Standard Platinum Plan 2017 Standard Plan AV after Adj: 90.99%

		2017 Standard Platinum Plan		2018 Platinum Alternate Mid-Level Plan 1		2018 Platinum Alternate Mid-Level Plan 2		2018 Platinum Alternate Rich Plan	
Global Plan Provisions (Individual Level)	Draft 2018 Actuarial Value	88.20%		89.77%		89.77%		91.98%	
	Medical Deductible	$0		$0		$0		$0	
	Prescription Drug Deductible	$0		$0		$0		$0	
	Dental Deductible	$0		$0		$0		$0	
	Out-of-Pocket Maximum	$2,000		$2,000		$1,500		$1,000	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible**	**Member Cost Share**	**Deductible**	**Member Cost Share**	**Deductible**	**Member Cost Share**	**Deductible**
Health Care Provider's Office or Clinic visit	PCP Visit Or Non-Specialist Practitioner Visit to Treat an Injury or Illness	$20		$10		$20		$15	
	Specialist Visit	$40		$20		$40		$30	
	Preventive Care/Screening/Immunization	$0		$0		$0		$0	
Tests	Laboratory Tests	$20		$10		$20		$20	
	X-Rays And Diagnostic Imaging	$40		$20		$40		$40	
	Imaging (CT Scans, PET Scans, MRIs)	$150		$100		$150		$150	
Drugs to Treat Illness or Condition	Generic	$5		$5		$5		$5	
	Preferred Brand	$15		$15		$15		$15	
	Non-Preferred Brand	$25		$25		$25		$25	
	Specialty	$100		$100		$100		$100	
Outpatient Surgery	Facility Fee (e.g. Hospital Room) Physician/Surgeon Fee	$250		$200		$250		$250	
Outpatient Non-Surgical Clinic Visit*	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital or hospital clinic	$75		$75		$75		$75	
Need Immediate Attention	Emergency Room Services (Waived If Admitted)	$150		$100		$150		$150	
	Emergency Medical Transportation	$150		$100		$150		$150	
	Urgent Care	$40		$20		$40		$30	
Hospital Stay	Facility Fee (e.g. Hospital Room) Physician/Surgeon Fee	$250 Per Day (Up To 5 Days)		$200 Per Day (Up To 5 Days)		$250 Per Day (Up To 5 Days)		$250 Per Day (Up To 5 Days)	
Mental/Behavioral Health	Office Visits	$20		$10		$20		$15	
	Outpatient Services	$20		$10		$20		$15	
	Inpatient Services	$250 Per Day (Up To 5 Days)		$200 Per Day (Up To 5 Days)		$250 Per Day (Up To 5 Days)		$250 Per Day (Up To 5 Days)	
Substance Abuse Needs	Outpatient Services	$20		$10		$20		$15	
	Inpatient Services	$250 Per Day (Up To 5 Days)		$200 Per Day (Up To 5 Days)		$250 Per Day (Up To 5 Days)		$250 Per Day (Up To 5 Days)	
Pregnancy	Prenatal Care And Preconception Services	$0		$0		$0		$0	
	Delivery And All Inpatient Services - Hospital	$250 Per Day (Up To 5 Days)		$200 Per Day (Up To 5 Days)		$250 Per Day (Up To 5 Days)		$250 Per Day (Up To 5 Days)	
	Delivery And All Inpatient Services - Prof								
Help Recovering or Other Special Health Needs	Home Health Care	$20		$10		$20		$20	
	Outpatient Rehabilitation Services	$20		$10		$20		$20	
	Outpatient Habilitation Services	$20		$10		$20		$20	
	Skilled Nursing Care	$150 Per Day (Up To 5 Days)		$100 Per Day (Up To 5 Days)		$150 Per Day (Up To 5 Days)		$150 Per Day (Up To 5 Days)	
	Durable Medical Equipment	10%		10%		10%		10%	
	Hospice Services	$0		$0		$0		$0	
Child Eye Care	Eye Exam	$0		$0		$0		$0	
	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	$0		$0		$0		$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0		$0		$0		$0	
	Preventive - Cleaning	$0		$0		$0		$0	
	Preventive - X-Ray	$0		$0		$0		$0	
	Sealants - Per Tooth	$0		$0		$0		$0	
	Topical Fluoride Application	$0		$0		$0		$0	
	Space Maintainers - Fixed	$0		$0		$0		$0	
Child Dental Basic Services	Amalgam Fill - 1 Surface	$25		$25		$25		$25	
Child Dental Major Services	Root Canal - Molar	$300		$300		$300		$300	
	Gingivectomy - Per Quad	$150		$150		$150		$150	
	Extraction - Single Tooth Exposed Root	$65		$65		$65		$65	
	Extraction - Complete Bony	$160		$160		$160		$160	
	Porcelain With Metal Crown	$300		$300		$300		$300	
Child Orthodontics	Medically Necessary Orthodontics	$1,000		$1,000		$1,000		$1,000	

