From:	DMHC Licensing eFiling
Subject:	APL 18-010 (OPL/OFR) - Update on Plan Compliance with MHPAEA Rules
Date:	Friday, July 6, 2018 10:46:06 AM
Attachments:	APL 18-010 - Plan Compliance with MHPAEA FR-QTL Rules 07-06-2018.pdf Exhibit J-11-B FR-QTL Calculation Worksheet 07-06-2018.xlsx

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Dear Health Plan Representative,

Please find the attached All Plan Letter regarding Plan Compliance with MHPAEA Rules for Financial Requirements and Quantitative Treatment Limitations

Thank you.

Edmund G. Brown Jr., Governor
State of California
Health and Human Services Agency
DEPARTMENT OF MANAGED HEALTH CARE
980 9th St., Ste. 500, Sacramento, CA 95814
Telephone: 916-324-8176 | Fax: 916-255-5241
www.HealthHelp.ca.gov

ALL PLAN LETTER

DATE: July 6, 2018

TO: All Commercial Health Plans Subject to MHPAEA

FROM: Sarah Ream, Deputy Director, Office of Plan Licensing
Pritika Dutt, Deputy Director, Office of Financial Review

SUBJECT: APL 18-010 Update on Plan Compliance with MHPAEA Rules for Financial Requirements and Quantitative Treatment Limitations

In light of lessons learned through compliance filings and focused surveys since 2014, this All Plan Letter (APL) provides additional guidance to plans on how to estimate annual claims and compute the "substantially all type" and "predominant level" of financial requirements (FRs) and quantitative treatment limitations (QTLs) to comply with the Mental Health Parity and Addiction Equity Act (MHPAEA)[1] and its regulations.[2]

This guidance applies to commercial coverage subject to MHPAEA, which includes any large group, small group, individual and family, and In-Home Supportive Services plans that cover both medical/surgical benefits and mental health/substance use disorder (MH/SUD) benefits.[3] These requirements do not apply to Medi-Cal, Medicare, Medicare Supplement, restricted, or specialized plans.

The Department of Managed Health Care (Department or DMHC) is not requesting that plans submit a compliance filing at this time. However, plans should use this additional guidance prospectively, before finalizing new and renewing plan products for 2019, to ensure the cost-sharing (FRs) and day, visit, and item limits (QTLs) applied to MH/SUD benefits are in parity with the FRs and QTLs applied to medical/surgical benefits in commercial plan products. A revised DMHC FR/QTL calculation workbook is attached to assist plans in conducting their parity analyses.

A. Guidance on Estimating Annual Claims

The Department reminds health plans that their claims estimations and financial requirements calculations must adhere not only to MHPAEA regulations at 45 CFR 146.136, but also to guidance issued by the federal Departments of Labor, Health and

[1] Public Law 110-343, 42 U.S.C. § 300gg-26.
[2] 45 CFR § 146.136 (2013).
[3] 45 CFR § 146.136(a) and California Health & Safety code § 1374.76.

Human Services, and the Treasury in Frequently Asked Questions (FAQs) and other federal guidance documents.

FAQ #31, Q.8, issued April 20, 2016, and FAQ #34, Q.3, issued October 27, 2016, prohibit plans from estimating claims based on the plan's overall book of business for the year. These FAQs clarify a group health plan must consider group "plan"-level data, not "product"-level data,[4] when estimating annual medical/surgical claims and performing the substantially all and predominant analyses for large group coverage. For small group and individual coverage, a health plan must also consider plan-level, not product-level, claims data for estimating claims and conducting the "substantially all and predominant" analyses, if the available data is credible to perform the required projections.

Health plans uncertain about the credibility of plan-level data should consult an actuary meeting qualifications set forth in FAQ #34 to examine whether that data are sufficient for making a reasonable projection of future claims. If the claims data are not sufficient, the health plan should use other reasonable claims data to make a reasonable projection of estimated claims to conduct the actuarially-appropriate analysis. Consult FAQs #31 and #34 for more federal guidance on how to reasonably estimate annual claims.

As noted in the FAQs, a health plan should document all assumptions used in choosing its data and making projections, and provide these assumptions in its narrative when submitting FR/QTL calculation worksheets to the Department.

Health plans may elect to obtain further guidance from the Department on estimating annual claims in compliance with FAQs #31 and #34 through a scheduled consultation or by submitting a limited-scope MHPAEA compliance filing consisting of completed FR/QTL calculation worksheets and narrative for a 2019 plan product in each market (individual, small group, large group) in which the plan is licensed.

B. Computing Financial Requirements and Quantitative Treatment Limitations in the Outpatient Benefits Classifications or Subclassifications

The federal final rules for MHPAEA permit plans to apply the FR and QTL rules either by using a single outpatient classification that includes all MH/SUD and medical/surgical services delivered in-network or out-of-network on an outpatient basis, or by dividing outpatient benefits into two subclassifications:

1. Outpatient Office Visits (such as physician visits), and

[4] FAQ #34 and 45 CFR 144.103 define "product" as a discrete package of health coverage benefits offered using a particular product network type within a service area; "plan" is defined as the pairing of the health coverage benefits under the product with a particular cost-sharing structure, provider network, and service area.

2. All Other Outpatient Items and Services (such as outpatient surgery, day treatment center charges, laboratory charges). 45 CFR 146.136(c)(2)(ii)(A)(3), 45 CFR 146.136(c)(3)(iii)(C).

During the MHPAEA survey reviews, the Department found that most plans continued to use the same classification approach for outpatient benefits as they used for their initial compliance filings: they either grouped all outpatient benefits into a single outpatient classification both times or split outpatient benefits into the two outpatient subclassifications both times. However, the Department recommends plans calculate FRs and QTLs using both classification approaches before selecting the approach that produces the most appropriate result for the plan for each commercial plan product. Note: a plan may vary the outpatient classification approaches it chooses to use from one plan product to the next. Plans should select the outpatient classification approach, complete calculations, and finalize disclosures of the resulting MHPAEA-compliant MH/SUD FR/QTLs *before* selling or renewing subscriber contracts for a plan product. Once a plan begins selling or renews a plan product for the following contract term with specified MH/SUD FRs/QTLs, the plan cannot change the MH/SUD FR/QTLs for that plan product until the next contract term.

C. Computing Financial Requirements When More Than One Type or Level of Cost-Sharing Applies Simultaneously or Consecutively to the Same Medical/Surgical Benefit

During the MHPAEA survey review for FR/QTL compliance, the Department examined for the first time plan products for which the plan charges multiple types and levels of cost-sharing either simultaneously for a single office visit or procedure or over consecutive visits for the same medical/surgical benefit. These cost-sharing structures are often used in PPO coverage.

The Department recommends plans conduct the FR and QTL analyses for these cost-sharing arrangements in a manner consistent with the approach taken by the California Department of Insurance as follows:

1. Multiple Types of Cost-Sharing Are Charged Simultaneously (or Virtually Simultaneously)

   Example: For every PCP office visit, the enrollee must pay a $25 copayment and coinsurance equaling 20% of the cost of the PCP visit that exceeds $25. No other medical/surgical benefit classified as an Outpatient Office Visit requires the enrollee to pay both a copayment and coinsurance for a single visit.

   Reporting Estimated Annual Claims: Because the cost to a plan of a PCP visit always exceeds $25, the plan may attribute the entire annual estimated claims for PCP visits in this plan product to both copayments and coinsurance.

a. On the DMHC's revised FR/QTL worksheet, Exhibit J-11-B, under Classification C, Outpatient, In-Network, in the row for PCP visits, plans should enter the total amount of annual estimated claims for PCP visits in column D (CY 2019 Projected Expense Subject to Copayment) and in column F (CY 2019 Projected Expense Subject to Coinsurance).
b. For all other medical/surgical visits listed in Classification C, plans should enter the total amount of annual estimated claims for each type of office visit (e.g., specialist physician visit, acupuncture visit) under either column D or column F as applicable, depending on whether enrollees are charged a copayment or a coinsurance or no cost-sharing for that type of office visit.
c. If the plan product provides out-of-network coverage, then plans should similarly enter annual estimated claims for out-of-network PCP and all other types of office visits on the FR/QTL calculation worksheet under Classification E, Outpatient, Out-of-Network.

Calculation of Substantially All Type: The Excel formulas embedded in the worksheet will add up the annual estimated claims for types of office visits subject to copayments, subject to coinsurance, or subject to no cost-sharing.

a. The worksheet will then reveal in column H the projected expense for all the office visit benefits that are subject to copayments and, in column I, the projected expense for all the office visit benefits that are subject to coinsurance.
b. If the total in column H equals or exceeds 66.67%, then copayments are the type of cost-sharing that applies to substantially all medical/surgical Outpatient Office Visit benefits.
c. If the total in column I equals or exceeds 66.67%, then coinsurance is the type of cost-sharing that applies to substantially all medical/surgical Outpatient Office Visit benefits.
d. Note: it is possible that (1) either copayments or coinsurance apply to substantially all medical/surgical Outpatient Office Visit benefits, or (2) both copayments and coinsurance apply to substantially all medical/surgical Outpatient Office Visit benefits, or (3) neither copayments nor coinsurance apply to substantially all medical/surgical Outpatient Office Visit benefits.

