12-2013

Creative Products in a Service Industry: A look into the Health Insurance Industry

Aaron Michael Lepsch
lepsam64@mail.buffalostate.edu

Advisor
J. Michael Fox
First Reader
J. Michael Fox

SUNY – Buffalo State
State University of New York
International Center for Studies in Creativity

Creative Products in a Service Industry: A look into the Health Insurance Industry

A Project
In Creative Studies
By
Aaron M. Lepsch

Submitted in Partial Fulfillment
Of the Requirements
For the Degree of
Master of Science

December 2013

ABSTRACT OF A PROJECT

Creative Products in a Service Industry: A look into the Health Insurance Industry

The purpose of this project is to look into products within the health insurance industry within New York State and determine whether current models can identify whether the insurance products are creative. With the advent to healthcare exchanges starting January 1, 2014, the healthcare industry is making tremendous changes within the industry. Federal and State regulators are mandating more coverage, implementing more rules and regulations as well with standardizing products. Due to this standardization, how might you classify one insurer's product more creative to another insurer with the exact same product? Models like the Creative Product Analysis Model (CPAM) and Consensual Assessment Technique (CAT) provide a framework to assess whether a product may be deemed creative. This project looks into current models to measure creative products and discussion occurs whether these models are sufficient. Questions and future research are identified within the project for future work.

Key Words: Creative Product, Exchange, Health Insurance

_____

_____

Date

SUNY – Buffalo State
State University of New York
International Center for Studies in Creativity

Creative Products in a Service Industry: A look into the Health Insurance Industry

A Project
In Creative Studies
By
Aaron M. Lepsch

Submitted in Partial Fulfillment
Of the Requirements
For the Degree of
Master of Science

December 2013

Dates of Approval:

_____ _____

Project Advisor: J. Michael Fox

_____ _____

Candidate: Aaron M. Lepsch

TABLE OF CONTENTS

LIST OF FIGURES

SECTION 1: BACKGROUND TO THE PROJECT

Purpose

The purpose of this project is to look at products in the health insurance industry, within New York State and determine ways to define how they may or may not be creative. In addition to determining whether the health insurance products may be creative, discussion will occur about current models and assessments that analyze the creativity of products and how these models and assessments for creative products may not suffice for such a heavily regulated business like health insurance. Health insurance products are not a normal consumable like ketchup or mustard. Health insurance products tend to be complex products made up of services and benefits which a member may or may not utilize.

Description

Health insurance products affect a vast majority of the U.S. population. Starting January 1, 2014, every citizen of the U.S. must have health insurance or face tax penalties under the Affordable Care Act that President Obama passed in 2010 (PPACA, 2013). Health Insurance may be obtained through what the government is calling “health care exchanges.” The U.S. government has its own exchange. States also had the ability to create their own exchange, for example, New York that decided to create its own healthcare exchange to meet the federal mandate.

This project looks at the New York State Exchange, which is formally called, “NY State of Health” (New York State of Health, 2013). Single and family coverage may be obtained for individuals and small group employers. My project focuses on the individual market within the

Buffalo area, where any New York resident within the Western New York area may obtain health insurance at their own discretion. My review mainly consists of what the New York Department of Financial Services calls “Standard Plans” (Standard benefit design cost sharing description chart, 2013). Discussions around non-standard plans occur, but the framework for discussion is around how a regulated product that has standard benefits may be creative to the individual considering purchasing the plan.

I looked at the benefits and designs that New York State has dictated and compared them against current creative models that are used to identify how products are creative. The two models that are used for discussion are the Creative Product Analysis Model (CPAM) by Susan P. Besemer (2006) and the second model is the Consensual Assessment Technique (CAT) by Teresa M. Amabile (Amabile, 1982). These two models vary in approach on how to assess creative products, but the constructs in which products are determined creative are quite similar.

The health insurance products discussed in this project are from several health insurance carriers that decided to participate in the exchange. These insurance carriers received New York State approval for their plan designs to be sold on the New York State Exchange. The products and information discussed will be applicable to only New York State, but cost structure to the member will be particular to the Buffalo, New York market.

Literature was reviewed for both the health insurance market in New York, but I also reviewed health insurance statistics across America. I focused my project on a particular set of offerings, but the principal behind the health care exchanges are similar across the board in

New York State and America. Literature was reviewed on the structure of the two creative product assessment models. Descriptions of each model are provided along with statistics that explain the validity and reliability of each model.

Questions around how the creative product models apply to the health insurance products are discussed. The questions will are created to discover gaps of identifying the creativity of each product. Questions are examined to determine whether the models have all the applicable tools and structure to measure the creativity of the health insurance products.

Through the examination and breakdown of the creative product models and health insurance products, further items are identified for plausible answers, identified gaps, areas of limitation and the potential for future research. Discussions around questions, gaps, limitations and future research are identified. Next steps are identified for each item of discussion.

Rationale for Selection

Why did I choose Creative Product?

During my studies at the International Center for Studies in Creativity, I was always fascinated by the literature around creative products. Through my tenure at the program, I noticed a large gap in research. There has been a lot of research around creative person, creative process and the creative environment, but there was a gap in quantity of research around creative product. The gaps in research made me want to dig further into creative product and understand why this subject has not been reviewed more often.

Besides the gaps of research, I am a fanatic for products in general. I am a person that enjoys taking things apart and understanding how they work. I often enjoy reviewing and understanding how similar products are different from one another and like to examine how each function may give it an advantage on the competition and influence an individual to purchase the product over another competitor's product.

Products influence our lives every day. It may be as simple as the quality of brew in our coffee machine, to the plethora of options we may have in our vehicles that we purchase. These products may assist us with our daily activities, nourish us for the daily grind, and represent who we are as individuals. Reasons like the above are why I am so motivated and passionate for understanding what makes a product creative.

Besides understanding what makes a product creative, I am also fascinated to see how these products change our lives. I often think of inventions like the printing press, telephone, computer and internet. Not only did the inventors feel that there was a need for this invention, but they saw an opportunity to change the world. These inventions created a legacy for the inventors, created companies to sell the products and gave consumers another way to make their lives more efficient and easier.

Why did I choose Health Insurance Products?

I chose the health insurance industry due to my exposure and experience as a Product Manager for HealthNow New York Inc. HealthNow sells individual and group insurance to employers and individuals throughout New York State. HealthNow is a health insurer headquarted in the Buffalo, New York area that sells health insurance under the brands of BlueCross BlueShield of Western New York, BlueShield of Northeastern New York and HealthNow New York Inc. (HealthNow New York Inc., 2013).

As a Product Manager, I was directly involved in the implementation of healthcare reform for my company. My team and I created health insurance products for the New York State Exchange. These products include some of the products that will be discussed in the proceeding sections of this project. My understanding of the health insurance market in New York and my experience as a Product Manager increased my motivation and passion for creative products.

The experience of creating and implementing these products has made me take a step back and look at what both New York State and my company wish to do for the future of healthcare in the state. I want to understand how the market will react to our changes along with understanding how the products HealthNow releases will affect the choice and lives of the people we serve. During my research and work, I wanted to see how I might incorporate creativity into the marketplace for consumers to become educated about health insurance and use their benefits to their maximum potential.

Health Insurance is something that everyone will use or wished they would have had in their lifetime (Kelly, 2013). Health Insurance products are distinctive in the realm of products since it performs multiple benefits for the individual using the product. Health insurance products are not your typical consumable or service that one would receive. Health Insurance products can provide benefits for wellness, provide access to doctors to save your life and to make you feel financially comfortable and sound that you won't have to pay your life savings because of a surgery.

Creative Products and Health Insurance

Because of the rapid change in America around health insurance and my experience as a Product Manager for a local health insurer, I felt it was necessary for me to review and compare how creative products and health insurance are linked together. Since every American will be forced to carry health insurance or face a penalty, I believe these products will have an ever growing impact on our lives.

It will be important for consumers to be educated around what kind of insurance coverage they are purchasing. It will be important for health insurance companies to provide the tools and services to arm their members with the knowledge necessary to take control of their health. It will be important for our country to implement necessary rules and regulations to help curb the rapid growing cost of healthcare.

If individuals, health insurers, hospitals, physicians and the government can work together, we can understand what kind of creative products that members will need to access their health insurance and use if effectively to maintain their health. Besides the necessary

collaboration between sectors, we first need to understand what makes a health insurance product creative. Creative Product Analysis Model (CPAM) and the Consensual Assessment Technique (CAT) may be a start to identify how a health insurance product is creative, but this is not the end. Further research needs to be conducted for healthcare products and creative products in order to further grow the opportunity to educate members and reduce unnecessary costs for ourselves, our government and our health insurers.

SECTION 2: LITEATURE REVIEW

During my review of the literature, I found a number of articles, books and websites to address several areas of importance. The areas of importance were identified to ensure that my review of creative products and health insurance products on the New York State Exchange are sufficient to support my findings. The following sections will be used to supplement my findings and were used to influence my work on this project.

Creative Product

What is a Creative Product?

One might say, creativity in products is in the eyes of the beholder. Consumers often walk in with an expectation of what they want in the product (Besemer, 2006, pg. 29). People might say that a product is creative because it looks clean and neat. You might have someone say that the product is creative because if fixes issues in half the time of competitors products. You might have someone say that the product is the first of its kind and no one has ever created something like this. Each answer may be deemed creative and it's up to the user to determine the creativity of the product based on the user's knowledge, preferences, likes and dislikes that they have.

If the person using the product thinks it is creative, then the company probably met its obligation for what they wanted to provide to the consumer. However, everyone has their own definition of creativity. In addition, what is creative to one individual may not be creative to another individual.

Susan P. Besemer and Teresa M. Amabile tried to capture what defines a creative product. Both researchers created assessments to try and determine the level of creativity a product may have. These models and assessments are great foundations of work to use. However, models and assessments should always be tested and tuned by additional research and refinement. There should never be an end when it comes to building of off prior findings and create something new or refined from previous work.

The Creative Product Analysis Model (CPAM)

The Creative Product Analysis Model (CPAM) began in 1981 when Susan P. Besemer and Donald J. Treffinger published the first iteration of the model. Besemer's research categorized dimensions of creativity in products (Besemer, & Treffinger, 1981). Besemer's created an assessment to supplement her model, it is called the Creative Product Semantic Scale (CPSS) (Besemer, & O'Quin, 1986).

The dimensions of the CPAM have been refined over the years and currently follow the categorization of dimensions as Novelty, Resolution and Style (Besemer, 2006). Style was originally referred to as Elaboration and Synthesis. Novelty is categorized as how new a product is to the individual. Resolution is categorized as how the well the product solves a problem or challenge it was meant for. Style is categorized as how aesthetically pleasing it is to the individual (Besemer, 2006). Similar references to these dimensions may be found in discussions around creative product and aesthetic elements by David Cropley and Arthur Cropley (2008) and how to assess product engineering creativity (Kobe, 2009).

Within these three dimensions of CPAM, there are subset items of each dimension. Novelty has two subsets, which are how original and surprising the product may be to the user. Resolution has four subsets, which are how logical, useful, valuable and understandable the product may be to the user. Resolution has three subsets, which are how organic, well crafted and elegant the product is to the user (Besemer, 2006). The below figure breaks the CPAM model out in more detail:

Figure 1: The Creative Product Analysis Model (CPAM)

NOVELTY	**RESOLUTION**	**STYLE**
The extent of newness in the product: In terms of the number and extent of new processes, new techniques, new concepts included	The degree to which the product fits or meets the needs of the problematic situation	The degree to which the product combines unlike elements into a refined, developed, coherent whole, statement or unit
ORIGINAL The product presents unexpected or unanticipated information to the user, listener, or viewer	LOGICAL The product or solution follows the acceptable and understood rules for the discipline	ORGANIC The product has a sense of wholeness or completeness about it. All the parts "work well" together
SURPRISING The product is unusual or infrequently seen in a universe of products made by people with similar experience and training	USEFUL The product has clear practical applications	WELL CRAFTED The product has been worked and reworked with care to develop it to its highest possible level for this point in time
	VALUABLE The product is judged worthy because it fills a financial, physical, social, or psychological need	ELEGANT The product shows a solution that is expressed in a refined, understated way
	UNDERSTANDABLE The product is presented in a communicative, self-disclosing way, which is "user-friendly"	

Besemer, S. P. (2006). *Creating products in the age of design.* Stillwater, OK: New Forums Press. Pg. 198.

The CPSS had a number of revisions over the years as well. When Besemer first created the assessment, it was a 110 item checklist that used a four point scale to rate the products creativity (Besemer, 1997). In 1989, the CPSS was reduced to a 55 item checklist (Besemer, 1997; Besemer, & O'Quin, 1989). The current CPSS has 55 items with contrasting adjectives that are used on a Likert scale from one to seven. The assessment takes approximately ten minutes to complete and comes in multiple languages (Ideafusion, 2013, October 20).

The CPAM and CPSS have gone through multiple studies where Besemer and other researchers have tested the reliability and validity of her model and the assessment (Besemer, 1989, 1997, 1998, 2006; White, 2001). The research has shown the CPSS is reliable and that the three dimensions and eleven subscales of the CPAM are valid. The CPSS assessment may be used in a variety of applications to assess how creative a product may be.

One example of how the assessment may be used was done in a study that compared three chairs (Besemer, 1998). The study used naïve judges and showed that participants differed among their considerations for what they thought was creative. This study confirmed that the CPAM and CPSS holds a good amount of reliability and validity around its dimensions to identify a creative product. The judges had no training or expertise in the field to make be regarded as an expert.

One example where the CPAM and CPSS were used by another individual for a study was in White and Smith's study on Advertising (2001). This study used both naïve judges and experts within the advertising industry. Students consistently gave the highest ratings for creativity, where the experts consistently game the lowest rating for creativity. The general

public usually split the middle between the students and experts. The study shows that both naïve judges and expert judges may assess the creativity of a product accurately based upon the constructs of the assessment.

Since most products are used for the purposes of a company or organization to make some kind of revenue, Besemer understood that the CPSS should be identified for use in business applications. Besemer identified that the assessment and model is best used for testing for marketability, testing product design, addressing product improvement areas, advertising, and team processes. Besemer also said that the CPSS may be used for screening ideas, diagnosing brand problems, and competition analysis (Besemer, & O'Quin, 2006). Besemer explains that through using the CPSS, the assessment will identify gaps and concerns that may need to be addressed. This would allow organizations to identify challenges and fix problems that occur through the findings of the CPSS.

The Consensual Assessment Technique (CAT)

Theresa Amabile has had a vast amount of research and experience in creativity. Amabile has focused a good portion of her work around motivation, but has research, a model and an assessment to identify creative products (Amabile, 1997). For example, studies conducted by Amabile have shown that reward based incentives often inhibits the creative process and that someone who was given free choice and motivation to complete the task without any rewards are often more creative (Amabile, 1997). Amabile believes creativity is the fruition of expertise, creative skills and task motivation working together. For example, an expert with motivation and training around creative skills, one could reasonably assume that a

higher rated creative product may be produced from the process rather than someone who didn't have the motivation, expertise, tools and training to be creative.

Amabile created an assessment called the Consensual Assessment Technique (CAT), which uses a panel of experts to judge the creativity of product based on a scale of high to low creativity. Examples of the scale are a rating of one to five or a one to six. If a higher number is represented, the higher the amount of creativity in the product (Amabile, 1982; Kaufman, 2008; Hickey, 2001).

The CAT is distinctive in the sense that it allows the expert to judge the creativity based on a subjective assessment of their expertise in the particular field of the product. The participants are asked to create some form of a product and then are judged by experts on their creation. Participants are given guidelines, but also given freedom to express themselves in a creative manner. Even though guidelines are set, no limitations are imposed in order to allow the participant free roam to create what they feel will answer the request. General examples of products that have been reviewed with this assessment are poems, musical compositions and paintings (Kaufman, 2007; Hickey, 2001).

One of the downsides of this approach is that it takes time and there is typically a cost associated with gathering experts to judge works of products. In addition to the bias and cost of an expert judge, some of the studies that have reviewed CAT have found that novice judges provided reliable ratings that correlated with the expert ratings (Kaufman, 2007; Kaufman, 2008). Discussions have identified that further research should be conducted to test between novice and expert judges.

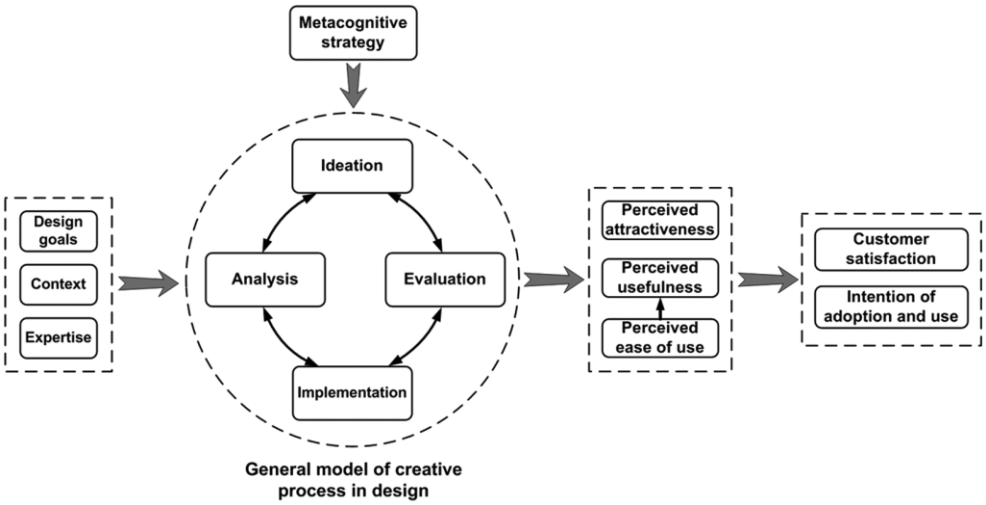
The CAT assessment has had several studies that were conducted to determine if the CAT was reliable and held the proper amount of validity. Each study that was reviewed confirmed that the CAT was both a reliable assessment the held the proper amount of validity (Kaufman, 2007; Kaufman, 2008; Hickey, 2001)). Examples of studies conducted reviewed whether raters could reasonably agree on creativity across multiple products (Kaufman, 2007), whether expert and non-expert ratings would differ (Kaufman, 2008) and whether multiple levels of experience would judge creativity of a product differently (Hickey, 2001). Each of the respective studies confirmed that CAT could provide a general consensus of creativity across multiple products, allowed reasonable agreement among products and showed that there were differences between ratings of experts and non-expert ratings.