***Copay may not apply in staff model HMO setting.**

****If deductible applies to benefit, member must first satisfy the deductible before "Member Cost Share" is applied**

Standard Gold Plan 2017 Standard Plan AV after Adj: 81.89%

		2017 Standard Gold Plan		2017 Standard Gold Copay Rx Plan		2018 Gold Alternate Lean Plan		2018 Gold Coins HSA Plan		2018 Gold Copay HSA Plan	
Global Plan Provisions (Individual Level)	Draft 2018 Actuarial Value	81.91%		81.91%		80.09%		80.30%		81.46%	
	Medical Deductible	$500		$500		$500		$1,350		$1,350	
	Prescription Drug Deductible	$0		$0		$0		Integrated with Medical		Integrated with Medical	
	Dental Deductible	$0		$0		$0		$0		$0	
	Out-of-Pocket Maximum	$3,500		$3,500		$4,000		$4,000		$2,000	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible**	**Member Cost Share**	**Deductible**	**Member Cost Share**	**Deductible**	**Member Cost Share**	**Deductible**	**Member Cost Share**	**Deductible**
Health Care Provider's Office or Clinic visit	PCP Visit Or Non-Specialist Practitioner Visit to Treat an Injury or Illness	$25		$25		$30		10%	X	$20	X
	Specialist Visit	$50		$50		$60		10%	X	$40	X
	Preventive Care/Screening/Immunization	$0		$0		$0		$0		$0	
Tests	Laboratory Tests	$30		$30		$40		10%	X	$20	X
	X-Rays And Diagnostic Imaging	$50		$50		$60		10%	X	$40	X
	Imaging (CT Scans, PET Scans, MRIs)	$250		$250		$250		10%	X	$200	X
Drugs to Treat Illness or Condition	Generic	$15		$15		$15		10%	X	$15	X
	Preferred Brand	$50		$50		$50		10%	X	$50	X
	Non-Preferred Brand	$70		$70		$70		10%	X	$70	X
	Specialty	20%		$150		20%		10%	X	$150	X
Outpatient Surgery	Facility Fee (e.g. Hospital Room) Physician/Surgeon Fee	$600		$600		$600		10%	X	$300	X
Outpatient Non-Surgical Clinic Visit*	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital or	$75		$75		$75		10%	X	$75	X
Need Immediate Attention	Emergency Room Services (Waived If Admitted)	$250		$250		$250		10%	X	$200	X
	Emergency Medical Transportation	$250		$250		$250		10%	X	$200	X
	Urgent Care	$60		$60		$60		10%	X	$60	X
Hospital Stay	Facility Fee (e.g. Hospital Room) Physician/Surgeon Fee	$600 Per Day (Up To 5 Days)	X	$600 Per Day (Up To 5 Days)	X	$600 Per Day (Up To 5 Days)	X	10%	X	$200 Per Day (Up To 5 Days)	X
Mental/Behavioral Health	Office Visits	$25		$25		$30		10%	X	$20	X
	Outpatient Services	$25		$25		$30		10%	X	$20	X
	Inpatient Services	$600 Per Day (Up To 5 Days)	X	$600 Per Day (Up To 5 Days)	X	$600 Per Day (Up To 5 Days)	X	10%	X	$200 Per Day (Up To 5 Days)	X
Substance Abuse Needs	Outpatient Services	$25		$25		$30		10%	X	$20	X
	Inpatient Services	$600 Per Day (Up To 5 Days)	X	$600 Per Day (Up To 5 Days)	X	$600 Per Day (Up To 5 Days)	X	10%	X	$200 Per Day (Up To 5 Days)	X
Pregnancy	Prenatal Care And Preconception Services	$0		$0		$0		$0		$0	
	Delivery And All Inpatient Services - Hospital	$600 Per Day (Up To 5 Days)	X	$600 Per Day (Up To 5 Days)	X	$600 Per Day (Up To 5 Days)	X	10%	X	$200 Per Day (Up To 5 Days)	X
	Delivery And All Inpatient Services - Prof										
Help Recovering or Other Special Health Needs	Home Health Care	$30		$30		$40		10%	X	$20	X
	Outpatient Rehabilitation Services	$30		$30		$40		10%	X	$20	X
	Outpatient Habilitation Services	$30		$30		$40		10%	X	$20	X
	Skilled Nursing Care	$300 Per Day (Up To 5 Days)		$300 Per Day (Up To 5 Days)		$300 Per Day (Up To 5 Days)		10%	X	$300 Per Day (Up To 5 Days)	X
	Durable Medical Equipment	20%		20%		20%		10%	X	20%	X
	Hospice Services	$0		$0		$0		10%	X	$0	X
Child Eye Care	Eye Exam	$0		$0		$0		$0		$0	
	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	$0		$0		$0		$0		$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0		$0		$0		$0		$0	
	Preventive - Cleaning	$0		$0		$0		$0		$0	
	Preventive - X-Ray	$0		$0		$0		$0		$0	
	Sealants - Per Tooth	$0		$0		$0		$0		$0	
	Topical Fluoride Application	$0		$0		$0		$0		$0	
	Space Maintainers - Fixed	$0		$0		$0		$0		$0	
Child Dental Basic Services	Amalgam Fill - 1 Surface	$25		$25		$25		$25		$25	
Child Dental Major Services	Root Canal - Molar	$300		$300		$300		$300		$300	
	Gingivectomy - Per Quad	$150		$150		$150		$150		$150	
	Extraction - Single Tooth Exposed Root	$65		$65		$65		$65		$65	
	Extraction - Complete Bony	$160		$160		$160		$160		$160	
	Porcelain With Metal Crown	$300		$300		$300		$300		$300	
Child Orthodontics	Medically Necessary Orthodontics	$1,000		$1,000		$1,000		$1,000		$1,000	