2. Multiple Types of Cost-Sharing Are Charged Over Consecutive Visits, Procedures

Example: For each of the first two PCP office visits during the contract term, the enrollee must pay a $50 copayment but no coinsurance. For each of the PCP office visits *after* the first two office visits during the contract term, the enrollee pays no copayment, but instead pays coinsurance equaling 20% of the cost of the PCP visit to the plan. No other medical/surgical benefit classified as an Outpatient Office Visit requires the enrollee to pay first a copayment for one or more office visits for that service and pay a coinsurance for subsequent office visits for that same service.

Reporting Estimated Annual Claims: Here, the plan must split total annual estimated claims for PCP visits into two amounts: the amount subject to the $50 copayment charge for an enrollee's first two PCP office visits annually and the amount subject to the 20% coinsurance for an enrollee's third and subsequent PCP office visits that same year.

a. On the DMHC's revised FR/QTL calculation worksheet, Exhibit J-11-B, Classification C, Outpatient, In-Network, in the row for PCP visits, plans should enter the amount of annual estimated claims for only those PCP visits that incurred a $50 copayment charge in column D (CY 2019 Projected Expense Subject to Copayment); and
b. Enter the amount of annual estimated claims for only those PCP visits that incurred a 20% coinsurance amount in column F (CY 2019 Projected Expense Subject to Coinsurance).
c. For all other medical/surgical visits listed in Classification C, plans should enter the total amount of annual estimated claims for each type of office visit (e.g., specialist physician visit, acupuncture visit) under either column D or column F as applicable, depending on whether enrollees are charged a copayment or a coinsurance or no cost-sharing for that type of office visit.
d. If the plan product provides out-of-network coverage, plans should similarly enter annual estimated claims for out-of-network PCP visits subject to copayments and PCP visits subject to coinsurance and all other types of office visits on the FR/QTL calculation worksheet under Classification E, Outpatient, Out-of-Network.

Calculation of Substantially All Type: The Excel formulas embedded in the worksheet will add up the annual estimated claims for types of office visits subject to copayments, subject to coinsurance, or subject to no cost-sharing.

a. Column H will show the projected expense for all the office visit benefits are subject to copayments; and
b. Column I will show the projected expense for all the office visit benefits subject to coinsurance.
c. If the total in column H equals or exceeds 66.67%, copayments are the type of cost-sharing that applies to substantially all medical/surgical Outpatient Office Visit benefits.
d. If the total in column I equals or exceeds 66.67%, coinsurance is the type of cost-sharing that applies to substantially all medical/surgical Outpatient Office Visit benefits.
e. Note: it is possible (1) either or (2) both or (3) neither copayments or coinsurance apply to substantially all medical/surgical Outpatient Office Visit benefits.

3. Multiple Types of Cost-Sharing are Charged Either Simultaneously or Over Consecutive Visits, Procedures

   Sometimes when multiple types of cost-sharing are charged for the same medical/surgical benefit, it is not immediately evident if all types are incurred for every visit or procedure, as discussed under C.1., or if the type of cost-sharing can vary for subsequent visits from the type(s) charged during the enrollee's initial visit or visits, as discussed under C.2. In this situation, plans are encouraged to contact the Department for advice on the methodology to use for estimating claims and calculating FRs and QTLs. The Department's contact information is provided below.

D. Effective Dates for Compliance with APL Guidance

The cost-sharing and quantitative treatment limits that plans charge for MH/SUD benefits must be in compliance with the guidance provided in this APL in all commercial coverage in effect on or after January 1, 2019.

E. Conclusion

As a general matter, plans should consider the implications on mental health parity of any change they propose when they amend or materially modify how they are currently licensed. To facilitate plans proactively adjusting MH/SUD cost-sharing, utilization management procedures, or any facet of coverage that impacts MHPAEA compliance, the Department encourages plans to address parity issues in the same filings they submit proposing a change to their products, or coverage, or provider contracts, or administrative service agreements. By anticipating the Department's concerns about parity and including cost-sharing calculations or other parity-related analyses in plan filings, as appropriate, review of these issues may be expedited. If a change proposed by a plan could have a substantial impact on its compliance with MHPAEA, then the Department will advise the plan to submit a separate, limited-scope MHPAEA compliance filing.

If you have questions regarding this APL, please contact Elizabeth Spring, Attorney IV, Office of Plan Licensing, at elizabeth.spring@dmhc.ca.gov. If you have questions about estimating claims or about financial requirement calculations, please contact Wayne Thomas, Chief Actuary, Office of Financial Review, at wayne.thomas@dmhc.ca.gov.

Instructions for Financial Requirements/Quantitative Treatment Limitations (FR/QTL) Worksheet

Please Also Consult MHPAEA Regulations at 45 CFR 146.136(c)(3)

I. Estimating Claims, Classifying Benefits

(1) Under the Narrative tab, provide a written narrative of the methodology used to estimate the total annual allowed costs. The plan may use any reasonable method to estimate the portion of annual plan payments (e.g. allowed costs) for medical/surgical benefits in a classification (e.g. Classification C, Outpatient, In-Network: Office Visits). However, when estimating claims, ensure that they are based on plan-specific data, as set forth in FAQs 31 and 34, issued by the Departments of Labor, Health and Human Services, and Treasury.

(2) For each benefit plan design (BPD) submitted for review in Exhibit J-11-A, complete the corresponding FR/QTL Worksheet in Exhibit J-11-B. Column A of each table has already been prepopulated with the medical/surgical benefits typically assigned to each Classification A through G for HMO in-network coverage. For PPO or other plans with out-of-network coverage, copy and paste the medical/surgical benefits listed in Classification A under Classification B; also duplicate the benefits in Classifications C and D under Classifications E and F, respectively. The Example tab provides a simplified table completed for Classification A.

(3) If necessary, please modify the benefits within a classification to ensure that the list of benefits for each BPD in Exhibit J-11-B is identical to the list of benefits for the same BPD shown in Table 3 of Exhibit J-11-A, while assuring all Knox-Keene Act mandated benefits are listed as covered.

II. Predominant & Substantially All Tests for Copayments and Coinsurance

(4) In Columns C and E of each table, enter the amount of member copay and coinsurance, respectively, as applicable to each medical/surgical benefit listed in Column A. If there is no member cost-share for a service, enter "0". (The amount entered in Columns C and E should be identical to the amount for that benefit as shown in Column B, Table 3 of Exhibit J-11-A.)

(5) In Column D and F of each table, enter the amount of projected annual allowed cost for each benefit listed. The total of the amounts entered should correspond to the total annual amount estimated using the methodology described under the Narrative tab.

(6) Using the formulas provided in Column H and I of the Example table, for each benefit listed in Column A calculate the percent of total allowed plan costs in Column H and I.

(7) In Column J, enter the substantially all type (coinsurance or copay) identified in the total section of Column H and I. (If no cost-share type (coinsurance or copay) represents at least 2/3, or 66.6667%, of the total allowed costs, STOP HERE. The classification FAILS the "substantially all" test. Enter "None" in Column H, last row for that classification.)

(8) Using the formulas provided in Column H and Column I of the Example table, for each benefit listed in Column A calculate the percent of total subject to copay $ and % of total subject to coinsurance %, whichever is applicable, in Columns H and I.

(9) Using the results in Column H and Column I of each table, determine if any of the calculated amounts satisfy the predominant test (i.e. amount of Column H or I is at least 50% of the substantially all type identified in Column J). If none of calculated amounts are at least 50%, starting with the highest cost-share level of the type identified in Column H and working toward the lowest, combine the percentages in Column H or I, whichever is applicable, until the total first exceeds 50%. At that point, the lowest cost-share level used in the calculation is the predominant cost-share level.

(10) In Column K, enter the predominant cost-share level (% coinsurance or $ copay) that represents at least 1/2 (50%) of the applicable substantially all type identified in Column J.

III. Substantially All Test for Deductible

(11) In Column B, enter “Y” or “N” to indicate whether the benefit in that classification is subject to a deductible. In Column C, enter the amount of the applicable deductible. Enter "0" if no deductible applies to the classification.

(12) In Column F, enter the total projected allowed plan costs for services in the classification for which the deductible applies. Enter "0" if no deductible applies to the classification. Use the formula provided in Column F of the Example table.

(13) Using the formula provided in Column G of the Example table, calculate the percent of "Total Projected Expense (Allowed)."

(14) Using the results in Column G of each table, determine if the calculated percentage satisfies the substantially all test (i.e. amount if Column E is at least 2/3, or 66.6667%). Enter “Y” or "N", whichever is applicable, in
Column J. The entry in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A.

- If the entry in Column J is "N" for all classifications within a BPD, enter "No" to question C of Table 1.
- If the answer in Column J is "N" for some, but not all, classifications, answer "No" to question C of Table 1, and identify the classification(s) with "N" in Column J by its classification name (e.g., Classification C, Outpatient, In-Network: Office Visits) in the space provided for question C in Table 1.
- If the entry in Column J is "Y" for all classifications within a BPD, answer "Yes" to question C of Table 1.

Please note: Use of the Exhibit J-11-A and Exhibit J-11-B worksheets is optional. Plans may elect to submit the information needed for the Department to evaluate compliance in a different manner, so long as the documents submitted provide proof that each product complies with the Mental Health Parity and Addiction Equity Act (MHPAEA) final rules for financial requirements, which includes but is not limited to: (a) a listing of all medical/surgical benefits and all mental health/substance use disorder (MH/SUD) benefits required to be covered under state and federal law for each product; (b) how the Plan has classified every benefit into the classifications and sub-classifications permitted in the federal final rules; (c) the cost-sharing (copayments, coinsurance, and/or deductible) charged in the applicable calendar year for the medical/surgical benefits in each product; (d) the applicable calendar year's estimated claims for medical/surgical benefits, by type of cost-sharing for each classification, for each product; (e) a worksheet showing how the Plan calculated the predominant amount and type of cost-sharing that applies to substantially all medical/surgical claims for each classification, for each product; (f) and the amount of cost-sharing that the Plan charged for MH/SUD benefits in each classification, for each product.

