>
<th>Overall Rank &amp; Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctors or other health care providers who spend time with me and does not rush</td>
<td>#1 (5.6x the average)</td>
</tr>
<tr>
<td>Doctors or other health care providers who listen and show they care about me</td>
<td>#3 (4.8x the average)</td>
</tr>
<tr>
<td>Doctors or other health care providers who clearly explain what they are doing and what I need to do later</td>
<td>#4 (4.3x the average)</td>
</tr>
<tr>
<td>Clear, helpful information about my diagnoses and conditions</td>
<td>#6 (2.8x the average)</td>
</tr>
</tbody>
</table>

Source: Deloitte Consumer Engagement Priorities September 2019
A Care Coordination Model Focused on You

Blue Care Coordination

• Each member is paired with an in-network primary care provider of their choice
• Personalized care based on demographics, health history and life situation
• Helping members get the right care at the right time through real-time data
• A new partner in Maricopa to enhance the provider-patient experience

Our members saved over 20% on unnecessary specialist visits and pharmacy costs

Source: BCBSAZ data 2016-2017
Why Our Plans Are Unique

Care designed for you

A doctor who understands you
Save money while getting healthy
Local support when you need it
I went to my doctor for my free annual wellness visit. I figured while I’m there I’ll talk to my doctor about this rash on my arm. My visit was great. Not only did I get a clean bill of health, I got a prescription to get rid of my rash. A month later to my surprise, I got a bill for my visit. I thought it was free.
Every ACA plan has free preventive visits but….

Our plans include **free primary care provider visits** with no copay or out of pocket cost regardless of diagnosis

Free primary care provider visits are not available on Portfolio HSA plans.
Save Money While Getting Healthy

MyBlue **rewards**

- Member reward programs
  - Incentives for healthy actions (e.g. doctor visits, health assessment)
  - MyBlue Welcome
Why Our Plans Are Unique

Care designed for you

- A doctor who understands you
- Save money while getting healthy
- Local support when you need it
Digital tools at your fingertips

- MyBlue Welcome onboarding
- MyBlue member account
- MyBlue AZ mobile app
- Find a Doctor/Care estimator
- BlueCare Anywhere℠ mobile app
- Welvie online surgery education
- Sharecare Wellness platform
Local Support When You Need It

MyBlue welcome

Five Step Education

1. Remind them about their designated PCP
2. Ensure they understand benefits
3. Determine how they want to receive communications
4. Understand their current health status
5. Give them access to their MyBlue member account

84% of consumers say that more post-purchase communication is critical if a purchase is expensive.
Hi, Neqmi!

Thanks for choosing Blue.

In this quick tour, you’ll see key features of your plan, choose how you want to hear from us, and learn how to get the most out of your plan.

Get started ➔

Español
Local Support When You Need It

MyBlue welcome

(Step 2 of 5)

How Benefits Work
My Health Plan: EverydayHealth HMO 6500

Let’s look at how your health plan works over the course of the year.

- Your deductible is the amount you pay for certain healthcare services before Blue starts to pay.
- Preventive services such as your annual wellness checkup are no charge.
- Your monthly premium and any copays for common services such as doctor visits and prescriptions drugs do not apply to your deductible.
- Some covered benefits are subject to a deductible.

### You pay 100% of covered services until your total reaches your:
- $6,500 member
- $13,000 family deductible

### You pay 10% of covered services until your total reaches your:
- $7,900 member
- $15,800 family out-of-pocket maximum

### You pay nothing
- For covered services after that. Blue pays 100% of in-network covered services until the end of the year.

- **$0** Start of Year
- **$6,500** Deductible to meet
- **$7,900** Your out-of-pocket maximum
- **End of Year**

Not all services will be covered. Plan limitations and exclusions apply.
Local Support When You Need It

MyBlue welcome

(Step 4 of 5)
My Health

Tell us a little about yourself with a short health survey. Your answers will in no way impact your health coverage or rate – we want to understand your needs to better serve you.

Get started
Local Support When You Need It

We understand healthcare

• Serving Arizonans for more than 80 years
• Call center representatives with an average 10 years experience
• Bilingual staff and support

“BCBSAZ provides excellent service for health plan. They are extremely knowledgeable on plans and answer any questions I may have. Been with them for years as a private plan, they are the best.”
- Nina, Phoenix
2020 Plan Portfolio
What’s New?
A designated PCP partner

- This doctor is their central point of care to review health history and identify health goals so that when needed, the member gets better care, lower costs and a healthier outcome.

- PCP coordinates referral to see most in-network specialists except:
  - Telehealth
  - OB/GYN
  - Outpatient mental health
  - Pediatric dental and vision
  - Emergency and urgent care
  - Chiropractic
  - Physical, occupational, speech and cognitive therapy
  - Certain rehabilitative and habilitative services

Key features of HMO plans

- Emergency care is covered out of network.
- Outside of Arizona, 24/7 online telehealth and urgent care from a BlueCard Traditional provider are covered.
Free means free – new free primary care provider visits

- 2 or more free PCP office visits on all non-HSA plans
- Regardless of diagnosis

Lower out-of-pocket costs for outpatient surgeries

- Deductible waived for the outpatient facility fee at an ambulatory surgery center
- Available on most plans
- Quality care at a lower cost while reducing risk of hospital acquired illnesses

24/7 access with board-certified online doctor visits

- Be seen for common illnesses like cold, flu, or sinus infection
- Available at home and when traveling outside Arizona
- Low copays and a 10 minute average wait time
Neighborhood Network
• Network for rural counties with access to advanced care in facilities in Maricopa County
• Available for members who live outside of Maricopa and Pima Counties

PimaFocus Network
• Access to Tucson Medical Center facilities and physicians in Pima County
• Available for members who live in Pima County

MaricopaFocus Network New
• Access to Dignity and Phoenix Children’s Hospital facilities and providers in Maricopa County
• Available for members who live in Maricopa County
Plans Designed for Every Individual

**EverydayHealth**
Predictable Out-of-Pocket Costs for Every Budget
Traditional plan design in Bronze, Silver, Gold

**TrueHealth**
For Those Who Need Specialist Care or Brand-Name Drugs
Strong fit for highly subsidized

**SimpleHealth**
For the Young and Healthy
Under 30 without a subsidy

**Portfolio**
For the Health Planner
Paired with a health savings account (HSA)

**AdvanceHealth**
For Peace-of-Mind Coverage
Low-cost generic drugs and online doctor visits
## Plan Availability in 2020

### 2020 Plans & Networks by County

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Maricopa County</th>
<th>Pima County</th>
<th>All other Arizona Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>NEW</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>MaricopaFocus Network</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Silver</strong></td>
<td>EverydayHealth HMO 2000</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Silver</strong></td>
<td>EverydayHealth HMO 4000</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Bronze</strong></td>
<td>EverydayHealth HMO 7000</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Silver</strong></td>
<td>TrueHealth HMO 6000</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Silver</strong></td>
<td><strong>NEW</strong> AdvanceHealth HMO 6500</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Bronze</strong></td>
<td>Portfolio HSA HMO 5000</td>
<td>Not available</td>
<td>✓</td>
</tr>
<tr>
<td><strong>Catastrophic</strong></td>
<td>SimpleHealth HMO</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>
### 2020 Plans – TrueHealth CSR Plans

