

Indicate requests for deviations from the 2018 Patient-Centered Benefit Plan Designs be entering alternate cost sharing for the appropriate service type. Applicant must document rationale for each requested deviation, and rationale must include reference to regulatory compliance, administrative or operational barriers to implementing the 2018 Patient-Centered Benefit Plan Designs.

				Platinum Coinsurance Plan		Platinum Copay Plan		Gold Coinsurance Plan		Gold Copay Plan		Silver Plan		Bronze Plan		Silver Plan 100%-150% FPL		Silver Plan 150%-200% FPL		Silver Plan 200%-250% FPL		Bronze Plan		Bronze HDHP Plan		phic Plan	Rationale for benefit deviation (must reference regulatory compliance, administrative or operational barriers)
Common Med ca Even	Serv ci		Member Cos Share	Dd b App	Member Cos Share	Dd b App	Member Cos Share	D d b App	Member Cos Share	D d b App	Member Cos Share	Dd b App	Member Cos Share	D d b App	Member Cos Share	Dd b App	Member Cos Share	D d b App	Member Cos Share	D d b App	Member Cos Share	Dd b App	Member Cos Share	D d b App	Member Cos Share	Dd b App	
	Primary care visit to treat an	injury, illness, or condition																									
	Routine Foot Care																										
Health care	Other practitioner office visi	t																									
provider's office or clinic visit	Acupuncture																										
or clinic visit	Diabetes Education																										
	Specialist visit																										
	Allergy Testing																										
	Preventive care/ screening/ im	munization																									
Tests	Laboratory Tests X-rays and Diagnostic Imaging	1	_																								
	Imaging (CT/PET scans, MRIs)																									
Drugs to treat	Tier 1																										
illness or	Tier 2																										
condition	Tier 3																										
	Tier 4																										
	Surgery facility fee (e.g., Abortion for Which I (non I	Public Funding is Prohibited MSP)																									
	Bariatric Surgery		_																								
Outpatient services	Physician/surgeon fees Outpatient visit																										
services	Dialysis																										
	Radiation																										
	Chemotherapy																										
	Emergency room combined fa (waived if admitted)	cility and physician fee																									
	(waived if admitted)																										
Need immediate	Emergency medical transports	ation																									
attention	Urgent care																										
	Facility fee (e.g. hospital roo												_														
	Facility fee (e.g. nospital roo	sm)																									
Hospital stay	Transplant Reconstructive Surger	v											_														
	Treatment for TMJ	,																									
	Physician/surgeon fee																										
	Mental/Behavioral health outp Mental/Behavioral health othe																										
	rendrer																										
Mental health, behavioral	Mental/Behavioral health inpat room)																										
health, or substance abuse	Mental/Behavioral health inpat																										
needs	Substance Use disorder outpa	tient office visits																									
	Substance Use disorder other services	outpatient items and																									
	Substance Use inpatient facili																										
	Substance use disorder inpati	ent physician/surgeon fee																									
	Prenatal care and preconcept	ion visits																									
Pregnancy	Delivery and all inpatient services	Professional																									
	Well Baby Visits																										
	Home health care																										
	Outpatient Rehabilitation se	rvices																									
	Rehabilitative Speech Rehabilitative Occupat	inerapy	_		_																						
Help recovering	Rehabilitative Occupat	oonai inerapy																									
Help recovering or other special	Rehabilitative Physical	Therapy																									
health needs	Outpatient Habilitation service Skilled nursing care	5																									
	Skilled nursing care Durable medical equipment																										
	Prosthetic Device																										
	Prosthetic Device Hospice service																										
Child and an	Eye exam																										
Child eye care	1 pair of glasses per year (or o	ontact lenses in lieu of glasses)																									
	Oral Exam																										
Child Dental	Preventive - Cleaning Preventive - X-ray Sealants per Tooth																										
Diagnostic and Preventive	Preventive - X-ray Sealants per Tooth																										
Preventive	Sealants per rootn Topical Fluoride Application Space Maintainers - Fixed																										
	Space Maintainers - Fixed																										
Child Dental Basic Services	Amalgam Fill - 1 Surface																										
Child Dental	Gingivectomy per Quad																										
Major Services	Extraction- Single Tooth Expo	sed Root or Erupted																									
	Root Canal-Molar Gingivectomy per Quad Extraction- Single Tooth Expo Extraction- Complete Bony Porcelain with Metal Crown																										
Child																											
Child Orthodontics	Medically necessary orthodon	tics	_																								
Additional Benefits	Adult Eye Exam																										
	Chiropractic			-	-																						