Please leave worksheets that are not applicable blank; do not rename or renumber the worksheets.

Narrative Explaining Plan's Methodology for Estimating Total Annual Allowed Claims

EXAMPLE

COLUMNS: A	B	C	D	E	F	G	H	I	J	K
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
A. Inpatient, In-Network										
Hospital facility services (e.g., hospital room)--acute inpatient	Y	$250	$ 792,350	0%	$ -	$ 792,350	79%	0.0%		$250
Physician/surgeon services--acute inpatient	Y	$10	$ 80,000	0%	$ -	$ 80,000	8%	0.0%		
Hospital facility services (e.g., hospital room)--female sterilization	N	$0	$ -	0%	$ -	$ 45,854	0%	0.0%		
Physician/surgeon services--female sterilization	N	$0	$ -	0%	$ -	$ 6,000	0%	0.0%		
Hospital facility services (e.g., hospital room)--maternity delivery	Y	$250	$ 121,680	0%	$ -	$ 121,680	12%	0.0%		
Professional services--maternity delivery	Y	$10	$ 13,000	0%	$ -	$ 13,000	1%	0.0%		
Inpatient hospice facility services (e.g., hospital room)	N	$0	$ -	0%	$ -	$ 33,340	0%	0.0%		
Skilled nursing facility services (e.g., facility room)	Y	$0		30%	$ 182,000	$ 182,000	0%	100.0%		
Total			$ 1,007,030		$ 182,000	$ 1,274,224	100%	100.0%		
	Total Subject to Copay $		79.0%			$ 1,007,030	79%		Copayment	
	Total Subject to Coinsurance %				14.3%	$ 182,000		14.3%	N	
	Total Subject to No Cost Sharing					$ 85,194				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible	$500			$ 1,189,030	93.3%			Y	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Please include any comments

Index

Plan Name:
Contact Name:
Telephone:
Email:

Filing #:
Date Filed:

Spreadsheet Number	Benefit Plan Design Identifier	Effective Date	Line of Business			
			HMO	**EPO**	**POS**	**PPO**
Example	*Basic Select*	*1/1/2019*	*X*			
Benefit Plan Design **#1** - Individual, Platinum						
Benefit Plan Design **#2** - Individual, Gold						
Benefit Plan Design **#3** - Individual, Silver						
Benefit Plan Design **#4** - Individual, Silver 200-250% FPL						
Benefit Plan Design **#5** - Individual, Bronze (Not HDHP/HSA)						
Benefit Plan Design **#6** - Individual, Catastrophic						
Benefit Plan Design **#7** - Individual, Alternative Plan Design (Non-Standard)						
Benefit Plan Design **#8** - Small Group, Platinum						
Benefit Plan Design **#9** - Small Group, Gold						
Benefit Plan Design **#10** - Small Group, Silver						
Benefit Plan Design **#11** - Small Group, Bronze (Not HDHP/HSA)						
Benefit Plan Design **#12** - Small Group, Alternative Plan Design (Non-Standard)						
Benefit Plan Design **#13** - Large Group, First Most Popular (including IHSS or PASC-SEIU plan designs)						
Benefit Plan Design **#14** - Large Group, Second Most Popular (including IHSS or PASC-SEIU plan designs)						
Benefit Plan Design **#15** - Large Group, Third Most Popular, or Design w/ Different Network than for #13 or #14 (including IHSS or PASC-SEIU plan designs)						

Please leave worksheets that are not applicable blank; do not rename or renumber the worksheets.

Benefit Plan Design #1 - Individual, Platinum

COLUMNS: A	B	C	D	E	F	G	H	I	J	K
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
A. Inpatient, In-Network										
Hospital facility services (e.g., hospital room)--acute inpatient							#DIV/0!	#DIV/0!		
Physician/surgeon services--acute inpatient							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--female sterilization							#DIV/0!	#DIV/0!		
Physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--maternity delivery							#DIV/0!	#DIV/0!		
Professional services--maternity delivery							#DIV/0!	#DIV/0!		
Inpatient hospice facility services (e.g., hospital room)							#DIV/0!	#DIV/0!		
Skilled nursing facility services (e.g., facility room)							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
B. Inpatient, Out-of-Network										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
C. Outpatient, In-Network: Office Visits										
Primary care visit to treat an injury, illness, or condition							#DIV/0!	#DIV/0!		
Other practitioner office visit							#DIV/0!	#DIV/0!		
Specialist physician visit							#DIV/0!	#DIV/0!		
Preventive care/screening/immunization							#DIV/0!	#DIV/0!		
Family planning							#DIV/0!	#DIV/0!		
Prenatal care and preconception visits							#DIV/0!	#DIV/0!		
Acupuncture							#DIV/0!	#DIV/0!		
Health education							#DIV/0!	#DIV/0!		
Child dental diagnostic and preventive services							#DIV/0!	#DIV/0!		
Child eye exam							#DIV/0!	#DIV/0!		
Urgent care							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
D. Outpatient, In-Network: Other Outpatient Items and Services										
Surgery facility services (e.g. Ambulatory Surgery Center)							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services							#DIV/0!	#DIV/0!		
Surgery facility services (e.g. Ambulatory Surgery Center)--female sterilization							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Outpatient visit (e.g. outpatient chemotherapy, radiation, infusion therapy, dialysis, and similar outpatient services)							#DIV/0!	#DIV/0!		
BRCA testing and related genetic counseling							#DIV/0!	#DIV/0!		
Laboratory tests							#DIV/0!	#DIV/0!		
X-rays and diagnostic imaging							#DIV/0!	#DIV/0!		
Imaging (CT/PET Scans, MRIs)							#DIV/0!	#DIV/0!		
Nonemergency ambulance and psychiatric transport services							#DIV/0!	#DIV/0!		
Outpatient rehabilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Outpatient habilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Home health							#DIV/0!	#DIV/0!		
Hospice							#DIV/0!	#DIV/0!		
Durable medical equipment, including in-home DME							#DIV/0!	#DIV/0!		
Medical supplies							#DIV/0!	#DIV/0!		
Prosthetic and orthotic services and devices							#DIV/0!	#DIV/0!		
Diabetes equipment and supply services							#DIV/0!	#DIV/0!		
Contact lenses for aniridia or aphakia							#DIV/0!	#DIV/0!		
Child eye glasses/contact lenses							#DIV/0!	#DIV/0!		
Child dental basic services							#DIV/0!	#DIV/0!		
Child dental major services							#DIV/0!	#DIV/0!		
Child medically necessary orthodontics							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
E. Outpatient, Out-of-Network: Office Visits										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
G. Emergency										
Emergency room facility services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency room physician services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency ambulance transport services							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Please include any comments

Benefit Plan Design #2 - Individual, Gold

COLUMNS: A	B	C	D	E	F	G	H	I	J	K
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
A. Inpatient, In-Network										
Hospital facility services (e.g., hospital room)--acute inpatient							#DIV/0!	#DIV/0!		
Physician/surgeon services--acute inpatient							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--female sterilization							#DIV/0!	#DIV/0!		
Physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--maternity delivery							#DIV/0!	#DIV/0!		
Professional services--maternity delivery							#DIV/0!	#DIV/0!		
Inpatient hospice facility services (e.g., hospital room)							#DIV/0!	#DIV/0!		
Skilled nursing facility services (e.g., facility room)							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

A	B	C	D	E	F	G	H	I	J	K
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
B. Inpatient, Out-of-Network										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
C. Outpatient, In-Network: Office Visits										
Primary care visit to treat an injury, illness, or condition							#DIV/0!	#DIV/0!		
Other practitioner office visit							#DIV/0!	#DIV/0!		
Specialist physician visit							#DIV/0!	#DIV/0!		
Preventive care/screening/immunization							#DIV/0!	#DIV/0!		
Family planning							#DIV/0!	#DIV/0!		
Prenatal care and preconception visits							#DIV/0!	#DIV/0!		
Acupuncture							#DIV/0!	#DIV/0!		
Health education							#DIV/0!	#DIV/0!		
Child dental diagnostic and preventive services							#DIV/0!	#DIV/0!		
Child eye exam							#DIV/0!	#DIV/0!		
Urgent care							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
D. Outpatient, In-Network: Other Outpatient Items and Services										
Surgery facility services (e.g. Ambulatory Surgery Center)							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services							#DIV/0!	#DIV/0!		
Surgery facility services (e.g. Ambulatory Surgery Center)--female sterilization							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Outpatient visit (e.g. outpatient chemotherapy, radiation, infusion therapy, dialysis, and similar outpatient services)							#DIV/0!	#DIV/0!		
BRCA testing and related genetic counseling							#DIV/0!	#DIV/0!		
Laboratory tests							#DIV/0!	#DIV/0!		
X-rays and diagnostic imaging							#DIV/0!	#DIV/0!		
Imaging (CT/PET Scans, MRIs)							#DIV/0!	#DIV/0!		
Nonemergency ambulance and psychiatric transport services							#DIV/0!	#DIV/0!		
Outpatient rehabilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Outpatient habilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Home health							#DIV/0!	#DIV/0!		
Hospice							#DIV/0!	#DIV/0!		
Durable medical equipment, including in-home DME							#DIV/0!	#DIV/0!		
Medical supplies							#DIV/0!	#DIV/0!		
Prosthetic and orthotic services and devices							#DIV/0!	#DIV/0!		
Diabetes equipment and supply services							#DIV/0!	#DIV/0!		
Contact lenses for aniridia or aphakia							#DIV/0!	#DIV/0!		
Child eye glasses/contact lenses							#DIV/0!	#DIV/0!		
Child dental basic services							#DIV/0!	#DIV/0!		
Child dental major services							#DIV/0!	#DIV/0!		
Child medically necessary orthodontics							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
E. Outpatient, Out-of-Network: Office Visits										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
G. Emergency										
Emergency room facility services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency room physician services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency ambulance transport services							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Please include any comments