<table>
<thead>
<tr>
<th>Eligibility Category</th>
<th>TrueHealth Silver 73AV</th>
<th>TrueHealth Silver 87AV</th>
<th>TrueHealth Silver 94AV</th>
</tr>
</thead>
<tbody>
<tr>
<td>200-250% FPL</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>$4,500</td>
<td>$1,750</td>
<td>$550</td>
</tr>
<tr>
<td><strong>Coinsurance (Plan/Member)</strong></td>
<td>100%/0%</td>
<td>100%/0%</td>
<td>100%/0%</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>$5,500</td>
<td>$1,850</td>
<td>$600</td>
</tr>
<tr>
<td><strong>Emergency Room Visit</strong></td>
<td>Deductible</td>
<td>Deductible</td>
<td>Deductible</td>
</tr>
<tr>
<td><strong>Inpatient Care</strong></td>
<td>Deductible</td>
<td>Deductible</td>
<td>Deductible</td>
</tr>
<tr>
<td><strong>Primary Care (PCP) Visit</strong></td>
<td>No charge first 2 visits, then $25</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Specialist Visit</strong></td>
<td>$60</td>
<td>$5</td>
<td>$5</td>
</tr>
<tr>
<td><strong>Telehealth - Medical</strong></td>
<td>$10</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>$75</td>
<td>$10</td>
<td>$10</td>
</tr>
<tr>
<td><strong>Diagnostic Tests &amp; Imaging</strong></td>
<td>Deductible</td>
<td>Deductible</td>
<td>Deductible</td>
</tr>
<tr>
<td><strong>Skilled Nursing</strong></td>
<td>Deductible</td>
<td>Deductible</td>
<td>Deductible</td>
</tr>
<tr>
<td><strong>Outpatient Facility – Non ASC</strong></td>
<td>Deductible</td>
<td>Deductible</td>
<td>Deductible</td>
</tr>
<tr>
<td><strong>Outpatient Facility - ASC</strong></td>
<td>50% coinsurance, deductible waived</td>
<td>50% coinsurance, deductible waived</td>
<td>50% coinsurance, deductible waived</td>
</tr>
<tr>
<td><strong>Outpatient Surgical</strong></td>
<td>Deductible</td>
<td>Deductible</td>
<td>Deductible</td>
</tr>
<tr>
<td><strong>Rx Tier 1</strong></td>
<td>$20</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>Rx Tier 2</strong></td>
<td>$100</td>
<td>$25</td>
<td>$15</td>
</tr>
<tr>
<td><strong>Rx Tier 3</strong></td>
<td>Deductible</td>
<td>Deductible</td>
<td>Deductible</td>
</tr>
<tr>
<td><strong>Specialty Drug</strong></td>
<td>50% coinsurance, deductible waived</td>
<td>50% coinsurance, deductible waived</td>
<td>50% coinsurance, deductible waived</td>
</tr>
</tbody>
</table>
## 2020 Plans – Portfolio & NEW AdvanceHealth

<table>
<thead>
<tr>
<th>Metal Level</th>
<th>Portfolio HSA HMO 5000</th>
<th>AdvanceHealth HMO 6500</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>Bronze</td>
<td>Silver</td>
</tr>
<tr>
<td>$5,000</td>
<td>$6,500</td>
<td></td>
</tr>
<tr>
<td>Coinsurance (Plan/Member)</td>
<td>90%/10%</td>
<td>90%/10%</td>
</tr>
<tr>
<td>$6,750</td>
<td>$8,000</td>
<td></td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>Deductible/Coinsurance</td>
<td>Ded/Coins</td>
</tr>
<tr>
<td>Emergency Room Visit</td>
<td>Deductible/Coinsurance</td>
<td>No charge first 3 visits, then Deductible/Coinsurance</td>
</tr>
<tr>
<td>Inpatient Care</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Primary Care (PCP) Visit</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Specialist Visit</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Telehealth - Medical</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Diagnostic Tests &amp; Imaging</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
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<tr>
<td>Skilled Nursing</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Outpatient Facility – Non ASC</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Outpatient Facility - ASC</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
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<tr>
<td>Outpatient Surgical</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Rx Tier 1</td>
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<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Rx Tier 2</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Rx Tier 3</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Specialty Drug</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$10</td>
</tr>
</tbody>
</table>

**Notes:**
- Outpatient Facility – ASC: Coinsurance, deductible waived
- Outpatient Surgical: Deductible/Coinsurance
- Rx Tier 1: Deductible/Coinsurance
- Rx Tier 2: Deductible/Coinsurance
- Rx Tier 3: Deductible/Coinsurance
- Specialty Drug: Deductible/Coinsurance
- Emergency Room Visit: Deductible/Coinsurance
- Inpatient Care: Deductible/Coinsurance
- Primary Care (PCP) Visit: Deductible/Coinsurance
- Specialist Visit: Deductible/Coinsurance
- Telehealth - Medical: Deductible/Coinsurance
- Urgent Care: Deductible/Coinsurance
- Diagnostic Tests & Imaging: Deductible/Coinsurance
- Skilled Nursing: Deductible/Coinsurance
- Outpatient Facility – Non ASC: Deductible/Coinsurance
- Outpatient Facility - ASC: Deductible/Coinsurance
- Outpatient Surgical: Deductible/Coinsurance
- Rx Tier 1: Deductible/Coinsurance
- Rx Tier 2: Deductible/Coinsurance
- Rx Tier 3: Deductible/Coinsurance
- Specialty Drug: Deductible/Coinsurance

**Premiums:**
- Portfolio HSA HMO 5000: Bronze - $5,000, Silver - $6,500
- AdvanceHealth HMO 6500: Silver - $6,500

**Coinsurance:**
- 90%/10%

**Out-of-Pocket Maximum:**
- $6,750
- $8,000

**Specialty Drug:**
- Deductible/Coinsurance

**Rx Tier:**
- Tier 1: $5
- Tier 2: Deductible/Coinsurance
- Tier 3: Deductible/Coinsurance

**Inpatient Care:**
- Deductible/Coinsurance

**Emergency Room Visit:**
- Deductible/Coinsurance

**Primary Care (PCP) Visit:**
- Deductible/Coinsurance

**Specialist Visit:**
- Deductible/Coinsurance

**Telehealth - Medical:**
- Deductible/Coinsurance

**Urgent Care:**
- Deductible/Coinsurance

**Diagnostic Tests & Imaging:**
- Deductible/Coinsurance

**Skilled Nursing:**
- Deductible/Coinsurance

**Outpatient Facility – Non ASC:**
- Deductible/Coinsurance

**Outpatient Facility - ASC:**
- Coinsurance, deductible waived

**Outpatient Surgical:**
- Deductible/Coinsurance

**Rx Tier:**
- Tier 1: $5
- Tier 2: Deductible/Coinsurance
- Tier 3: Deductible/Coinsurance

**Specialty Drug:**
- Deductible/Coinsurance
### 2020 Plans – NEW AdvanceHealth CSR Plans

<table>
<thead>
<tr>
<th>Eligibility Category</th>
<th>Silver 73 AV</th>
<th>Silver 87AV</th>
<th>Silver 94 AV</th>
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<tbody>
<tr>
<td></td>
<td>200-250% FPL</td>
<td>150-200% FPL</td>
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<table>
<thead>
<tr>
<th>Plan</th>
<th>AdvanceHealth Silver 73AV</th>
<th>AdvanceHealth Silver 87AV</th>
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<td>90%/10%</td>
<td>90%/10%</td>
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<td>Deductible/Coinsurance</td>
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<td>Deductible/Coinsurance</td>
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<tr>
<td>Primary Care (PCP) Visit</td>
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<td>No charge first 3 visits, then Deductible/Coinsurance</td>
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<tr>
<td>Specialist Visit</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td>Telehealth – Medical</td>
<td>$10</td>
<td>$10</td>
<td>$5</td>
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<td>Deductible/Coinsurance</td>
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<td>Deductible/Coinsurance</td>
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<td>Diagnostic Tests &amp; Imaging</td>
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<tr>
<td>Outpatient Facility - ASC</td>
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<td>Outpatient Surgical</td>
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<td>Deductible/Coinsurance</td>
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<tr>
<td>Rx Tier 1</td>
<td>$5</td>
<td>$2</td>
<td>$2</td>
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<tr>
<td>Rx Tier 2</td>
<td>Deductible/Coinsurance</td>
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<td>Rx Tier 3</td>
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<td>Specialty Drug</td>
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<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
</tbody>
</table>
What’s New in Arizona?

