MASSACHUSETTS HEALTH CONNECTOR
the right place for the right plan

2019 Health and Dental Plan Seal of Approval (SOA)

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2019 Seal of Approval Landscape

The proposed 2019 Seal of Approval approach responds to a dynamic and increasingly complex health care landscape. In 2019, the Health Connector product shelf must be able to respond to:

1. The continued need for affordability and sustainability in the ConnectorCare program, in light of the federal withdrawal of Cost-Sharing Reductions (CSRs) previously available to reduce costs for low-income enrollees
2. Ongoing efforts to safeguard unsubsidized members from the impacts of higher silver tier premiums associated with CSR withdrawal, to the greatest extent possible
3. Renewed focus on the health insurance needs of small businesses, as part of the Commonwealth's broader effort to support employers in offering coverage to their workers
4. Continuous improvement in member experience, aligning with the Commonwealth's goals of value, quality, and transparency in health care

Member Feedback

In a time of change, the Health Connector is listening to member feedback to chart a path forward, expanding choices to meet new unsubsidized and small group needs.

- The proposed nongroup strategy is rooted in member feedback from the 2017 Customer Experience Survey
  - Significantly fewer members said there were the right number of plans (39% down from 53%), with increases in members indicating too few plans or that they were unsure
  - Non-ConnectorCare members are significantly less satisfied with their Health Connector experience overall, and more likely to face affordability challenges
  - Members expressed strong interest in decision-support
- While the Health Connector has not yet fielded its 2018 Customer Experience Survey, similar trends are expected due to high costs associated with CSR withdrawal
- The proposed small group strategy is based on a landscape scan of popular small group market offerings, as well as regular surveys of group and broker experience

The 2017 Customer Experience Survey was fielded in August 2017 with 1,216 current and former nongroup members. The Health Connector regularly offers other feedback opportunities.

Overview of Goals and Strategies

The Health Connector product shelf can continue to meet shifting member needs with a more flexible product shelf, with strategies tailored to different groups of members.

Goal	Responsive Strategy
1. Maintain affordability and sustainability for the ConnectorCare program	• Maintain existing ConnectorCare program design with no member-facing changes • Offer a nongroup silver tier that is better equipped to offer a sustainable ConnectorCare program • In partnership with the Division of Insurance, anticipate permitting ConnectorCare carriers to continue a "load" on nongroup silver premiums to offset the absence of federal CSRs
2. Offer choice for unsubsidized nongroup members seeking alternatives to silver plans affected by price increases associated with federal CSR withdrawal	• Expand Standard plan offerings to support unsubsidized individuals seeking alternatives to these high-premium "CSR-loaded" silver plans
3. Offer choice to meet the unique needs of new Health Connector for Business members	• Expand Standard plan offerings to support the needs of small groups and their employees
4. Improve member experience with value, quality, and transparency initiatives	• Continue existing quality and value initiatives • Continue enhancements in decision support tools to help members understand and control costs • Streamline dental coverage member experience to support oral health

Qualified Health Plans (QHPs)

2019 Health Plan Product Shelf: Standard Plans

In recent years, the Health Connector has sought to maintain product shelf stability and keep premiums low. For 2019, we propose new options that balance these goals with new standard plan offerings intended to meet additional policy priorities.

- Carriers will continue to be required to propose, on their broadest commercial network, at least one (1) standardized plan on each of the platinum, gold, silver, and bronze tiers for both nongroup and small group
- In addition, the proposed standard plan shelf will feature new options:
  - *New* Carriers must offer an additional standard "low gold" plan to both nongroup and small group members, to offer choice for individuals and small businesses seeking a comprehensive alternative to the silver tier that is still relatively affordable
  - *New* Carriers must offer an additional standard "low silver HSA-compatible" plan to small group members only, to ensure greater choice for small group members
  - *New* Carriers must offer at least one standard bronze plan to both nongroup and small group members (previously, carriers were permitted to withdraw their proposed bronze plans if we received a sufficient number of plans), to ensure greater choice for nongroup members seeking alternatives to the silver tier