Creative Product and Process

In the section above, I mentioned how Amabile identified creative processes and expertise may affect the outcome of a creative product. During my review of the literature, I found a study that used such thoughts of the creative process affecting the level of creativity along with domain specific knowledge having a direct impact on the level of creativity. The study found that both domain specific knowledge and the creative process have a positive correlation in the level of creativity of a product being produced. The products that they were reviewing were in the domain of information technology (Zeng, 2011).

The individuals who worked on this study created their own general model of creative process, which is represented in the figure below:

Figure 2: Model of creative process and perceived value by the consumer



Note: from Zeng, L., Proctor, R. W., & Salvendy, G. (2011). pg. 247).

The above figure identifies key aspects that Amabile mentions to influence motivation in creativity. Zeng mentions that expertise should be categorized, a creative process is used, along with having the motivation of goals and context in which you want to solve the challenge. Arthur Cropley and David Cropley provided a similar model to the one discussed above, which confirms a similar process towards approaching creative product and process (Cropley, & Cropley, 2008.)

Creative Product and Style

Another area of interest during my review of creative product literature was around style. I thought it would be interesting to reference how an individual's style may influence how creative a product may be judged. Puccio and Treffinger used the Kirton adaptor-innovator theory to examine style. This theory identifies a cognitive style preference towards creativity. Innovator is categorized as someone that liked constant change and high degrees of novelty, in

the sense of originality. Adaptor is categorized someone that liked minimal change with less amounts of surprising characteristics to the novelty of the creativity (Puccio, & Treffinger, 1995).

What Puccio and Treffinger found was the adaptors were more likely to be concerned around creating products that would solve a problem. Innovators were more focused on creating products that would exhibit high levels of novelty. These findings were value neutral. Puccio and Treffinger did state the further research should be done since this is a preference and that someone could be pushed towards the opposite end of the continuum if the need arose.

Creative Product and Culture

One of the gaps goes untouched when it comes to creative products is the cultural differences that a product may bring to a market. If the product is offensive from a cultural perspective, it may be stagnant in terms of sales to consumers. A study done by Levickaitė discusses how industries and economies are tied to each other from a cultural perspective. Levickaitė talks about how creative industries often embrace the culture in which they are working and tend to be the backbone of the economy (Levickaitė, 2012). A study was not conducted in this article, but Levickaitė discussed points that should be researched and reviewed further. Rasa Levickaitė captures this in the following statement, “If culture is perceptible in the anthropological or functional sense, one might use the concept of the cultural product” (Levickaitė, 2012, pg. 256).

Health Insurance Products

Health Insurance creates products that allow consumers to access healthcare from physicians and facilities to maintain and take care of someone's health. These products are not like normal consumable goods, but they are complex products that bring in a mix of service and care for the consumer. No research or studies were found to relate current creative product assessments to health insurance products.

What is Health Insurance?

Health Insurance is the process of insuring that the premiums paid by a pool of people and/or organizations sufficiently cover the medical expenses incurred among the individuals enrolled in the insurance (Glossary of Health Coverage and Medical Terms, 2013). Health Insurance products offer a defined benefit structure that the member may utilize to obtain healthcare services from hospitals and providers. There are multiple product designs, which will be discussed in proceeding sections.

Health Insurance provides coverage for services that may range from wellness benefits like a gym membership to important emergency room visits that may save someone's life that is in critical care. Healthcare offers a different perspective into products since it provides services, but must protect itself from risk of unnecessary medical expenses by members, providers and hospitals. In addition, health insurance products are often not completely understood by members and providers. There are multiple levels of coverage and costs are often incurred by all three parties; the insurer, the member and the provider (Austin, 2010).

Health Insurance companies originated in the 1930's and have evolved over the decades that followed. The spur for health insurance occurred due to the great depression that followed the market crash in 1929. Efforts to abide by medical guidelines created organizations to adopt the BlueCross and BlueShield symbol to represent adhering to American Hospital Association (AHA) guidelines (Austin, 2010).

Over the decades, federal and state sponsored programs grew to provide employees with comprehensive coverage for medical benefits. Examples include programs like Medicare and Medicaid programs. These programs are still in use today and are commonly discussed due to the rising cost of healthcare.

Common Terms

For the purposes of my discussion in the proceeding sections, definition of terms are essential to understand language used in the healthcare industry. Since the signing of the Affordable Care Act (ACA) in 2010 by President Barack Obama, standardization has been sought by all federal and state regulators. The terms defined in this section are a reference to a glossary that the federal government demands be used by insurers when providing plan benefits to members (Glossary, 2013; Glossary of Health Coverage and Medical Terms, 2013). For further definitions, please reference appendix A.

- Co-insurance

  Member share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. Member pays co-insurance plus any deductibles they owe. For example, if the health insurance or

plan's allowed amount for an office visit is $100 and they've met the deductible, the member's co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

- Co-payment

A fixed amount (for example, $15) a member pays for a covered health care service, usually when a member receives the service. The amount can vary by the type of covered health care service.

- Deductible

The amount the member owes for health care services that the member's health insurance or plan covers before the member's health insurance or plan begins to pay. For example, if the member's deductible is $1000, the plan won't pay anything until the member has met their $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.

- Excluded Services

Health care services that the health insurance or plan doesn't pay for or cover.

- Health Insurance

A contract that requires the member's health insurer to pay some or all of the member's health care costs in exchange for a premium.

- Hospitalization

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

- In-Network

Contracts with doctors, hospitals, labs, etc. to provide health services to its customers. This group of health care professionals forms a network. Customers usually pay less when they use these in-network health care professionals.

- Medically Necessary

Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

- Network

The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

- Non-Preferred Provider

A provider who doesn't have a contract with your health insurer or plan to provide services to the member. The member will pay more to see a non-preferred provider. Members should check their policy to see if they can go to all providers who have contracted with their health insurance plan, or if their health insurance plan has a "tiered" network and the member must pay extra to see some providers.

- Out-of-Network

Health care professionals, hospitals, clinics and labs that do not belong to the network. Some plans provide coverage for services received from out-of-network health care professionals, but customers will typically pay more and might have to file a separate claim for payment.

- Out-of-Pocket Limit

The most a member pays during a policy period (usually a year) before the member's health insurance plan begins to pay 100% of the allowed amount. This limit never includes the member's premium, balance-billed charges or health care that the member's health insurance plan does not cover. Some health insurance or plans don't count all of the member's co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

- Premium

The amount that must be paid for the member's health insurance or plan. The member and/or the member's employer usually pay this monetary amount monthly, quarterly or yearly.

- Primary Care Physician (PCP)

A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

- Specialist

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

Note: Definitions adapted from Glossary, 2013; Glossary of Health Coverage and Medical Terms, 2013.

Cost of Health Insurance

Over the past decades, healthcare costs have been rising much faster than inflation and employees wages. This has often created political debates on how to solve the growing problem in America. Local, state and federal regulators as well private insurance companies are trying to devise programs and strategies to address this concern.

Medicare may be used as an example when referring to the healthcare cost discussion. In 1967, it was anticipated that Medicare would cost $12 billion by 1990. Actual Medicare costs were roughly $110 billion. That is a $98 billion dollar discrepancy that should be alarming to all regulators, insurers and members. Another statistic is commercial health insurance premiums rose four times faster than employees wages from the years of 1999 to 2007 (Kelly, 2013).

The cost of healthcare is driven by items like the costs of medical services, the costs of prescription drugs, administration costs for the health insurer and mandated benefits that must be covered per federal and state regulators. Health insurers arrange agreements with these

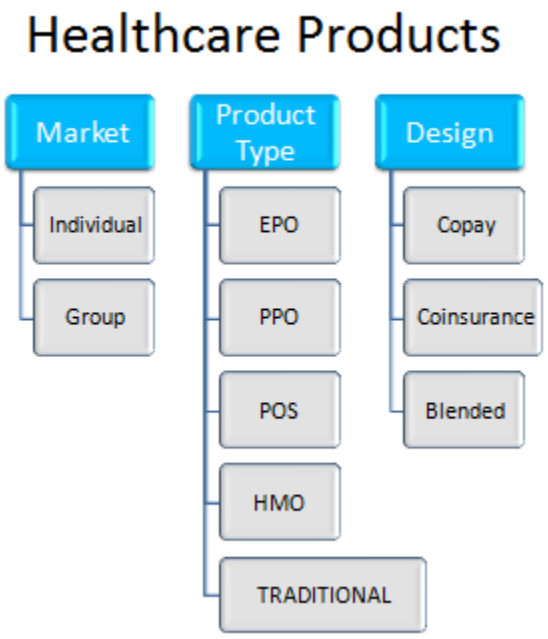
providers, hospitals and pharmacies, but the cost may be much more than one would anticipate. For example, patients may be charge $18 for each diabetes test strip used, where if they were to go on Amazon, an individual may purchase a box of 50 test strips for $27 (Stengel, 2013).

Healthcare costs in America often exceed costs in other countries. This statement often holds true for costs around both medical services and pharmaceutical drugs. For example, the price of one Lipitor pill in the U.S. is equivalent to purchasing three in Argentina. The cost of one Nexium pill in the U.S. is equivalent to purchasing eight in France. The cost of a Coronary Bypass is listed at $67,000 in the U.S., where it is listed at $4,500 in India and $41,000 in Canada (Stengel, 2013).

Health Insurance Products

Health Insurance products may be broken up into many categories. Some of these categories include market, product type and product design. The market may determine what kind of product is sold and may restrict cost shares and plan designs to fit criteria set by both federal and state regulators. Product types will serve a group or individual with a particular need of healthcare services. This may range from a requirement of having a participating provider (PCP) or free roam to go see anyone you want in the pre-determined network. The plan design allows a group or individual to choose what kind of cost sharing parameters they want to pay for the healthcare services. One consistent item between plan designs is the fact that everyone has to pay a premium to the health insurer. Figure 3 below briefly describes some different product attributes:

Figure 3: Healthcare Product Breakdown



Note: Adapted from Health Insurance Basics, 2013.

In order to put the above figure into perspective, I will use federal and New York State classifications. New York State defines the individual market as people who seek out health insurance coverage for themselves or their family without the aid of an employer. Group insurance is broken out as small group and large group. Small group is an employer that has between 2-50 employees. Large group is an employer that has 50 employees or more (Health Insurance Information for Insurers, 2013).

Product types will determine how you will use the plan and if there are strict rules as to providers and hospitals that you may visit for care. Health Maintenance Organizations (HMO) and Exclusive Provider Organizations (EPO) do not allow you to visit providers and hospitals that

are outside of the network. The difference between the two is that you must select a PCP for the HMO plan. EPO plans will allow a member to see any PCP that is in the plans network. Preferred Provider Organizations (PPO) and Point of Service (POS) plans offer out-of-network benefits to the member. However, the POS plan requires a member to select a PCP in order to receive care (Health Insurance Basics, 2013).

Plan designs influence how you will pay for the services allowed under your health insurance plan. If you choose a copay plan, you will pay a fixed dollar amount for services. For example, if you go into the emergency room, you might expect to pay $100 for the visit. If you choose a coinsurance plan and go into the emergency room, you will pay a percentage of the total cost of the visit. For example, if the total cost of the emergency room visit is $1,000 and you have a coinsurance of 20%, you would have to pay $200 for the visit. A blended design is a mix of both coinsurance and copay plans. For example, you may pay a copay for a visit to your PCP, but you may have to pay a coinsurance when you visit the hospital.

Healthcare Exchanges

Healthcare Exchange came about when President Obama signed the Affordable Care Act in 2010. The exchanges are to be implemented for small groups and individuals seeking health insurance on January 1, 2014 and forward. There is a federal exchange for states that did not implement their own exchange. New York State opted in implement an exchange and has named it the New York State of Health (New York State of Health, 2013).

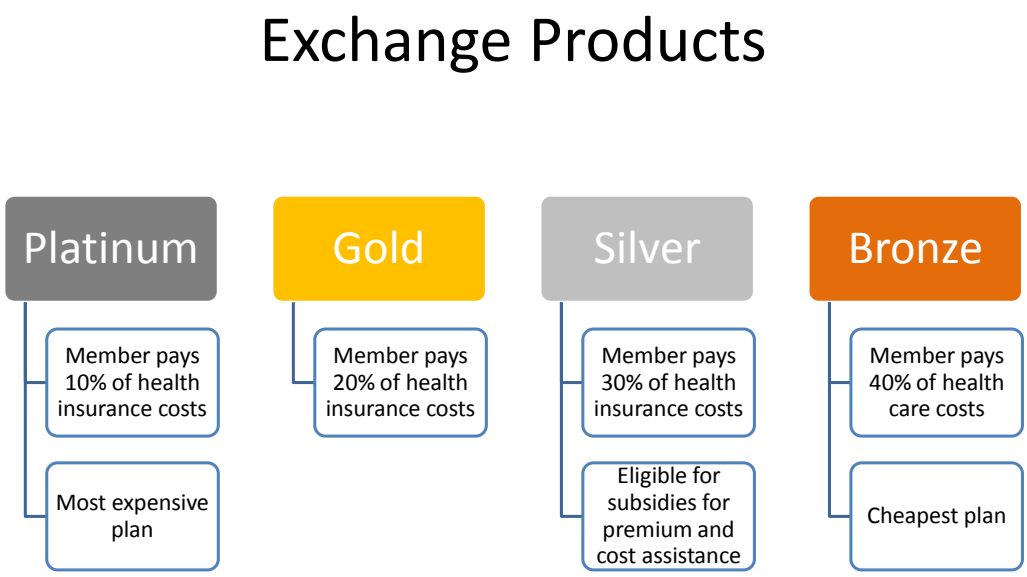
The first healthcare exchange was implemented in Massachusetts per a state law put into effect in 2006. This implementation provided data and framework for states like New York

and the federal implementation. For example, the federal implementation and all states will use plan designs classified at metal levels and will use an actuarial values to determine the metal level. The Massachusetts law has succeeded in reducing the amount of uninsured individuals and unnecessary hospitalizations for preventable illnesses (Ericson, 2012).

New York State Exchange

As described in the previous section, New York State has opted to implement an exchange and must abide by federal regulations of the ACA. The New York State of Health will provide a platform for health insurers to offer health insurance plans for individuals and small groups (2-50 subscribers) on January 1, 2013. Enrollment began on October 1, 2013. Plans will be offered in the following format according to figure 4.

Figure 4: New York State of Health Plan Classification



Note: Adapted from Patient Protection and Affordable Care Act (PPACA), 2013 & Standard benefit design cost sharing description chart (5-6-2013), 2013.

Plans offered by health insurers must meet several criteria. The first criterion addresses actuarial value. Actuarial value assesses a percentage value to which a member and the health plan pay for health care costs. These values are broken out in metallic values, which are identified as Platinum, Gold, Silver and Bronze. Platinum is described as plan in which the member will pay 10% of healthcare costs and the insurer will bear 90% of healthcare costs. Gold plans will embrace 20% of healthcare costs for members, Silver plans will embrace 30% of

healthcare costs for members and Bronze plans will embrace 40% of healthcare costs for members (Actuarial Value Calculator, 2012; Health Insurance Information for Insurers, 2013).

In addition to the above criteria, New York State reviewed the largest membership plans to identify essential health benefits (EHB). EHB's are benefits that must be provided by all plans in the New York State exchange. The largest plan in New York State was Oxford's EPO plan, which was used to determine what benefits must be offered by all plans. This information was compiled by a organization called Milliman (2012). Please reference appendix B for a list of all EHB's.

New York State also implemented what they called "model language" for all plans to use for the exchange. Model language provided a framework for all insurers to complete a legal document called a member certificate. A member certificate is a legal document that writes out what benefits, rules and regulations members have for their health insurance plan (Model Language, 2013). Please visit appendix C and D for examples of model language. These member certificates must be submitted by all insurers and must be approved by New York State Department of Financial Services. These submissions occur through a third party website called Serff (Health Insurance Information for Insurers, 2013; Serff, 2013).

Standard Plans

When New York State created the framework for the exchange, they created a standard plan for each metal level. These plans all had the Essential Health Benefits (EHB), but contained pre-determined cost sharing levels of copayments and coinsurance. Each insurer was required to offer these standard plans on the exchange if the insurer wished to participate in the exchange. This allowed a level playing field for members to choose pre-determined plans. The only thing insurers could control was the amount of premium that they could charge members and groups (Standard, 2013). Figure 5 below provides a high level overview of the standard plans. Please visit appendix E for a complete list of benefits for the standard plan designs.