Benefit Plan Design #3 - Individual, Silver

COLUMNS: A	B	C	D	E	F	G	H	I	J	K
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
A. Inpatient, In-Network										
Hospital facility services (e.g., hospital room)--acute inpatient							#DIV/0!	#DIV/0!		
Physician/surgeon services--acute inpatient							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--female sterilization							#DIV/0!	#DIV/0!		
Physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--maternity delivery							#DIV/0!	#DIV/0!		
Professional services--maternity delivery							#DIV/0!	#DIV/0!		
Inpatient hospice facility services (e.g., hospital room)							#DIV/0!	#DIV/0!		
Skilled nursing facility services (e.g., facility room)							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
B. Inpatient, Out-of-Network										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
C. Outpatient, In-Network: Office Visits										
Primary care visit to treat an injury, illness, or condition							#DIV/0!	#DIV/0!		
Other practitioner office visit							#DIV/0!	#DIV/0!		
Specialist physician visit							#DIV/0!	#DIV/0!		
Preventive care/screening/immunization							#DIV/0!	#DIV/0!		
Family planning							#DIV/0!	#DIV/0!		
Prenatal care and preconception visits							#DIV/0!	#DIV/0!		
Acupuncture							#DIV/0!	#DIV/0!		
Health education							#DIV/0!	#DIV/0!		
Child dental diagnostic and preventive services							#DIV/0!	#DIV/0!		
Child eye exam							#DIV/0!	#DIV/0!		
Urgent care							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
D. Outpatient, In-Network: Other Outpatient Items and Services										
Surgery facility services (e.g. Ambulatory Surgery Center)							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services							#DIV/0!	#DIV/0!		
Surgery facility services (e.g. Ambulatory Surgery Center)--female sterilization							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Outpatient visit (e.g. outpatient chemotherapy, radiation, infusion therapy, dialysis, and similar outpatient services)							#DIV/0!	#DIV/0!		
BRCA testing and related genetic counseling							#DIV/0!	#DIV/0!		
Laboratory tests							#DIV/0!	#DIV/0!		
X-rays and diagnostic imaging							#DIV/0!	#DIV/0!		
Imaging (CT/PET Scans, MRIs)							#DIV/0!	#DIV/0!		
Nonemergency ambulance and psychiatric transport services							#DIV/0!	#DIV/0!		
Outpatient rehabilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Outpatient habilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Home health							#DIV/0!	#DIV/0!		
Hospice							#DIV/0!	#DIV/0!		
Durable medical equipment, including in-home DME							#DIV/0!	#DIV/0!		
Medical supplies							#DIV/0!	#DIV/0!		
Prosthetic and orthotic services and devices							#DIV/0!	#DIV/0!		
Diabetes equipment and supply services							#DIV/0!	#DIV/0!		
Contact lenses for aniridia or aphakia							#DIV/0!	#DIV/0!		
Child eye glasses/contact lenses							#DIV/0!	#DIV/0!		
Child dental basic services							#DIV/0!	#DIV/0!		
Child dental major services							#DIV/0!	#DIV/0!		
Child medically necessary orthodontics							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
E. Outpatient, Out-of-Network: Office Visits										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
F. Outpatient, Out-of-Network: Other Outpatient Items and Services										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
G. Emergency										
Emergency room facility services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency room physician services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency ambulance transport services							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Please include any comments

Benefit Plan Design #4 - Individual, Silver 200-250% FPL

COLUMNS: A	B	C	D	E	F	G	H	I	J	K
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
A. Inpatient, In-Network										
Hospital facility services (e.g., hospital room)--acute inpatient							#DIV/0!	#DIV/0!		
Physician/surgeon services--acute inpatient							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--female sterilization							#DIV/0!	#DIV/0!		
Physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--maternity delivery							#DIV/0!	#DIV/0!		
Professional services--maternity delivery							#DIV/0!	#DIV/0!		
Inpatient hospice facility services (e.g., hospital room)							#DIV/0!	#DIV/0!		
Skilled nursing facility services (e.g., facility room)							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
B. Inpatient, Out-of-Network										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Exhibit J-11-B

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
C. Outpatient, In-Network: Office Visits										
Primary care visit to treat an injury, illness, or condition							#DIV/0!	#DIV/0!		
Other practitioner office visit							#DIV/0!	#DIV/0!		
Specialist physician visit							#DIV/0!	#DIV/0!		
Preventive care/screening/immunization							#DIV/0!	#DIV/0!		
Family planning							#DIV/0!	#DIV/0!		
Prenatal care and preconception visits							#DIV/0!	#DIV/0!		
Acupuncture							#DIV/0!	#DIV/0!		
Health education							#DIV/0!	#DIV/0!		
Child dental diagnostic and preventive services							#DIV/0!	#DIV/0!		
Child eye exam							#DIV/0!	#DIV/0!		
Urgent care							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
D. Outpatient, In-Network: Other Outpatient Items and Services										
Surgery facility services (e.g. Ambulatory Surgery Center)							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services							#DIV/0!	#DIV/0!		
Surgery facility services (e.g. Ambulatory Surgery Center)--female sterilization							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Outpatient visit (e.g. outpatient chemotherapy, radiation, infusion therapy, dialysis, and similar outpatient services)							#DIV/0!	#DIV/0!		
BRCA testing and related genetic counseling							#DIV/0!	#DIV/0!		
Laboratory tests							#DIV/0!	#DIV/0!		
X-rays and diagnostic imaging							#DIV/0!	#DIV/0!		
Imaging (CT/PET Scans, MRIs)							#DIV/0!	#DIV/0!		
Nonemergency ambulance and psychiatric transport services							#DIV/0!	#DIV/0!		
Outpatient rehabilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Outpatient habilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Home health							#DIV/0!	#DIV/0!		
Hospice							#DIV/0!	#DIV/0!		
Durable medical equipment, including in-home DME							#DIV/0!	#DIV/0!		
Medical supplies							#DIV/0!	#DIV/0!		
Prosthetic and orthotic services and devices							#DIV/0!	#DIV/0!		
Diabetes equipment and supply services							#DIV/0!	#DIV/0!		
Contact lenses for aniridia or aphakia							#DIV/0!	#DIV/0!		
Child eye glasses/contact lenses							#DIV/0!	#DIV/0!		
Child dental basic services							#DIV/0!	#DIV/0!		
Child dental major services							#DIV/0!	#DIV/0!		
Child medically necessary orthodontics							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
E. Outpatient, Out-of-Network: Office Visits										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
G. Emergency										
Emergency room facility services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency room physician services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency ambulance transport services							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Please include any comments

Benefit Plan Design #5 - Individual, Bronze

COLUMNS: A	B	C	D	E	F	G	H	I	J	K
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
A. Inpatient, In-Network										
Hospital facility services (e.g., hospital room)--acute inpatient							#DIV/0!	#DIV/0!		
Physician/surgeon services--acute inpatient							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--female sterilization							#DIV/0!	#DIV/0!		
Physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--maternity delivery							#DIV/0!	#DIV/0!		
Professional services--maternity delivery							#DIV/0!	#DIV/0!		
Inpatient hospice facility services (e.g., hospital room)							#DIV/0!	#DIV/0!		
Skilled nursing facility services (e.g., facility room)							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

A	B	C	D	E	F	G	H	I	J	K
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
B. Inpatient, Out-of-Network										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
C. Outpatient, In-Network: Office Visits										
Primary care visit to treat an injury, illness, or condition							#DIV/0!	#DIV/0!		
Other practitioner office visit							#DIV/0!	#DIV/0!		
Specialist physician visit							#DIV/0!	#DIV/0!		
Preventive care/screening/immunization							#DIV/0!	#DIV/0!		
Family planning							#DIV/0!	#DIV/0!		
Prenatal care and preconception visits							#DIV/0!	#DIV/0!		
Acupuncture							#DIV/0!	#DIV/0!		
Health education							#DIV/0!	#DIV/0!		
Child dental diagnostic and preventive services							#DIV/0!	#DIV/0!		
Child eye exam							#DIV/0!	#DIV/0!		
Urgent care							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	

* Amount to be entered in Exhibit J-11-A Table 3, Column C.