2019 Health Plan Product Shelf: Standard Plans (*cont'd.*)

- Carriers may continue to submit one (1) additional version of each plan offered on a different network (*e.g.*, smaller) for a maximum of twelve (12) possible standardized plans offered
  - Carriers may seek an exemption for good cause to offer an additional network
- Carriers will continue to have the option to withdraw their proposed catastrophic plans if we receive a sufficient number of plans per zip code
- We will continue to utilize the federally-allowable expansion of the actuarial value of bronze plans up to 65% (+5/-2%) in our 2019 standardized bronze plan designs
  - This allows unsubsidized enrollees who previously might have selected a "low silver" (68% AV) plan to find a relatively close alternative, if their plan is affected by the CSR premium "load"

2019 Health Plan Product Shelf: Standard Plans (cont'd.)

In recent years, the Health Connector has maintained uniformity in the nongroup and small group shelf, but is now proposing bifurcating its Standard offerings in response to new silver-tier needs. Carriers would still meet merged market requirements.

	2018 (Nongroup & Small Group)	2019 (Nongroup)	2019 (Small Group)
Platinum	~88%	~89%	~89%
Gold	~80%	High Gold: ~80%	High Gold: ~80%
		New Low Gold: ~76%	*New* Low Gold: ~76%
Silver	~71%	High Silver: ~72%	High Silver: ~72%
			New Low Silver HSA: ~69%
Bronze	High Bronze: ~65%	High Bronze: ~65%	High Bronze: ~65%
	High Bronze HSA: ~65%	High Bronze HSA: ~65%	High Bronze HSA: ~65%

2019 Health Plan Product Shelf: Non-Standard Plans

The Health Connector is proposing changes to its allowable non-standardized product shelf for 2019 in order to respond to new dynamics on the silver tier.

- For platinum, gold, and bronze plans, the Health Connector proposes to continue to allow the option to propose up to three (3) non-standard plans, inclusive of network variation
- *New* For 2019, the Health Connector proposes to limit the availability of non-standardized silver plans to maximize ConnnectorCare program design
  - For the nongroup shelf, carriers will be prohibited from offering non-standard silver plans and may only offer the standard "high silver" plan designed by the Health Connector
  - For the small group shelf, carriers may offer additional non-standard silver plans as currently allowed
- The Health Connector proposes to accept only those non-standardized bronze and silver plans with an actuarial value of no less than 2% below the 60% and 70% thresholds, respectively
  - Platinum and gold plans are proposed to be considered within the full de minimis range, as federally allowed

2019 Health Plan Product Shelf: Spotlight on Silver Tier Strategy

Given ongoing uncertainty regarding the resumption of federal Cost-Sharing Reductions, the Health Connector has reevaluated its approach to its silver tier, which forms the base of the ConnectorCare program.

- In previous years, the Health Connector has strategically driven competition on the silver tier to enhance affordability across the merged market
- In 2018, the Health Connector rapidly adapted its silver tier strategy to the late-breaking withdrawal of federal CSRs, partnering with the Division of Insurance and carriers to permit a premium "load" (*i.e.* higher premiums) on ConnectorCare carriers' nongroup silver tier plans to offset the loss
- While we remain concerned about the impact of this load on remaining unsubsidized silver tier members, the unpredictability of federal CSR availability does not leave a viable alternative to continuing this "silver load" approach for 2019
- In response to this new reality, the Health Connector is reevaluating certain weaknesses of its current silver tier strategy:
  - The current ConnectorCare program incentivizes low premium rates from carriers, and as a result, is based largely upon non-standardized silver plans that rely on coinsurance to keep rates low
  - These plans have been problematic for ConnectorCare members who "downgrade" into the base silver plans after losing eligibility for ConnectorCare, as they tend to feature high coinsurance
  - Further, low premiums on the silver tier do not maximize APTCs and result in increased "back-end" liability for the Commonwealth in the form of state cost-sharing subsidies

2019 Health Plan Product Shelf: Silver Tier Strategy (*cont'd.*)

To ensure the continued viability of the ConnectorCare program given shifting circumstances, the Health Connector is proposing changes to the nongroup silver tier to incentivize "high silver" plans.

