

		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 Applies**			
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)	\$250	\$200	\$250	\$250
	Physician/Surgeon Fee				
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)	\$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)
	Physician/Surgeon Fee				
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 Delivery And All Inpatient Services - Prof	\$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)
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%
Child Eye Care	Hospice Services	\$0	\$0	\$0	\$0
	Eye Exam	\$0	\$0	\$0	\$0
Child Dental Diagnostic and Preventive	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	\$0	\$0	\$0	\$0
	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
Child Dental Basic Services	Space Maintainers - Fixed	\$0	\$0	\$0	\$0
	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

		2017 Standard Gold Plan	2018 Gold Alternate Lean Plan
Global Plan Provisions (Individual Level)	Draft 2018 Actuarial Value	81.91%	80.09%
	Medical Deductible	\$500	\$500
	Prescription Drug Deductible	\$0	\$0
	Dental Deductible	\$0	\$0
	Out-of-Pocket Maximum	\$3,500	\$4,000
Common Medical Event	Service Type	Member Cost Share Deductible Applies**	Member Cost Share Deductible Applies**
Health Care Provider's Office or Clinic visit	PCP Visit Or Non-Specialist Practitioner Visit to Treat an Injury or Illness	\$25	\$30
	Specialist Visit	\$50	\$60
	Preventive Care/Screening/Immunization	\$0	\$0
Tests	Laboratory Tests	\$30	\$40
	X-Rays And Diagnostic Imaging	\$50	\$60
	Imaging (CT Scans, PET Scans, MRIs)	\$250	\$250
Drugs to Treat Illness or Condition	Generic	\$15	\$15
	Preferred Brand	\$50	\$50
	Non-Preferred Brand	\$70	\$70
	Specialty	20%	20%
Outpatient Surgery	Facility Fee (e.g. Hospital Room)	\$600	\$600
	Physician/Surgeon Fee		
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
Need Immediate Attention	Emergency Room Services (Waived If Admitted)	\$250	\$250
	Emergency Medical Transportation	\$250	\$250
	Urgent Care	\$60	\$60
Hospital Stay	Facility Fee (e.g. Hospital Room)	\$600 Per Day (Up To 5 Days)	\$600 Per Day (Up To 5 Days)
	Physician/Surgeon Fee	X	X
Mental/Behavioral Health	Office Visits	\$25	\$30
	Outpatient Services	\$25	\$30
	Inpatient Services	\$600 Per Day (Up To 5 Days) X	\$600 Per Day (Up To 5 Days) X
Substance Abuse Needs	Outpatient Services	\$25	\$30
	Inpatient Services	\$600 Per Day (Up To 5 Days) X	\$600 Per Day (Up To 5 Days) X
Pregnancy	Prenatal Care And Preconception Services	\$0	\$0
	Delivery And All Inpatient Services - Hospital Delivery And All Inpatient Services - Prof	\$600 Per Day (Up To 5 Days) X	\$600 Per Day (Up To 5 Days) X
Help Recovering or Other Special Health Needs	Home Health Care	\$30	\$40
	Outpatient Rehabilitation Services	\$30	\$40
	Outpatient Habilitation Services	\$30	\$40
	Skilled Nursing Care	\$300 Per Day (Up To 5 Days)	\$300 Per Day (Up To 5 Days)
	Durable Medical Equipment	20%	20%
Child Eye Care	Hospice Services	\$0	\$0
	Eye Exam	\$0	\$0
Child Dental Diagnostic and Preventive	1 Pair Of Glasses/Year (or Contact Lenses in Lieu of Glasses)	\$0	\$0
	Oral Exam	\$0	\$0
	Preventive - Cleaning	\$0	\$0
	Preventive - X-Ray	\$0	\$0
	Sealants - Per Tooth	\$0	\$0
	Topical Fluoride Application	\$0	\$0
Child Dental Basic Services	Space Maintainers - Fixed	\$0	\$0
	Amalgam Fill - 1 Surface	\$25	\$25
Child Dental Major Services	Root Canal - Molar	\$300	\$300
	Gingivectomy - Per Quad	\$150	\$150
	Extraction - Single Tooth Exposed Root	\$65	\$65
	Extraction - Complete Bony	\$160	\$160
	Porcelain With Metal Crown	\$300	\$300
Child Orthodontics	Medically Necessary Orthodontics	\$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