Figure 5: Standard Plan Designs

New York State Standard Plans

Type of Service	Platinum	Gold	Silver	Bronze
Deductible (single)	$0	$600	$2,000	$3,000
Out-of-Pocket Maximum (single)	$2,000	$4,000	$5,500	$6,350
PCP	$15	$25	$30	50%
Specialist	$35	$40	$50	50%
Inpatient	$500	$1,000	$1,500	50%
Surgery	$100	$100	$100	50%
Emergency Room	$100	$150	$150	50%

Note: Adapted from Approved Monthly Premium Rates, 2013.

All cost shares were determined by New York State and copayments were represented in a fixed dollar amount. Coinsurance was represented by a percentage. Deductible amounts were listed for single plans, but family deductible amounts are two times the single plan amount. Out-of-pocket maximum amounts were listed for single plans, but family out-of-pocket maximum amounts are two times the single plan amount (Standard, 2013).

Since premiums were the only thing that insurers had control over, each plan had to assess the cost to their company through actuarial analysis. Actuaries must submit premium rates to New York State Department of Financial Services for approval as well. New York State published these rates and a high level overview is provided below in Figure 6.

Figure 6: Approved New York State Premium Rates for Standard Plan Designs

New York State Exchange Rates

Insurer	Platinum	Gold	Silver	Bronze
American Progressive	$559.66	$499.11	$433.80	$349.65
Excellus	$635.41	$548.72	$473.43	$366.75
Freelancers	$371.87	$316.93	$280.43	$221.58
GHI	$737.26	$619.56	$527.05	$444.06
HealthNow	$568.41	$494.10	$406.36	$340.10
HIPIC	$834.66	$688.17	$569.67	$487.45
IHBC	$618.94	$538.05	$470.81	$395.74
MVP	$493.30	$418.95	$348.68	$269.50
Fidelis	$500.18	$413.99	$338.11	$267.20

Note: Adapted from Approved Monthly Premium Rates, 2013.

The premium rates above are for standard plans in the Buffalo market. These rates are approved for standard plans offered on the New York State Exchange from January 1, 2014 to December 31, 2014. It is important to note that the list did not state the brand that would be represented in the particular market. For Example, HealthNow would be branded as BlueCross BlueShield of Western New York in the Buffalo market (Approved Monthly Premium Rates, 2013). In addition, it is important to note that the above rates might differ from what you would find on the exchange. This is due to things like dependent coverage and amendments of what insurers wanted to offer on the exchange between the publications released by New York State and when the exchange was opened for enrollment (Approved Monthly Premium Rates, 2013; New York State of Health, 2013).

SECTION 3: METHODOLOGY/PURPOSE

The purpose of my project is to look at the literature of creative products and the literature around healthcare exchanges in New York State and combine them to see if current models and assessments are sufficient to assess whether health insurance products are creative. Before I looked at health insurance products, I reviewed products that may be deemed creative and evaluated whether CPAM and CAT are sufficient models to assess the products creativity. From there, I reviewed what are some aspects that makes consumers want to purchase products. Once that was done, I went into the healthcare exchange products in New York State and evaluated whether CPAM and CAT are sufficient models to assess the products creativity. Both Standard and Non-Standard products were reviewed. To Supplement the Non-Standard products, I reviewed some creative products in the healthcare industry today and how the fit into the New York State Exchange market.

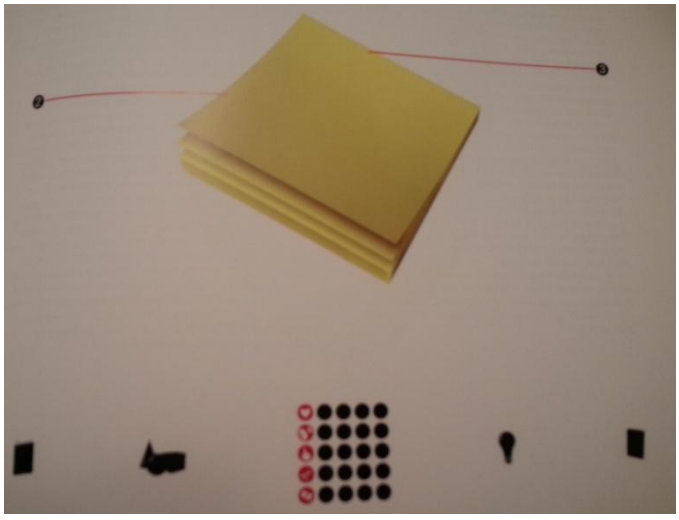
Three Successful Products

I reviewed three products that are in use today and were successful in their respective markets. The three products are the Post-it Note, the Jawbone Wireless Headset and the Model 302-F1 Telephone. These products were assessed by the authors on aesthetics, function, usability, sustainability and commercial success for each product. Each dimension was given a score of one to four (Lidwell & Manacsa, 2009).

Post-it Note

The first product I reviewed is the Post-it Note. The Post-it Note was given a perfect score of 20. The dimensions of aesthetics, function, usability, sustainability and commercial success scored a four out of four. This product was chosen since it is commonly used in the household, office and other places of personal and professional development. The Post-it Note allows an individual to write their ideas down and stick it on a surface. The great advantage of the Post-it Note is that it may be moved from place to place and still adhere to the surface it is placed on (Lidwell & Manacsa, 2009).

Figure 7: Post-it Note



Note: Screen shot of Lidwell, & Manacsa, 2009.

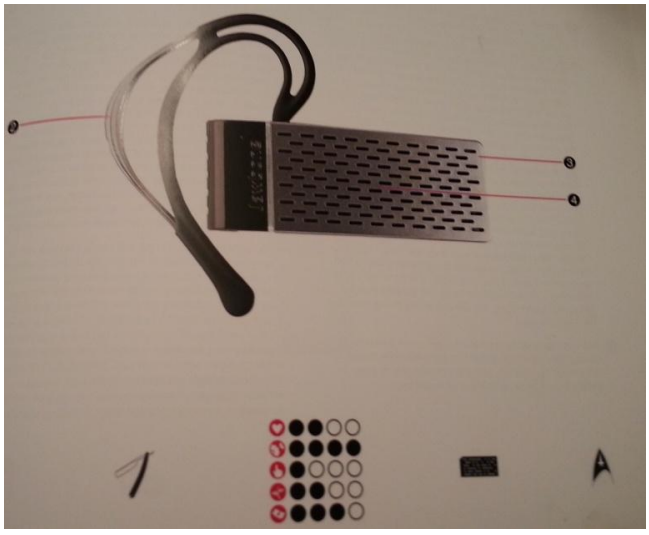
If this product was reviewed by the CPAM and CAT creative products models, one would assume that the Post-it Note should achieve high scores since it was a revolutionary product that never existed before and has maintained great commercial success. The product has a high degree of novelty since it was the first of its kind. The product has a high level of resolution

since it solves the problem of writing your ideas down and having the usability to move it around as needed. Finally, the product comes in many shapes and sizes to allow for the user to pick the style that fits their needs.

Jawbone Wireless Headset

The second product I reviewed is the Jawbone Wireless Headset. The Jawbone Wireless Headset was given a score of 12 out of 20. The dimension of aesthetics achieved a score of two, the dimension of function achieved a score of four, the dimension of usability achieved a score of one, the dimension of sustainability achieved a score of two and the dimension of commercial success achieved a score of three. This product was chosen since it is an example of a product that did not achieve higher scores in each respective dimension. The Jawbone Wireless Headset allows the user to take wirelessly from their cell phone or device without having to hold it to their head (Lidwell & Manacsa, 2009).

Figure 8: Jawbone Wireless Headset



Note: Screen shot from Note: Screen shot of Lidwell, & Manacsa, 2009.

If this product was reviewed by the CPAM and CAT creative products models, one would assume that the Jawbone Wireless Headset should achieve medium scores for creativity. The product has a medium degree of novelty since it is distinctive to the market and is a newer technology. The product has a high level of resolution since it solves the problem talking without cords and without having to hold a device to your head. Finally, the style of the product is symmetrical, but it is rugged since it is not round and pleasing to the eye when compared to most designs in the market today.

Model 302-F1 Telephone

The third product I reviewed is the Model 302-F1 Telephone. The Model 302-F1 Telephone was given a score of 16 out of 20. The dimension of aesthetics achieved a score of three, the dimension of function achieved a score of four, the dimension of usability achieved a score of two, the dimension of sustainability achieved a score of three and the dimension of commercial success achieved a score of four. This product was chosen since it is an example of a product that achieved higher scores in each dimension, but it is a technology that would necessarily not be applicable to the market in 2013 and beyond. The Model 302-F1 Telephone allows the user to make phone calls to the number in which they dial (Lidwell & Manacsa, 2009).

Figure 9: Model 302-F1 Telephone

Note: Screen shot from Note: Screen shot of Lidwell, & Manacsa, 2009.

If this product was reviewed by the CPAM and CAT creative products models, one would assume that the Model 302-F1 Telephone should achieve different scores for creativity based on the context of the assessment. The Model 302-F1 Telephone was released in 1938 and was meant for that time period. This allowed the user to call phone numbers. With the advent of touch screens and smart phones, this product is now obsolete in 2013. If the assessment was given in the context of its time period, the product should be given a medium degree of creativity. The product has medium level of novelty since it was an adaption of a current invention, but made refinements to improve the product. The product has a high level of resolution since it solves the problem calling someone that may be a couple blocks away or on a different continent. Finally, the style of the product is medium-high for the time period since the shell was ergonomic and futuristic for the time period.

Influences to Purchasing Products

The three products described above show how products can be creative in the sense of providing something innovative like the Post-it Note that was never created before and also how little changes in the telephone make people's lives easier. However, creativity in the product does not mean that everyone will see their value and will purchase the products. There are many factors that go into a purchase decision, for example, people might have psychological factors to drive their purchase since they feel a need or a want for the product (Besemer, 2006). In addition to the psychological factors, people have socioeconomic factors that could drive purchase decisions. A product may fit well into a culture within the United States, but it may not fit well into a different culture that has different values (Besemer, 2006).

Selecting the Right Product

Organizations have a complicated decision to make in which they have to account for so many purchasing factors that could influence a customer to purchase their product. If organizations need to account for these factors, how do they choose what product to sell? The product development process often tries to identify what customers are best suited for their product through market research and looking at specific aspects of each product.

Organizations have to look at factors like utility, need, sales appeal advantages to competitor products, market size, patentability, research and development costs, setup costs, profit potential, sustainability, assessment of your competition, product life and compatibility of the product (Arnold, 2010; Athma & Kumar, 2007; Kroll, Condoor, & Jansson, 2001; Niebel & Draper, 1974). Each factor will assess whether the product is a viable choice to sell to

consumers and will provide the organization with a product that will be commercially successful along with achieving the mission and values of the company. If the product meets the necessary criteria, it could be seen to production, but there also may be many products that will never see the market or production line since it didn't provide the necessary criteria to meet the organizations expectations.

Insurance Products vs. Consumables

Insurance products do not differ in the selection process of whether a product is a viable choice for the market in which they wish to sell. However, insurance products do have two features that bring in additional assessment of whether the product is viable. One feature that is additional to insurance products is the fact they have to weigh the risk of the individuals that will choose a product and assign a value to that risk that will meet all expenses. In addition to this feature, insurance is a product that receives premiums from its members rather than a normal consumable that you purchase and then own once the exchange has been completed. This premium needs to be assessed as to whether the consumer can afford the coverage of the product.

How Health Insurance Products Evolved

Health insurance products have evolved over the years and within the past decade, there has been multiple new innovations to try and mitigate costs and put the consumer in a place to manage their health more effectively. Examples of how the industry has changed are the introduction of Medicare and Medicaid programs in the late 1950's, the introduction of health maintenance organizations (HMO's) in the 1970's, high deductible health plans (HDHP)

in the early 2000's and recent advent of tiered-network products (Austin & Hungerford, 2010; Regopoulos, Christianson, Claxton & Trude, 2006). Each of these innovations is different and provides a change that tried to cater to particular demographic of individuals.

Medicare and Medicaid products are programs that are regulated by the federal and state government. Medicare products are for individuals that are at the age of 65 or older. Medicaid products are for individuals who are disabled and meet the qualifications for the program. HMO's are products that promote care to be directed by your physician (PCP). HDHP plans are plans that require a member to pay a higher deductible before cost sharing requirements are introduced, but allow members to contribute funds to a health savings account (HSA) or health reimbursement arrangements (HRA). Tiered-network products try to influence coordination of care between the insurance company, physician, hospital and member through a partnership to reduce unnecessary expenses and provide higher quality of care (Austin & Hungerford, 2010; Regopoulos, Christianson, Claxton & Trude, 2006).

Each change in the insurance industry provides the same resolution to the health insurance products. All the changes described above provide healthcare products to the members, which allow them to seek services to maintain their health and/or save their lives. Styles of the health insurance products are controlled by how the insurers market the products to members. The insurers try to create marketing messages and materials that provide a sense of an organic message that is well crafted, along with providing elegant marketing materials that spread the message. Novelty of each product may be the greatest indicator of the products creativity. Each innovation in the industry was created to allow members to take advantage of

new programs and provide members with tools that would allow them to take more control over their health.

Healthcare exchanges that will be implemented on January 1st, 2014 will bring a new dynamic to the industry. The exchange allows individuals and small employer groups to shop for health insurance through a website. The individuals and small employer groups will have the ability to review plans and compare prices. This was not previously available in the health insurance industry. This advent brings a sense of novelty to the products and provides the resolution of providing insurance to individuals that could not previously purchase insurance. Each product has a particular type of style through branding of the company and what type of cost sharing arrangements that the product offers.

Standard Exchange Products

Standard Exchange products are different than normal health insurance products that are offered today. These products are heavily regulated by New York State. The state advises the insurers that they have to offer these products if they wish to participate in a market, the state controls the benefits that are offered and also controls the cost shares that may be administered for all benefits (Health Insurance Information for Insurers, 2013; Milliman, 2012).

The state controls each plan design for each metal level. They have plan designs for Platinum, Gold, Silver, Bronze and Catastrophic. To see the standard plan designs, please visit appendix E. These designs may not have cost sharing requirements amended by any health insurer. This allows customers to have set level of benefits to choose in each “metal” level. In addition to choosing the cost share for the benefits, every insurer must cover the same benefits

to fulfill the essential health benefits clause of the Patient Protection and Affordable Care Act (PPACA) (Milliman, 2012; Patient Protection and Affordable Care Act (PPACA), 2013).

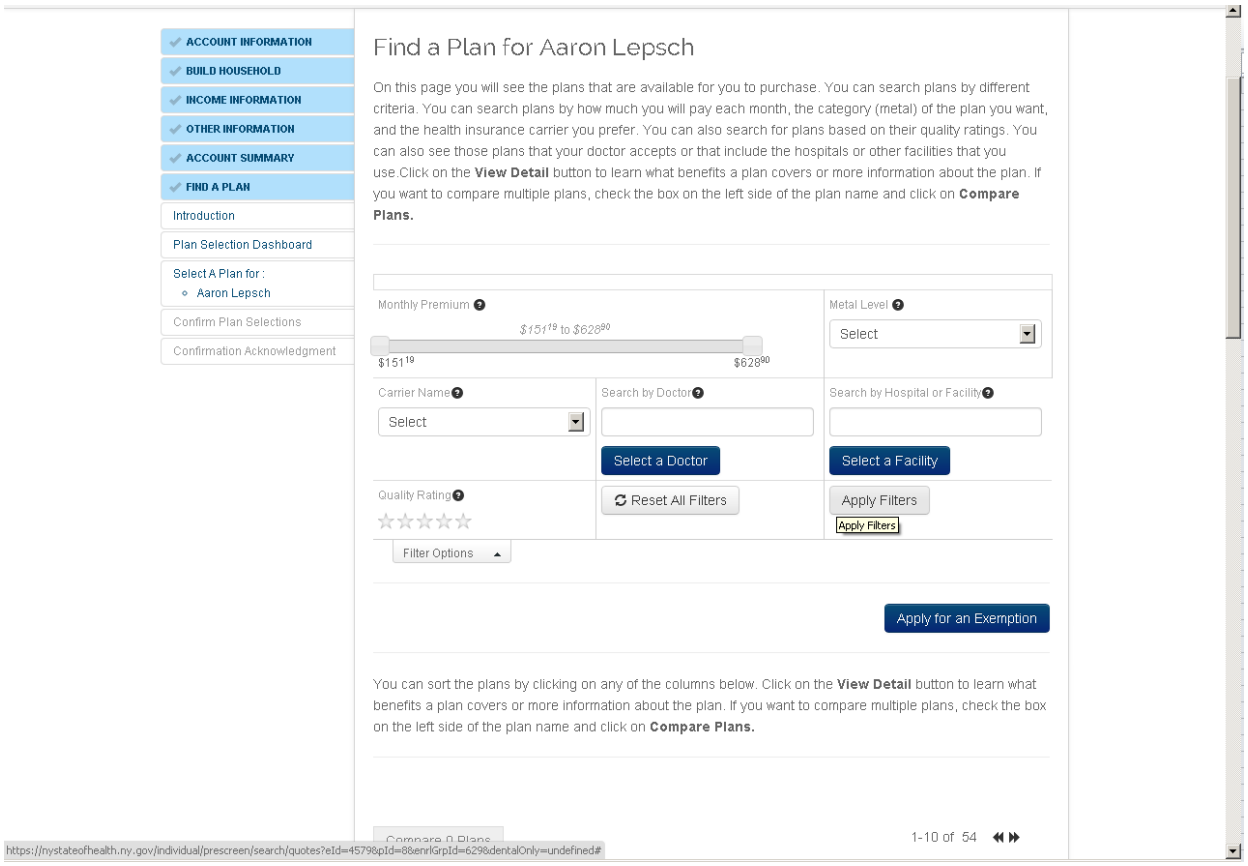
These restrictions do not allow health insurers a lot of flexibility to create products that are different from the competition. The two areas to differentiate the product are the price of each product by each competitor and then the brand that the company holds with the market in which they are selling. This removes all novelty from the product since each product is the same along with all resolution as the products solve the same problem. Style is also restricted since insurers are regulated as to what marketing materials they may put on the New York State website (New York State of Health, 2013). The following figures show the New York State Exchange and how a member may look at plans:

Figure 10: The home page for the New York State of Health

Note: Screen shot from New York State of Health, 2013.

