Group Name- Company XYZ	
Deductible	In-network: $500 individual $1,000 family Out-of-network: $1,000 individual $2,000 family
Coinsurance	In-network: 90% Out-of-network: 70%
Out-of-pocket Maximum	In-network: $3,000 individual $6,000 family Out-of-network: $6,000 individual $12,000 family
HSA Contribution	None
Annual visit	100%
Individual premium	$280/month
Family premium	$900/month

Group Name- MAX Bupa	Plan A		Plan B		Plan C - HSA	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Deductible Amount						
Single	$1,000	$2,000	$2,500	$5,000	$4,000	$8,000
Family	$2,000	$4,000	$5,000	$10,000	$8,000	$16,000
Co-Insurance	80%	60%	80%	60%	N/A	N/A
Out of Pocket Maximum	Single		Single		Single	
	$3,000	$6,000	$5,000	$10,000	$4,000	$8,000
	Family		Family		Family	
	$4,000	$8,000	$7,000	$14,000	$8,000	$16,000
	Max Out of Pocket is Deductible + Co-Insurance				No Co-Pay or Co-Insurance	
Preventative	100%	Ded. & Co. Ins.	100%	Ded. & Co. Ins.	100%	Ded. & Co. Ins.
Dr. Office Co-Pay						
Primary Care	$25	Ded. & Co. Ins.	$25	Ded. & Co. Ins.	N/A	N/A
Specialist	$25	Ded. & Co. Ins.	$25	Ded. & Co. Ins.	N/A	N/A

		ICICI Lombard Ihealth	Max Bupa Heartbeat Gold	Apollo Munich Optima Restore	Tata AIG MediPrime	Star Health Comprehensive
	Basic sum insured	10 lacs	10 lacs	10 lacs	10 lacs	10 lacs
	Premium	10,643	22,696	13,607	12,205	17,483
	Hosptalization benefits					
1	Waiting period	Pre-existing diseases: 2 years Specific illnesses/ treatments: 2 years	Pre-existing diseases: 2 years Specific illnesses/treatments: None	Pre-existing diseases: 3 years Specific illnesses/ treatments: 2 years	Pre-existing diseases: 4 years Specific illnesses/ treatments: 2 years	Pre-existing diseases: 4 years Specific illnesses/ treatments: 2 years
2	Hospital accomodation	No restriction /sub-limits	No restriction /sub-limits	No restriction /sub-limits	No restriction /sub-limits	No restriction /sub-limits
3	Pre-hospitalization	30 days	30 days	60 days	60 days if informed of hospitalization 5 days in advance, else 30 days	30 days
4	Post hospitalization	60 days after	60 days after	180 days	90 days if informed of hospitalization 5 days in advance, else 60 days	60 days
5	Hospital cash/Daily Cash	No	Not applicable	Only in case of shared accomodation. Rs 800 per day for maximum of 6 days	Only for accompanying insured child. Rs 500 per day subject to a maximum of Rs 15000	Rs 750 per day upto 120 days with a maximum of 7 days per occurrence
6	Emergency ambulance	Rs. 1500 per hospitalization	Actual cost at Network hospital, Rs 2000 per hosptalization otherwise	Rs 2000 per hospitalization	Rs 2500 per hospitalization	Rs 3500 per policy period
7	Organ donor expense	Not covered	Covered	Covered	Covered	Not covered
8	Co-payment feature /Annual deductible	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
9	Day care procedures	140 day care procedures covered	All day care procedures covered	All day care procedures covered	140 day care procedures covered	101 day care procedures covered
10	Domicilliary hospitalization	No	Yes, upto Rs 50,000	Yes	Yes	No
11	Alternative treatments	No	No	No	Upto Rs 25000	No
12	Maternity benefits (delivery expenses)	Waiting period of 36 months	Waiting period of 24 months. Expenses for 2 deliveries, upto Rs 50000 per year Husband and wife to be covered under the same policy	None	None	Waiting period of 36 months. Upto Rs 40000 per delivery for 2 deliveries
13	New born baby cover	None	Automatic covered (without additional charge) till the expiry of policy year in which the baby was born. Vaccination expenses covered	None	None	Automatically covered upto Rs 1 lac (without additional charge) till the expiry of policy year in which the baby was born. Vaccination expenses upto Rs 1000 covered
	Renewal benefits					
14	**Renewal benefits**	No Claim : Additional 10% sum insured at the time of renewal for every claim free year. In case of a claim, cumulative additional sum insured to go down by 50%	Irrespective of whether the claim was made : Gift rewards worth 10% of last paid premium or additional 10% sum insured	No claim: Bonus of 50% of the Basic Sum Insured In case of claim, accumulated bonus to be reduced by 50% of the basic sum insured.	No claim: Sum insured enhanced by 10% (bonus) each year . In case of claim: Cumulative bonus reduced by 10% of the basic sum insured	No claim: bonus sum insured at 100% of basic sum insured. In case of claim: bonus sum insured becomes zero
15	**Loading on claims**	NA	NA	NA	NA	NA
16	**Health checkup**	Yes	Yes (Annual)	No	Once every four years claim free years	Once every three claim free years
17	**Claim settlement record**	96.9%	82.2%	79.0%	84.8%	69.0%

Source: Policy documents for the respective policies (December 2014). For claim settlement data: Mint Mediclaim ratings, Claim settlement ratio calculated as 100%-(%claims repudiated +% claims pending for over six months)

Company Name- ABC Ltd.