• New 2020 ACA plans – in all counties
• Free means free – new free primary care provider visits
• Ways to save – ambulatory surgical center
• 24/7 access – online doctor visits
• More healthy rewards – added value throughout the year
• Easy ways to get answers – more digital tools
thank you!
## 2020 Plans – EverydayHealth

### Metal Level
<table>
<thead>
<tr>
<th>EverydayHealth HMO 2000</th>
<th>EverydayHealth HMO 4000</th>
<th>EverydayHealth HMO 7000</th>
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<td><strong>Bronze</strong></td>
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<td>$4,000</td>
<td>$7,000</td>
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<tr>
<td>Coinsurance (Plan/Member)</td>
<td>Coinsurance (Plan/Member)</td>
<td>Coinsurance (Plan/Member)</td>
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<tr>
<td>80%/20%</td>
<td>80%/20%</td>
<td>55%/45%</td>
</tr>
<tr>
<td>$6,000</td>
<td>$7,500</td>
<td>$8,150</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>Out-of-Pocket Maximum</td>
<td>Out-of-Pocket Maximum</td>
</tr>
<tr>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
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<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>No charge for first 2 visits then $15</td>
<td>No charge for first 2 visits then $20</td>
</tr>
<tr>
<td>$60</td>
<td>$60</td>
<td>$100</td>
</tr>
<tr>
<td>$10</td>
<td>$75</td>
<td>$10</td>
</tr>
<tr>
<td>$60</td>
<td>$10</td>
<td>$60</td>
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<tr>
<td>$10</td>
<td>$10</td>
<td>$75</td>
</tr>
<tr>
<td><strong>Primary Care (PCP) Visit</strong></td>
<td><strong>Specialist Visit</strong></td>
<td><strong>Telehealth - Medical</strong></td>
</tr>
<tr>
<td>No charge for first 2 visits then $15</td>
<td>No charge for first 2 visits then $20</td>
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<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td><strong>Inpatient Care</strong></td>
<td><strong>Diabetic Tests &amp; Imaging</strong></td>
<td><strong>Skilled Nursing</strong></td>
</tr>
<tr>
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<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
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<td>Deductible/Coinsurance</td>
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<tr>
<td><strong>Outpatient Care</strong></td>
<td><strong>Outpatient Facility – Non ASC</strong></td>
<td><strong>Outpatient Facility - ASC</strong></td>
</tr>
<tr>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
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<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td><strong>Outpatient Surgical</strong></td>
<td><strong>Rx Tier 1</strong></td>
<td><strong>Rx Tier 2</strong></td>
</tr>
<tr>
<td>Deductible/Coinsurance</td>
<td>$10</td>
<td>$15</td>
</tr>
<tr>
<td>Deductible/Coinsurance</td>
<td>$60 after $350 drug deductible</td>
<td>$75 after $500 drug deductible</td>
</tr>
<tr>
<td>Deductible/Coinsurance</td>
<td>40% after $350 drug deductible with $100 minimum</td>
<td>40% after $500 drug deductible with $120 minimum</td>
</tr>
<tr>
<td>Deductible/Coinsurance</td>
<td>50% coinsurance, deductible waived</td>
<td>50% coinsurance, deductible waived</td>
</tr>
<tr>
<td><strong>Rx Tier 3</strong></td>
<td><strong>Rx Tier 2</strong></td>
<td><strong>Rx Tier 3</strong></td>
</tr>
<tr>
<td>Deductible/Coinsurance</td>
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<td>$15</td>
</tr>
<tr>
<td>Deductible/Coinsurance</td>
<td>$60 after $350 drug deductible</td>
<td>$75 after $500 drug deductible</td>
</tr>
<tr>
<td>Deductible/Coinsurance</td>
<td>40% after $350 drug deductible with $100 minimum</td>
<td>40% after $500 drug deductible with $120 minimum</td>
</tr>
<tr>
<td>Deductible/Coinsurance</td>
<td>50% coinsurance, deductible waived</td>
<td>50% coinsurance, deductible waived</td>
</tr>
<tr>
<td><strong>Specialty Drug</strong></td>
<td><strong>Rx Tier 3</strong></td>
<td><strong>Rx Tier 3</strong></td>
</tr>
<tr>
<td>Deductible/Coinsurance</td>
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<td>$15</td>
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<tr>
<td>Deductible/Coinsurance</td>
<td>$60 after $350 drug deductible</td>
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<td>Deductible/Coinsurance</td>
<td>50% coinsurance, deductible waived</td>
<td>50% coinsurance, deductible waived</td>
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</table>
## 2020 Plans – TrueHealth & SimpleHealth

<table>
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<tr>
<th>Metal Level</th>
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<th>SimpleHealth HMO 8150</th>
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<td>Catastrophic $8,150</td>
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<td>100%/0%</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>$6,500</td>
<td>$8,150</td>
</tr>
<tr>
<td>Emergency Room Visit</td>
<td>Deductible</td>
<td>Deductible</td>
</tr>
<tr>
<td>Inpatient Care</td>
<td>Deductible</td>
<td>Deductible</td>
</tr>
<tr>
<td>Primary Care (PCP) Visit</td>
<td>No charge first 2 visits, then $25</td>
<td>No charge first 3 visits, then Deductible</td>
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<tr>
<td>Specialist Visit</td>
<td>$100</td>
<td>Deductible</td>
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<tr>
<td>Telehealth - Medical</td>
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<td>Deductible</td>
</tr>
<tr>
<td>Urgent Care</td>
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<td>Deductible</td>
</tr>
<tr>
<td>Diagnostic Tests &amp; Imaging</td>
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<td>Deductible</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>Deductible</td>
<td>Deductible</td>
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<tr>
<td>Outpatient Facility – Non ASC</td>
<td>Deductible</td>
<td>Deductible</td>
</tr>
<tr>
<td>Outpatient Facility - ASC</td>
<td>50% coinsurance, deductible waived</td>
<td>Deductible</td>
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<tr>
<td>Outpatient Surgical</td>
<td>Deductible</td>
<td>Deductible</td>
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<tr>
<td>Rx Tier 1</td>
<td>$25</td>
<td>Deductible</td>
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</tr>
<tr>
<td>Specialty Drug</td>
<td>50% coinsurance, deductible waived</td>
<td>Deductible</td>
</tr>
</tbody>
</table>
There are two types of help:

1) A discount on the **monthly premium**

2) A discount that **lowers out-of-pocket costs** such as deductibles, copayments, and coinsurance is called a cost-share reduction (CSR). Consumers must enroll in a plan in the Silver category to get the extra savings.

---

Financial Help is Available

### Qualifying Income Levels

2019 income will be used to calculate eligibility for a subsidy in 2020.

<table>
<thead>
<tr>
<th>Persons in Household</th>
<th>138% FPL</th>
<th>250% FPL</th>
<th>400% FPL</th>
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<tbody>
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<td>$17,236</td>
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<td>2</td>
<td>$23,335</td>
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<td>3</td>
<td>$29,435</td>
<td>$53,325</td>
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<td>4</td>
<td>$35,535</td>
<td>$64,375</td>
<td>$103,000</td>
</tr>
<tr>
<td>5</td>
<td>$41,634</td>
<td>$75,425</td>
<td>$120,680</td>
</tr>
<tr>
<td>6</td>
<td>$47,734</td>
<td>$86,475</td>
<td>$138,360</td>
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<tr>
<td>7</td>
<td>$53,833</td>
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</tr>
<tr>
<td>8</td>
<td>$59,933</td>
<td>$108,575</td>
<td>$173,720</td>
</tr>
<tr>
<td>9+</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*If household is larger than 8 people, add $4,320 for each additional person.*
## 2020 Plans – EverydayHealth CSR Plans