***Copay may not apply in staff model HMO setting.**

****If deductible applies to benefit, member must first satisfy the deductible before "Member Cost Share" is applied**

Standard Silver Plan 2017 Standard Plan AV after Adj: 71.72%

		2017 Standard Silver Plan		2018 Standard Silver Plan		2018 Standard Silver Copay Rx Plan		2018 Standard Silver HSA Plan		2018 Silver Alternate Mid-Level Plan	
Global Plan Provisions (Individual Level)	Draft 2018 Actuarial Value	75.36%		71.94%		71.94%		69.98%		70.00%	
	Medical Deductible	$2,000		$3,500		$3,500		$2,750		$4,500	
	Prescription Drug Deductible	$250		$250		$250		Integrated with Medical		$500	
	Dental Deductible	$0		$0		$0		$0		$0	
	Out-of-Pocket Maximum	$6,250		$6,250		$6,250		$5,000		$6,500	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible**	**Member Cost Share**	**Deductible**	**Member Cost Share**	**Deductible**	**Member Cost Share**	**Deductible**	**Member Cost Share**	**Deductible**
Health Care Provider's Office or Clinic visit	PCP Visit Or Non-Specialist Practitioner Visit to Treat an Injury or Illness	$25		$40		$40		20%	X	$40	
	Specialist Visit	$50		$80		$80		20%	X	$80	
	Preventive Care/Screening/Immunization	$0		$0		$0		$0	X	$0	
Tests	Laboratory Tests	$45		$50		$50		20%	X	$45	
	X-Rays And Diagnostic Imaging	$65		$70		$70		20%	X	$65	
	Imaging (CT Scans, PET Scans, MRIs)	$250		$250		$250		20%	X	$300	
Drugs to Treat Illness or Condition	Generic	$15		$15		$15		$15	X	$15	
	Preferred Brand	$50	X	$50	X	$50	X	$55	X	$50	X
	Non-Preferred Brand	$70	X	$70	X	$70	X	20%	X	$70	X
	Specialty	20%	X	20%	X	$150	X	30% (Max of $150)	X	20%	X
Outpatient Surgery	Facility Fee (e.g. Hospital Room) Physician/Surgeon Fee	20%	X	20%	X	20%	X	20%	X	20%	X
Outpatient Non-Surgical Clinic Visit*	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital or	20%	X	20%	X	20%	X	20%	X	20%	X
Need Immediate Attention	Emergency Room Services (Waived If Admitted)	$250	X	$250	X	$250	X	20%	X	$300	X
	Emergency Medical Transportation	$250	X	$250	X	$250	X	20%	X	$300	X
	Urgent Care	$90		$90		$90		20%	X	$90	
Hospital Stay	Facility Fee (e.g. Hospital Room) Physician/Surgeon Fee	20%	X	20%	X	20%	X	20%	X	20%	X
Mental/Behavioral Health	Office Visits	$25		$40		$40		20%	X	$40	
	Outpatient Services	5%		5%		5%		20%	X	5%	
	Inpatient Services	20%	X	20%	X	20%	X	20%	X	20%	X
Substance Abuse Needs	Outpatient Services	$25		$40		$40		20%	X	$40	
	Inpatient Services	20%	X	20%	X	20%	X	20%	X	20%	X
Pregnancy	Prenatal Care And Preconception Services	$0		$0		$0		$0		$0	
	Delivery And All Inpatient Services - Hospital Delivery And All Inpatient Services - Prof	20%	X	20%	X	20%	X	20%	X	20%	X
Help Recovering or Other Special Health Needs	Home Health Care	$45		$50		$50		20%	X	$45	
	Outpatient Rehabilitation Services	$45		$50		$50		20%	X	$45	
	Outpatient Habilitation Services	$45		$50		$50		20%	X	$45	
	Skilled Nursing Care	20%	X	20%	X	20%	X	20%	X	20%	X
	Durable Medical Equipment	20%		20%		20%		20%	X	20%	
	Hospice Services	$0		$0		$0		20%	X	$0	
Child Eye Care	Eye Exam	$0		$0		$0		$0		$0	
	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	$0		$0		$0		$0		$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0		$0		$0		$0		$0	
	Preventive - Cleaning	$0		$0		$0		$0		$0	
	Preventive - X-Ray	$0		$0		$0		$0		$0	
	Sealants - Per Tooth	$0		$0		$0		$0		$0	
	Topical Fluoride Application	$0		$0		$0		$0		$0	
	Space Maintainers - Fixed	$0		$0		$0		$0		$0	
Child Dental Basic Services	Amalgam Fill - 1 Surface	$25		$25		$25		$25		$25	
Child Dental Major Services	Root Canal - Molar	$300		$300		$300		$300		$300	
	Gingivectomy - Per Quad	$150		$150		$150		$150		$150	
	Extraction - Single Tooth Exposed Root	$65		$65		$65		$65		$65	
	Extraction - Complete Bony	$160		$160		$160		$160		$160	
	Porcelain With Metal Crown	$300		$300		$300		$300		$300	
Child Orthodontics	Medically Necessary Orthodontics	$1,000		$1,000		$1,000		$1,000		$1,000	