** The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
D. Outpatient, In-Network: Other Outpatient Items and Services										
Surgery facility services (e.g. Ambulatory Surgery Center)							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services							#DIV/0!	#DIV/0!		
Surgery facility services (e.g. Ambulatory Surgery Center)--female sterilization							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Outpatient visit (e.g. outpatient chemotherapy, radiation, infusion therapy, dialysis, and similar outpatient services)							#DIV/0!	#DIV/0!		
BRCA testing and related genetic counseling							#DIV/0!	#DIV/0!		
Laboratory tests							#DIV/0!	#DIV/0!		
X-rays and diagnostic imaging							#DIV/0!	#DIV/0!		
Imaging (CT/PET Scans, MRIs)							#DIV/0!	#DIV/0!		
Nonemergency ambulance and psychiatric transport services							#DIV/0!	#DIV/0!		
Outpatient rehabilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Outpatient habilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Home health							#DIV/0!	#DIV/0!		
Hospice							#DIV/0!	#DIV/0!		
Durable medical equipment, including in-home DME							#DIV/0!	#DIV/0!		
Medical supplies							#DIV/0!	#DIV/0!		
Prosthetic and orthotic services and devices							#DIV/0!	#DIV/0!		
Diabetes equipment and supply services							#DIV/0!	#DIV/0!		
Contact lenses for aniridia or aphakia							#DIV/0!	#DIV/0!		
Child eye glasses/contact lenses							#DIV/0!	#DIV/0!		
Child dental basic services							#DIV/0!	#DIV/0!		
Child dental major services							#DIV/0!	#DIV/0!		
Child medically necessary orthodontics							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	

* Amount to be entered in Exhibit J-11-A Table 3, Column C.

** The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
E. Outpatient, Out-of-Network: Office Visits										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
G. Emergency										
Emergency room facility services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency room physician services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency ambulance transport services							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Please include any comments

Benefit Plan Design #6 - Individual, Catastrophic

COLUMNS: A	B	C	D	E	F	G	H	I	J	K
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
A. Inpatient, In-Network										
Hospital facility services (e.g., hospital room)--acute inpatient							#DIV/0!	#DIV/0!		
Physician/surgeon services--acute inpatient							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--female sterilization							#DIV/0!	#DIV/0!		
Physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--maternity delivery							#DIV/0!	#DIV/0!		
Professional services--maternity delivery							#DIV/0!	#DIV/0!		
Inpatient hospice facility services (e.g., hospital room)							#DIV/0!	#DIV/0!		
Skilled nursing facility services (e.g., facility room)							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
B. Inpatient, Out-of-Network										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
C. Outpatient, In-Network: Office Visits										
Primary care visit to treat an injury, illness, or condition							#DIV/0!	#DIV/0!		
Other practitioner office visit							#DIV/0!	#DIV/0!		
Specialist physician visit							#DIV/0!	#DIV/0!		
Preventive care/screening/immunization							#DIV/0!	#DIV/0!		
Family planning							#DIV/0!	#DIV/0!		
Prenatal care and preconception visits							#DIV/0!	#DIV/0!		
Acupuncture							#DIV/0!	#DIV/0!		
Health education							#DIV/0!	#DIV/0!		
Child dental diagnostic and preventive services							#DIV/0!	#DIV/0!		
Child eye exam							#DIV/0!	#DIV/0!		
Urgent care							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
D. Outpatient, In-Network: Other Outpatient Items and Services										
Surgery facility services (e.g. Ambulatory Surgery Center)							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services							#DIV/0!	#DIV/0!		
Surgery facility services (e.g. Ambulatory Surgery Center)--female sterilization							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Outpatient visit (e.g. outpatient chemotherapy, radiation, infusion therapy, dialysis, and similar outpatient services)							#DIV/0!	#DIV/0!		
BRCA testing and related genetic counseling							#DIV/0!	#DIV/0!		
Laboratory tests							#DIV/0!	#DIV/0!		
X-rays and diagnostic imaging							#DIV/0!	#DIV/0!		
Imaging (CT/PET Scans, MRIs)							#DIV/0!	#DIV/0!		
Nonemergency ambulance and psychiatric transport services							#DIV/0!	#DIV/0!		
Outpatient rehabilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Outpatient habilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Home health							#DIV/0!	#DIV/0!		
Hospice							#DIV/0!	#DIV/0!		
Durable medical equipment, including in-home DME							#DIV/0!	#DIV/0!		
Medical supplies							#DIV/0!	#DIV/0!		
Prosthetic and orthotic services and devices							#DIV/0!	#DIV/0!		
Diabetes equipment and supply services							#DIV/0!	#DIV/0!		
Contact lenses for aniridia or aphakia							#DIV/0!	#DIV/0!		
Child eye glasses/contact lenses							#DIV/0!	#DIV/0!		
Child dental basic services							#DIV/0!	#DIV/0!		
Child dental major services							#DIV/0!	#DIV/0!		
Child medically necessary orthodontics							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
E. Outpatient, Out-of-Network: Office Visits										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
G. Emergency										
Emergency room facility services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency room physician services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency ambulance transport services							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Please include any comments

Benefit Plan Design #7 - Individual, Alternative Plan Design (Non-Standard)

COLUMNS: A	B	C	D	E	F	G	H	I	J	K
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
A. Inpatient, In-Network										
Hospital facility services (e.g., hospital room)--acute inpatient							#DIV/0!	#DIV/0!		
Physician/surgeon services--acute inpatient							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--female sterilization							#DIV/0!	#DIV/0!		
Physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--maternity delivery							#DIV/0!	#DIV/0!		
Professional services--maternity delivery							#DIV/0!	#DIV/0!		
Inpatient hospice facility services (e.g., hospital room)							#DIV/0!	#DIV/0!		
Skilled nursing facility services (e.g., facility room)							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
B. Inpatient, Out-of-Network										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
C. Outpatient, In-Network: Office Visits										
Primary care visit to treat an injury, illness, or condition							#DIV/0!	#DIV/0!		
Other practitioner office visit							#DIV/0!	#DIV/0!		
Specialist physician visit							#DIV/0!	#DIV/0!		
Preventive care/screening/immunization							#DIV/0!	#DIV/0!		
Family planning							#DIV/0!	#DIV/0!		
Prenatal care and preconception visits							#DIV/0!	#DIV/0!		
Acupuncture							#DIV/0!	#DIV/0!		
Health education							#DIV/0!	#DIV/0!		
Child dental diagnostic and preventive services							#DIV/0!	#DIV/0!		
Child eye exam							#DIV/0!	#DIV/0!		
Urgent care							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
D. Outpatient, In-Network: Other Outpatient Items and Services										
Surgery facility services (e.g. Ambulatory Surgery Center)							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services							#DIV/0!	#DIV/0!		
Surgery facility services (e.g. Ambulatory Surgery Center)--female sterilization							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Outpatient visit (e.g. outpatient chemotherapy, radiation, infusion therapy, dialysis, and similar outpatient services)							#DIV/0!	#DIV/0!		
BRCA testing and related genetic counseling							#DIV/0!	#DIV/0!		
Laboratory tests							#DIV/0!	#DIV/0!		
X-rays and diagnostic imaging							#DIV/0!	#DIV/0!		
Imaging (CT/PET Scans, MRIs)							#DIV/0!	#DIV/0!		
Nonemergency ambulance and psychiatric transport services							#DIV/0!	#DIV/0!		
Outpatient rehabilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Outpatient habilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Home health							#DIV/0!	#DIV/0!		
Hospice							#DIV/0!	#DIV/0!		
Durable medical equipment, including in-home DME							#DIV/0!	#DIV/0!		
Medical supplies							#DIV/0!	#DIV/0!		
Prosthetic and orthotic services and devices							#DIV/0!	#DIV/0!		
Diabetes equipment and supply services							#DIV/0!	#DIV/0!		
Contact lenses for aniridia or aphakia							#DIV/0!	#DIV/0!		
Child eye glasses/contact lenses							#DIV/0!	#DIV/0!		
Child dental basic services							#DIV/0!	#DIV/0!		
Child dental major services							#DIV/0!	#DIV/0!		
Child medically necessary orthodontics							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
E. Outpatient, Out-of-Network: Office Visits										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	

* Amount to be entered in Exhibit J-11-A Table 3, Column C.

** The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	

* Amount to be entered in Exhibit J-11-A Table 3, Column C.

** The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
G. Emergency										
Emergency room facility services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency room physician services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency ambulance transport services							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	

* Amount to be entered in Exhibit J-11-A Table 3, Column C.