<table>
<thead>
<tr>
<th>Eligibility Category</th>
<th>EverydayHealth Silver 73AV</th>
<th>EverydayHealth Silver 87AV</th>
<th>EverydayHealth Silver 94AV</th>
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<tbody>
<tr>
<td><strong>Deductible</strong></td>
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<td>$1,000</td>
<td>$25</td>
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<td><strong>Coinsurance (Plan/Member)</strong></td>
<td>80%/20%</td>
<td>90%/10%</td>
<td>90%/10%</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Maximum</strong></td>
<td>$6,500</td>
<td>$2,250</td>
<td>$1,500</td>
</tr>
<tr>
<td><strong>Emergency Room Visit</strong></td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td><strong>Inpatient Care</strong></td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td><strong>Primary Care (PCP) Visit</strong></td>
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<td>No charge first 2 visits, then $10</td>
<td>No charge first 2 visits, then $5</td>
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<tr>
<td><strong>Specialist Visit</strong></td>
<td>$60</td>
<td>$30</td>
<td>$10</td>
</tr>
<tr>
<td><strong>Telehealth - Medical</strong></td>
<td>$10</td>
<td>$10</td>
<td>$5</td>
</tr>
<tr>
<td><strong>Urgent Care</strong></td>
<td>$60</td>
<td>$40</td>
<td>$20</td>
</tr>
<tr>
<td><strong>Diagnostic Tests &amp; Imaging</strong></td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td><strong>Skilled Nursing</strong></td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td><strong>Outpatient Facility – Non ASC</strong></td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td><strong>Outpatient Facility - ASC</strong></td>
<td><strong>Coinsurance, deductible waived</strong></td>
<td><strong>Coinsurance, deductible waived</strong></td>
<td><strong>Coinsurance, deductible waived</strong></td>
</tr>
<tr>
<td><strong>Outpatient Surgical</strong></td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
<td>Deductible/Coinsurance</td>
</tr>
<tr>
<td><strong>Rx Tier 1</strong></td>
<td>$15</td>
<td>$10</td>
<td>$5</td>
</tr>
<tr>
<td><strong>Rx Tier 2</strong></td>
<td>$75 after $400 drug deductible</td>
<td>$40 after $100 drug deductible</td>
<td>$10 after $25 drug deductible</td>
</tr>
<tr>
<td><strong>Rx Tier 3</strong></td>
<td>40% after $400 drug deductible with $120 minimum</td>
<td>40% after $100 drug deductible with $35 minimum</td>
<td>40% after $25 drug deductible with $20 minimum</td>
</tr>
<tr>
<td><strong>Specialty Drug</strong></td>
<td>50% coinsurance, deductible waived</td>
<td>50% coinsurance, deductible waived</td>
<td>50% coinsurance, deductible waived</td>
</tr>
</tbody>
</table>
## 2020 Plans – TrueHealth CSR Plans

<table>
<thead>
<tr>
<th>Eligibility Category</th>
<th>Silver 73 AV</th>
<th>Silver 87AV</th>
<th>Silver 94 AV</th>
</tr>
</thead>
<tbody>
<tr>
<td>200-250% FPL</td>
<td>Silver 73AV</td>
<td>TrueHealth Silver 73AV</td>
<td>$4,500</td>
</tr>
<tr>
<td>150-200% FPL</td>
<td>TrueHealth Silver 87AV</td>
<td>$1,750</td>
<td></td>
</tr>
<tr>
<td>100-150% FPL</td>
<td>TrueHealth Silver 94AV</td>
<td>$550</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>TrueHealth Silver 73AV</th>
<th>TrueHealth Silver 87AV</th>
<th>TrueHealth Silver 94AV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$4,500</td>
<td>$1,750</td>
<td>$550</td>
</tr>
<tr>
<td>Coinsurance (Plan/Member)</td>
<td>100%/0%</td>
<td>100%/0%</td>
<td>100%/0%</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>$5,500</td>
<td>$1,850</td>
<td>$600</td>
</tr>
<tr>
<td>Emergency Room Visit</td>
<td>Deductible</td>
<td>Deductible</td>
<td>Deductible</td>
</tr>
<tr>
<td>Inpatient Care</td>
<td>Deductible</td>
<td>Deductible</td>
<td>Deductible</td>
</tr>
<tr>
<td>Primary Care (PCP) Visit</td>
<td>No charge first 2 visits, then $25</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Specialist Visit</td>
<td>$60</td>
<td>$5</td>
<td>$5</td>
</tr>
<tr>
<td>Telehealth - Medical</td>
<td>$10</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$75</td>
<td>$10</td>
<td>$10</td>
</tr>
<tr>
<td>Diagnostic Tests &amp; Imaging</td>
<td>Deductible</td>
<td>Deductible</td>
<td>Deductible</td>
</tr>
<tr>
<td>Skilled Nursing</td>
<td>Deductible</td>
<td>Deductible</td>
<td>Deductible</td>
</tr>
<tr>
<td>Outpatient Facility – Non ASC</td>
<td>Deductible</td>
<td>Deductible</td>
<td>Deductible</td>
</tr>
<tr>
<td>Outpatient Facility - ASC</td>
<td>50% coinsurance, deductible waived</td>
<td>50% coinsurance, deductible waived</td>
<td>50% coinsurance, deductible waived</td>
</tr>
<tr>
<td>Outpatient Surgical</td>
<td>Deductible</td>
<td>Deductible</td>
<td>Deductible</td>
</tr>
<tr>
<td>Rx Tier 1</td>
<td>$20</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Rx Tier 2</td>
<td>$100</td>
<td>$25</td>
<td>$15</td>
</tr>
<tr>
<td>Rx Tier 3</td>
<td>Deductible</td>
<td>Deductible</td>
<td>Deductible</td>
</tr>
<tr>
<td>Specialty Drug</td>
<td>50% coinsurance, deductible waived</td>
<td>50% coinsurance, deductible waived</td>
<td>50% coinsurance, deductible waived</td>
</tr>
</tbody>
</table>
Led by a best-in-class team

Innovative leadership

Our executive leadership team is fresh, bold, and filled with the brightest minds in the industry.

G. Mike Mikan
President and Chief Financial Officer

Tom Valdivia
Chief Health Officer

Rachel Winokur
Chief Business Officer

Brian Gambs
Chief Technology Officer

Ali Wing
Chief Consumer Officer

Jon Watson
President, Individual and Family Plans

Michael Muchnicki
President, Medicare Advantage

Jon Porter
Chief Product Officer

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A brief history
Bright Health has assembled a best-in-class team, proven the validity of our Care Partner model, and demonstrated the ability to scale effectively.

1. **2016**
   - **Assemble Team and Craft the Concept**
     - Developed deep management bench with substantial healthcare, informatics and consumer expertise.
     - Crafted unique Care Partnership model that drives strong performance, leading clinical outcomes and affordable care.

2. **2017**
   - **“Prove” the Care Partner Model**

3. **2018**
   - **Demonstrate Scalability**

4. **2019**
   - **Growth and Expansion**
     - **Gain Membership**
     - **Ability to Scale**
     - **Successful First Care Partnership**

### 2019:
- **Year 3 membership**: 60,000+
- **New Care Partners**: 6
- **Revenue growth**: 2.8x
- **In new capital**: $200M

### 2018:
- **Year 2 membership**: 25,000+
- **Year 2 MLR**: 76%
- **New Care Partners**: 2
- **Medicare Advantage products**: 3

### 2017:
- **Year 2 membership**: 10,791
- **Year 1 MLR**: 86%
- **In-network inpatient utilization rate**: 95%
- **Care navigation engagement**: 50%
- **Guided Net Promoter Score**: 45

### Key Metrics:
- **New Care Partners**: 6
- **Revenue growth**: 2.8x
- **In new capital**: $200M
- **Basic Washington and Medicaid products**: 3
- **Medicare Advantage products**: 3
- **In-network inpatient utilization rate**: 95%
- **Care navigation engagement**: 50%
- **Guided Net Promoter Score**: 45
Bright Health 2020

Our 2020 expansions mark a 300% increase in product offerings compared to 2019.

Current IFP Markets
- Denver
- Birmingham
- Phoenix
- Tucson
- Memphis
- Nashville
- Knoxville

New IFP Markets
- Jacksonville
- Pensacola
- Tampa
- Daytona Beach
- Orlando
- Palm Beach
- Oklahoma City
- Charlotte
- Winston-Salem
- Greenville
- Anderson
- Nebraska statewide
Our Health Plan Care Partner Model makes us different.

Traditional Health Plan Model:
- Separates the entities providing care and paying for care
- Disjointed data across multiple systems

Bright Health Model:
- Integrates the payer and provider structures
- Synchronizes claim and member data
- Focuses on in-network care
- Creates a close relationship between Bright Health and our Care Partners
What is our approach?

Bright Health partners with high quality providers and designs competitive benefits in order to offer access to high quality care at the lowest cost.

**Smart Networks** built around key Care Partner relationships

**Thoughtful benefit design**, promoting access to care

**LOWER OUT OF POCKET COST**
- Low Deductibles and MOOP
- Co-pays over co-insurance

**COMPETITIVE PREMIUM PRICING**

**UNIQUE SERVICES AVAILABLE TO ALL MEMBERS**
- Rides to doctor visits
- Meals post surgery
- Cash Rewards

**HIGH QUALITY**

**LOW COST**

**ACCESS TO CARE**
Pharmacy benefits

We've partnered with pharmacy benefit manager Envision Rx to provide access to thousands of pharmacies locally and across the country.