***Copay may not apply in staff model HMO setting.**

****If deductible applies to benefit, member must first satisfy the deductible before "Member Cost Share" is applied**

Standard Bronze Plan 2017 Standard Plan AV after Adj: 61.96%

		2017 Standard Bronze Plan		2018 Standard Bronze Plan		2018 Standard Bronze Copay Rx Plan		2018 Standard Bronze Eq Coins Plan		2018 Bronze Alternate Rich Plan		2018 Bronze Alternate - Lean HSA Plan		2018 Bronze Alternate - Rich HSA Plan	
Global Plan Provisions (Individual Level)	Draft 2018 Actuarial Value	66.89%		64.98%		64.95%		64.99%		61.80%		58.54%		61.28%	
	Medical Deductible	$5,000		$5,250		$5,250		$5,250		$7,000		$7,350		$5,000	
	Prescription Drug Deductible	$300		$500		$600		$500		Integrated with Medical		Integrated with Medical		Integrated with Medical	
	Dental Deductible	$0		$0		$0		$0		$0		$0		$0	
	Out-of-Pocket Maximum	$7,150		$7,350		$7,350		$7,350		$7,350		$7,350		$7,000	
Common Medical Event	**Service Type**	**Member Cost Share**	**Deductible**	**Member Cost Share**	**Deductible**	**Member Cost Share**	**Deductible**	**Member Cost Share**	**Deductible**	**Member Cost Share**	**Deductible**	**Member Cost Share**	**Deductible**	**Member Cost Share**	**Deductible**
Health Care Provider's Office or Clinic visit	PCP Visit Or Non-Specialist Practitioner Visit to Treat an Injury or Illness	$50		$50		$50		$50		$50		0%	X	20%	X
	Specialist Visit	$50		$100		$100		$100		$100		0%	X	20%	X
	Preventive Care/Screening/Immunization	$0		$0		$0		$0		$0		$0		$0	
Tests	Laboratory Tests	$50	X	$55	X	$55	X	$55	X	$50	X	0%	X	20%	X
	X-Rays And Diagnostic Imaging	$50	X	$75	X	$75	X	$75	X	$70	X	0%	X	20%	X
	Imaging (CT Scans, PET Scans, MRIs)	$500	X	$500	X	$500	X	$500	X	$500	X	0%	X	20%	X
Drugs to Treat Illness or Condition	Generic	$25		$25		$25		$25		$25		0%	X	20%	X
	Preferred Brand	50%	X	50%	X	$75	X	30%	X	50%	X	0%	X	20%	X
	Non-Preferred Brand	50%	X	50%	X	$100	X	30%	X	50%	X	0%	X	20%	X
	Specialty	50%	X	50%	X	$250	X	30%	X	50%	X	0%	X	20%	X
Outpatient Surgery	Facility Fee (e.g. Hospital Room) Physician/Surgeon Fee	20%	X	20%	X	20%	X	30%	X	20%	X	0%	X	20%	X
Outpatient Non-Surgical Clinic Visit*	Non-surgical service, not otherwise elaborated herein, rendered in the outpatient department of a hospital or	20%	X	20%	X	20%	X	30%	X	20%	X	0%	X	20%	X
Need Immediate Attention	Emergency Room Services (Waived If Admitted)	20%	X	20%	X	20%	X	30%	X	20%	X	0%	X	20%	X
	Emergency Medical Transportation	$0		20%	X	20%	X	30%	X	20%	X	0%	X	20%	X