** The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.

Please include any comments

Benefit Plan Design #8 - Small Group, Platinum

COLUMNS: A	B	C	D	E	F	G	H	I	J	K
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
A. Inpatient, In-Network										
Hospital facility services (e.g., hospital room)--acute inpatient							#DIV/0!	#DIV/0!		
Physician/surgeon services--acute inpatient							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--female sterilization							#DIV/0!	#DIV/0!		
Physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--maternity delivery							#DIV/0!	#DIV/0!		
Professional services--maternity delivery							#DIV/0!	#DIV/0!		
Inpatient hospice facility services (e.g., hospital room)							#DIV/0!	#DIV/0!		
Skilled nursing facility services (e.g., facility room)							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
B. Inpatient, Out-of-Network										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
C. Outpatient, In-Network: Office Visits										
Primary care visit to treat an injury, illness, or condition							#DIV/0!	#DIV/0!		
Other practitioner office visit							#DIV/0!	#DIV/0!		
Specialist physician visit							#DIV/0!	#DIV/0!		
Preventive care/screening/immunization							#DIV/0!	#DIV/0!		
Family planning							#DIV/0!	#DIV/0!		
Prenatal care and preconception visits							#DIV/0!	#DIV/0!		
Acupuncture							#DIV/0!	#DIV/0!		
Health education							#DIV/0!	#DIV/0!		
Child dental diagnostic and preventive services							#DIV/0!	#DIV/0!		
Child eye exam							#DIV/0!	#DIV/0!		
Urgent care							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
D. Outpatient, In-Network: Other Outpatient Items and Services										
Surgery facility services (e.g. Ambulatory Surgery Center)							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services							#DIV/0!	#DIV/0!		
Surgery facility services (e.g. Ambulatory Surgery Center)--female sterilization							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Outpatient visit (e.g. outpatient chemotherapy, radiation, infusion therapy, dialysis, and similar outpatient services)							#DIV/0!	#DIV/0!		
BRCA testing and related genetic counseling							#DIV/0!	#DIV/0!		
Laboratory tests							#DIV/0!	#DIV/0!		
X-rays and diagnostic imaging							#DIV/0!	#DIV/0!		
Imaging (CT/PET Scans, MRIs)							#DIV/0!	#DIV/0!		
Nonemergency ambulance and psychiatric transport services							#DIV/0!	#DIV/0!		
Outpatient rehabilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Outpatient habilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Home health							#DIV/0!	#DIV/0!		
Hospice							#DIV/0!	#DIV/0!		
Durable medical equipment, including in-home DME							#DIV/0!	#DIV/0!		
Medical supplies							#DIV/0!	#DIV/0!		
Prosthetic and orthotic services and devices							#DIV/0!	#DIV/0!		
Diabetes equipment and supply services							#DIV/0!	#DIV/0!		
Contact lenses for aniridia or aphakia							#DIV/0!	#DIV/0!		
Child eye glasses/contact lenses							#DIV/0!	#DIV/0!		
Child dental basic services							#DIV/0!	#DIV/0!		
Child dental major services							#DIV/0!	#DIV/0!		
Child medically necessary orthodontics							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
E. Outpatient, Out-of-Network: Office Visits										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
G. Emergency										
Emergency room facility services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency room physician services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency ambulance transport services							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Please include any comments

Benefit Plan Design #9 - Small Group, Gold

COLUMNS: A	B	C	D	E	F	G	H	I	J	K
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
A. Inpatient, In-Network										
Hospital facility services (e.g., hospital room)--acute inpatient							#DIV/0!	#DIV/0!		
Physician/surgeon services--acute inpatient							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--female sterilization							#DIV/0!	#DIV/0!		
Physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--maternity delivery							#DIV/0!	#DIV/0!		
Professional services--maternity delivery							#DIV/0!	#DIV/0!		
Inpatient hospice facility services (e.g., hospital room)							#DIV/0!	#DIV/0!		
Skilled nursing facility services (e.g., facility room)							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
B. Inpatient, Out-of-Network										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
C. Outpatient, In-Network: Office Visits										
Primary care visit to treat an injury, illness, or condition							#DIV/0!	#DIV/0!		
Other practitioner office visit							#DIV/0!	#DIV/0!		
Specialist physician visit							#DIV/0!	#DIV/0!		
Preventive care/screening/immunization							#DIV/0!	#DIV/0!		
Family planning							#DIV/0!	#DIV/0!		
Prenatal care and preconception visits							#DIV/0!	#DIV/0!		
Acupuncture							#DIV/0!	#DIV/0!		
Health education							#DIV/0!	#DIV/0!		
Child dental diagnostic and preventive services							#DIV/0!	#DIV/0!		
Child eye exam							#DIV/0!	#DIV/0!		
Urgent care							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
D. Outpatient, In-Network: Other Outpatient Items and Services										
Surgery facility services (e.g. Ambulatory Surgery Center)							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services							#DIV/0!	#DIV/0!		
Surgery facility services (e.g. Ambulatory Surgery Center)--female sterilization							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Outpatient visit (e.g. outpatient chemotherapy, radiation, infusion therapy, dialysis, and similar outpatient services)							#DIV/0!	#DIV/0!		
BRCA testing and related genetic counseling							#DIV/0!	#DIV/0!		
Laboratory tests							#DIV/0!	#DIV/0!		
X-rays and diagnostic imaging							#DIV/0!	#DIV/0!		
Imaging (CT/PET Scans, MRIs)							#DIV/0!	#DIV/0!		
Nonemergency ambulance and psychiatric transport services							#DIV/0!	#DIV/0!		
Outpatient rehabilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Outpatient habilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Home health							#DIV/0!	#DIV/0!		
Hospice							#DIV/0!	#DIV/0!		
Durable medical equipment, including in-home DME							#DIV/0!	#DIV/0!		
Medical supplies							#DIV/0!	#DIV/0!		
Prosthetic and orthotic services and devices							#DIV/0!	#DIV/0!		
Diabetes equipment and supply services							#DIV/0!	#DIV/0!		
Contact lenses for aniridia or aphakia							#DIV/0!	#DIV/0!		
Child eye glasses/contact lenses							#DIV/0!	#DIV/0!		
Child dental basic services							#DIV/0!	#DIV/0!		
Child dental major services							#DIV/0!	#DIV/0!		
Child medically necessary orthodontics							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
E. Outpatient, Out-of-Network: Office Visits										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
G. Emergency										
Emergency room facility services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency room physician services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency ambulance transport services							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Please include any comments

Benefit Plan Design #10 - Small Group, Silver

COLUMNS: A	B	C	D	E	F	G	H	I	J	K
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
A. Inpatient, In-Network										
Hospital facility services (e.g., hospital room)--acute inpatient							#DIV/0!	#DIV/0!		
Physician/surgeon services--acute inpatient							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--female sterilization							#DIV/0!	#DIV/0!		
Physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--maternity delivery							#DIV/0!	#DIV/0!		
Professional services--maternity delivery							#DIV/0!	#DIV/0!		
Inpatient hospice facility services (e.g., hospital room)							#DIV/0!	#DIV/0!		
Skilled nursing facility services (e.g., facility room)							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
B. Inpatient, Out-of-Network										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
C. Outpatient, In-Network: Office Visits										
Primary care visit to treat an injury, illness, or condition							#DIV/0!	#DIV/0!		
Other practitioner office visit							#DIV/0!	#DIV/0!		
Specialist physician visit							#DIV/0!	#DIV/0!		
Preventive care/screening/immunization							#DIV/0!	#DIV/0!		
Family planning							#DIV/0!	#DIV/0!		
Prenatal care and preconception visits							#DIV/0!	#DIV/0!		
Acupuncture							#DIV/0!	#DIV/0!		
Health education							#DIV/0!	#DIV/0!		
Child dental diagnostic and preventive services							#DIV/0!	#DIV/0!		
Child eye exam							#DIV/0!	#DIV/0!		
Urgent care							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
D. Outpatient, In-Network: Other Outpatient Items and Services										
Surgery facility services (e.g. Ambulatory Surgery Center)							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services							#DIV/0!	#DIV/0!		
Surgery facility services (e.g. Ambulatory Surgery Center)--female sterilization							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Outpatient visit (e.g. outpatient chemotherapy, radiation, infusion therapy, dialysis, and similar outpatient services)							#DIV/0!	#DIV/0!		
BRCA testing and related genetic counseling							#DIV/0!	#DIV/0!		
Laboratory tests							#DIV/0!	#DIV/0!		
X-rays and diagnostic imaging							#DIV/0!	#DIV/0!		
Imaging (CT/PET Scans, MRIs)							#DIV/0!	#DIV/0!		
Nonemergency ambulance and psychiatric transport services							#DIV/0!	#DIV/0!		
Outpatient rehabilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Outpatient habilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Home health							#DIV/0!	#DIV/0!		
Hospice							#DIV/0!	#DIV/0!		
Durable medical equipment, including in-home DME							#DIV/0!	#DIV/0!		
Medical supplies							#DIV/0!	#DIV/0!		
Prosthetic and orthotic services and devices							#DIV/0!	#DIV/0!		
Diabetes equipment and supply services							#DIV/0!	#DIV/0!		
Contact lenses for aniridia or aphakia							#DIV/0!	#DIV/0!		
Child eye glasses/contact lenses							#DIV/0!	#DIV/0!		
Child dental basic services							#DIV/0!	#DIV/0!		
Child dental major services							#DIV/0!	#DIV/0!		
Child medically necessary orthodontics							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
E. Outpatient, Out-of-Network: Office Visits										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	

* Amount to be entered in Exhibit J-11-A Table 3, Column C.

** The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	

* Amount to be entered in Exhibit J-11-A Table 3, Column C.

** The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
G. Emergency										
Emergency room facility services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency room physician services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency ambulance transport services							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	

* Amount to be entered in Exhibit J-11-A Table 3, Column C.