- **2,000** Statewide pharmacy locations
- **65,000** National pharmacy locations

Includes access to pharmacies at stores where members already shop.

Costco Pharmacy, Rite Aid, Harris Teeter Pharmacy, Safeway Pharmacy, Publix Pharmacy, Sam’s Pharmacy and may other chain and Independent Pharmacies
Get urgent care at home with DispatchHealth.*

If you need care and can’t wait for an appointment but it’s not an emergency, have Dispatch Health come to you!

We’ve partnered with DispatchHealth to deliver on-demand urgent care at home with ER-trained, mobile healthcare teams. Here’s how it works:

1. **Request care**
   Use the DispatchHealth mobile app, website, or call directly

2. **Explain your symptoms**
   Clinical support will call to talk about what’s wrong so you get the right care

3. **Receive care**
   The DispatchHealth team will be there soon

4. **Rest easy**
   Everything will be handled, from updating your PCP to calling in your prescription

*Benefit only available in AZ, CO, and OK Markets
What happens after enrollment?

The onboarding process is triggered when an applicant makes their first payment of the year. Next, members receive:

1. **ID card**
   Once members have their ID card, they can set up their Member Hub account and receive care (after their effective date).

2. **Welcome Packet**
   The welcome packet includes benefit highlights and information to help members get the most out of their plan.

3. **Ongoing communications**
   Members will receive ongoing communications via their preferred channels. These include information about monthly payments, the Member Hub, Cash Rewards, and more.
Arizona Overview

Click here for video
Arizona Overview
Why Arizona?

**Sizeable Market opportunity**
- ~120k addressable lives in target markets

**Collaborative partners**
- Multiple strong, market-leading Care Partners

**Competitive Landscape**
- Limited competition offers opportunity for new entrants

**Diverse distribution channels**
- Strong Broker Channel
- Many consumers use FFM
- Navigator footprint
Service Areas

Maricopa County
Phoenix Metro

Pima County
Tucson
Maricopa County provider network
ACN and Bright Health
Transforming Healthcare for Arizona
Why ACN?

- Largest primary care network in Arizona
- Affiliation with Phoenix Children’s Care Network
- Use of leading technologies to support our network and patients
ACN At-a-Glance

DIVERSE VALUE-BASED CONTRACTS

- Medicare
- Medicaid
- Commercial
- Direct to Employer

5,807 Providers

13 Care locations statewide

310,000+ $1 Billion in annual medical cost

$41 Million Total Medical Cost Savings

Quality outcomes achieving
Network Designed for Success: Hospitals and Urgent Cares

Hospitals and Free-Standing Emergency Centers
- Abrazo Arizona Heart Hospital
- Abrazo Free-Standing Emergency Centers
- Dignity Health Hospitals
- Dignity Health Urgent Care Locations (not shown: Maricopa Urgent Care)
- Phoenix Children’s Hospitals and Urgent Care Locations
- MedPost Urgent Care Locations
- NextCare Urgent Care Locations

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitals and Free-Standing Emergency Centers</td>
<td>18</td>
</tr>
<tr>
<td>Urgent Cares</td>
<td>54</td>
</tr>
</tbody>
</table>
Bright Health does not cover out-of-network care unless in the case of emergency, urgently needed services out-of-area dialysis services are needed.
PCCN At-a-Glance

Phoenix Children’s Care Network

- 1096 Pediatric Providers
- 178 Unique Care Locations
- 385 Primary Care Providers
- 631 Pediatric Specialty Providers
- +137,000 Covered Lives

- Largest Pediatric MM platform in SW US
- Developed proprietary CM application

Phoenix Children’s Hospital

- 33 Primary Pediatric Specialties
- 55 Pediatric Subspecialties
- 525 Employed Physicians
- 433 Licensed beds in Phoenix
- 48 Licensed beds at MGMC

- +13,500 Inpatient Discharges/Year
- +327,500 Outpatient Visits/Year
- +138,500 ED/Urgent Care Visits/Year

Quality and Cost

- $26M Total Medical Cost Savings
- 82% Performance exceeding CQMs
- 1st URAC Accredited Pediatric CIN
- 10/10 Ranked Specialties by US News

- Focused on Quality
- Proprietary, proven patient stratification
- Successful National Care Management Model
PCCN – Where We Are
Phoenix Children’s Hospital – East Valley Expansion

Women’s and Children’s Pavilion at Mercy Gilbert Medical Center

- Groundbreaking in November 2018
- Grand Opening Spring 2021
- Pediatric Services:
  - 24-Bed Pediatric Emergency Department
  - 6 Operating Rooms + Procedural Suites
  - Diagnostic Imaging
  - 60-Bed Level III NICU
  - 24-Bed Inpatient Unit (24 additional shelled beds)
  - Pediatric Lab
  - Pediatric Pharmacy
Phoenix Children’s Hospital – East Valley Expansion

New Medical Office Building at Mercy Gilbert Medical Center

- Opening January 2020
- 80,000 square feet total
  - PCH to occupy ~45,000 square feet

- 7 Key Specialty Anchors
  - Gastroenterology (GI)
  - Orthopedic Surgery
  - General Surgery
  - Neurology
  - Otolaryngology (ENT)
  - Endocrinology
  - Hematology Oncology (beginning in 2021)

- Behavioral Health Services
- Ancillary support
  - Imaging
  - Rehab
  - Nutrition
  - Social Services
  - Child Life
Get urgent care at home with DispatchHealth.*

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3. **Receive care**
   - The DispatchHealth team will be there soon

4. **Rest easy**
   - Everything will be handled, from updating your PCP to calling in your prescription

*Benefit only available in AZ, CO, and OK Markets.
SAME AS TREATMENT AVAILABLE IN URGENT CARE:

COMMON CONDITIONS
NAUSEA, VOMITING, DIARRHEA
MIGRAINE, HEADACHE, & NEUROLOGICAL
ASTHMA & RESPIRATORY
URINARY
EAR, NOSE & THROAT
LABS, IVS AND TESTS

MEMBER COST:
Urgent care $75, or $275 for plans without copay
Pima county provider network

And Physicians Performance Network of Tucson (PPNT)
Carondelet Health Network

- One of the largest healthcare providers in Southern Arizona
- 2 Acute Care hospitals
- 1 critical access hospital
- 1 microhospital (opening Spring, 2019)
- 5 imaging centers
- 3 ambulatory surgery centers and
- 13 medical group practice locations.
Physician Performance Network of Tucson Overview

**Provider Network**

- Highly respected private practice physicians
- Comprehensive system improves quality
- Delivery of better value
2020 Individual & Family Plan – Arizona

On-Exchange
- Gold
- Silver 1
- Silver 2
- Silver 3
- Silver 4

Off-Exchange
- Silver 1 Direct
- Silver 2 Direct

On/Off Exchange
- Bronze
- Bronze Plus
- Bronze Premier
- Bronze HSA
Bronze and Silver Strategy

We’ve taken a thoughtful approach to our Bronze and Silver portfolios

Bright Health Bronze Portfolio

<table>
<thead>
<tr>
<th>Plan</th>
<th>AV</th>
<th>Target Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td>~61%</td>
<td></td>
</tr>
<tr>
<td>Bronze Plus</td>
<td>~63%</td>
<td></td>
</tr>
<tr>
<td>Bronze Premier</td>
<td>~64%</td>
<td></td>
</tr>
</tbody>
</table>

Expanded Bronze Plans

- Bronze plan with richer benefits
- Goal to capture on-exchange individuals who qualify for subsidy - can’t afford silver plan
- Or off-exchange individuals who want a richer benefit, but not at the cost of a full silver plan

Silver “Direct” Offerings

- Silver 1, 2, 3 … (On/Off Exchange)
  - Include CSRs and are eligible for premium subsidies
- Bronze/Silver “Direct”
  - Do not include CSR pricing and are NOT eligible for subsidies

Silver Direct (Off Exchange Only)

- Silver variations only available off exchange
- Direct plans only available through Bright
- Do not have CSR priced into the premium, so plans range anywhere from 10% to 30% cheaper than their on-exchange equivalent plans
# Bright Health 2020 plan names

Unique plan structures require different naming conventions for each plan metal tier.