The screen shot above captures the current home page of the New York State exchange. This is where small group employers and individuals will begin their shopping by logging into their account and/or creating an account to begin the shopping process. Resources are also available for members to review as well with a phone number to talk to a live person.

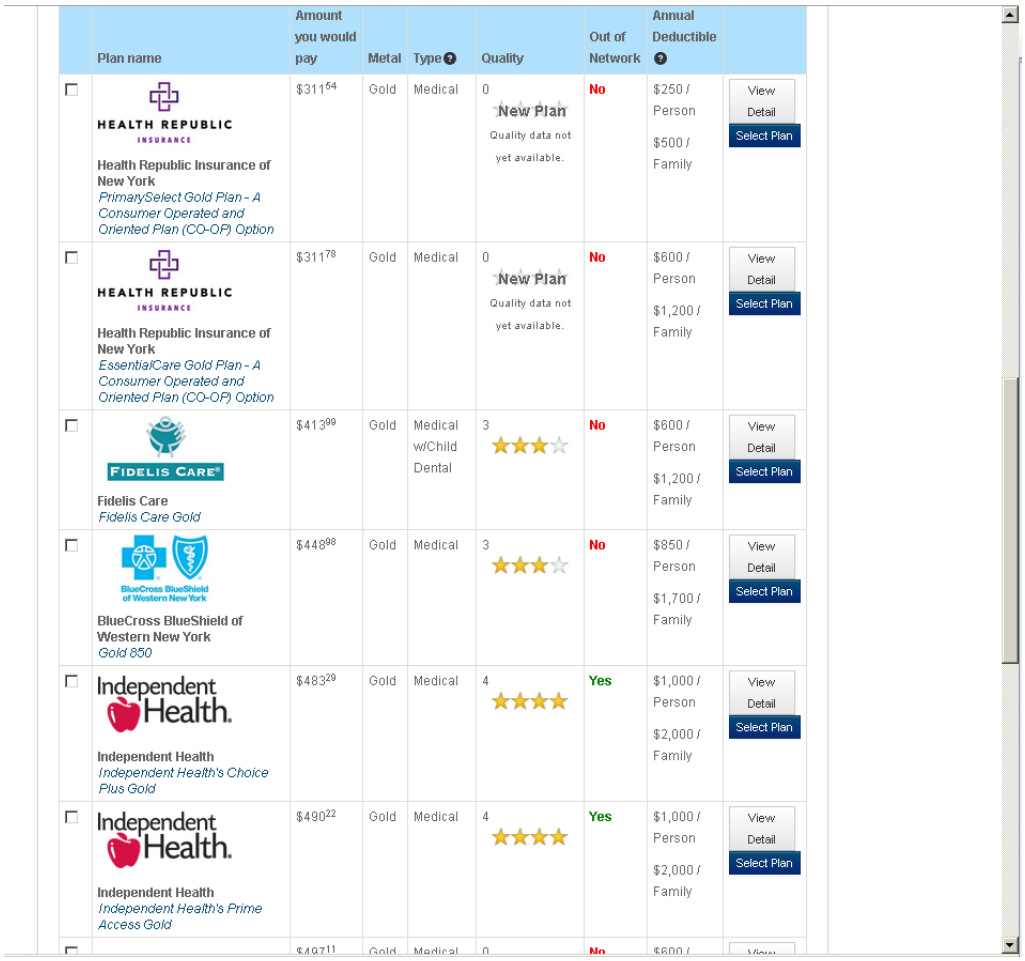
Figure 11: Filtering criteria to search for health plans



Note: Screen shot from New York State of Health, 2013.

The screen shot above illustrates the search function for an individual searching for a health insurance plan. Individuals may filter by premium costs, metal level, health insurer, doctors, facilities and quality rating. These filters will then show the plans that meet the desired criteria.

Figure 12: Screen shot of health plans available in the Buffalo area

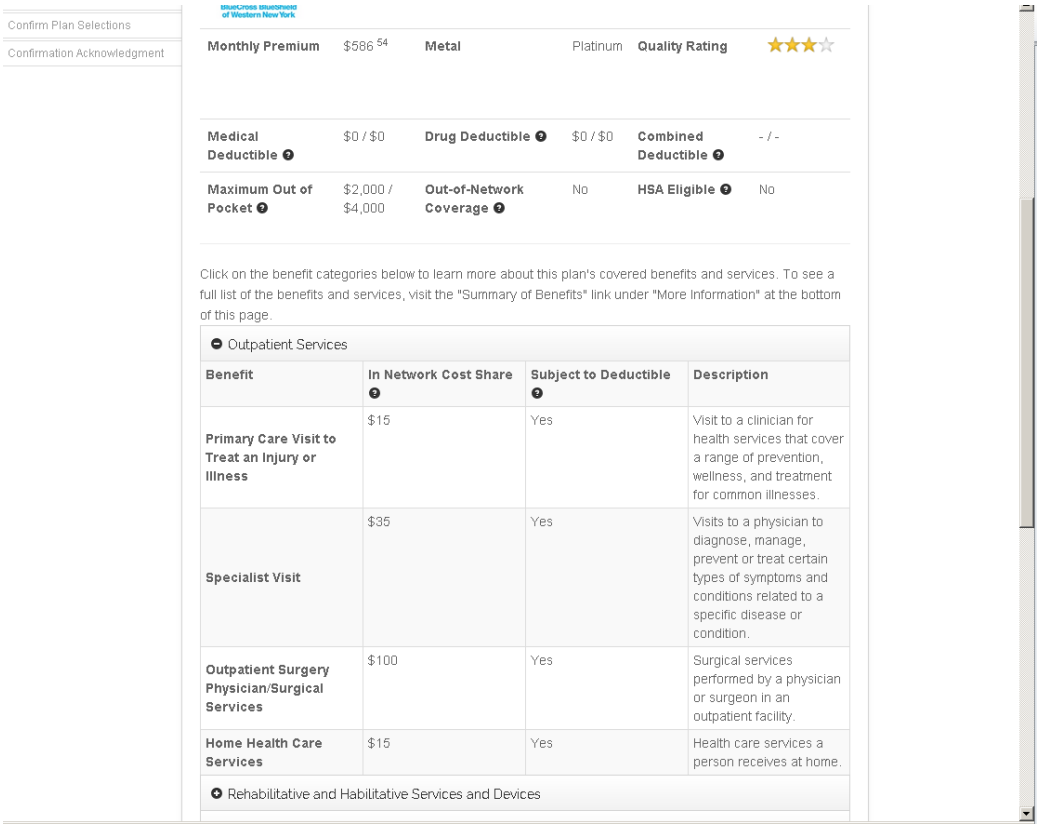


	Plan name	Amount you would pay	Metal	Type	Quality	Out of Network	Annual Deductible	
☐	HEALTH REPUBLIC INSURANCE Health Republic Insurance of New York *PrimarySelect Gold Plan - A Consumer Operated and Oriented Plan (CO-OP) Option*	$311.54	Gold	Medical	0 New Plan Quality data not yet available.	No	$250 / Person $500 / Family	View Detail Select Plan
☐	HEALTH REPUBLIC INSURANCE Health Republic Insurance of New York *EssentialCare Gold Plan - A Consumer Operated and Oriented Plan (CO-OP) Option*	$311.78	Gold	Medical	0 New Plan Quality data not yet available.	No	$600 / Person $1,200 / Family	View Detail Select Plan
☐	FIDELIS CARE® Fidelis Care *Fidelis Care Gold*	$413.99	Gold	Medical w/Child Dental	3 ★★★☆	No	$600 / Person $1,200 / Family	View Detail Select Plan
☐	BlueCross BlueShield of Western New York BlueCross BlueShield of Western New York *Gold 850*	$448.98	Gold	Medical	3 ★★★☆	No	$850 / Person $1,700 / Family	View Detail Select Plan
☐	Independent Health Independent Health *Independent Health's Choice Plus Gold*	$483.29	Gold	Medical	4 ★★★★	Yes	$1,000 / Person $2,000 / Family	View Detail Select Plan
☐	Independent Health Independent Health *Independent Health's Prime Access Gold*	$490.22	Gold	Medical	4 ★★★★	Yes	$1,000 / Person $2,000 / Family	View Detail Select Plan
☐		$497.11	Gold	Medical	0	No	$600 /	View

Note: Screen shot from New York State of Health, 2013.

The screen shot above illustrates plans that are currently available for purchase in 2014 within the Buffalo area. Various health insurers have their company logo on the left, followed by premium, metal level, quality rating, whether they have out-of-network coverage and the deductible costs. Each plan may be chosen to view further information about the plan by clicking on the buttons on the far right.

Figure 13: Screen shot of a platinum plan detail from BlueCross BlueShield of WNY



Note: Screen shot from New York State of Health, 2013.

The screen shot above illustrates a breakout of a single health insurance plan on the exchange. The health plan chosen above is from BlueCross BlueShield of Western New York. The breakout of the plan will contain further cost sharing information, along with a description of what the services denote.

Non-Standard Exchange Products

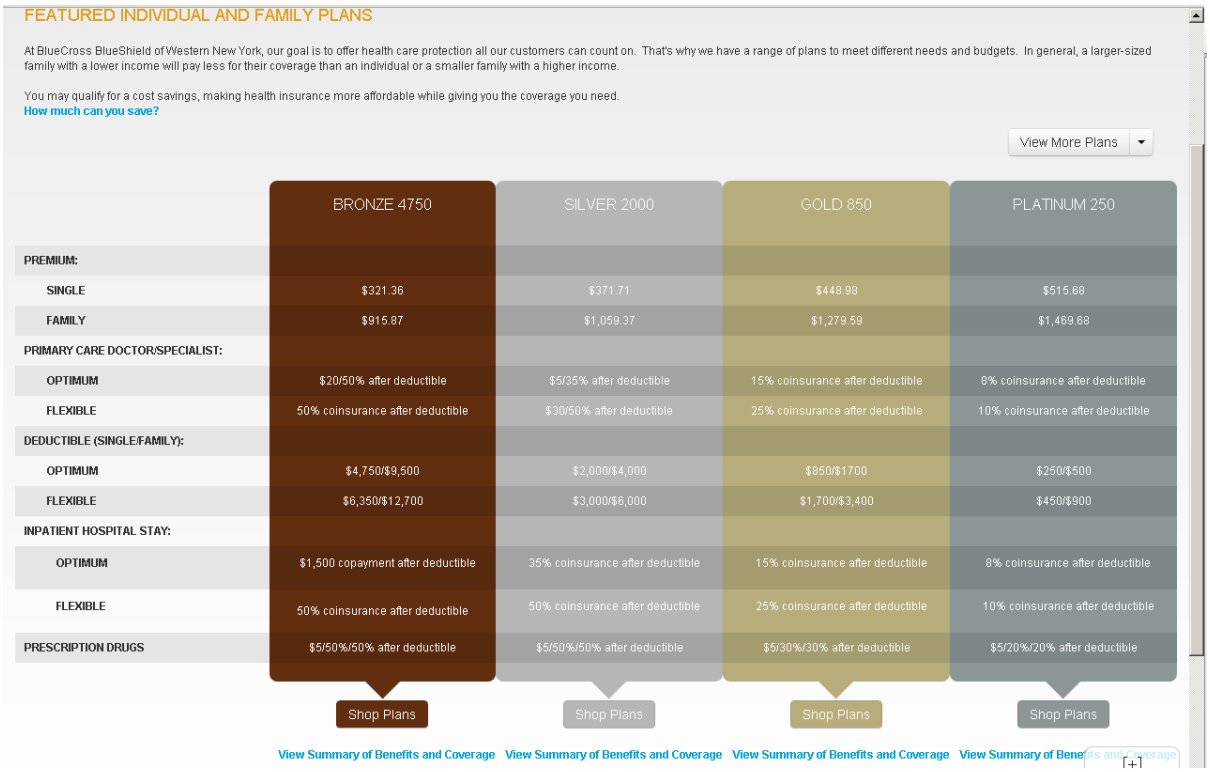
New York State also allows insurers to create their own plan designs as well. However, they must meet an actuarial value metal level of platinum, gold, silver or bronze. Health insurers in New York State were not required to create non-standard plan designs, but most

health insurers did create non-standard in order to differentiate themselves in the market place (New York State of Health, 2013).

One item that is the same among all health insurers and their non-standard plan designs are that they have to offer the essential health benefits as mandated per PPACA. This means that all benefits are the same among the non-standard plans, but the insurers were allowed to affect cost share requirements, network requirements and price. Health Insurers could also offer health savings accounts (HSA) if the plan met the IRS guidelines to offer the tax free savings account. Two of the largest health insurers in the Buffalo, NY areas offered non-standard plan designs with a tiered network. These health insurers were BlueCross BlueShield of Western New York and Independent Health (Individual and Family Plans, 2013; Small Group Plans, 2013).

Typically, health insurance products have in-network benefits and out-of-network benefits. A tiered product has two levels of in-network benefits with different cost sharing requirements in each tier. The reason for the different tiers is to financially draw members to physicians, hospitals and facilities in which they will coordinate the care of the members more effectively and help reduce costs. Figure 14 below shows an example of BlueCross BlueShield of Western New York non-standard plan designs. Full summaries of benefits for some non-standard plan designs may be found in appendix E.

Figure 14: Non-standard plan designs for BlueCross BlueShield of Western New York



Note: Individual and Family Plans, 2013

The screen shot above illustrates non-standard exchange plans that are offered by BlueCross BlueShield of Western New York in the Buffalo region. The screen shot is from the website of BlueCross BlueShield of Western New York. The top of the figure denotes the products name and metal level. The rows of each column represent the premium for the plan, the cost sharing levels for various providers under Optimum and Flexible and the cost for prescription drugs. Further information about each plan is available under the shop plan button at the bottom of the page.

SECTION 4: ANALYSIS AND DISCUSSION

Standard Products

Since standard products on the exchange are fixed for benefits, cost sharing and information represented, how would Besemer's CPAM model fair against assessing the creativity of the products? The Novelty dimension of her model should not render a high score of novelty since most of the product's attributes are fixed and are not drastically new product designs in the market place for health insurance. One would assume that a novelty score should be identical among products since they are essentially the same product from competitor to competitor. If the score is the same, one cannot conclude this dimension would be useful to differentiate the product among competitors.

The products among the competitors solve the same problem and offer the same solution. This dimension should render the same score among competitor products since they are standardized. Style may be the only dimension that may differ to due someone's feelings about the brand. The same information must be posted and represented in the same way as all competitors, so this does not allow much differentiation as well.

Amabile's CAT model should render similar results as well, since the only difference among competitors for these products are price and brand. Since the products are standardized throughout the market region within New York State, they should render similar scores among competitors. One may assume that scores would maybe differ from judge to judge based on personal experience and bias.

Non-Standard Products

Non-Standard products on the healthcare exchange should render different scores when reviewing against the CPAM and CAT model. These products have the same benefits among all products and the products are represented the same way on the exchange for each competitor. However, health insurers may choose cost share requirements, network requirements and offer additional benefits like an health savings account (HAS). Figure 15 below shows the different cost sharing requirements for the metal level of Gold.

Figure 15: Gold Non-Standard Plans

Non-Standard Plans

Health Carrier	BlueCross Blue Shield of WNY		Independent Health	
Type of Service	Optimum Choice	Flexible Choice	Network A	Network B
Deductible (single)	$50	$1,700	$1,000	$2,000
Out-of-Pocket Maximum (single)	$6,350	$6,350	$5,000	$6,350
PCP	15%	25%	$30	40%
Specialist	15%	25%	$50	40%
Inpatient	15%	25%	$500	40%
Surgery	15%	25%	$150	50%
Emergency Room	15%	15%	$150	$150

Note: Adapted from Individual and Family Plans, 2013; Small Group Plans, 2013

Resolution and style among the products should be similar among competitors since the information is represented the same way and these products solve the same problem.

However, novelty should be different for the products since the cost sharing requirements may draw attention to areas of the product design. For example, if you know that you're going to see your doctor in the next month, you may not be comfortable paying a coinsurance since you don't know what your doctor's total charges might be. Someone may like the ability to know the total amount that they will have to pay for a service. Expert judges should also score similarly among other expert judges, but may score different than the normal individual since they are aware of how plan designs affect cost and other aspects of the insurance product.

How the Health Insurance Exchange is Developing

The federal exchange and all the state exchanges are fortunate to have a template to work from. Massachusetts implemented their exchange back in 2006. The exchange has successfully reduced the amount of people who are uninsured along with reducing hospitalizations for preventable illness (Marzilli & Starc, 2012). Enrollees in the Massachusetts exchange often chose the cheapest plan. This often is the best way for someone to evaluate an insurance plan since most people are not familiar with the intricacies of health insurance and what their benefit coverage actually means (Marzilli & Starc, 2012).

The implementation and enrollment of the exchanges for New York and the U.S. is currently underway. The first effective date of these plans will be on January 1st, 2014. Enrollment began on October 1st, 2013. The federal rollout of the exchanges has been a debacle to date and President Obama has faced major criticism throughout the country. Some reasons include website failures, increases in premiums for health insurance plans, and cancelled plans due to rules and regulations of PPACA (Roy, 2013).