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

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

		2017 Standard Bronze Plan	2018 Standard Bronze 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%	61.80%	58.54%	61.28%					
	Medical Deductible	\$5,000	\$5,250	\$7,000	\$7,350	\$5,000					
	Prescription Drug Deductible	\$300	\$500	Integrated with Medical	Integrated with Medical	Integrated with Medical					
	Dental Deductible	\$0	\$0	\$0	\$0	\$0					
	Out-of-Pocket Maximum	\$7,150	\$7,350	\$7,350	\$7,350	\$7,000					
Common Medical Event	Service Type	Member Cost Share	Deductible Applies**	Member Cost Share	Deductible Applies**	Member Cost Share	Deductible Applies**	Member Cost Share	Deductible Applies**	Member Cost Share	Deductible Applies**
Health Care Provider's Office or Clinic visit	PCP Visit Or Non-Specialist Practitioner Visit to Treat an Injury or Illness	\$50		\$50		\$50		0%	X	20%	X
	Specialist Visit	\$50		\$100		\$100		0%	X	20%	X
	Preventive Care/Screening/Immunization	\$0		\$0		\$0		\$0		\$0	
Tests	Laboratory Tests	\$50	X	\$55	X	\$50	X	0%	X	20%	X
	X-Rays And Diagnostic Imaging	\$50	X	\$75	X	\$70	X	0%	X	20%	X
	Imaging (CT Scans, PET Scans, MRIs)	\$500	X	\$500	X	\$500	X	0%	X	20%	X
Drugs to Treat Illness or Condition	Generic	\$25		\$25		\$25		0%	X	20%	X
	Preferred Brand	50%	X	50%	X	50%	X	0%	X	20%	X
	Non-Preferred Brand	50%	X	50%	X	50%	X	0%	X	20%	X
	Specialty	50%	X	50%	X	50%	X	0%	X	20%	X
Outpatient Surgery	Facility Fee (e.g. Hospital Room)	20%	X	20%	X	20%	X	0%	X	20%	X
	Physician/Surgeon Fee										
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	0%	X	20%	X
Need Immediate Attention	Emergency Room Services (Waived If Admitted)	20%	X	20%	X	20%	X	0%	X	20%	X
	Emergency Medical Transportation	\$0		20%	X	20%	X	0%	X	20%	X
	Urgent Care	\$50		\$100		\$100		0%	X	20%	X
Hospital Stay	Facility Fee (e.g. Hospital Room)	20%	X	20%	X	20%	X	0%	X	20%	X
	Physician/Surgeon Fee										
Mental/Behavioral Health	Office Visits	\$50		\$50		\$50		0%	X	20%	X
	Outpatient Services	10%		10%		10%		0%	X	20%	X
	Inpatient Services	20%	X	20%	X	20%	X	0%	X	20%	X
Substance Abuse Needs	Outpatient Services	\$50		\$50		\$50		0%	X	20%	X
	Inpatient Services	20%	X	20%	X	20%	X	0%	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	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	0%	X	20%	X
	Outpatient Rehabilitation Services	\$50	X	\$50	X	\$50	X	0%	X	20%	X
	Outpatient Habilitation Services	\$50	X	\$50	X	\$50	X	0%	X	20%	X
	Skilled Nursing Care	20%	X	20%	X	20%	X	0%	X	20%	X
	Durable Medical Equipment	20%	X	20%	X	20%	X	0%	X	20%	X
	Hospice Services	20%	X	20%	X	20%	X	0%	X	20%	X
Child Eye Care	Eye Exam (OD)	\$50		\$50		\$50		\$50		\$50	
	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	\$41		\$41		\$41		\$41		\$41	
Child Dental Major Services	Root Canal - Molar	\$512		\$512		\$512		\$512		\$512	
	Gingivectomy - Per Quad	\$279		\$279		\$279		\$279		\$279	
	Extraction - Single Tooth Exposed Root	\$69		\$69		\$69		\$69		\$69	
	Extraction - Complete Bony	\$241		\$241		\$241		\$241		\$241	
	Porcelain With Metal Crown	\$523		\$523		\$523		\$523		\$523	
Child Orthodontics	Medically Necessary Orthodontics	\$3,422		\$3,422		\$3,422		\$3,422		\$3,422	

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