<table>
<thead>
<tr>
<th>Bronze</th>
<th>Silver</th>
<th>Catastrophic &amp; Gold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Names</td>
<td>Names</td>
<td>Names</td>
</tr>
<tr>
<td>• Bright Health Bronze</td>
<td>• Bright Health Silver 1</td>
<td>• Bright Health Catastrophic</td>
</tr>
<tr>
<td>• Bright Health Bronze Plus</td>
<td>• Bright Health Silver 2</td>
<td>• Bright Health Gold</td>
</tr>
<tr>
<td>• Bright Health Bronze Premier</td>
<td>• Bright Health Silver 3… etc.</td>
<td></td>
</tr>
<tr>
<td>(Add modifiers where applicable)</td>
<td>(Add modifiers where applicable)</td>
<td></td>
</tr>
<tr>
<td>Modifiers</td>
<td>Modifiers</td>
<td>Modifiers</td>
</tr>
<tr>
<td>• “HSA” – for plans eligible for Health Savings Accounts</td>
<td>• “HSA” – for plans eligible for Health Savings Accounts</td>
<td>• No modifiers</td>
</tr>
<tr>
<td>• “Direct” – for versions sold only Off-Exchange</td>
<td>• “Direct” – for versions sold only Off-Exchange</td>
<td></td>
</tr>
<tr>
<td>Rationale</td>
<td>Rationale</td>
<td>Rationale</td>
</tr>
<tr>
<td>• Names convey value</td>
<td>• Our silver plans are very similar to each other in terms of overall value but have more variable benefits</td>
<td>• One version per market</td>
</tr>
<tr>
<td>• Our Bronze plans are more different from each other</td>
<td>• Fewer plan variations than Silver</td>
<td></td>
</tr>
<tr>
<td>• Fewer plan variations than Silver</td>
<td>• Simple number approach allows the consumer to distinguish between plans and the items that matter to them (premium, deductible, MOOP)</td>
<td></td>
</tr>
</tbody>
</table>
Plan summary

Arizona Product Strategy

- Desire lowest Bronze, lowest Silver, 2nd lowest Silver
- Competitive Gold & Catastrophic
- Focus on benefits displayed prominently on Exchange
- Maintained 2019 plans to allow for passive renewals and better retention
- Added 2 new Silver plans to position as lowest & 2nd lowest cost; 1 new Bronze for expanded/richer benefits
- Silver Direct options offer cheaper off-exchange plans for unsubsidized consumers
- Anticipate Bright Bronze will capture our most premium-focused consumers and Bronze Premier will capture subsidized and unsubsidized members looking for a richer benefit without the price
Plan strategies

- Minimal changes to existing plans to allow passive renewals & better retention
- Adding 2 new Silver plans targeted to price-shoppers without affecting renewals in existing plans
- Differentiate CSR variations – options with lower deductible or MOOP
- Our CSR load is spread across all Silver plans, so unsubsidized consumers can purchase either of our 2 “Silver Direct” plan off-exchange at a lower cost
Plan highlights and copays

Plan highlights

• No Primary Care Selection Required
• No referrals required
• Minimal Changes - most related to Federal limits, deductible and Maximum Out of Pocket changes
• Plans available on and off exchange
• Out of network coverage - urgent/emergent services only
## Plan overviews – Phoenix & Tucson

### GOLD and SILVER

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Gold</th>
<th>Silver 1</th>
<th>Silver 2</th>
<th>Silver 3</th>
<th>Silver 4</th>
<th>Silver 1 Direct Direct</th>
<th>Silver 2 Direct Direct</th>
</tr>
</thead>
<tbody>
<tr>
<td>IND Deductible</td>
<td>$3,500</td>
<td>$4,700</td>
<td>$4,000</td>
<td>$5,000</td>
<td>$3,200</td>
<td>$5,500</td>
<td>$3,500</td>
</tr>
<tr>
<td>FAM Deductible</td>
<td>$7,000</td>
<td>$9,400</td>
<td>$8,000</td>
<td>$10,000</td>
<td>$6,400</td>
<td>$11,000</td>
<td>$7,000</td>
</tr>
<tr>
<td>IND MOOP</td>
<td>$8,150</td>
<td>$8,150</td>
<td>$8,150</td>
<td>$8,150</td>
<td>$8,150</td>
<td>$8,150</td>
<td>$8,150</td>
</tr>
<tr>
<td>FAM MOOP</td>
<td>$16,300</td>
<td>$16,300</td>
<td>$16,300</td>
<td>$16,300</td>
<td>$16,300</td>
<td>$16,300</td>
<td>$16,300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>20%</td>
<td>40%</td>
<td>40%</td>
<td>40%</td>
<td>30%</td>
<td>40%</td>
<td>30%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>2 Free visits Then $20 per visit visit</td>
<td>$40</td>
<td>$35</td>
<td>$40</td>
<td>$30</td>
<td>$40</td>
<td>$30</td>
</tr>
<tr>
<td>Specialist Care</td>
<td>$45</td>
<td>40%</td>
<td>40%</td>
<td>$75</td>
<td>$75</td>
<td>$75</td>
<td>$75</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$75</td>
<td>$75</td>
<td>$75</td>
<td>$75</td>
<td>$75</td>
<td>$75</td>
<td>$75</td>
</tr>
</tbody>
</table>

### RETAIL RX

| Tier 1: Preventive | $0 | $0 | $0 | $0 | $0 | $0 | $0 |
| Tier 2: Generics   | $10 | $15 | $15 | $25 | $15 | $25 | $15 |
| Tier 3: Pref Brands| $50 | $0 | $0 | $80 | $80 | $100 | $80 |
| Tier 4: Non-Pref Brand Brand | $0 | $0 | $0 | Ded/Coins | Ded/Coins | $0 | Ded/Coins |
| Tier 5: Specialty  | $0 | $0 | $0 | $0 | Ded/Coins | Ded/Coins | $0 | Ded/Coins |

*Benefits for In-network services and providers only.*
# Plan overviews – Phoenix & Tucson
## BRONZE and CATASTROPHIC

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Bronze</th>
<th>Bronze Plus</th>
<th>Bronze Premier</th>
<th>Bronze HSA</th>
<th>Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td>IND Deductible</td>
<td>$8,150</td>
<td>$7,500</td>
<td>$5,000</td>
<td>$6,850</td>
<td>$8,150</td>
</tr>
<tr>
<td>FAM Deductible</td>
<td>$16,300</td>
<td>$15,000</td>
<td>$10,000</td>
<td>$13,700</td>
<td>$16,300</td>
</tr>
<tr>
<td>IND MOOP</td>
<td>$8,150</td>
<td>$7,500</td>
<td>$8,150</td>
<td>$6,850</td>
<td>$8,150</td>
</tr>
<tr>
<td>FAM MOOP</td>
<td>$16,300</td>
<td>$15,000</td>
<td>$16,300</td>
<td>$13,700</td>
<td>$16,300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>0%</td>
<td>0%</td>
<td>40%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Primary Care</td>
<td>2 visits $50 then Ded/Coins</td>
<td>2 visits $50 then Ded/Coins</td>
<td>$25</td>
<td>0%</td>
<td>3 visits $20 Then Ded/Coins</td>
</tr>
<tr>
<td>Specialist Care</td>
<td>Ded/Coins</td>
<td>Ded/Coins</td>
<td>Ded/Coins</td>
<td>Ded/Coins</td>
<td>Ded/Coins</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$75</td>
<td>$75</td>
<td>$75</td>
<td>$75</td>
<td>$75</td>
</tr>
<tr>
<td>Inpatient Hospital</td>
<td>Ded/Coins</td>
<td>Ded/Coins</td>
<td>Ded/Coins</td>
<td>Ded/Coins</td>
<td>Ded/Coins</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>Ded/Coins</td>
<td>Ded/Coins</td>
<td>Ded/Coins</td>
<td>Ded/Coins</td>
<td>Ded/Coins</td>
</tr>
<tr>
<td>RETAIL RX</td>
<td>Tier 1: Preventive</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Tier 2: Generics</td>
<td>$25</td>
<td>$20</td>
<td>$25</td>
<td>0%</td>
<td>Ded/Coins</td>
</tr>
<tr>
<td>Tier 3: Pref Brands</td>
<td>Ded/Coins</td>
<td>Ded/Coins</td>
<td>$0</td>
<td>Ded/Coins</td>
<td>Ded/Coins</td>
</tr>
<tr>
<td>Tier 4: Non-Pref Brand Brand</td>
<td>Ded/Coins</td>
<td>Ded/Coins</td>
<td>$0</td>
<td>Ded/Coins</td>
<td>Ded/Coins</td>
</tr>
<tr>
<td>Tier 5: Specialty</td>
<td>Ded/Coins</td>
<td>Ded/Coins</td>
<td>$0</td>
<td>Ded/Coins</td>
<td>Ded/Coins</td>
</tr>
</tbody>
</table>

-Benefits for In network services and providers only.
Pharmacy benefits

We've partnered with pharmacy benefit manager Envision Rx to provide access to thousands of pharmacies locally and across the country.