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Please include any comments

Benefit Plan Design #11 - Small Group, Bronze

COLUMNS: A	B	C	D	E	F	G	H	I	J	K
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
A. Inpatient, In-Network										
Hospital facility services (e.g., hospital room)--acute inpatient							#DIV/0!	#DIV/0!		
Physician/surgeon services--acute inpatient							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--female sterilization							#DIV/0!	#DIV/0!		
Physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--maternity delivery							#DIV/0!	#DIV/0!		
Professional services--maternity delivery							#DIV/0!	#DIV/0!		
Inpatient hospice facility services (e.g., hospital room)							#DIV/0!	#DIV/0!		
Skilled nursing facility services (e.g., facility room)							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
B. Inpatient, Out-of-Network										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
C. Outpatient, In-Network: Office Visits										
Primary care visit to treat an injury, illness, or condition							#DIV/0!	#DIV/0!		
Other practitioner office visit							#DIV/0!	#DIV/0!		
Specialist physician visit							#DIV/0!	#DIV/0!		
Preventive care/screening/immunization							#DIV/0!	#DIV/0!		
Family planning							#DIV/0!	#DIV/0!		
Prenatal care and preconception visits							#DIV/0!	#DIV/0!		
Acupuncture							#DIV/0!	#DIV/0!		
Health education							#DIV/0!	#DIV/0!		
Child dental diagnostic and preventive services							#DIV/0!	#DIV/0!		
Child eye exam							#DIV/0!	#DIV/0!		
Urgent care							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
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Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
D. Outpatient, In-Network: Other Outpatient Items and Services										
Surgery facility services (e.g. Ambulatory Surgery Center)							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services							#DIV/0!	#DIV/0!		
Surgery facility services (e.g. Ambulatory Surgery Center)--female sterilization							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Outpatient visit (e.g. outpatient chemotherapy, radiation, infusion therapy, dialysis, and similar outpatient services)							#DIV/0!	#DIV/0!		
BRCA testing and related genetic counseling							#DIV/0!	#DIV/0!		
Laboratory tests							#DIV/0!	#DIV/0!		
X-rays and diagnostic imaging							#DIV/0!	#DIV/0!		
Imaging (CT/PET Scans, MRIs)							#DIV/0!	#DIV/0!		
Nonemergency ambulance and psychiatric transport services							#DIV/0!	#DIV/0!		
Outpatient rehabilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Outpatient habilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Home health							#DIV/0!	#DIV/0!		
Hospice							#DIV/0!	#DIV/0!		
Durable medical equipment, including in-home DME							#DIV/0!	#DIV/0!		
Medical supplies							#DIV/0!	#DIV/0!		
Prosthetic and orthotic services and devices							#DIV/0!	#DIV/0!		
Diabetes equipment and supply services							#DIV/0!	#DIV/0!		
Contact lenses for aniridia or aphakia							#DIV/0!	#DIV/0!		
Child eye glasses/contact lenses							#DIV/0!	#DIV/0!		
Child dental basic services							#DIV/0!	#DIV/0!		
Child dental major services							#DIV/0!	#DIV/0!		
Child medically necessary orthodontics							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
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Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
E. Outpatient, Out-of-Network: Office Visits										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
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Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
F. Outpatient, Out-of-Network: Other Outpatient Items and Services										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
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Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
G. Emergency										
Emergency room facility services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency room physician services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency ambulance transport services							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Please include any comments

Benefit Plan Design #12 - Small Group, Alternative Plan Design (Non-Standard)

COLUMNS: A	B	C	D	E	F	G	H	I	J	K
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
A. Inpatient, In-Network										
Hospital facility services (e.g., hospital room)--acute inpatient							#DIV/0!	#DIV/0!		
Physician/surgeon services--acute inpatient							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--female sterilization							#DIV/0!	#DIV/0!		
Physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--maternity delivery							#DIV/0!	#DIV/0!		
Professional services--maternity delivery							#DIV/0!	#DIV/0!		
Inpatient hospice facility services (e.g., hospital room)							#DIV/0!	#DIV/0!		
Skilled nursing facility services (e.g., facility room)							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
B. Inpatient, Out-of-Network										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
C. Outpatient, In-Network: Office Visits										
Primary care visit to treat an injury, illness, or condition							#DIV/0!	#DIV/0!		
Other practitioner office visit							#DIV/0!	#DIV/0!		
Specialist physician visit							#DIV/0!	#DIV/0!		
Preventive care/screening/immunization							#DIV/0!	#DIV/0!		
Family planning							#DIV/0!	#DIV/0!		
Prenatal care and preconception visits							#DIV/0!	#DIV/0!		
Acupuncture							#DIV/0!	#DIV/0!		
Health education							#DIV/0!	#DIV/0!		
Child dental diagnostic and preventive services							#DIV/0!	#DIV/0!		
Child eye exam							#DIV/0!	#DIV/0!		
Urgent care							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	

* Amount to be entered in Exhibit J-11-A Table 3, Column C.

** The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
D. Outpatient, In-Network: Other Outpatient Items and Services										
Surgery facility services (e.g. Ambulatory Surgery Center)							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services							#DIV/0!	#DIV/0!		
Surgery facility services (e.g. Ambulatory Surgery Center)--female sterilization							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Outpatient visit (e.g. outpatient chemotherapy, radiation, infusion therapy, dialysis, and similar outpatient services)							#DIV/0!	#DIV/0!		
BRCA testing and related genetic counseling							#DIV/0!	#DIV/0!		
Laboratory tests							#DIV/0!	#DIV/0!		
X-rays and diagnostic imaging							#DIV/0!	#DIV/0!		
Imaging (CT/PET Scans, MRIs)							#DIV/0!	#DIV/0!		
Nonemergency ambulance and psychiatric transport services							#DIV/0!	#DIV/0!		
Outpatient rehabilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Outpatient habilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Home health							#DIV/0!	#DIV/0!		
Hospice							#DIV/0!	#DIV/0!		
Durable medical equipment, including in-home DME							#DIV/0!	#DIV/0!		
Medical supplies							#DIV/0!	#DIV/0!		
Prosthetic and orthotic services and devices							#DIV/0!	#DIV/0!		
Diabetes equipment and supply services							#DIV/0!	#DIV/0!		
Contact lenses for aniridia or aphakia							#DIV/0!	#DIV/0!		
Child eye glasses/contact lenses							#DIV/0!	#DIV/0!		
Child dental basic services							#DIV/0!	#DIV/0!		
Child dental major services							#DIV/0!	#DIV/0!		
Child medically necessary orthodontics							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	

* Amount to be entered in Exhibit J-11-A Table 3, Column C.

** The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
E. Outpatient, Out-of-Network: Office Visits										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	

* Amount to be entered in Exhibit J-11-A Table 3, Column C.

** The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	

* Amount to be entered in Exhibit J-11-A Table 3, Column C.

** The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
G. Emergency										
Emergency room facility services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency room physician services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency ambulance transport services							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	

* Amount to be entered in Exhibit J-11-A Table 3, Column C.

** The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.

Please include any comments

Benefit Plan Design #13 - Large Group, First Most Popular

COLUMNS: A	B	C	D	E	F	G	H	I	J	K
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
A. Inpatient, In-Network										
Hospital facility services (e.g., hospital room)--acute inpatient							#DIV/0!	#DIV/0!		
Physician/surgeon services--acute inpatient							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--female sterilization							#DIV/0!	#DIV/0!		
Physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--maternity delivery							#DIV/0!	#DIV/0!		
Professional services--maternity delivery							#DIV/0!	#DIV/0!		
Inpatient hospice facility services (e.g., hospital room)							#DIV/0!	#DIV/0!		
Skilled nursing facility services (e.g., facility room)							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
B. Inpatient, Out-of-Network										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
C. Outpatient, In-Network: Office Visits										
Primary care visit to treat an injury, illness, or condition							#DIV/0!	#DIV/0!		
Other practitioner office visit							#DIV/0!	#DIV/0!		
Specialist physician visit							#DIV/0!	#DIV/0!		
Preventive care/screening/immunization							#DIV/0!	#DIV/0!		
Family planning							#DIV/0!	#DIV/0!		
Prenatal care and preconception visits							#DIV/0!	#DIV/0!		
Acupuncture							#DIV/0!	#DIV/0!		
Health education							#DIV/0!	#DIV/0!		
Child dental diagnostic and preventive services							#DIV/0!	#DIV/0!		
Child eye exam							#DIV/0!	#DIV/0!		
Urgent care							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
D. Outpatient, In-Network: Other Outpatient Items and Services										
Surgery facility services (e.g. Ambulatory Surgery Center)							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services							#DIV/0!	#DIV/0!		
Surgery facility services (e.g. Ambulatory Surgery Center)--female sterilization							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Outpatient visit (e.g. outpatient chemotherapy, radiation, infusion therapy, dialysis, and similar outpatient services)							#DIV/0!	#DIV/0!		
BRCA testing and related genetic counseling							#DIV/0!	#DIV/0!		
Laboratory tests							#DIV/0!	#DIV/0!		
X-rays and diagnostic imaging							#DIV/0!	#DIV/0!		
Imaging (CT/PET Scans, MRIs)							#DIV/0!	#DIV/0!		
Nonemergency ambulance and psychiatric transport services							#DIV/0!	#DIV/0!		
Outpatient rehabilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Outpatient habilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Home health							#DIV/0!	#DIV/0!		
Hospice							#DIV/0!	#DIV/0!		
Durable medical equipment, including in-home DME							#DIV/0!	#DIV/0!		
Medical supplies							#DIV/0!	#DIV/0!		
Prosthetic and orthotic services and devices							#DIV/0!	#DIV/0!		
Diabetes equipment and supply services							#DIV/0!	#DIV/0!		
Contact lenses for aniridia or aphakia							#DIV/0!	#DIV/0!		
Child eye glasses/contact lenses							#DIV/0!	#DIV/0!		
Child dental basic services							#DIV/0!	#DIV/0!		
Child dental major services							#DIV/0!	#DIV/0!		
Child medically necessary orthodontics							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
E. Outpatient, Out-of-Network: Office Visits										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
G. Emergency										
Emergency room facility services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency room physician services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency ambulance transport services							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Please include any comments