- Starting in 2019, the Health Connector proposes that carriers may only offer standardized silver plans to nongroup members, with high actuarial value and no coinsurance
- This approach will create trade-offs, yielding longer-term stability but also some near-term disruption:

Pros	Cons
• Will minimize state liability, saving the Commonwealth several million in cost-sharing reduction liability each year • Will not impact ConnectorCare members, which form the bulk of silver tier membership • Members in these silver plans are already likely to be impacted by premium increases and movement to other plans, given likely CSR-loaded silver plans	• Will require existing silver plan closures and member mapping to new standardized silver plans • Likely to result in premium increases for unsubsidized or limited APTC-only members remaining in silver plans

- In the event federal CSRs return in 2019, this "high silver" approach is still recommended given the associated state CSR savings and removal of low-value coinsurance plans from the nongroup shelf

2019 Health Plan Product Shelf: Member Impact of Silver Strategy

As the proposed silver tier strategy would require the closure of the five current non-standard silver plans, Health Connector staff is considering the associated implications to ensure members have a seamless renewal experience.

- Roughly 14,300 unsubsidized and APTC-only members are currently enrolled in non-standard silver plans
- These members will be mapped to a new plan with their carrier upon renewal to ensure continuity of coverage
- To mitigate any adverse impacts, the Health Connector expects to:
  - Discuss renewal mapping with carriers, to ensure we consider all impacts of mapping existing members in non-standardized silver plans to a new standard silver option
  - Pair the silver changes with required "high bronze" (~65% AV) and "low gold" (~76% AV) standardized offerings, to ensure that unsubsidized silver members seeking alternatives have an array of comparable choices
  - Offer enhanced member communications and decision-support tools to continue to reinforce the message that unsubsidized members currently enrolled in silver tier plans should review other options

2019 Health Plan Strategic Initiatives: Small Group Offerings

The Health Connector proposes to deepen the product options available through Health Connector for Business to better reflect employer market needs.

- *New* Carriers that offer a PPO product off-Exchange must offer a PPO in their small group offerings
  - Many carriers currently offer a PPO product in the off-Exchange market, so this new policy would create parity in access to choices through the Health Connector
  - The PPO may be either standardized or non-standardized, but must be available at either the silver and gold tiers
  - The Health Connector will work closely with carriers to support appropriate operationalization
- *New* As detailed in previous slides, the Health Connector proposes that carriers must offer a new standardized silver plan on the small group shelf that is HSA-compatible
  - This responds to employer interest in an affordable plan option that maintains the silver level of coverage typical of the small employer market
- The Health Connector will continue to facilitate the same "employee choice" options for 2019, with evaluation of additional metallic tier selections anticipated in future years
  - The "one carrier" model will include platinum, gold, and silver options
  - The "one level" model will include gold and silver options

2019 Health Plan Strategic Initiatives: Quality

The Health Connector continues to support Commonwealth-wide quality initiatives, including its ConnectorCare Opioid Addiction Prevention and Treatment intervention as well as Quality Improvement Strategy (QIS) initiatives.

- The Health Connector will continue to require that ConnectorCare carriers provide the following opioid addiction treatment at zero dollar cost sharing for all ConnectorCare plan types:
  - Full range of FDA-approved medication-assisted treatment (MAT) medications
  - Services directly related to an MAT visit
  - Opioid antagonist medication approved for use in a take-home setting (e.g., with a standing prescription) and by a health care professional
  - ConnectorCare carriers must also continue to demonstrate that they have, at a minimum, offered to contract in good faith with all clinical stabilization services (CSS) provider locations
- In partnership with the Health Policy Commission, the Health Connector will continue to require at least two QIS submissions from each carrier:
  - Required Substance Use Disorder (SUD) QIS, as part of the Health Connector's evaluation of the 2017 Opioid Addiction Prevention and Treatment intervention
  - Progress on last year's QIS
  - *New* The Health Policy Commission will offer a "model QIS" focused on hospital readmissions, for any carriers interested in implementing a new QIS or replacing their current QIS

2019 Health Plan Strategic Initiatives: Value

The Health Connector continues to permit optional Value-Based Insurance Design offerings (VBID), building toward a possible standardized VBID plan in the future.

