

		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)	\$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%	
	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

		2017 Standard Gold Plan	2017 Standard Gold Copay Rx Plan	2018 Gold Alternate Lean Plan			
Global Plan Provisions (Individual Level)	Draft 2018 Actuarial Value	81.91%	81.91%	80.09%			
	Medical Deductible	\$500	\$500	\$500			
	Prescription Drug Deductible	\$0	\$0	\$0			
	Dental Deductible	\$0	\$0	\$0			
	Out-of-Pocket Maximum	\$3,500	\$3,500	\$4,000			
Common Medical Event	Service Type	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	
	Specialist Visit	\$50		\$50		\$60	
	Preventive Care/Screening/Immunization	\$0		\$0		\$0	
Tests	Laboratory Tests	\$30		\$30		\$40	
	X-Rays And Diagnostic Imaging	\$50		\$50		\$60	
	Imaging (CT Scans, PET Scans, MRIs)	\$250		\$250		\$250	
Drugs to Treat Illness or Condition	Generic	\$15		\$15		\$15	
	Preferred Brand	\$50		\$50		\$50	
	Non-Preferred Brand	\$70		\$70		\$70	
	Specialty	20%		\$150		20%	
Outpatient Surgery	Facility Fee (e.g. Hospital Room)						
	Physician/Surgeon Fee	\$600		\$600		\$600	
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	
Need Immediate Attention	Emergency Room Services (Waived If Admitted)	\$250		\$250		\$250	
	Emergency Medical Transportation	\$250		\$250		\$250	
	Urgent Care	\$60		\$60		\$60	
Hospital Stay	Facility Fee (e.g. Hospital Room)	\$600 Per Day (Up To 5 Days)	X	\$600 Per Day (Up To 5 Days)	X	\$600 Per Day (Up To 5 Days)	X
	Physician/Surgeon Fee						
Mental/Behavioral Health	Office Visits	\$25		\$25		\$30	
	Outpatient Services	\$25		\$25		\$30	
	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
Substance Abuse Needs	Outpatient Services	\$25		\$25		\$30	
	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
Pregnancy	Prenatal Care And Preconception Services	\$0		\$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	\$600 Per Day (Up To 5 Days)	X
Help Recovering or Other Special Health Needs	Home Health Care	\$30		\$30		\$40	
	Outpatient Rehabilitation Services	\$30		\$30		\$40	
	Outpatient Habilitation Services	\$30		\$30		\$40	
	Skilled Nursing Care	\$300 Per Day (Up To 5 Days)		\$300 Per Day (Up To 5 Days)		\$300 Per Day (Up To 5 Days)	
	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	

*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 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		
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		\$150		20%	X	\$300	
Drugs to Treat Illness or Condition	Generic	\$15		\$15		\$15			X	\$15	
	Preferred Brand	\$50	X	\$50	X	\$50	X		X	\$50	X
	Non-Preferred Brand	\$70	X	\$70	X	\$70	X		X	\$70	X
	Specialty	20%	X	20%	X	20%	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	
	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	
	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	
	Root Canal - Molar	\$300		\$300		\$300				\$300	
Child Dental Major Services	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	
	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

Global Plan Provisions (Individual Level)	Draft 2018 Actuarial Value Medical Deductible Prescription Drug Deductible Dental Deductible Out-of-Pocket Maximum	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	
		66.89%	\$5,000 \$300 \$0 \$7,150	64.98%	\$5,250 \$500 \$0 \$7,350	64.95%	\$5,250 \$600 \$0 \$7,350	64.99%	\$5,250 \$500 \$0 \$7,350	61.80%	\$7,000 Integrated with Medical \$0 \$7,350	58.54%	\$7,350 Integrated with Medical \$0 \$7,350	61.28%	\$5,000 Integrated with Medical \$0 \$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%		20%	
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)											0%			
	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)	20%	X	20%	X	20%	X	30%	X	20%	X	0%	X	20%	X
	Physician/Surgeon Fee														
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
Substance Abuse Needs	Inpatient Services	20%	X	20%	X	20%	X	30%	X	20%	X	0%	X	20%	X
	Outpatient Services	\$50		\$50		\$50		\$50		\$50		0%	X	20%	X
Pregnancy	Inpatient Services	20%	X	20%	X	20%	X	30%	X	20%	X	0%	X	20%	X
	Prenatal Care And Preconception Services Delivery And All Inpatient Services - Hospital Delivery And All Inpatient Services - Prof	\$0		\$0		\$0		\$0		\$0		0%		20%	
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	
	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	
Child Dental Major Services	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 applied