New York State has been successful so far and accounts for a large amount of the enrollment in the country as of November 17, 2013. New York State did have issues with their website for the first couple days after October 1st, 2013, but the state quickly addressed issues and fixed the problems. Even though this system is supposed to make purchasing insurance easier for individuals and small employers, it is not as easy as purchasing a plane ticket or booking a hotel (Mulder, 2013).

Influences to Purchase

Based on the experience of the Massachusetts exchange, one might anticipate that enrollees will choose the cheapest plan more often than not. If price will be the driving factor for individuals to choose plans, this will often be plans that are in the Bronze metal level and/or a Catastrophic plan. However, this is not the only factor that will move individuals to choose a plan. Items like your health, age, education, and understanding of insurance and political views may sway your decisions on how to choose a plan.

If you're healthy, it is probably in your best interest to pick up a cheap plan since you will not use many services. If you're unhealthy, you'll probably be more likely to choose a plan that has lower copayments and out-of-pocket maximum. This will allow individuals to spend less out of their pocket, but will have a higher monthly premium. One benefit among all plans on and off the exchange is that they must cover routine services. These routine services are covered in full under PPACA. Preventive services range from an annual physical to lab tests to prevent conditions that may hospitalize you and may make you sick (Patient Protection and Affordable Care Act, 2013).

If you're older, you may be more willing to pay higher premiums. These plans often have the best coverage, in terms of copayments for services. In addition to paying a higher premium, these individuals may have been with one insurance company for years and will want to continue insurance under that company even though other companies are cheaper. This often provides individuals the "peace of mind" mentality.

Since PPACA has made a big stir among the political parties, it is not uncommon to hear individuals say that they refuse to purchase health insurance on the exchange due to their political beliefs. Individuals do have the ability not to purchase insurance, but will have to pay a tax penalty for no insurance coverage (Patient Protection and Affordable Care Act, 2013). Education and understanding of the health plans often play a big role in choice. If you don't understand the plan you are purchasing, other factors may sway your choice more than it probably should (Marzilli & Starc, 2012).

What Might be Other Ways to Measure Creative Products

Based on the review of these insurance products and how they are regulated and presented to the public, CPAM and CAT may not be comprehensive enough to identify if all products may be deemed creative. The research has shown that the models are valid and reliable for consumer goods, but what about products like these health insurance products on healthcare exchanges?

If products are regulated and standardized to the point that novelty, resolution and style cannot successfully measure the products creativity, what might be the other aspects to measure the products creativity? Is it as simple to measure the price of the product? Does the

brand have more influence over purchasing under this scenario? How might socioeconomic and psychological purchasing factors influence the decision on how the product is creative? How might education around health insurance provide consumers with more insight to manage their health? These are all questions that do not have answers at this point and further investigation and formal research should be conducted to assess whether my findings are accurate.

Evolutionary Creativity vs. Revolutionary Creativity

Every product that is introduced into their respective market may contain an amount of evolutionary creativity or revolutionary creativity. Evolutionary creativity represents a change that develops an existing product or construct and improves on the previous version. Revolutionary creativity represents a change that creates a new paradigm that has never been seen previously.

The evolution of health insurance has seen many changes happen over recent decades. The implementation of health care exchanges represents a large change in the health insurance industry. Health care exchanges in America represent a revolutionary change since this construct was never previously available to the public, with the exception of the Massachusetts health care exchange. However, the products offered on these health care exchanges represent an evolutionary change. The products have not fundamentally changed and are an extension of existing paradigms.

SECTION 5: SUMMARY AND RECOMMENDATIONS

Summary

Even though there are multiple ways to assess creativity of a product, there are limitations to which the product may be assessed. The creative product models of CPAM and CAT have a large amount of research to support their reliability and validity. CPAM and CAT are great ways to assess the creativity of a consumable product. However, a complicated product like a health insurance has multiple components that CPAM and CAT seem to miss.

Assessing a creative product with the use of experts, users and dimensions like novelty, resolution and style provide a framework to follow. The CPAM and CAT models have been around for years and have undergone testing by the creators and outside resources to test the validity and reliability of their models. Most products tested under these assessments have been consumables, musical compositions, poems and paintings. During my findings, a review of insurance products to test their creativity was not found for CPAM and CAT.

There are multiple questions that still remain to be reviewed and answered. These questions are fundamental to further dig into what makes a product creative. The possibility for further models and assessments allow an opportunity to grow the field of research around creative product. Such growth is necessary in order to for organizations to understand their consumer and provide products that meet the consumers needs and wants as well as achieving the organizations vision and mission. The growth is also necessary to assist the expansion of scholarly work around a topic that does not have as much volume as other areas of creativity.

Limitations

This review of creative products and health insurance was a preliminary look into the matter. There are multiple limitations of this review. The limitations are around research and discussion points throughout this project. These limitations are opportunities to break out this subject into areas of further research.

The first and largest research limitation of this project is the fact that no formal qualitative and quantitative research was conducted. Data were simply reviewed and assessed based on current available research. Further qualitative and quantitative research should be conducted around creative product and health insurance.

The second limitation is the CPAM and CAT assessments were not used to assess whether the health insurance products were creative. Dimensions of each model that support these assessments were reviewed and discussed, but no qualitative and quantitative research was done to address whether these models may accurately detect creativity within health insurance products. Further studies should be conducted using these assessments to address whether they can detect the creativity of the health insurance product to a level of sufficient reliability and validity.

The third limitation was the focused view on exchange products for New York State in the Buffalo region. There are exchange products throughout the United States that differ from that which is offered in the Buffalo region. Offerings in Buffalo also differ from offerings in the Albany area. A comprehensive look into exchange products would be able to identify trends throughout the country, but may also be skewed as different rules and regulations may be in

place by the state in which the product is being offered. In addition, health insurance products that are offered to large groups are not subject to the same rules and regulations of the healthcare exchange. These products may be a more complicated since groups typically pick their benefits and plan design offerings.

The fourth limitation is the focused view on health insurance products. There are multiple areas of insurance, such as life, auto, pet, etc. These insurance industries have products that should be reviewed and assess whether CPAM, CAT and other models are sufficient to determine whether their products are creative. These products may not have the strict rules and regulations that health insurance products on the healthcare exchange have to conform to.

The fifth limitation is the availability of information around the health insurance industry. More information is currently available on these health insurance products than previously seen by the public, but there is still a large amount of proprietary data that is not accounted for. This data allows the company to maintain competitive edges within their respective regions and also provide a framework in which they develop their strategies in which they create the health insurance products.

The sixth limitation is around the availability of demographic information. This information is available to the insurance companies based on existing data within their company. This data allows the insurance company to determine rates based on the assumed risk that may be taken in by these plans. Actuarial analysis determines these costs, but the development of how Actuarial analysts create rates is not available to the public. This

information would allow the researcher to understand items like the health and risk of age groups, regions of the city and trends of diseases that are common among different groups.

The seventh limitation is around the timing of this project. No historical information is available due to the fact that the exchange products are being rolled out as this paper is written. Further information around the success and failure of these health insurance products will be available in years of 2014 and beyond. This information will be key in determining trends and how products have changed to the situations that have come about.

Recommendations

The first recommendation is to test CPAM and CAT against health insurance products. If these models and assessments are tested in a study for these exchange products, quantitative data would be available to assess whether the models and assessments may predict the creativity of the health insurance product. The quantitative data would be a integral part to identify gaps in which further research should be conducted.

The second recommendation is to test CPAM and CAT against insurance products within the insurance industry. A study like this would expand the review to products within insurance industries like life, auto, etc. The expansion into a different industry would be able to identify whether the CPAM and CAT are sufficient to identify creativity within these insurance products. The quantitative data would be an integral part to identify gaps in which further research should be conducted. In addition to identifying creativity within the products, it would allow someone to assess whether the same occurrences happens across insurance products or may be industry specific.

The third recommendation is to conduct further gap analysis between the models and assessments that try to identify creativity within products. Gap analysis will be critical to identify areas that need further research. These identified areas will determine where these models and assessments are not sufficient to determine creativity within products.

The fourth recommendation is to conduct qualitative studies. The qualitative studies would allow understanding around the sticking points for what makes a health insurance product creative to the user. The data would be able to determine whether different backgrounds, culture and demographics affect how someone determines insurance products as creative. This research may uncover various gaps that had not been identified by the research around creative product.

The fifth recommendation is to identify the need around new models and assessments for creative products. If the current models and assessments are not sufficient, how might we create a new model? There is always the possibility to create new ways to assess creativity in products. A new model and assessment may bring about an additional step in the paradigm of understanding creativity. If a new model and assessment were created, this should be subject to a rigorous review to determine the reliability and validity of the model and assessment.

REFERENCES

Actuarial Value Calculator (2012). *Centers for medicare and medicaid services*. Retrieved October 1, 2013, from http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/av-calculator-final.xlsm.

Amabile, T. M. (1997). Motivating creativity in organizations: On doing what you love and loving what you do. *California Management Review*, 40(1), 39-58.

Amabile, T. M. (1982). Social psychology of creativity: A consensual assessment technique. *Journal of Personality and Social Psychology, 43*, 997-1013.

Approved Monthly Premium Rates. (2013). Retrieved October 20, 2013, from http://www.governor.ny.gov/assets/documents/Approved2014HealthInsuranceRates.pdf.

Arnold, A. K. (2010). *Commercializing creative products*. Creative Studies Graduate Student Master's Projects, Paper 6. Retrieved October 20, 2013, from http://digitalcommons.buffalostate.edu/cgi/viewcontent.cgi?article=1005&context=creativeprojects.

Athma, P., & Kumar, J. (2007). An explorative study of life insurance purchase decision making: Influence of product and non-product factors. *ICFAI Journal Of Risk & Insurance*, 4(4), 40-48.

Austin, D. A., & Hungerford, T. L. (2010). *The market structure of the health insurance industry*. Congressional Research Service, 7-5700, R40834.

Besemer, S. P., & O'Quin, K. (2006). Using the creative product semantic scale as a metric for results-oriented business, *Creativity and Innovation Management 15*(1), 31-41.

Besemer, S. P. (2006). *Creating products in the age of design.* Stillwater, OK: New Forums Press.

Besemer, S. P. (1998). Creative product analysis matrix: Testing the model structure and a comparison among products – Three novel chairs, *Creativity Research Journal 11(4),* 333-346.

Besemer, S. P. (1997). *Creative product analysis: The search for a valid model for understanding creativity in products.* Dept. of Psychosocial Science, University of Bergen, Norway.

Besemer, S. P., & O'Quin, K. (1989). The development, reliability, and validity of the revised creative product semantic scale. *Creativity Research Journal*, *2(4)*, 267-278.

Besemer, S. P. & O'Quin, K. (1986). Analyzing creative products: Refinement and test of a judging instrument. *Journal of Creative Behavior, 20, 2*, 115-126.

Besemer, S. P. & Treffinger, D. H. (1981). Analysis of creative products: Review and synthesis. *Journal of Creative Behavior 15(3),* 158-178.

Cropley, A. & Cropley, D. (2008). Elements of a universal aesthetic of creativity. *Psychology of Aesthetics, Creativity and the Arts, 2*(3), 155-161.

Cropley, A. & Cropley, D. (2008). Resolving the paradoxes of creativity: An extended phase model. *Cambridge Journal of Education. 38*(3), 355-373.

Glossary of Health Coverage and Medical Terms. (2013). Retrieved September 20, 2013, from http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf.

Glossary. (2013). *Cigna*. Retrieved September 20, 2013, from http://www.cigna.com/glossary.

HealthNow New York Inc. (2013). *Company Profile*. Retrieved October 20, 2013, from http://biz.yahoo.com/ic/108/108753.html.

Health Insurance Information for Insurers. (2013). Retrieved October 15, 2013, from http://www.dfs.ny.gov/insurance/ihealth.htm.

Hickey, M. (2001). An application of Amabile's consensual assessment technique for rating the creativity of children's musical compositions. *Journal of Research in Music Education* , *49*(3), 234-244.

Ideafusion. (2013, October 20). Retrieved October 20, 2013 from http://ideafusion.biz/home/.

Individual and Family Plans. (2013). *BlueCross BlueShield of Western New York*, Retrieved October 22, 2013, from https://securews.bcbswny.com/web/content/WNYmember/get-coverage/individual-family-plans.html.

Kelly, A. (2013). The cost conundrum: Financing the business of health care insurance. *J Health Care Finance, 39*(4), 15-27.

Kroll, E., Condoor, S., & Jansson, D. (2001). *Innovative conceptual design: Theory and application of parameter analysis*. New York, NY: Cambridge University Press.

Levickaitė, R. (2012). Interlinks of cultural and creative economies through creative products and services. *Science: Future of Lithuania*, 4(3), 256-261.

Lidwell, W., & Manacsa, G. (2009). Deconstructing product design. Beverly, MA: Rockport Publishers Inc.

Marzilli, & Starc, A. (2012). *Designing and regulating health insurance exchanges: Lessons from Massachusetts*. Inquiry (00469580), 49(4), 327-338.

Milliman (2012). Essential *health benefits for the new york health benefits exchange*. Retrieved on September 15, 2013, from http://www.healthbenefitexchange.ny.gov/sites/default/files/milliman_report_essential_health_benefit_options.pdf.

Model Language. (2013, September 20). Retrieved September 20, 2013, from http://www.dfs.ny.gov/insurance/health/model_lang_indx.htm.

Mulder, J. T. (2013, November 17). *Six things to know about Obamacare and exchanges; As easy to use as Expedia?*. Retrieved November 17, 2013, from

http://www.syracuse.com/news/index.ssf/2013/11/5_things_to_know_about_obamacare_exchanges_as_easy_to_use_as_expedia_no_way.html.

Niebel, B., & Draper, A. (1974). *Product design and process engineering*. New York , NY: McGraw-Hill, Inc.

New York State of Health. (2013, October 20). Retrieved October 20, 2013, from https://nystateofhealth.ny.gov.

Patient Protection and Affordable Care Act (PPACA). (2013). *Center for Consumer Information & Insurance Oversight*. Retrieved September 20, 2013, from http://www.cms.gov/CCIIO/Resources/Files/Downloads/hie3r-ria-032012.pdf.

Regopoulos, L., Christianson, J. B., Claxton, G., & Trude, S. (2006). Market watch: Consumer-directed health insurance products: Local-market perspectives. *Health Affairs,* 25(3), 766-773.

Roy, A. (2013, November 12). The Obamacare exchange scorecard: Around 100,000 enrollees and five million cancellations. *Forbes*. Retrieved November 17, 2013, from http://www.forbes.com/sites/theapothecary/2013/11/12/the-obamacare-exchange-scorecard-around-100000-enrollees-and-five-million-cancellations/

Serff (2013, October 22) Retrieved October 22, 2013, from http://www.serff.com/.

Small Group Plans. (2013). *Independent Health*. Retrieved October 22, 2013, from https://www.independenthealth.com/portal/site/IndependentHealth/menuitem.8d665

0be7a71896a818e6c1020a08a0c/?vgnextoid=bf271ef14c711410VgnVCM100000113110acRCRD.

Standard benefit design cost sharing description chart (5-6-2013). (2013, May 6). Retrieved September 20, 2013, from http://www.dfs.ny.gov/insurance/health/std-exch-bdesign.pdf.

Stengel, R. (2013, March 4). The high cost of Care. *Time*, 3-55.

Health Insurance Basics (2013). What are the different types of health insurance? Retrieved October 20, 2013, from https://www.healthcare.gov/what-are-the-different-types-of-health-insurance//.

Zeng, L., Proctor, R. W., & Salvendy, G. (2011). Fostering creativity in product and service development: Validation in the domain of information technology. *Human Factors*, 53(3), 245-270.

Appendix A: Healthcare Definitions

Glossary of Health Coverage and Medical Terms

- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Bold blue text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

Allowed Amount
Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal
A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing
When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may *not* balance bill you for covered services.

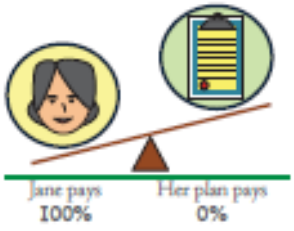
Co-insurance
Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance *plus* any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

(See page 4 for a detailed example.)

Complications of Pregnancy
Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Co-payment
A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible
The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services.



(See page 4 for a detailed example.)

Durable Medical Equipment (DME)
Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition
An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation
Ambulance services for an emergency medical condition.

Emergency Room Care
Emergency services you get in an emergency room.

Emergency Services
Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Excluded Services
Health care services that your health insurance or plan doesn't pay for or cover.

Grievance
A complaint that you communicate to your health insurer or plan.

Habilitation Services
Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance
A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care
Health care services a person receives at home.

Hospice Services
Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization
Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care
Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance
The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment
A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

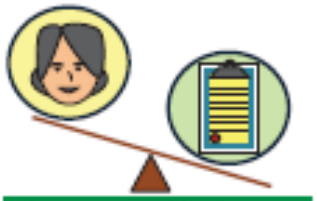
Medically Necessary
Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider
A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.

Out-of-network Co-insurance
The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do *not* contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-network Co-payment
A fixed amount (for example, $30) you pay for covered health care services from providers who do *not* contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network co-payments.

Out-of-Pocket Limit


(See page 4 for a detailed example.)

The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

Physician Services
Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan
A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization
A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider
A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium
The amount that must be paid for your health insurance or plan. You and/or your employer usually pay it monthly, quarterly or yearly.

Prescription Drug Coverage
Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs
Drugs and medications that by law require a prescription.