- The Health Connector will continue the same approach as last year, encouraging carriers to voluntarily reduce enrollee costs for select high-value providers within Health Connector-defined guardrails
  - This intervention may apply for ConnectorCare, standardized, or non-standardized plans
  - For carrier-selected providers/facilities, carriers may:
    - Offer financial incentives to enrollees that do not impact premium or cost-sharing, such as "cash-back" incentives
    - Waive or reduce cost-sharing below the standard cost-sharing levels set by the Health Connector
  - Carriers must only reduce enrollee costs (a "carrot" approach, rather than a "stick")
  - While carriers may use their discretion to define high-value providers, carriers are encouraged to include:
    - Community hospitals (defined according to CHIA acute care hospital cohorts)
    - Provider/facilities certified as Accountable Care Organizations by the Health Policy Commission, particularly those participating in MassHealth's ACO initiative
- With guidance from Health Connector Board of Directors, the Health Connector is evaluating the possibility of introducing additional VBID elements into its standardized plans for 2020
  - A diverse workgroup of national experts is evaluating potential approaches
  - The Health Connector would seek local feedback from the Board of Directors, carriers, consumer representatives, and provider representatives before implementing such a plan

2019 Health Plan Strategic Initiatives: Decision Support

Alongside a more varied product shelf, the Health Connector expects to continue to support consumer decision-making with enhanced decision-support tools.

- In recent years, the Health Connector has introduced provider search and formulary search tools
- Consumer feedback indicates that these tools are appreciated and widely used
  - 92% of nongroup members surveyed would like a tool that shows total cost for the year based on the health care services "a person like you might use"
- *New* Starting as soon as 2019, we propose to enhance our decision support offerings with a new tool that allows consumers to determine the estimated total cost of plans
  - A new decision support tool offered via Picwell will help users compare the aggregate cost of plans, including premiums as well as estimated out-of-pocket cost-sharing for a given member
  - The tool compares member inputs to a large claims database, helping members understand the overall costs people like them tend to face – as well as other user preferences such as network and formulary design
- We also continue to explore options to notify members, within the shopping experience, that some silver plans feature higher premiums as a result of CSR withdrawal, and to explore all their options

Qualified Dental Plans (QDPs)

2019 Dental Plan Product Shelf: Standard and Non-Standard Plans

The Health Connector seeks to continue a stable approach to the number of dental offerings, while making operational improvements for a better member experience.

Standardized Plan Offerings (Nongroup & Small Group Requirement)

- Carriers offering dental plans in the nongroup market outside of the Health Connector are required to propose plans for the Health Connector's nongroup segment
- Likewise, carriers offering dental plans in the small group market outside of the Health Connector are required to propose to offer plans to the Health Connector's small group segment, but may seek an exemption from this requirement due to technical constraints
- Carriers will continue to be required to offer (1) one offering for each of the required three standardized plan designs: Pediatric-only, Family High and Family Low
  - Carriers may continue to submit one (1) additional version of each plan offered on a different network (*e.g.*, smaller) for a maximum of six (6) possible standardized plans offered

Non-standardized Plans (Nongroup & Small Group Requirement)

- We will continue to allow carriers to submit no more than three (3) non-standardized dental plans, inclusive of network variation
  - Example: Carrier A proposes to offer 2 non-standardized plan designs, and offers 1 design on a single network and the second design on 2 different networks; Carrier A has used up all 3 of its allowable non-standardized plans