2,000 Statewide pharmacy locations

65,000 National pharmacy locations

Includes access to pharmacies at stores where members already shop.

Walmart

CVS Pharmacy

Walgreens

Costco Pharmacy, Rite Aid, Harris Teeter Pharmacy, Safeway Pharmacy, Publix Pharmacy, Sam’s Pharmacy and may other chain and Independent Pharmacies
Pediatric Dental and Vision

Pediatric dental & vision coverage is for plan members under age 19 and includes:

- Diagnostic and preventive procedures
- Basic restorative services
- Extraction surgery
- Endodontics
- Medically necessary orthodontia and prosthodontics *
- One set of standard frames or contact lenses

*Cleft lip an Cleft Palate
Rides, Meals, & Cash Rewards
Our members get more for less

Bright Health offers more than just benefits to our members.

Rides
Get rides to and from appointments.

Meals
Have meals delivered after a hospital stay.

Bright Health Rewards
Earn cash by completing healthy actions.
Perks → Rides, Meals, & Cash Rewards

Bright will offer legacy “Perks” plan designs in 2020 - with new plan names.
Changing “Perks” to Rides, Meals, & Cash Rewards for all members!

### Plans Offering Conditions

<table>
<thead>
<tr>
<th>PLANS</th>
<th>OFFERING</th>
<th>CONDITIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rides</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bronze</td>
<td>4 one-way trips</td>
<td>Must enroll in a “Perks” specific plan and enroll in recurring payments</td>
</tr>
<tr>
<td>Silver</td>
<td>8 one-way trips</td>
<td></td>
</tr>
<tr>
<td><strong>Meals</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bronze</td>
<td>10 meals</td>
<td>Must enroll in a “Perks” specific plan, enroll in recurring payments, and have an inpatient hospital stay (first stay only)</td>
</tr>
<tr>
<td>Silver</td>
<td>14 meals</td>
<td></td>
</tr>
<tr>
<td><strong>Copays</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bronze</td>
<td>Variable based on market $25-$50</td>
<td>Must enroll in a “Perks” specific plan, enroll in recurring payments, and visit a PCP</td>
</tr>
<tr>
<td>Silver</td>
<td>Variable based on market $25-$50</td>
<td></td>
</tr>
</tbody>
</table>

### Plans Offering Conditions

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<tbody>
<tr>
<td><strong>Rides</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAT, Bronze, Silver, &amp; Gold</td>
<td>Up to 4 one-way trips</td>
<td>No recurring payments requirement – all plans qualify</td>
</tr>
<tr>
<td><strong>Meals</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAT, Bronze, Silver, &amp; Gold</td>
<td>4 days of meals (14 meals)</td>
<td>No recurring payments requirement – all plans qualify, triggered by each discrete inpatient hospital stay</td>
</tr>
<tr>
<td><strong>Cash Rewards</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAT, Bronze, Silver, &amp; Gold</td>
<td>Variable rewards offered for taking healthy actions (could include PCP visit, etc.)</td>
<td>All reward conditions will be reward by reward</td>
</tr>
</tbody>
</table>
Rides

What do members receive?

• Up to four rides to and from their doctor through our partner, Circulation, who contracts and credentials local non-emergency medical transportation (NEMT) companies and Lyft drivers
• Option to bring up to two guests per ride
• Ability to request one of their previous drivers

Other ride details

• Members can schedule rides on-demand or up to six months in advance
• Number of available rides and pre-approved locations depend on member’s plan

Members can call Member Services to schedule a ride.
Meals

What do members receive?

• One-time meal delivery of nutritious, shelf-stable or flash frozen meals following each hospital stay
• Option to personalize meals based on dietary needs and restrictions

Other meal details

• More than four days of meals - 14 per hospital stay
• Ability to include eligible family members
• Discounts on future purchases

Members simply call Member Services to request their meals.
Bright Health Rewards – Earn Cash

Members can earn cash rewards for taking healthy actions.

Log in to the Member Hub and create a profile

Complete healthy actions

Bright Health sends members a preloaded Bright Health Rewards Visa®

Health actions include things like finding a Primary Care Provider (PCP) or going to an annual wellness visit. Rewards also change throughout the year, like getting a flu shot during flu season.
Marketing
The Brighty Bunch is back! (so is the whistle)
Agency: Figliulo & Partners, LLC
Client: Bright Health Management, Inc.
Title: Fast Exits IFP Master
Length: :30
Code: BIHM0185000H
Date: 06/05/2019

Not for Broadcast; Pending Substantiation & Legal Disclosures

(See more?)
Thank you!
Changes to Public Charge
Public Charge
Final Rule Update

Presented by Erika Mach | Updated September 25, 2019

*This presentation is NOT legal advice. For more details, please speak with an immigration attorney.*
Bite size facts
WHAT is the Public Charge definition?

PREVIOUS DEFINITION
• A person who is considered “likely to become primarily dependent on the government for subsistence.”

NEW DEFINITION
• A person who “receives one or more public benefit... for more than 12 months in the aggregate within any 36-month period...”

Under the new definition:
(Number of Benefits) x (Number of Months Used) = Aggregate of Benefits
The public charge test takes place in the following instances:

1. When a person who is in the United States (i.e. work visa, student visa, family petition) applies to adjust his/her status to a lawful permanent resident (LPR) (or green card)

2. Applies from another country (embassy) to enter the U.S.

3. A green card holder leaves the U.S. for more than 180 consecutive days (6 months) and reenters
WHO is excluded from the Public Charge test?

The following is a list of people who would NOT go through the public charge test:

- People applying for citizenship
- People renewing their green card (unless they have been out of the country for 180 consecutive days)
- Refugees
- Asylees
- Survivors of domestic violence, and victims of trafficking or other serious crimes
- Special immigrant juveniles
- Temporary protected status (TPS)
- DACA recipients (only when applying for DACA or renewing their DACA status)
- Certain other groups (Amerasians, Afghan and Iraqi military translators, certain Cuban and Haitian adjustment applicants, certain Nicaraguans and Central Americans under NACARA, registry applicants, Soviet and Southeast Asian Lautenberg parolees)

www.AACHC.org
WHAT are the Public Charge Benefits Considered?

**Old Rule**

- *Cash Assistance for Income Maintenance*
- Long Term Institutional Care at Government Expense

**New Rule**

- Supplemental Nutrition Assistance Program (SNAP or Food Stamps)
- Federal, State, Local and Tribal Cash Assistance
- Housing Assistance (Public Housing or Section 8 Housing Vouchers and Rental Assistance)
- **Medicaid** (with exceptions)

* Included under current policy
** Exceptions for **MEDICAID ONLY** (1) emergency medical conditions, (2) coverage of children under 21, (3) women who are pregnant and up to 60 days postpartum, and (4) Medicaid services provided through the Individuals with Disabilities Education Act (IDEA) and schools.
WHICH programs are excluded from public charge?

Any programs NOT listed on the previous slide, including, but not limited to:

- School-based nutrition services
- Public education, including Head Start
- WIC
- CHIP program (KidsCare)
- ACA tax credits
- Earned Income Tax Credit (EITC)
- Medicare Part D financial assistance
- Community Health Centers and their sliding-fee scale
WHAT are other factors looked at?

Totality of Circumstances

- Age
- Health
- Family status
- Financial status
- Education and skills
- Affidavit of support

The public charge test is forward-looking

Is the person likely to rely on cash or long-term care in the future?

- No one factor (including past use of cash benefits) can alone determine whether or not someone is a “public charge”
- Positive factors can be weighed against negative factors
WHAT is looked at in the Totality of Circumstances Test?