	Urgent Care	$50		$100		$100		$100		$100		0%	X	20%	X
Hospital Stay	Facility Fee (e.g. Hospital Room) Physician/Surgeon Fee	20%	X	20%	X	20%	X	30%	X	20%	X	0%	X	20%	X
Mental/Behavioral Health	Office Visits	$50		$50		$50		$50		$50		0%	X	20%	X
	Outpatient Services	10%		10%		10%		30%		10%		0%	X	20%	X
	Inpatient Services	20%	X	20%	X	20%	X	30%	X	20%	X	0%	X	20%	X
Substance Abuse Needs	Outpatient Services	$50		$50		$50		$50		$50		0%	X	20%	X
	Inpatient Services	20%	X	20%	X	20%	X	30%	X	20%	X	0%	X	20%	X
Pregnancy	Prenatal Care And Preconception Services	$0		$0		$0		$0		$0		$0		$0	
	Delivery And All Inpatient Services - Hospital Delivery And All Inpatient Services - Prof	20%	X	20%	X	20%	X	30%	X	20%	X	0%	X	20%	X
Help Recovering or Other Special Health Needs	Home Health Care (Up to 90 Visits for 4 Hours per Calendar Yr)	$0	X	$50	X	$50	X	$50	X	$50	X	0%	X	20%	X
	Outpatient Rehabilitation Services	$50	X	$50	X	$50	X	$50	X	$50	X	0%	X	20%	X
	Outpatient Habilitation Services	$50	X	$50	X	$50	X	$50	X	$50	X	0%	X	20%	X
	Skilled Nursing Care	20%	X	20%	X	20%	X	30%	X	20%	X	0%	X	20%	X
	Durable Medical Equipment	20%	X	20%	X	20%	X	30%	X	20%	X	0%	X	20%	X
	Hospice Services	20%	X	20%	X	20%	X	30%	X	20%	X	0%	X	20%	X
Child Eye Care	Eye Exam (OD)	$50		$50		$50		$50		$50		$50		$50	
	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	$0		$0		$0		$0		$0		$0		$0	
Child Dental Diagnostic and Preventive	Oral Exam	$0		$0		$0		$0		$0		$0		$0	
	Preventive - Cleaning	$0		$0		$0		$0		$0		$0		$0	
	Preventive - X-Ray	$0		$0		$0		$0		$0		$0		$0	
	Sealants - Per Tooth	$0		$0		$0		$0		$0		$0		$0	
	Topical Fluoride Application	$0		$0		$0		$0		$0		$0		$0	
	Space Maintainers - Fixed	$0		$0		$0		$0		$0		$0		$0	
Child Dental Basic Services	Amalgam Fill - 1 Surface	$41		$41		$41		$41		$41		$41		$41	
Child Dental Major Services	Root Canal - Molar	$512		$512		$512		$512		$512		$512		$512	
	Gingivectomy - Per Quad	$279		$279		$279		$279		$279		$279		$279	
	Extraction - Single Tooth Exposed Root	$69		$69		$69		$69		$69		$69		$69	
	Extraction - Complete Bony	$241		$241		$241		$241		$241		$241		$241	
	Porcelain With Metal Crown	$523		$523		$523		$523		$523		$523		$523	
Child Orthodontics	Medically Necessary Orthodontics	$3,422		$3,422		$3,422		$3,422		$3,422		$3,422		$3,422	

***Copay may not apply in staff model HMO setting**

****If deductible applies to benefit, member must first satisfy the deductible before "Member Cost Share" is applie**