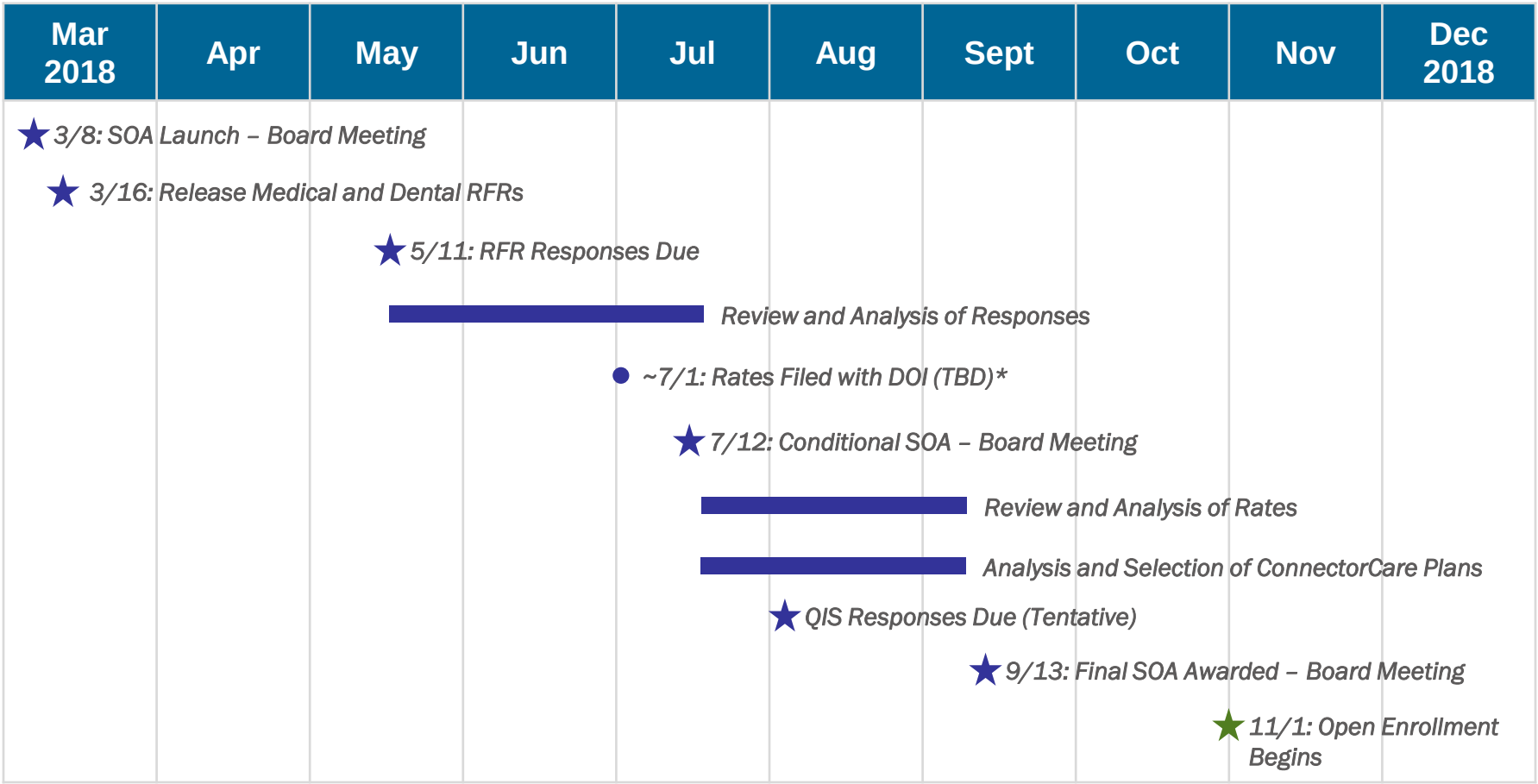
2019 Dental Plans: Product Shelf Requirements (*cont'd.*)

The Health Connector proposes aligning its nongroup dental plan year with the calendar year, streamlining the member experience to reduce confusion.

- *New* Starting in Plan Year 2019 with a Plan Year 2020 effective date, we are proposing to shift nongroup Qualified Dental Plans to a calendar year cycle
- The current rolling nongroup dental renewal process presents significant operational complexity and consumer confusion – especially during Open Enrollment – and is poorly aligned with the nongroup medical shelf
- Nongroup QDPs would transition to calendar year enrollment in 2019, with all Plan Year 2019 dental enrollments ending 12/31/19
  - New dental members can continue to enroll at any point during the year, but all plans, regardless of start date, will term at the end of the calendar year and renew the first of the new year
- As a result of the design of dental plans, including the use of calendar year benefit maximums and time-based benefit exclusions, we do not expect that this shift will require the proration of benefits during the transition period
- We are working closely with carriers to determine implementation capabilities and timelines

SOA Timeline

SOA Timeline (Draft)



*Rate filing deadlines will be communicated to carriers by the Division of Insurance.

All dates subject to change. Changes to dates published on CommBUYS will be amended and re-posted to CommBUYS.

Appendix

2018-2019: Standard Platinum

There are no changes proposed to the platinum tier. This ensures stability for members in need of the most robust coverage.