- **Income and Financial Status**
  - Under 125% FPL (negative); Over 250% FPL (heavy positive)

- **Age**
  - Under 18 or over 61 (negative)

- **Education and Skills**
  - Includes proficiency in English

- **Health**
  - Medical condition likely to require extensive treatment, institutionalization or interfere with ability to care for self, attend school or work

- **Family Status**

- **Affidavit of Support**
WHEN will the Public Charge rule go into effect?

Changes to the Public Charge rule will take effect October 15, 2019.

To date, six federal lawsuits have been filed against the changes and may delay the implementation date.

(For the newly added benefits, benefits used before the implementation date WILL NOT be considered.)
WHAT should I keep in mind?

Ayensa Millan | Managing Attorney, Founder and CEO at Cima Law Group
WHAT should I keep in mind?

● The rule is not in effect yet.
  ○ Applies only to applications submitted on or after October 15, 2019.
  ○ Newly named benefits used prior to that date will not be considered.

● Not everyone is subject to the rule.
  ○ Many immigrants are exempt from the public charge inadmissibility ground.
  ○ Benefits used by family members will not be counted.

● Positive factors can be weighed against negative factors in this forward-looking test.

● Every situation is different.
  ○ You can consult with an immigration attorney if you have questions about your own case.
WHICH resources are available?
WHAT do we tell immigrants and their families?
Community-Facing Talking Points

- **Fight fear with facts - KNOW YOUR RIGHTS.**
  - The public charge rule was designed to be confusing, complicated, and scary on purpose. You have rights in this country no matter where you were born.

- **It’s not over - we still have a chance to stop the rule.**
  - Advocates are using every tool at their disposal to stop this rule from taking effect - including in the courtroom.

- **This public charge test does not apply to every immigrant.**
  - Exempt immigrants include: refugees; asylees; survivors of trafficking, domestic violence, or other serious crimes (T or U visa applicants/holders); VAWA self-petitioners; special immigrant juveniles; and certain people paroled into the U.S. Benefits received when people are in one of these statuses will not be counted against them. And lawful permanent residents (green card–holders) are not subject to a public charge test when they apply for U.S. citizenship.
Community-Facing Talking Points

- Use of public benefits alone will not make you a public charge.
- The public charge test does not consider benefits used by family members.
  - Benefits used by eligible family members are not counted unless the family members are also applying for a green card.
- The rule does not consider benefits used before October 15, 2019.
  - *For NEWLY added benefits only.
- Your personal information is protected.

*Ultimately, health care, nutrition, and housing programs can help you and your children remain strong, productive, and stable. The best thing a family can do is keep meeting their children's needs - keep taking them to the doctor, keep feeding them, keep a roof over their heads.*
Conversations with Immigrants

Do you or your family members already have green cards?
The DHS public charge test does not apply to you. However, if you plan to leave the country for more than 6 months, it is a good idea to talk with an immigration attorney. *The public charge test is not part of a US Citizenship application.

Do you have or have applied for one of the following statuses?

- U.S. Citizenship
- U or T Visa
- Green card renewal
- Asylum or Refugee status
- DACA renewal
- Special Immigrant Juvenile Status
- TPS

The public charge test does not apply to the categories listed here. If you already have or are in the process of applying for one of these immigration statuses, you can continue to use any government programs that you qualify for.
Conversations with Immigrants

Does your family plan to apply for a green card or visa from inside the United States?
If you aren’t sure whether or not this policy applies to you, we recommend that you seek advice from an attorney who understands the new changes. If you are not subject to the public charge test, we recommend that you continue to get the assistance that you and your family needs.

Does your family plan to apply for a green card or visa from outside the United States?
U.S. consular offices abroad use different rules in making this decision. You should talk with an expert for advice on your case before making any decisions.

For free or low-cost options near you, go to:
www.immigrationadvocates.org/nonprofit/legaldirectory
Questions from Immigrants

I was just granted asylum status a few months ago, now I’m worried that using SNAP is going to stop me from getting my green card.

I’m scared to sign up for WIC, I know that WIC is a public benefit.

I’m pregnant and need help. I’m currently enrolled in Medicaid but I’m afraid it will be used against me.

Coverage under my Medicaid plan is the only option for health insurance for my children who 12 and 19 years old.

My friend says public charge will apply to her. She disenrolled from SNAP. She said I should too.

My brother is applying for citizenship but uses Section 8 housing vouchers. Is he a public charge?

www.AACHC.org
How to respond to questions

I was just granted asylum status a few months ago, now I’m worried that using SNAP is going to stop me from getting my green card.

I’m pregnant and need help. I’m currently enrolled in Medicaid but I’m afraid it will be used against me.

My friend says public charge will apply to her and so she disenrolled from SNAP. He said I should too.

The public charge test does not apply to asylees. We encourage you to stay enrolled in SNAP - it will not impact your green card application.

The public charge test will not consider non-emergency Medicaid used by pregnant women up until 60 days after they give birth. We encourage you to get the health care that you and your baby need.

Everyone’s situation is different. What may be good advice for one person could be bad advice for another. We encourage you to learn more about your situation and speak to an immigration attorney.
How to respond to questions

I’m scared to sign up for WIC, I know that WIC is a public benefit.

You’re right - WIC is a public benefit. BUT it is not included in the public charge test. We encourage you to sign up for programs you are eligible for.

Coverage under my Medicaid plan is the only option for health insurance for my children who 12 and 19 years old.

The public charge test has a specific exception for children under the age of 21 that use Medicaid. Your kids fall under that exception - their use of Medicaid will not be considered in their public charge test.

My brother is applying for citizenship but uses Section 8 housing vouchers. Is he a public charge?

The public charge test does not come up when people apply for U.S. citizenship. Section 8 housing vouchers are considered for public charge, yes. But since your brother is applying for citizenship - public charge does not apply.
EMPOWERMENT THROUGH COMMUNITY EDUCATION

*The more we know about our rights - the harder it is for us to be intimidated*

Educate communities on the following:

- **Accessing services and assistance**
  - Feel safe going to the doctor’s office and sensitive locations

- **Enrolling in benefits programs**
  - Figure out what you are eligible for
  - Privacy protections of personal information
  - Children’s eligibility for programs
  - State-funded programs
WHAT can organizations and our communities do to fight back against public charge?
Direct and Indirect Effects

• **Directly affected individuals**
  - The proposed threats could prevent immigrants from using the programs their tax dollars help support, preventing access to healthy, nutritious food and secure housing.

• **Broader population of people subject to “chilling effect”**
  - Family members living with or sponsoring immigrants, particularly U.S. citizen children
  - Non-family sponsors, co-sponsors, and joint sponsors (community members, religious congregants, family friends, etc.)

• **States and localities**
• **Providers and communities**
• **All of us**
The Big Picture

As many as **26 million** people in families with immigrants might be chilled from participating in programs that make their families healthier and stronger.¹

There is already a chilling effect. The Urban Institute reported that 1 out of 5 low-income immigrant families were afraid to access public benefits.²

1 in 4 children have an immigrant parent.³

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¹“Public Charge Proposed Rule: Implications for Non-Citizens and Citizen Family Members Data Dashboard,” Manatt Health, October 2018
³"Nearly 20 Million Children Live in Immigrant Families that Could Be Affected by Evolving Immigration Policies" Kaiser Family Foundation, 2018
Document the Harm

Be aware how our communications could add to this chilling effect.

• Meanwhile, please help us continue documenting this harm/chilling effect
• Documentation needs:
  o Disenrollment from Medicaid, SNAP, WIC, or other public benefits
    ✓ Even if the program is not included in final rule
  o Cases where immigrants/immigrant families share fears about public charge (to teachers, doctors, attorneys, pastors, etc.)
  o For state/local governments, ask eligibility workers to report examples of chilling effects, and monitor own administrative data for trends in decreased enrollment/utilization

www.AACHC.org
Thank You

Erika Mach
Grassroots Coordinator
602.288.7542 | erikam@aachc.org
ARIZONA ENROLLMENT TOOLS

1-800-377-3536
Where to Conduct Outreach?

Interactive maps are available at www.coveraz.org/outreach

- Click on “Uninsured Rate by County” Link
Thank you!

Please complete your evaluation!

Please TAKE FLYERS!