Benefit Plan Design #14 - Large Group, Second Most Popular

COLUMNS: A	B	C	D	E	F	G	H	I	J	K
Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
A. Inpatient, In-Network										
Hospital facility services (e.g., hospital room)--acute inpatient							#DIV/0!	#DIV/0!		
Physician/surgeon services--acute inpatient							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--female sterilization							#DIV/0!	#DIV/0!		
Physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--maternity delivery							#DIV/0!	#DIV/0!		
Professional services--maternity delivery							#DIV/0!	#DIV/0!		
Inpatient hospice facility services (e.g., hospital room)							#DIV/0!	#DIV/0!		
Skilled nursing facility services (e.g., facility room)							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									
Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
B. Inpatient, Out-of-Network										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Exhibit J-11-B

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
C. Outpatient, In-Network: Office Visits										
Primary care visit to treat an injury, illness, or condition							#DIV/0!	#DIV/0!		
Other practitioner office visit							#DIV/0!	#DIV/0!		
Specialist physician visit							#DIV/0!	#DIV/0!		
Preventive care/screening/immunization							#DIV/0!	#DIV/0!		
Family planning							#DIV/0!	#DIV/0!		
Prenatal care and preconception visits							#DIV/0!	#DIV/0!		
Acupuncture							#DIV/0!	#DIV/0!		
Health education							#DIV/0!	#DIV/0!		
Child dental diagnostic and preventive services							#DIV/0!	#DIV/0!		
Child eye exam							#DIV/0!	#DIV/0!		
Urgent care							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
D. Outpatient, In-Network: Other Outpatient Items and Services										
Surgery facility services (e.g. Ambulatory Surgery Center)							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services							#DIV/0!	#DIV/0!		
Surgery facility services (e.g. Ambulatory Surgery Center)--female sterilization							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Outpatient visit (e.g. outpatient chemotherapy, radiation, infusion therapy, dialysis, and similar outpatient services)							#DIV/0!	#DIV/0!		
BRCA testing and related genetic counseling							#DIV/0!	#DIV/0!		
Laboratory tests							#DIV/0!	#DIV/0!		
X-rays and diagnostic imaging							#DIV/0!	#DIV/0!		
Imaging (CT/PET Scans, MRIs)							#DIV/0!	#DIV/0!		
Nonemergency ambulance and psychiatric transport services							#DIV/0!	#DIV/0!		
Outpatient rehabilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Outpatient habilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Home health							#DIV/0!	#DIV/0!		
Hospice							#DIV/0!	#DIV/0!		
Durable medical equipment, including in-home DME							#DIV/0!	#DIV/0!		
Medical supplies							#DIV/0!	#DIV/0!		
Prosthetic and orthotic services and devices							#DIV/0!	#DIV/0!		
Diabetes equipment and supply services							#DIV/0!	#DIV/0!		
Contact lenses for aniridia or aphakia							#DIV/0!	#DIV/0!		
Child eye glasses/contact lenses							#DIV/0!	#DIV/0!		
Child dental basic services							#DIV/0!	#DIV/0!		
Child dental major services							#DIV/0!	#DIV/0!		
Child medically necessary orthodontics							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
E. Outpatient, Out-of-Network: Office Visits										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	

* Amount to be entered in Exhibit J-11-A Table 3, Column C.

** The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	

* Amount to be entered in Exhibit J-11-A Table 3, Column C.

** The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
G. Emergency										
Emergency room facility services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency room physician services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency ambulance transport services							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	

* Amount to be entered in Exhibit J-11-A Table 3, Column C.

** The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.

Please include any comments

Benefit Plan Design #15 - Large Group, Third Most Popular

COLUMNS: A	B	C	D	E	F	G	H	I	J	K
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
A. Inpatient, In-Network										
Hospital facility services (e.g., hospital room)--acute inpatient							#DIV/0!	#DIV/0!		
Physician/surgeon services--acute inpatient							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--female sterilization							#DIV/0!	#DIV/0!		
Physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Hospital facility services (e.g., hospital room)--maternity delivery							#DIV/0!	#DIV/0!		
Professional services--maternity delivery							#DIV/0!	#DIV/0!		
Inpatient hospice facility services (e.g., hospital room)							#DIV/0!	#DIV/0!		
Skilled nursing facility services (e.g., facility room)							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									
Classification from Exhibit J-11-A	**Deductible Applies (Y or N)**	**Copayment ($) Amount**	**CY 2019 Projected Expense Subject to Copayment**	**Coinsurance (%) Amount**	**CY 2019 Projected Expense Subject to Coinsurance**	**CY 2019 Total Projected Expense (Allowed)**	**Projected Expense for this Benefit as % of Projected Claims Subject to Copay $**	**Projected Expense for this Benefit as % of Projected Claims Subject to Coins %**	**Substantially All Cost Share Type (2/3 test)**	**Predominant Level (50% test)***
B. Inpatient, Out-of-Network										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
C. Outpatient, In-Network: Office Visits										
Primary care visit to treat an injury, illness, or condition							#DIV/0!	#DIV/0!		
Other practitioner office visit							#DIV/0!	#DIV/0!		
Specialist physician visit							#DIV/0!	#DIV/0!		
Preventive care/screening/immunization							#DIV/0!	#DIV/0!		
Family planning							#DIV/0!	#DIV/0!		
Prenatal care and preconception visits							#DIV/0!	#DIV/0!		
Acupuncture							#DIV/0!	#DIV/0!		
Health education							#DIV/0!	#DIV/0!		
Child dental diagnostic and preventive services							#DIV/0!	#DIV/0!		
Child eye exam							#DIV/0!	#DIV/0!		
Urgent care							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
D. Outpatient, In-Network: Other Outpatient Items and Services										
Surgery facility services (e.g. Ambulatory Surgery Center)							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services							#DIV/0!	#DIV/0!		
Surgery facility services (e.g. Ambulatory Surgery Center)--female sterilization							#DIV/0!	#DIV/0!		
Surgery facility--physician/surgeon services--female sterilization							#DIV/0!	#DIV/0!		
Outpatient visit (e.g. outpatient chemotherapy, radiation, infusion therapy, dialysis, and similar outpatient services)							#DIV/0!	#DIV/0!		
BRCA testing and related genetic counseling							#DIV/0!	#DIV/0!		
Laboratory tests							#DIV/0!	#DIV/0!		
X-rays and diagnostic imaging							#DIV/0!	#DIV/0!		
Imaging (CT/PET Scans, MRIs)							#DIV/0!	#DIV/0!		
Nonemergency ambulance and psychiatric transport services							#DIV/0!	#DIV/0!		
Outpatient rehabilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Outpatient habilitation services (e.g. PT/OT/ST including for pervasive developmental disorder or autism)							#DIV/0!	#DIV/0!		
Home health							#DIV/0!	#DIV/0!		
Hospice							#DIV/0!	#DIV/0!		
Durable medical equipment, including in-home DME							#DIV/0!	#DIV/0!		
Medical supplies							#DIV/0!	#DIV/0!		
Prosthetic and orthotic services and devices							#DIV/0!	#DIV/0!		
Diabetes equipment and supply services							#DIV/0!	#DIV/0!		
Contact lenses for aniridia or aphakia							#DIV/0!	#DIV/0!		
Child eye glasses/contact lenses							#DIV/0!	#DIV/0!		
Child dental basic services							#DIV/0!	#DIV/0!		
Child dental major services							#DIV/0!	#DIV/0!		
Child medically necessary orthodontics							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	
*	Amount to be entered in Exhibit J-11-A Table 3, Column C.									
**	The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.									

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
E. Outpatient, Out-of-Network: Office Visits										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	

* Amount to be entered in Exhibit J-11-A Table 3, Column C.

** The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
F. Outpatient, Out-of-Network: Other Outpatient Items and Services										
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	

* Amount to be entered in Exhibit J-11-A Table 3, Column C.

** The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.

Classification from Exhibit J-11-A	Deductible Applies (Y or N)	Copayment ($) Amount	CY 2019 Projected Expense Subject to Copayment	Coinsurance (%) Amount	CY 2019 Projected Expense Subject to Coinsurance	CY 2019 Total Projected Expense (Allowed)	Projected Expense for this Benefit as % of Projected Claims Subject to Copay $	Projected Expense for this Benefit as % of Projected Claims Subject to Coins %	Substantially All Cost Share Type (2/3 test)	Predominant Level (50% test)*
G. Emergency										
Emergency room facility services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency room physician services (waived if admitted)							#DIV/0!	#DIV/0!		
Emergency ambulance transport services							#DIV/0!	#DIV/0!		
Total			$ -		$ -	$ -	#DIV/0!	#DIV/0!		
	Total Subject to Copay $		#DIV/0!			$ -	#DIV/0!		#DIV/0!	
	Total Subject to Coinsurance %				#DIV/0!	$ -		#DIV/0!	#DIV/0!	
	Total Subject to No Cost Sharing					$ -				
		Deductible $			**CY 2019 Projected Expense (Allowed) Subject to Deductible**	**CY 2019 Projected Expense (Allowed) Subject to Deductible as % of Total Plan Cost (Allowed)**			**Substantially All Deductible (2/3 test)****	
	Total Subject to Deductible				$ -	#DIV/0!			#DIV/0!	

* Amount to be entered in Exhibit J-11-A Table 3, Column C.

** The entry ("Y" or "N") in Column J should provide the basis of the answer to question C in Table 1 of Exhibit J-11-A. Refer to instruction (14) in the Instructions tab.

Please include any comments