Plan Feature/ Service *A check mark (✓) indicates this benefit is subject to the annual deductible*		2018 Platinum	2019 Platinum
Annual Deductible – Combined		$0	$0
		$0	$0
Annual Deductible – Medical		N/A	N/A
		N/A	N/A
Annual Deductible – Prescription Drugs		N/A	N/A
		N/A	N/A
Annual Out-of-Pocket Maximum		$3,000	$3,000
		$6,000	$6,000
Primary Care Provider (PCP) Office Visits		$20	$20
Specialist Office Visits		$40	$40
Emergency Room		$150	$150
Urgent Care		$40	$40
Inpatient Hospitalization		$500	$500
Skilled Nursing Facility		$500	$500
Durable Medical Equipment		20%	20%
Rehabilitative Occupational and Rehabilitative Physical Therapy		$40	$40
Laboratory Outpatient and Professional Services		$0	$0
X-rays and Diagnostic Imaging		$0	$0
High-Cost Imaging		$150	$150
Outpatient Surgery: Ambulatory Surgery Center		$250	$250
Outpatient Surgery: Physician/Surgical Services		$0	$0
Prescription Drug	Retail Tier 1	$10	$10
	Retail Tier 2	$25	$25
	Retail Tier 3	$50	$50
	Mail Tier 1	$20	$20
	Mail Tier 2	$50	$50
	Mail Tier 3	$150	$150
Federal Actuarial Value Calculator		88.24%	**88.82%**

Bold indicates changes from 2018.

2018-2019: Standard Gold

New for 2019, we propose offering a new "low gold" option alongside the traditional "high gold" option. This will offer choice for individuals and small businesses seeking a comprehensive alternative to the silver tier that is still relatively affordable.

Plan Feature/ Service *A check mark (✓) indicates this benefit is subject to the annual deductible*		2018 Gold	2019 High Gold	*New* 2019 Low Gold
Annual Deductible – Combined		N/A	N/A	N/A
		N/A	N/A	N/A
Annual Deductible – Medical		$1,000	$1,000	**$2,000**
		$2,000	$2,000	**$4,000**
Annual Deductible – Prescription Drugs		$0	$0	**$250**
		$0	$0	**$500**
Annual Out-of-Pocket Maximum		$5,000	$5,000	**$5,500**
		$10,000	$10,000	**$11,000**
Primary Care Provider (PCP) Office Visits		$30	**$25**	$30
Specialist Office Visits		$45	$45	**$50**
Emergency Room		$150 ✓	$150 ✓	**$350**
Urgent Care		$45	$45	**$50**
Inpatient Hospitalization		$500 ✓	$500 ✓	**$750** ✓
Skilled Nursing Facility		$500 ✓	$500 ✓	**$750** ✓
Durable Medical Equipment		20% ✓	20% ✓	20% ✓
Rehabilitative Occupational and Rehabilitative Physical Therapy		$45	$45	**$50**
Laboratory Outpatient and Professional Services		$20 ✓	**$25** ✓	**$50** ✓
X-rays and Diagnostic Imaging		$20 ✓	**$25** ✓	**$50** ✓
High-Cost Imaging		$200 ✓	$200 ✓	**$250** ✓
Outpatient Surgery: Ambulatory Surgery Center		$250 ✓	$250 ✓	**$500** ✓
Outpatient Surgery: Physician/Surgical Services		$0 ✓	$0 ✓	$0 ✓
Prescription Drug	Retail Tier 1	$20	$20	**$25**
	Retail Tier 2	$30	**$40**	**$50** ✓
	Retail Tier 3	$50	**$60**	**$100** ✓
	Mail Tier 1	$40	**$40**	**$50**
	Mail Tier 2	$60	**$80**	**$100** ✓
	Mail Tier 3	$150	**$180**	**$300** ✓
Federal Actuarial Value Calculator		79.69%	**80.34%**	**76.11%**

Bold indicates changes from 2018. A check mark (✓) indicates that the benefit is subject to the annual deductible.

2018-2019: Standard Silver

New for 2019, we propose only permitting standard silver plans for nongroup, to maximize ConnectorCare program stability. Small groups will continue to have access to standard and non-standard silver, as well as a new "low silver" HSA-compatible option to meet employer interest in silver choices.