Source- Google

Group Name	ABC Ltd
Group Number	123
Renewal Date	01-01-2024
No of employees enrolled	20
Group State	CT
Market	Large
In Network (IN):	
Copay	30/45
IN Coinsurance %	100/0
IN Deductible	2500/5000
Out of Network (OON):	
OON Coinsurance %	100/0
OON Deductible	2500/5000

Group Financial Information

Please see Rate Model for available plan combinations

Link to PDML: http://pdml/

Plan Design: KACTOHP63RD

	In-Network		Out-of-Network		
Office Copay:					
PCP:	No Charge after Deductible		UCR: 100% of Medicare	Modified UCR: Standard	
Specialist:	No Charge after Deductible				
ER Copay:	No Charge after Deductible				
Hospital Copay					
Inpatient:	No Charge after Deductible				
Outpatient Hospital Setting:	No Charge after Deductible				
Single Deductible:	$2,850	Modified Cost Share:	Single Deductible:	$2,850	Modified Cost Share:
Family Deductible:	$5,700		Family Deductible:	$5,700	
Coinsurance:	None		Coinsurance:	30%	
Single M.O.O.P.	$4,000		Single M.O.O.P.	$5,850	
Family M.O.O.P.	$8,000		Family M.O.O.P.	$11,700	

Financial Accumulation Period: Calendar Year

Prescription Plan

Please see Rate Model for available plan combinations

Rx Tracking ID:

Evaluation Warning: The document was created with Spire.XLS for Python

Group name- Pearson	
Deductible	$1000/$2000
Out-of-Pocket Max	$6850/$13,700
Office Visit – Primary Care	$10
Office Visit – Specialty Care	$40
Emergency Room	$250
Urgent Care	$50
Inpatient Care	70% covered
Preventive Care	100% covered
Rx	$10 Generic ONLY
POS	

Group Name-	UnitedHealthcare Effective Date: 11/1/2020
DEDUCTIBLE	
Individual	PPO: $250 OON: $1,000
Family	PPO: $500 (embedded) OON: $2,000 (embedded)
OUT-OF-POCKET MAX	
Individual	PPO: $3,500 (includes ded.) OON: $7,000 (includes ded.)
Family	PPO: $7,000 (embedded; includes ded.) OON: $14,000 (embedded; includes ded.)
PHYSICIAN SERVICES	
Office Visits	PPO: 0%/$75 (ded. waived) OON: 50% after ded.
Telemedicine	PPO: Virtual Visits: 0% (ded. waived) OON: Not Covered
Preventive Care	PPO: 0% (ded. waived) OON: Not Covered
Diagnostic Lab/X-Ray	PPO: 20% after ded. OON: 50% after ded.
Imaging (CT/PET scans, MRIs)	PPO: 20% after ded. OON: 50% after ded.
Rehabilitation/Habilitation (PT/OT/ST)	PPO: 0% (ded. waived) OON: 50% after ded.
Chiropractic Care	PPO: 0% (ded. waived; 24 Manipulative Treatments) OON: 50% after ded.

Group Name = Vantage Medical

Vantage Medical Home HMO

Medical Coverage				
	Employee-Only	Employee +1 (Spouse or child)	Employee + Children	Family
Deductible (Tier I)	$400	$800	$1,200	$1,200
Deductible (Tier II & Out-of-Network)	$1,500	$3,000	$4,500	$4,500
Out-of-pocket max (Tier I)	$2,500	$5,000	$5,000	$7,500
Out-of-pocket max (Tier II & Out-of-Network)	Unlimited	Unlimited	Unlimited	Unlimited
Co-Payment PCP (Tier I)	$10 AHN/$20	$10 AHN/$20	$10 AHN/$20	$10 AHN/$20
Co-Payment Specialist (Tier I)	$35 AHN/$45	$35 AHN/$45	$35 AHN/$45	$35 AHN/$45
Coinsurance – PCP (Out-of-Network)	50% coverage; subject to out-of-network deductible			
Coinsurance – Specialist (Out-of-Network)	50% coverage; subject to out-of-network deductible			

Prescription Coverage	
Tier	Member Responsibility
Tier 1 Preferred Generics	$5
Tier 2 Non-Preferred Generics	$20
Tier 3 Preferred Brand	$50
Tier 4 Non-Preferred Brand	$80
Tier 5 Specialty	$150

Tier I Providers

Members seeing Tier I providers pay the Tier I co-pays, co-insurance and deductibles as listed in the Certificate of Coverage and Cost Share Schedule. Tier I consists of two networks:

- A preferred provider network, Affinity Health Network (AHN), which has lower co-payments for certain covered services; and
- A standard provider network

Tier II Providers

Members who chose to see these providers will have to pay an additional 20% coinsurance in addition to their Tier I cost share, after the applicable deductible is met.

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