Primary Care Physician
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider
A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery
Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

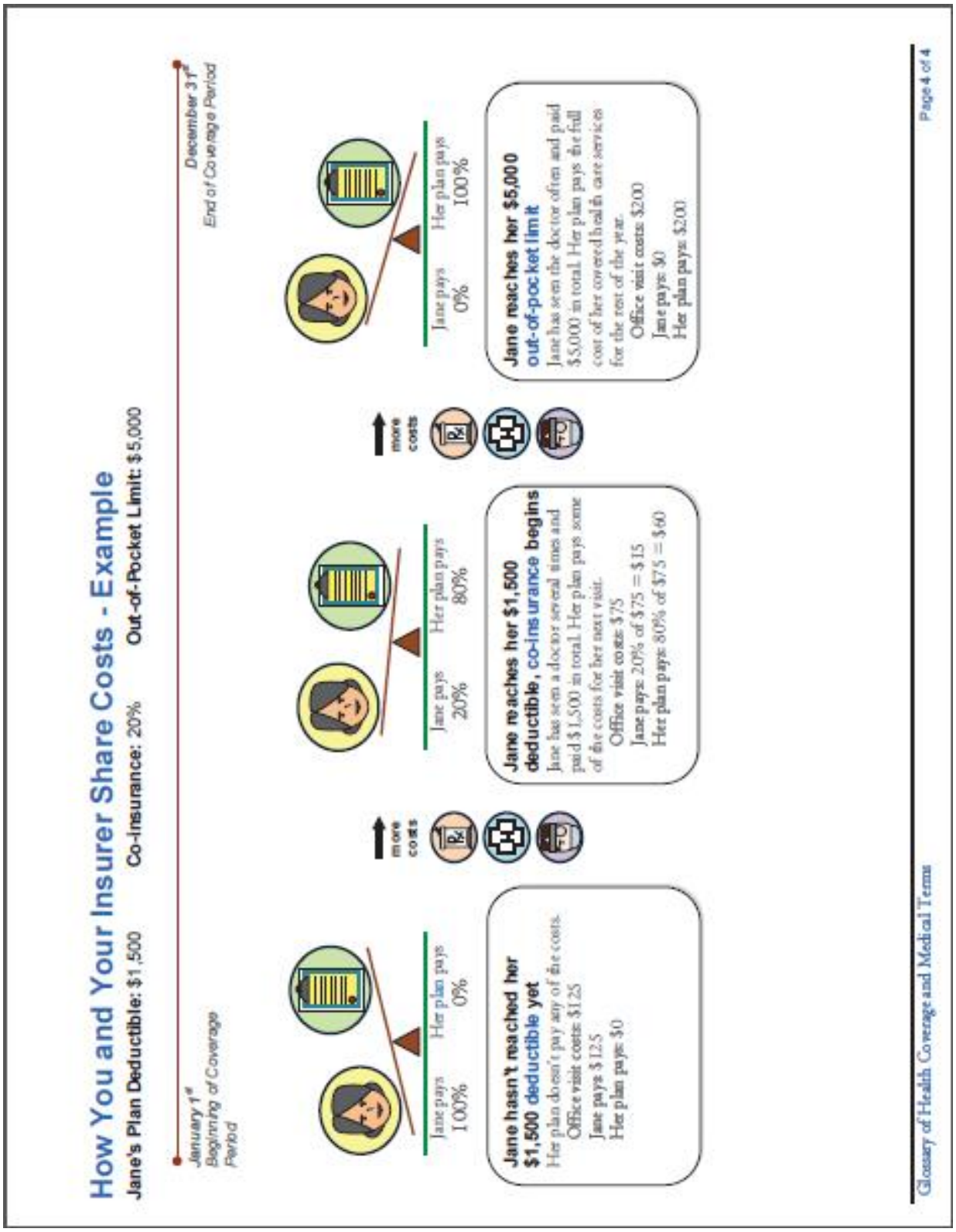
Rehabilitation Services
Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care
Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist
A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable)
The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care
Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.



Note: Screen shots from Glossary of Health Coverage and Medical Terms, 2013.

Appendix B: Essential Health Benefits

Exhibit 3
New York State
Essential Health Benefits Study
Illustrative Essential Health Benefits

TYPE OF SERVICE	Commercial Plans Oxford EPO	Illustrative Essential Health Benefits
Inpatient Hospital Services	Covered	Covered
Outpatient Hospital Services	Covered	Covered
Preadmission Testing	Covered	Covered
Emergency Medical Services	Covered	Covered
Maternity Care	Covered	Covered
- Including newborn care	Covered	Covered
- Midwifery Services	Covered	Covered
Skilled Nursing Care Facility	Covered, 200 days per calendar year. Riders are available for unlimited coverage.	Covered, 200 days per calendar year
Hospice	Covered, 210 days per calendar year combined inpatient/outpatient days. (One outpatient visit, either facility based or at home, equals 1 day.)	Covered, 210 days per calendar year combined inpatient/outpatient days
Home Health Care Services	Covered, 40 visits per calendar year.	Covered, 40 visits per calendar year.
Therapy Treatments		
- Chemotherapy	Covered	Covered
- Radiation	Covered	Covered
- Renal Dialysis	Covered. R for out of network coverage at in network rates when traveling	Covered
Second Surgical Opinion	Covered	Covered
Second Opinion - Cancer	Covered	Covered
Physician Office Visits	Covered	Covered
Preventive & Primary Care: Adults	Base Coverage and R.	
- Routine exams	Covered	Covered
- Immunizations	Covered	Covered
- Bone Density Testing	Covered	Covered
- Prostate Cancer Screening	Covered	Covered
- Allergy Testing	Covered	Covered
- Mammography	Covered	Covered
- Cervical Cytology	Covered	Covered
Preventive & Primary Care: Children	Base Coverage and R.	
- Well-child Care	Covered	Covered
- Immunizations/Vaccines	Covered	Covered
- Routine check-ups	Covered	Covered
Chiropractic Services	Covered	Covered
Mastectomy, Lumpectomy, lymph node dissection	Base Coverage and R.	Covered
Breast Reconstructive Surgery	Covered	Covered
External Mastectomy Prostheses	Covered	Covered
Diagnostic Laboratory Services	Covered	Covered
Radiology & Imaging Services	Covered	Covered
Ambulatory Patient Services (Awaiting HHS definition)	Covered	Covered
Outpatient Surgical Services		

R- Required Rider
OR-Optional Rider

Exhibit 3
New York State
Essential Health Benefits Study
Illustrative Essential Health Benefits

TYPE OF SERVICE	Commercial Plans Oxford EPO	Illustrative Essential Health Benefits
- Physician's Office	Covered	Covered
- Surgical Centers	Covered	Covered
Chronic Disease Management	Covered	Covered
Eating Disorders - Comprehensive Care Centers	Covered	Covered
Diabetes Equipment, Supplies and Self Education	Covered	Covered
Durable Medical Equipment	Covered by R for standard DME and medical supplies up to $1,500 per calendar year. OR with unlimited coverage available. Motorized equipment, electronic and neuromuscular stimulators, and myoelectric prosthesis are not covered benefits.	Covered for standard DME and medical supplies. Motorized equipment, electronic and neuromuscular stimulators, and myoelectric prosthesis are not covered benefits.
Prostheses	Covered for Internal and External Prosthetic Devices.	Covered for Internal and External Prosthetic Devices.
Orthotics	Not Covered	Not Covered
Habilitative Services (awaiting HHS definition)		
Rehabilitation Services (Awaiting HHS definition)	Covered with visit limits. The visit limits referenced below refer to a combined visit limit for OT, PT and SP.	Covered with visit limits. The visit limits referenced below refer to a combined visit limit for OT, PT and SP.
- Physical Therapy	Covered, 60 consecutive inpatient days per condition per lifetime and 60 consecutive outpatient visits per condition/lifetime.	Covered, 60 consecutive inpatient days per condition per lifetime and 60 consecutive outpatient visits per condition/lifetime.
- Occupational Therapy	Covered, 60 consecutive inpatient days per condition per lifetime and 60 consecutive outpatient visits per condition/lifetime.	Covered, 60 consecutive inpatient days per condition per lifetime and 60 consecutive outpatient visits per condition/lifetime.
- Speech Therapy	Covered, 60 consecutive inpatient days per condition per lifetime and 60 consecutive outpatient visits per condition/lifetime.	Covered, 60 consecutive inpatient days per condition per lifetime and 60 consecutive outpatient visits per condition/lifetime.

R- Required Rider
OR-Optional Rider

Exhibit 3
New York State
Essential Health Benefits Study
Illustrative Essential Health Benefits

TYPE OF SERVICE	Commercial Plans Oxford EPO	Illustrative Essential Health Benefits
MENTAL HEALTH/SUBSTANCE ABUSE		
Mental Health Treatment Services	R	
- Inpatient Services	R-- Covered, 30 inpatient days per calendar year. OR--unlimited MH coverage.	Covered, no limit due to mental health and addiction parity requirement
- Outpatient Services	Covered, R -- 30 outpatient visits per calendar year. This number includes office and facility visits.	Covered, no limit due to mental health and addiction parity requirement
Chemical Dependence Services		
- Inpatient Services	Covered, 30 days per calendar year.	Covered, no limit due to mental health and addiction parity requirement
- Outpatient Services	Covered, 60 visits, including 20 family counseling visits per calendar year. This number includes office and	Covered, no limit due to mental health and addiction parity requirement
- Detoxification Services	Covered, 7 days of inpatient detoxification per calendar year.	Covered, no limit due to mental health and addiction parity requirement
- Rehab	Covered, 7 days of inpatient detoxification per calendar year.	Covered, no limit due to mental health and addiction parity requirement
PRESCRIPTION DRUG BENEFITS		
- Prescription Drugs	Coverage available via OR RX rider	Covered
- Enteral Formula	Coverage provided under OR RX rider	Covered when prescribed
- Off label Cancer Drugs	Coverage provided under OR RX rider	Covered
- Non-Prescription Drugs	Not covered	Not Covered
TRANSPORTATION SERVICES		
- Emergency Transportation (Ambulance)	Covered	Covered
- Emergency Transportation (Air Ambulance)	Covered	Covered
- Non-Emergency Transport	Covered, non-emergent ambulance services (e.g. inter-facility transports, air or ground) covered if preauthorized.	Covered, non-emergent ambulance services (e.g. inter-facility transports, air or ground) covered if preauthorized.

R- Required Rider
OR-Optional Rider

Exhibit 3
New York State
Essential Health Benefits Study
Illustrative Essential Health Benefits

TYPE OF SERVICE	Commercial Plans Oxford EPO	Illustrative Essential Health Benefits
VISION SERVICES		
- Vision services related to specific medical condition	Covered	Covered
- Routine Vision Services	Covered, one vision screening examination (without refraction) within a 12 month period. This screening is performed by the PCP for both children and adults. **OR**-$50 reimbursement every 12 months for a comprehensive exam including refraction.	Covered, one vision screening examination (without refraction) within a 12 month period. This screening is performed by the PCP for both children and adults. Full eye exams for children covered.
Appliances (e.g. glasses and contact lenses)	**OR**--Groups that purchase the vision rider may also purchase a $70-200 benefit for one set of appliances.	Covered for children.
DENTAL SERVICES		
- Emergency Dental Services (e.g., treatment of accidental injuries to sound, natural teeth)	Covered	Covered
- Routine Dental Services	Covered by **OR**. There are 2 levels of coverage and Oxford has a provider network in place for dental services.	Covered for children, two exams/cleaning per year, all typical Class I, II, or III services covered, no orthodontia.
Oral Surgery (inpatient and outpatient)	Covered	Covered
OTHER SERVICES		
Hearing Related Services		
- Testing	Covered for Children. **R**--Covered for adults.	Covered for children and adults.
- Hearing Aids	**R**--Covered. Coverage for hearing aids is limited to (a) $1500 and (b) a single purchase including repair and replacement every 3 years. **OR**--coverage available up to $5,000.	Covered. Coverage for hearing aids is limited to a single purchase including repair and replacement every 3 years.
- Cochlear Implants	Covered	Covered

R- Required Rider
OR-Optional Rider

Exhibit 3
New York State
Essential Health Benefits Study
Illustrative Essential Health Benefits

TYPE OF SERVICE	Commercial Plans Oxford EPO	Illustrative Essential Health Benefits
Infertility Services	**R and OR**	
- Diagnosis and treatment of infertility	R--Covered for basic infertility services.	Covered for basic infertility services.
- Assisted reproductive technology procedures	Not covered	Not covered
Family Planning/ Reproductive Health Services		
- Contraceptives	R--Covered	Covered
- Voluntary sterilization	Covered	Covered
- Abortion (medically necessary)	Covered, therapeutic abortions and non-therapeutic abortions in cases of rape, incest, or fetal malformation.	Covered, therapeutic abortions and non-therapeutic abortions in cases of rape, incest, or fetal malformation.
- Abortion (elective)	Covered subject to benefit limits. Benefits may be excluded based on religion.	Covered subject to benefit limits. Benefits may be excluded based on religion.
Foot Care Services		
- Foot Care related to a specific medical condition	Covered	Covered
- Routine Foot Care (Such as cutting, trimming, or removal of corns, calluses, etc.)	Not Covered	Not Covered
- Foot Orthotics / Shoe Inserts	Not Covered.	Not Covered.
Organ Transplants	Covered	Covered
Smoking Cessation	Not specifically covered. Some services may be covered under the base coverage (e.g. counseling) and prescription drug coverage may be available under the prescription drug rider.	Basic counseling services and prescription drug coverage available under the prescription drug benefit.
Misc. Services		
-Allergy Shots	Covered	Covered
- Acupuncture	**OR**	Not Covered
- Weight Loss Programs	Not Covered	Not Covered
- Gym membership	**OR.** If a member completes 50 gym visits within a 6-month period, then Oxford will reimburse $200. If the member's spouse (or Domestic Partner if the Group has purchased this coverage) completes 50 gym visits within a 6-month period, then Oxford will reimburse $100.	Not Covered
Autism Spectrum Disorders (Effective Nov. 1, 2012)	Will be covered	Covered

ABA determination for autism based on OCIIO Bulletin on December 16, 2011, page 5.

R- Required Rider
OR-Optional Rider

Prepared for New York Department of Health by Milliman

Page 5

Note: Screen shots from Milliman, 2012.

Appendix C: Examples of New York State Model Language – Emergency Services

SECTION VI

Emergency Services

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

We Cover Emergency Services for the treatment of an Emergency Condition.

We define an **Emergency Condition** to mean: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain;
- Severe or multiple injuries;
- Severe shortness of breath;
- Sudden change in mental status (e.g., disorientation);
- Severe bleeding;
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis;
- Poisonings; or
- Convulsions.

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. We will also Cover Emergency Services to treat Your Emergency Condition worldwide. However, We will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition.

We define **Emergency Services** to mean: Evaluation of an Emergency Condition and treatment to keep the condition from getting worse including:

- A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and
- Within the capabilities of the staff and Facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

Please follow the instructions listed below regardless of whether or not You are in Our Service Area at the time Your Emergency Condition occurs.

A. Hospital Emergency Department Visits

In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. However, **only Emergency Services for the treatment of an Emergency Condition, as defined above, are Covered in an emergency department**. [If You are uncertain whether this is the most appropriate place to receive care You can call Us before You seek treatment.] [Our Medical Management Coordinators are available 24 hours a day, 7 days a week. Your Coordinator will direct You to the emergency department of a Hospital or other appropriate Facility.]

Follow-up care or routine care provided in a Hospital emergency department is not Covered. [You should contact Us to make sure You receive the appropriate follow-up care.]

B. Emergency Hospital Admissions

In the event You are **admitted** to the Hospital: You or someone on Your behalf must notify Us at the telephone number listed [in this] [Certificate, Contract, Policy] [and] [on Your ID card] within [48] hours of Your admission, or as soon as is reasonably possible.

[We Cover inpatient Hospital services at a Non-Participating Hospital at the In-Network Cost-Sharing for as long as Your medical condition prevents Your transfer to a Participating Hospital. Any inpatient Hospital services received from a Non-Participating Hospital after Your medical condition no longer prevents Your transfer to a Participating Hospital will be Covered at the Out-of-Network Cost-Sharing [, unless We authorize continued treatment at the Non-Participating Hospital].]

[We Cover inpatient Hospital services at a Non-Participating Hospital [at the In-Network Cost-Sharing] for as long as Your medical condition prevents Your transfer to a Participating Hospital [, unless We authorize continued treatment at the Non-Participating Hospital]. If Your medical condition permits Your transfer to a Participating Hospital We will notify You and arrange the transfer. Any inpatient Hospital services received from a Non-Participating Hospital after we have notified You and arranged for a transfer to a Participating Hospital will [not be Covered] [Covered at the Out-of-Network Cost-Sharing]. See section [XXX] of the [Contract; Certificate; Policy] for Your Appeal rights.]

C. Payments Relating to Emergency Services Rendered

The amount We pay a Non-Participating Provider for Emergency Services will be [the greater of: (1) the amount We have negotiated with Participating Providers for the Emergency Service received (and if more than one amount is negotiated, the median of the amounts); (2) 100% of the Allowed Amount for Services provided by a Non-Participating Provider (i.e., the amount We would pay in the absence of any Cost-Sharing that would otherwise apply for services of Non-Participating Providers); or (3) the amount that would be paid under Medicare. The amounts described above exclude any Copayment or Coinsurance that applies to Emergency Services provided by a Participating Provider.] [the Non-Participating Provider's Charge.]

You are responsible for any Deductible, Coinsurance or Copayment. [You will be held harmless for any Non-Participating Provider charges that exceed Your Coinsurance or Copayment.]

