



2017 Patient-Centered Benefit Designs and Medical Cost Shares

Benefits in blue are NOT subject to a deductible. Benefits in blue with a white corner are subject to a deductible after the first three visits.

Coverage Category	Minimum Coverage	Bronze	Silver	Enhanced Silver 73	Enhanced Silver 87	Enhanced Silver 94	Gold	Platinum
Percent of cost coverage	Covers 0% until out-of-pocket maximum is met	Covers 60% average annual cost	Covers 70% average annual cost	Covers 73% average annual cost	Covers 87% average annual cost	Covers 94% average annual cost	Covers 80% average annual cost	Covers 90% average annual cost
Cost-sharing Reduction Single Income Range	N/A	N/A	N/A	\$23,451 to \$29,425 (>200% to ≤250% FPL)	\$17,656 to \$23,450 (>150% to ≤200% FPL)	up to \$17,655 (100% to ≤150% FPL)	N/A	N/A
Annual Wellness Exam	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Primary Care Visit	after first 3 non-preventive visits, pay negotiated carrier rate per instance until out-of-pocket maximum is met	\$75*	\$35	\$30	\$10	\$5	\$30	\$15
Urgent Care		\$75*	\$35	\$30	\$10	\$5	\$30	\$15
Specialist Visit	pay negotiated carrier rate per service until out-of-pocket maximum is met	\$105*	\$70	\$55	\$25	\$8	\$55	\$40
Laboratory Tests		\$40	\$35	\$35	\$15	\$8	\$35	\$20
X-Rays and Diagnostics		Full cost until deductible is met	\$70	\$65	\$25	\$8	\$55	\$40
Imaging			\$300	\$300	\$100	\$50	\$275 copay or 20% coinsurance***	\$150 copay or 10% coinsurance***
Tier 1 (Generic Drugs)	pay negotiated carrier rate per script until out-of-pocket maximum is met	Full cost up to \$500 after drug deductible is met	\$15	\$15	\$5	\$3	\$15	\$5
Tier 2 (Preferred Drugs)			\$55**	\$50**	\$20**	\$10	\$55 or less	\$15 or less
Tier 3 (Non-preferred Drugs)			\$80**	\$75**	\$35**	\$15	\$75 or less	\$25 or less
Tier 4 (Specialty Drugs)			20% up to \$250** per script	20% up to \$250** per script	15% up to \$150** per script	10% up to \$150 per script	20% up to \$250 per script	10% up to \$250 per script
Medical Deductible	N/A	Individual: \$6,300 Family: \$12,600	Individual: \$2,500 Family: \$5,000	Individual: \$2,200 Family: \$4,400	Individual: \$650 Family: \$1,300	Individual: \$75 Family: \$150	N/A	N/A
Pharmacy Deductible	N/A	Individual: \$500 Family: \$1,000	Individual: \$250 Family: \$500	Individual: \$250 Family: \$500	Individual: \$50 Family: \$100	N/A	N/A	N/A
Annual Out-of-Pocket Maximum	\$7,150 individual only	\$6,800 individual \$13,600 family	\$6,800 individual \$13,600 family	\$5,700 individual \$11,400 family	\$2,350 individual \$4,700 family	\$2,350 individual \$4,700 family	\$6,750 individual \$13,500 family	\$4,000 individual \$8,000 family

Drug prices are for a 30 day supply.

* Copay is for any combination of services(primary care, specialist, urgent care) for the first three visits. After three visits, future visits will be at full cost until the medical deductible is met.

** Price is after pharmacy deductible amount is met.

*** See plan Evidence of Coverage for imaging cost share.