Urgent Care

Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. **Urgent Care is Covered in** [**or out of**] **Our Service Area**.

A. In-Network

You may obtain Urgent Care from a Participating Physician or a Participating Urgent Care Center. [You do not need to contact Us prior to, or after Your visit.]

B. Out-of-Network

[You may obtain Urgent Care from a Non-Participating Urgent Care Center [or Physician].] [However, You must obtain Preauthorization from Us [for services to be covered at the In-Network Cost-Sharing. Please contact Us at [***] [or] [the telephone number on Your ID card] and You will be provided with instructions.] [We are available around the clock to help You in urgent medical situations.]

[We do not cover Urgent Care from Non-Participating Urgent Care Centers [or Physicians] [in Our Service Area].]

If Urgent Care results in an Emergency admission please follow the instructions for Emergency Hospital admissions described above.

Note: Adapted language from Model Language, 2013.

Appendix D: Examples of New York State Model Language – Schedule of Benefits

SECTION [XIII, XIV]

[XXX Plan Name] SCHEDULE OF BENEFITS
[Metal Level]
[Group Name]

COST-SHARING	**[Preferred** **Member Responsibility for Cost-Sharing]**	**Participating** **Member Responsibility for Cost-Sharing**	**Non-Participating** **Member Responsibility for Cost-Sharing**	
Deductible	[None; $[ ]]	[None; $[ ]]		
• Individual	[None; $[ ]]	[None; $[ ]]	[None; $[ ]]	
• Family			[None; $[ ]]	
[Benefit Specific Deductible]				
	[$]	[$]		
Out-of-Pocket Limit			[$]	
• Individual				
• Family	$[ ]	$[ ]		
	$[ ]	$[ ]	[$]	
			[$]	
			[The Allowed Amount is [XXX]] [See section [XXX] of the [Contract; Certificate; Policy] for a description of how We calculate the Allowed Amount.] [Any charges of a Non-Participating Provider that are in	

			excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount by which the Non-Participating Provider's charge exceeds Our Allowed Amount.] [Non-Participating Provider services are not Covered except as required for Emergency Care [and Urgent Care].]	
OFFICE VISITS	**[Preferred Member Responsibility for Cost-Sharing]**	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits) Medications Administered in Office	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [After $ [Primary Care; Office Visit] Allowance] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [After $ [Primary Care; Office Visit]	[$ Copayment] [with Referral] [without Referral] [% Coinsurance] [with Referral] [without Referral] [after; not subject to Deductible] [After $ [Primary Care; Office Visit] Allowance] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [After $ [Primary Care; Office Visit]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to	See Benefit For Description

	Allowance]	Allowance]	Deductible] [After $ [Primary Care; Office Visit] Allowance]	
Specialist Office Visits (or Home Visits) Medications Administered in Office **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [After $ [Primary Care; Office Visit] Allowance] **[Preauthorization; Referral Required]**	[$ Copayment] [with Referral] [without Referral] [% Coinsurance] [with Referral] [without Referral] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [After $ [Primary Care; Office Visit] Allowance] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [After $ [Primary Care; Office Visit] Allowance] **[Preauthorization; Referral Required]**	See Benefit For Description
PREVENTIVE CARE	**[Preferred Member Responsibility for Cost-Sharing]**	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
• Well Child Visits and Immunizations*	Covered in full	Covered in full	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services	See Benefit For Description

			Are Not Covered and You Pay the Full Cost]	
• Adult Annual Physical Examinations*	Covered in full	Covered in full	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost]	
• Adult Immunizations*	Covered in full	Covered in full	[$ Copayment] [% Coinsurance] [after; not subject to Deductible]	
• Routine Gynecological Services/Well Woman Exams*	Covered in full	Covered in full	[Non-Participating Provider Services Are Not Covered and You Pay the Full Cost]	
• Mammography Screenings*	Covered in full	Covered in full	[$ Copayment] [% Coinsurance] [after; not subject to Deductible]	
• [Sterilization Procedures for Women*]	Covered in full	Covered in full	[Non-Participating Provider Services Are Not Covered and You Pay the Full Cost]	
• [Vasectomy]	Covered in full	Covered in full	[$ Copayment] [% Coinsurance] [after; not subject to Deductible]	

• Bone Density Testing* • Screening for Prostate Cancer	Covered in full [Covered in full] [$ Copayment] [% Coinsurance] [after; not subject to Deductible]	Covered in full [Covered in full] [$ Copayment] [% Coinsurance] [after; not subject to Deductible]	[Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after Deductible]	
• All other preventive services required by USPSTF and HRSA. • *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA. **[Referral Required]**	Covered in full [Covered in full] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] Covered in full	Covered in full [Covered in full] [$ Copayment] [% Coinsurance] [after Deductible] Covered in full	[Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to	

			Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost]	
	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing) **[Referral Required]**	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing) **[Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost]	
			Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing) [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Referral Required]**	

EMERGENCY CARE	**[Preferred Member Responsibility for Cost-Sharing]**	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	[$ Copayment] [% Coinsurance] [after; not subject to Deductible]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible]	See Benefit For Description
Non-Emergency Ambulance Services **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	See Benefit For Description
Emergency Department [Copayment / Coinsurance waived if Hospital admission.]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible]	See Benefit For Description
Urgent Care Center **[Preauthorization Required for Out-of-Network Urgent Care;** **Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization Required for Out-of-Network Urgent Care;** **Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization Required for Out-of-Network Urgent Care;** **Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services [in Our Service Area] Are Not Covered and You Pay the Full Cost] **[Preauthorization Required for Out-of-**	See Benefit For Description

			Network Urgent Care; **Referral Required]**	
PROFESSIONAL SERVICES AND OUTPATIENT CARE	**[Preferred Member Responsibility for Cost-Sharing]**	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	See Benefit For Description
Allergy Testing & Treatment **[Preauthorization; Referral Required]**	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory &	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory &	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic	See Benefit For Description

	Diagnostic Procedures) **[Preauthorization; Referral Required]**	Diagnostic Procedures) **[Preauthorization; Referral Required]**	Procedures) [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	
Ambulatory Surgical Center Facility Fee **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	See Benefit For Description
Anesthesia Services (all settings) **[Preauthorization; Referral Required]**	[Covered in full] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[Covered in full] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	See Benefit For Description
Autologous Blood Banking	[Covered in full]	[Covered in full]	[$ Copayment] [% Coinsurance]	See Benefits For

[Preauthorization; Referral Required]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	Description
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Included As Part of Inpatient Hospital Service Cost-Sharing] **[Preauthorization; Referral**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after ; not subject to Deductible] [Included As Part of Inpatient Hospital Service Cost-Sharing] **[Preauthorization; Referral**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [Included As Part of Inpatient Hospital Service Cost-	See Benefits For Description

	Required]	**Required]**	Sharing] **[Preauthorization; Referral Required]**	
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost]	See Benefit For Description

			[Preauthorization; Referral Required]	
Chiropractic Services **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	See Benefit For Description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost]	See Benefit For Description

[Preauthorization; **[Referral Required]**	**[Preauthorization; Referral Required]**	to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance]	See Benefit For Description [Dialysis Performed by Non-Participating Providers is Limited to [10] Visits Per Calendar Year]

	[Preauthorization; Referral Required]	**[Preauthorization; Referral Required]**	[after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	[60 visits per condition, per lifetime combined therapies]
Home Health Care **[Preauthorization; Referral Required]**	[Covered in Full] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[Covered in Full] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	[40] Visits per Plan Year
Infertility Services	Use Cost Sharing for Appropriate	Use Cost Sharing for Appropriate	Use Cost Sharing for Appropriate Service	See Benefit For

[Preauthorization; Referral Required]	Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) **[Preauthorization; Referral Required]**	Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) **[Preauthorization; Referral Required]**	(Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	Description
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment]	See Benefit For Description

• Home Infusion Therapy **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	[Home Infusion counts towards Home Health Care Visit Limits]
Inpatient Medical Visits	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	See Benefit For Description
Laboratory Procedures • Performed in a PCP Office	[$ Copayment]	[$ Copayment]	[$ Copayment]	See Benefit For Description

• Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services **[Preauthorization; Referral Required]**	[% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	
Maternity & Newborn Care • Prenatal Care				See Benefit For

• Inpatient Hospital Services [and Birthing Center] • Physician and Nurse Midwife Services for Delivery • Breast Pump **[Preauthorization Required][for Inpatient Services; Breast Pump]**	Covered in Full [$ Copayment] [% Coinsurance] per admission [after; not subject to Deductible] [Covered in full] [$ Copayment] [% Coinsurance] per admission [after; not subject to Deductible] [Covered in Full] **[Preauthorization Required][for Inpatient Services; Breast Pump]**	Covered In Full [$ Copayment] [% Coinsurance] per admission [after; not subject to Deductible] [Covered in full] [$ Copayment] [% Coinsurance] per admission [after; not subject to Deductible] Covered in Full **[Preauthorization Required][for Inpatient Services; Breast Pump]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered	Description [1] Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast feeding

			and You Pay the Full Cost] **[Preauthorization Required][for Inpatient Services; Breast Pump]**	
Outpatient Hospital Surgery Facility Charge	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	See Benefit For Description
Preadmission Testing **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	See Benefit For Description
Diagnostic Radiology Services • Performed in a PCP Office	[$ Copayment] [% Coinsurance]	[$ Copayment] [% Coinsurance]	[$ Copayment] [% Coinsurance]	See Benefit For Description

• Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services **[Preauthorization; Referral Required]**	[after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as	[$ Copayment] [% Coinsurance] [after; not subject to Deductible]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating	See Benefit For Description

Outpatient Hospital Services **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	[60 visits per condition, per lifetime combined therapies] [Speech and Physical Therapy are only Covered following a Hospital stay or surgery.]
Second Opinions on the Diagnosis of Cancer, Surgery & Other	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization;**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization;**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered	See Benefit For Description

[Preauthorization; Referral Required]	**Referral Required]**	**Referral Required]**	and You Pay the Full Cost] Second Opinions on Diagnosis of Cancer are Covered at Participating Cost-Sharing for Non-Participating Specialist [when a Referral is obtained]. **[Preauthorization; Referral Required]**	
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after ; not subject to Deductible]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to	See Benefit For Description **[All Transplants Must be Performed at Designated Facilities]**

• Office Surgery **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**[Preferred Member Responsibility for Cost-Sharing]**	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder **[Preauthorization; Referral**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating	[680] Hours Per Plan Year

Required]	**[Preauthorization; Referral Required]**	**[Preauthorization; Referral Required]**	Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	
Assistive Communication Devices for Autism Spectrum Disorder **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply) • Diabetic Education **[Preauthorization; Referral Required][for Insulin Pump]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [See the Prescription Drug Cost-Sharing] [$ Copayment] [% Coinsurance] [after; not subject to [See the Prescription Drug	[$ Copayment] [% Coinsurance] [after Deductible] [See the Prescription Drug Cost-Sharing] [$ Copayment] [% Coinsurance] [after Deductible] [See the Prescription Drug	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-	See Benefit For Description [See Prescription Drug Benefit]

	Cost-Sharing] Deductible] **[Preauthorization; Referral Required]**	Cost-Sharing] **[Preauthorization; Referral Required]**	Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	
Durable Medical Equipment & Braces **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	See Benefit For Description
External Hearing Aids **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	[Single Purchase Once Every 3 Years]

Cochlear Implants **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	[One Per Ear Per Time Covered]
Hospice Care • Inpatient • Outpatient **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] per admission [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] per admission [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] per admission [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	[210] Days per Plan Year [5] Visits for Family Bereavement Counseling
Medical Supplies	[$ Copayment] [% Coinsurance]	[$ Copayment] [% Coinsurance]	[$ Copayment] [% Coinsurance]	See Benefit For

[Preauthorization; Referral Required]	[after; not subject to Deductible] **[Preauthorization; Referral Required]**	[after; not subject to Deductible] **[Preauthorization; Referral Required]**	[after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	Description
[Orthotics] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	See Benefit For Description
Prosthetic Devices • External • Internal **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization;**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization;**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating	[One prosthetic device, per limb, per lifetime] Unlimited See Benefit For Description

	Referral Required]	**Referral Required]**	Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	
INPATIENT SERVICES & FACILITIES	**[Preferred Member Responsibility for Cost-Sharing]**	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] per admission [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] per admission [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] per admission [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	See Benefit For Description
Observation Stay **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac & Pulmonary	[$ Copayment]	[$ Copayment]	[$ Copayment] [% Coinsurance] per	[200] Days

Rehabilitation) **[Preauthorization; Referral Required]**	[% Coinsurance] per admission [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[% Coinsurance] per admission [after; not subject to Deductible] **[Preauthorization; Referral Required]**	admission [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	Per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] per admission [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] per admission [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] per admission [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	[60 Consecutive Days Per Condition, Per Lifetime]
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	**[Preferred Member Responsibility for Cost-Sharing]**	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) **[Preauthorization; Referral Required. However, Preauthorization is Not Required for Emergency Admissions]**	[$ Copayment] [% Coinsurance] per admission [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] per admission [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] per admission [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost]	See Benefit For Description

			[Preauthorization; Referral Required]	
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services) **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required]**	See Benefit For Description
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) **[Preauthorization; Referral Required. However, Preauthorization is Not Required for Emergency Admissions]**	[$ Copayment] [% Coinsurance] per admission [after; not subject to Deductible] **[Preauthorization; Referral Required. However, Preauthorization is Not Required for Emergency Admissions]**	[$ Copayment] [% Coinsurance] per admission [after; not subject to Deductible] **[Preauthorization; Referral Required. However, Preauthorization is Not Required for Emergency Admissions]**	[$ Copayment] [% Coinsurance] per admission [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Preauthorization; Referral Required. However, Preauthorization is Not Required for Emergency Admissions]**	See Benefit For Description
Outpatient Substance Use Services **[Preauthorization; Referral Required]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered	Unlimited; Up to [20] Visits a Plan Year May Be Used For Family Counseling

	[Preauthorization; Referral Required]	**[Preauthorization; Referral Required]**	and You Pay the Full Cost] **[Preauthorization; Referral Required]**	
PRESCRIPTION DRUGS	**[Preferred Member Responsibility for Cost-Sharing]**	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy				
30 Day Supply [Tier 1 Tier 2 Tier 3]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost]	See Benefit For Description

[Up to a 90 Day Supply For Maintenance Drugs] [Tier 1 Tier 2 Tier 3]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost]	See Benefit For Description
[Mail Order Pharmacy]				
[Up to a 90 Day Supply Tier 1	[$ Copayment] [% Coinsurance] [after; not subject to Deductible]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible]	See Benefit For Description

Tier 2 Tier 3]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost]	
WELLNESS BENEFITS	**[Preferred Member Responsibility for Cost-Sharing]**	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	
[Gym Reimbursement]	[Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse]	[Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse]	[Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse]	[Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse]
PEDIATRIC [DENTAL &]VISION CARE	**[Preferred Member Responsibility for Cost-Sharing]**	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**	**Limits**
[Pediatric Dental Care]				[One Dental Exam &

• Preventive/Routine Dental Care • Major Dental (Endodontics & Prosthodontics • Orthodontia **[Orthodontia & Major Dental Require Preauthorization;]** **[Referral]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Orthodontia & Major Dental Require Preauthorization;]** **[Referral]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] **[Orthodontia & Major Dental Require Preauthorization;]** **[Referral]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Orthodontia & Major Dental Require Preauthorization;]** **[Referral]**	Cleaning Per 6-Month Period]
Pediatric Vision Care • Exams	[$ Copayment]	[$ Copayment]	[$ Copayment]	One Exam Per 12-Month Period; One Prescribed

	[% Coinsurance] [after; not subject to Deductible] [$ Copayment]	[% Coinsurance] [after; not subject to Deductible] [$ Copayment]	[% Coinsurance] [after; not subject to Deductible]	Lenses & Frames in a 12-Month Period
• Lenses & Frames	[% Coinsurance] [after; not subject to Deductible] [$ Copayment]	[% Coinsurance] [after; not subject to Deductible] [$ Copayment]	[$ Copayment] [% Coinsurance] [after; not subject to Deductible]	
• Contact Lenses **[Contact Lenses Require Preauthorization; Referral]**	[% Coinsurance] [after; not subject to Deductible] **[Contact Lenses Require Preauthorization; Referral]**	[% Coinsurance] [after; not subject to Deductible] **[Contact Lenses Require Preauthorization; Referral]**	[$ Copayment] [% Coinsurance] [after; not subject to Deductible] [Non-Participating Provider Services Are Not Covered and You Pay the Full Cost] **[Contact Lenses Require Preauthorization; Referral]**	

Note: Adapted language from Model Language, 2013.

Appendix E: New York State Standard Plan Designs

STANDARD BENEFIT DESIGN COST SHARING DESCRIPTION CHART (5-6-2013)

NOTE: The standard plan design descriptions are based on current understanding of HHS Regulations and the Actuarial Value Calculator (Feb 2013 final versions) and NYS laws/regulations.
****Note: The Catastrophic plan design was revised to reflect the official OOP maximum of $6,350 (single) for calendar year 2014**

For all the standard plan designs, the deductible must be met first, and then the cost sharing copay or coinsurance is applied to the remainder of the allowed amount until the maximum out of pocket limit is reached.
If the copay payable is more than the allowed amount (or remainder of the allowed amount), the copay payable is reduced to the allowed amount (or to the remainder of the allowed amount)
The maximum out of pocket limit is an aggregate over all covered services (medical, pediatric dental, pediatric vision, and prescription drugs), and includes the deductible.
The deductible is over a calendar year for individual products and over the calendar year or plan year (option of insurer) for small group products.
For the Platinum, Gold, Silver and Silver-CSR Plans the deductible applies only to medical, pediatric dental, and pediatric vision services (including lenses/frames), and does not apply to prescription drugs.
For the Bronze and Catastrophic Plans the deductible applies to all services combined (medical, pediatric dental, pediatric vision (including lenses/frames), and prescription drugs).
No deductible or cost sharing applies to the preventive care visits/services defined in section 2713 of ACA.
Per ACA the Catastrophic Plan must include 3 primary care visits per calendar year to which the deductible does not apply.
These 3 primary care visits are in addition to the ACA mandated preventive services for which no cost sharing can apply.
These 3 primary care visits are covered in full by the insurance plan (i.e., no deductible and no cost sharing).
The family deductible is two times the single deductible and the family out-of-pocket limit is two times the single maximum out-of-pocket limit. The plan designs below are non-HSA plan designs and each family member is subject to a maximum deductible equal to the single deductible and to a maximum out-of-pocket limit equal to the single out-of-pocket limit. Once all members of the family in aggregate meet the family deductible amount (or family out-of-pocket limit amount) then no family member needs to accumulate any more dollars towards the deductible (or out-of-pocket limit).
Note: The pediatric dental cost sharing indicated is when pediatric dental is included as part of the standard design medical QHP plan. A stand-alone pediatric dental plan will have its own deductible and cost sharing arrangements and associated premium.
****Note: IRS Revenue Procedure 2013-25 provides the calendar year 2014 maximum out of pocket limit.**
The maximum out of pocket limit for calendar year 2014 is $6,350 for self only coverage, and $12,700 for family coverage.
Plans will need to amend the individual rate filing to reflect the revised catastrophic plan design.
Plans that submitted any plan design with a maximum out of pocket limit exceeding the official maximums will need to submit an amendment to the filing to revise such out of pocket limit.

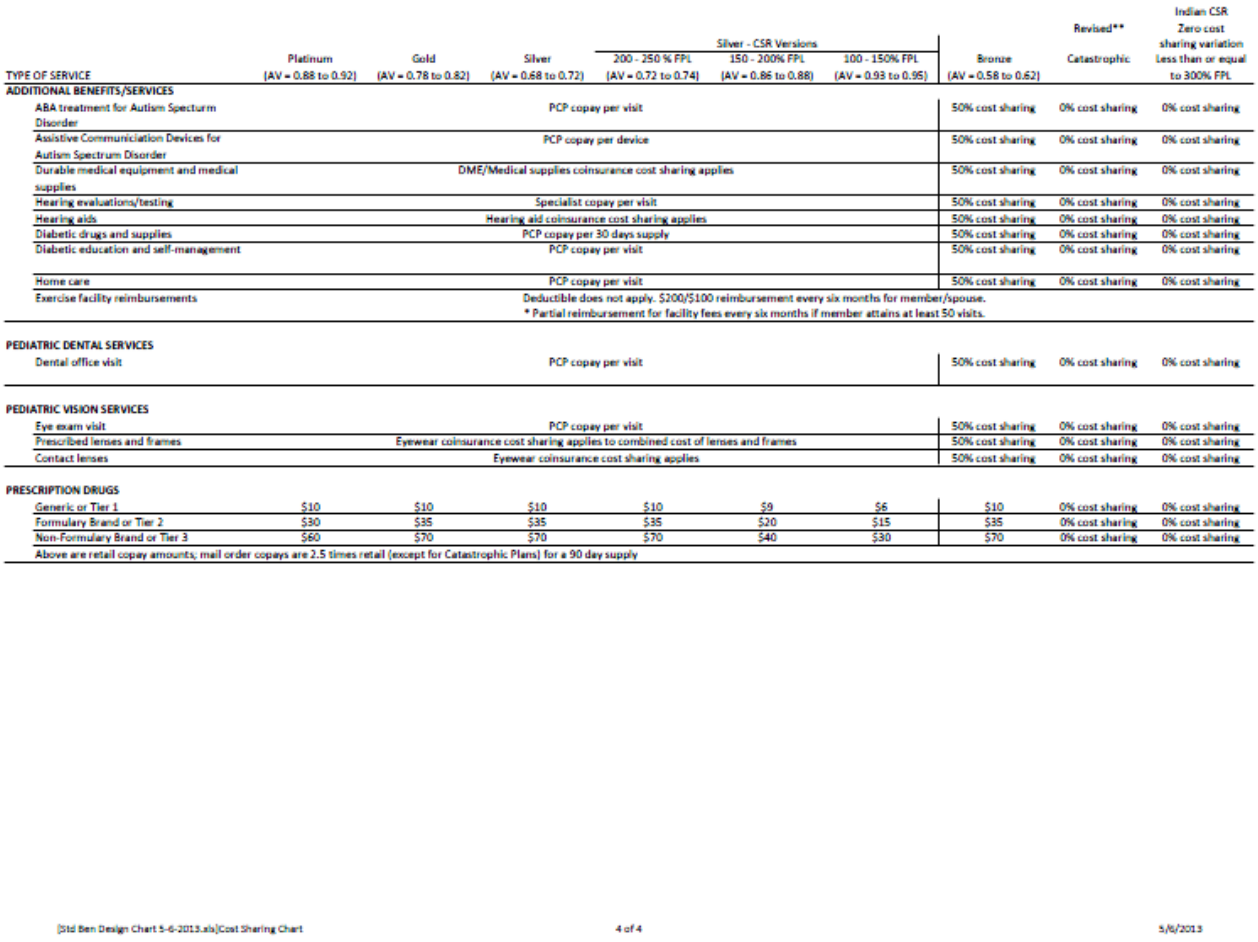
TYPE OF SERVICE	Platinum (AV = 0.88 to 0.92)	Gold (AV = 0.78 to 0.82)	Silver (AV = 0.68 to 0.72)	Silver - CSR Versions: 200 - 250 % FPL (AV = 0.72 to 0.74)	150 - 200% FPL (AV = 0.86 to 0.88)	100 - 150% FPL (AV = 0.93 to 0.95)	Bronze (AV = 0.58 to 0.62)	Revised** Catastrophic	Indian CSR Zero cost sharing variation Less than or equal to 300% FPL
DEDUCTIBLE (single)	$0	$600	$2,000	$1,750	$250	$0	$3,000	$6,350	$0
MAXIMUM OUT OF POCKET LIMIT (single) Includes the deductible	$2,000	$4,000	$5,500	$4,000	$2,000	$1,000	$6,350	$6,350	$0
COST SHARING - MEDICAL SERVICES									
Inpatient Facility/SNF/Hospice	$500 per admission	$1,000 per admission	$1,500 per admission	$1,500 per admission	$250 per admission	$100 per admission	50% cost sharing	0% cost sharing	0% cost sharing

The following applies to the Platinum, Gold, Silver and Silver-CSR Plans:
For an inpatient admission the only copay that applies during an inpatient stay is the inpatient facility per admission copay, and if surgery is performed a surgeon copay, and if a maternity delivery is performed a maternity delivery copay which is the same as the surgeon copay if this copay has not already been collected as part of another maternity related claim.
There are no additional copays for diagnostic tests, medical supplies, in-hospital physician visits, anesthesia, assistant surgeon, other staff doctors, etc.
For a maternity stay the inpatient per admission copay covers charges for the mother and a well newborn.
The inpatient facility copay per admission is waived for a re-admission within 90 days of a previous discharge for the same or a related condition.

Outpatient Facility-Surgery, including freestanding surgicenters	$100	$100	$100	$100	$75	$25	50% cost sharing	0% cost sharing	0% cost sharing
Surgeon - Inpatient facility, outpatient facility, including freestanding surgicenters	$100	$100	$100	$100	$75	$25	50% cost sharing	0% cost sharing	0% cost sharing
	One such copay per surgery and applies only to surgery performed in a hospital inpatient or hospital outpatient facility setting, including freestanding surgicenters, not to office surgery. See also "Maternity delivery and post natal care-physician/midwife" under "physician services".								
PCP	$15	$25	$30	$30	$15	$10	50% cost sharing	0% cost sharing	0% cost sharing
Specialist	$35	$40	$50	$50	$35	$20	50% cost sharing	0% cost sharing	0% cost sharing

TYPE OF SERVICE	Platinum (AV = 0.88 to 0.92)	Gold (AV = 0.78 to 0.82)	Silver (AV = 0.68 to 0.72)	Silver - CSR Versions 200 - 250 % FPL (AV = 0.72 to 0.74)	150 - 200% FPL (AV = 0.86 to 0.88)	100 - 150% FPL (AV = 0.93 to 0.95)	Bronze (AV = 0.58 to 0.62)	Revised** Catastrophic	Indian CSR Zero cost sharing variation Less than or equal to 300% FPL
PT/OT/ST - rehabilitative & habilitative therapies	$25	$30	$30	$30	$25	$15	50% cost sharing	0% cost sharing	0% cost sharing
ER	$100	$150	$150	$150	$75	$50	50% cost sharing	0% cost sharing	0% cost sharing
Ambulance	$100	$150	$150	$150	$75	$50	50% cost sharing	0% cost sharing	0% cost sharing
Urgent Care	$55	$60	$70	$70	$50	$30	50% cost sharing	0% cost sharing	0% cost sharing
DME/Medical supplies	10% cost sharing	20% cost sharing	30% cost sharing	25% cost sharing	10% cost sharing	5% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Hearing aids	10% cost sharing	20% cost sharing	30% cost sharing	25% cost sharing	10% cost sharing	5% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Eyewear	10% cost sharing	20% cost sharing	30% cost sharing	25% cost sharing	10% cost sharing	5% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
INPATIENT HOSPITAL SERVICES									
Observation stay/observation care unit	ER copay per case, copay is waived if direct transfer from outpatient surgery setting to an observation care unit						50% cost sharing	0% cost sharing	0% cost sharing
Hospital services - non-maternity	Inpatient Facility copay per admission #						50% cost sharing	0% cost sharing	0% cost sharing
Maternity care stay (covers mother and well newborn combined)	Inpatient Facility copay per admission #						50% cost sharing	0% cost sharing	0% cost sharing
Mental health/Behavorial health care	Inpatient Facility copay per admission #						50% cost sharing	0% cost sharing	0% cost sharing
Detoxification	Inpatient Facility copay per admission #						50% cost sharing	0% cost sharing	0% cost sharing
Substance abuse disorder services	Inpatient Facility copay per admission #						50% cost sharing	0% cost sharing	0% cost sharing
Skilled nursing facility	Inpatient Facility copay per admission # Indicated copay per admission is waived if direct transfer from hospital inpatient setting to skilled nursing facility						50% cost sharing	0% cost sharing	0% cost sharing
Hospice (inpatient)	Inpatient Facility copay per admission # Indicated copay per admission is waived if direct transfer from hospital inpatient setting or skilled nursing facility to hospice facility						50% cost sharing	0% cost sharing	0% cost sharing
EMERGENCY MEDICAL SERVICES									
Facility charge - Emergency Room	ER copay per case - copay is waived if patient is admitted as an inpatient (including as an observation stay or to an observation care unit) directly from the emergency room						50% cost sharing	0% cost sharing	0% cost sharing
Physician charge - Emergency Room visit	$0 copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Facility charge - Freestanding urgent care center	Urgent Care copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Physician charge - Free standing urgent care center visit	$0 copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Prehospital emergency services/ transportation, includes air ambulance	Ambulance copay per case						50% cost sharing	0% cost sharing	0% cost sharing
OUTPATIENT HOSPITAL/FACILITY SERVICES									
Outpatient facility surgery - hospital facility charge, including freestanding surgicenters	Outpatient Facility-Surgery copay per case						50% cost sharing	0% cost sharing	0% cost sharing
Pre-admission/pre-operative testing	$0 copay						50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine laboratory and pathology	Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine imaging services including Xray; excluding CAT/PET scans, MRI	Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Imaging: CAT/PET scans, MRI	Specialist copay						50% cost sharing	0% cost sharing	0% cost sharing
Chemotherapy	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Radiation therapy	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing

TYPE OF SERVICE	Platinum (AV = 0.88 to 0.92)	Gold (AV = 0.78 to 0.82)	Silver (AV = 0.68 to 0.72)	Silver - CSR Versions: 200 - 250 % FPL (AV = 0.72 to 0.74)	Silver - CSR Versions: 150 - 200% FPL (AV = 0.86 to 0.88)	Silver - CSR Versions: 100 - 150% FPL (AV = 0.93 to 0.95)	Bronze (AV = 0.58 to 0.62)	Revised** Catastrophic	Indian CSR Zero cost sharing variation Less than or equal to 300% FPL
Hemodialysis/Renal dialysis	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Mental health/Behavorial health care	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Substance abuse disorder services	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Covered therapies (PT, OT, ST) - rehabilitative & habilitative	PT/OT/ST copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Home care	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Hospice	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
PREVENTIVE & PRIMARY CARE SERVICES									
Bone density testing Cervical cytology Colonoscopy screening Gynecological exams Immunizations Mammography Prenatal maternity care Prostate cancer screening Routine exams Women's preventive health services	NOTE: For preventive care visits/services as defined in section 2713 of ACA no deductible or cost sharing applies. Otherwise the cost sharing indicated below applies to all services in this benefit service category.						50% cost sharing	0% cost sharing	0% cost sharing
	PCP/Specialist copay per visit (based on type of physician performing the service)								
PHYSICIAN/PROFESSIONAL SERVICES									
Inpatient hospital surgery - surgeon	Surgeon copay per case						50% cost sharing	0% cost sharing	0% cost sharing
Outpatient hospital and freestanding surgicenter - surgeon	Surgeon copay per case						50% cost sharing	0% cost sharing	0% cost sharing
Office surgery	PCP/Specialist copay per visit (based on type of physician performing the service)						50% cost sharing	0% cost sharing	0% cost sharing
Anesthesia (any setting)	Covered in full, no deductible and no cost sharing applies						50% cost sharing	0% cost sharing	0% cost sharing
Covered therapies (PT, OT, ST) - rehabilitative & habilitative	PT/OT/ST copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Additional surgical opinion	Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Second medical opinion for cancer	Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Maternity delivery and post natal care - physician or midwife	Surgeon copay per case for delivery and post natal care services combined (only one such copay per pregnancy)						50% cost sharing	0% cost sharing	0% cost sharing
In-hospital physician visits	$0 copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic office visits	PCP/Specialist copay per visit (based on type of physician performing the service)						50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine laboratory and pathology	PCP/Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine imaging services including Xray; excluding CAT/PET scans, MRI	PCP/Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Imaging: CAT/PET scans, MRI	Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Allergy testing	PCP/Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Allergy shots	PCP/Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Office/outpatient consultations	PCP/Specialist copay per visit (based on type of physician performing the service)						50% cost sharing	0% cost sharing	0% cost sharing
Mental health/Behavorial health care	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Substance abuse disorder services	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Chemotherapy	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Radiation therapy	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Hemodialysis/Renal dialysis	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Chiropractic care	Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing



TYPE OF SERVICE	Platinum (AV = 0.88 to 0.92)	Gold (AV = 0.78 to 0.82)	Silver (AV = 0.68 to 0.72)	Silver - CSR Versions: 200 - 250 % FPL (AV = 0.72 to 0.74)	150 - 200% FPL (AV = 0.86 to 0.88)	100 - 150% FPL (AV = 0.93 to 0.95)	Bronze (AV = 0.58 to 0.62)	Revised** Catastrophic	Indian CSR Zero cost sharing variation less than or equal to 300% FPL
ADDITIONAL BENEFITS/SERVICES									
ABA treatment for Autism Specturm Disorder	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Assistive Communiclation Devices for Autism Spectrum Disorder	PCP copay per device						50% cost sharing	0% cost sharing	0% cost sharing
Durable medical equipment and medical supplies	DME/Medical supplies coinsurance cost sharing applies						50% cost sharing	0% cost sharing	0% cost sharing
Hearing evaluations/testing	Specialist copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Hearing aids	Hearing aid coinsurance cost sharing applies						50% cost sharing	0% cost sharing	0% cost sharing
Diabetic drugs and supplies	PCP copay per 30 days supply						50% cost sharing	0% cost sharing	0% cost sharing
Diabetic education and self-management	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Home care	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Exercise facility reimbursements	Deductible does not apply. $200/$100 reimbursement every six months for member/spouse. * Partial reimbursement for facility fees every six months if member attains at least 50 visits.								
PEDIATRIC DENTAL SERVICES									
Dental office visit	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
PEDIATRIC VISION SERVICES									
Eye exam visit	PCP copay per visit						50% cost sharing	0% cost sharing	0% cost sharing
Prescribed lenses and frames	Eyewear coinsurance cost sharing applies to combined cost of lenses and frames						50% cost sharing	0% cost sharing	0% cost sharing
Contact lenses	Eyewear coinsurance cost sharing applies						50% cost sharing	0% cost sharing	0% cost sharing
PRESCRIPTION DRUGS									
Generic or Tier 1	$10	$10	$10	$10	$9	$6	$10	0% cost sharing	0% cost sharing
Formulary Brand or Tier 2	$30	$35	$35	$35	$20	$15	$35	0% cost sharing	0% cost sharing
Non-Formulary Brand or Tier 3	$60	$70	$70	$70	$40	$30	$70	0% cost sharing	0% cost sharing
Above are retail copay amounts; mail order copays are 2.5 times retail (except for Catastrophic Plans) for a 90 day supply									

[Std Ben Design Chart 5-6-2013.xls]Cost Sharing Chart 4 of 4 5/6/2013

Note: Screen shots from Standard benefit design cost sharing description chart (5-6-2013),

2013.