Plan Feature/ Service *A check mark (✓) indicates this benefit is subject to the annual deductible*		2018 Silver	2019 High Silver	*New* for Small Group Only 2019 Low Silver (HSA)
Annual Deductible – Combined		$2,000	$2,000	$2,000
		$4,000	$4,000	$4,000
Annual Deductible – Medical		N/A	N/A	N/A
		N/A	N/A	N/A
Annual Deductible – Prescription Drugs		N/A	N/A	N/A
		N/A	N/A	N/A
Annual Out-of-Pocket Maximum		$7,350	**$7,900**	**$6,700***
		$14,700	**$15,800**	**$13,400***
Primary Care Provider (PCP) Office Visits		$30	$30	**$25** ✓
Specialist Office Visits		$50	**$55**	**$50** ✓
Emergency Room		$700 ✓	**$300** ✓	**$250** ✓
Urgent Care		$50	**$55**	**$50** ✓
Inpatient Hospitalization		$1,000 ✓	$1,000 ✓	**$500** ✓
Skilled Nursing Facility		$1,000 ✓	$1,000 ✓	**$500** ✓
Durable Medical Equipment		20% ✓	20% ✓	20% ✓
Rehabilitative Occupational and Rehabilitative Physical Therapy		$50	**$55**	$50 ✓
Laboratory Outpatient and Professional Services		$25 ✓	**$50** ✓	**$50** ✓
X-rays and Diagnostic Imaging		$25 ✓	**$50** ✓	**$50** ✓
High-Cost Imaging		$500 ✓	$500 ✓	**$250** ✓
Outpatient Surgery: Ambulatory Surgery Center		$750 ✓	**$500** ✓	**$250** ✓
Outpatient Surgery: Physician/Surgical Services		$0 ✓	$0 ✓	$0 ✓
Prescription Drug	Retail Tier 1	$20	**$25**	**$25** ✓
	Retail Tier 2	$60	**$50**	**$50** ✓
	Retail Tier 3	$90 ✓	**$75** ✓	**$100** ✓
	Mail Tier 1	$40	**$50**	**$50** ✓
	Mail Tier 2	$120	**$100**	**$100** ✓
	Mail Tier 3	$270 ✓	**$225** ✓	**$300** ✓
Federal Actuarial Value Calculator		71.40%	**71.97%**	**69.44%**

Bold indicates changes from 2018.
A check mark (✓) indicates that the benefit is subject to the annual deductible.
**The out-of-pocket maximum for this plan may need to be revised upon the publication of the 2019 OOP max for HSA plans.*

2018-2019: Standard Bronze

New for 2019, carriers must offer at least one bronze plan, choosing between two options. This will ensure greater choice for nongroup members seeking alternatives to the silver tier.

Plan Feature/ Service *A check mark (✓) indicates this benefit is subject to the annual deductible*		2018 Bronze #1	2019 Bronze #1	2018 Bronze #2 (HSA)	2019 Bronze #2 (HSA)
Annual Deductible – Combined		$2,500	**$2,750**	$3,000	**$3,300**
		$5,000	**$5,500**	$6,000	**$6,600**
Annual Deductible – Medical		N/A	N/A	N/A	N/A
		N/A	N/A	N/A	N/A
Annual Deductible – Prescription Drugs		N/A	N/A	N/A	N/A
		N/A	N/A	N/A	N/A
Annual Out-of-Pocket Maximum		$7,350	**$7,900**	$6,650	**$6,700***
		$14,700	**$15,800**	$13,300	**$13,400***
Primary Care Provider (PCP) Office Visits		$30 ✓	**$25** ✓	$20 ✓	**$25** ✓
Specialist Office Visits		$50 ✓	$50 ✓	$40 ✓	**$50** ✓
Emergency Room		$700 ✓	**$250** ✓	$250 ✓	$250 ✓
Urgent Care		$50 ✓	$50 ✓	$40 ✓	**$50** ✓
Inpatient Hospitalization		$1,000 ✓	**$750** ✓	$750 ✓	$750 ✓
Skilled Nursing Facility		$1,000 ✓	**$750** ✓	$750 ✓	$750 ✓
Durable Medical Equipment		20% ✓	20% ✓	20% ✓	20% ✓
Rehabilitative Occupational and Rehabilitative Physical Therapy		$50 ✓	$50 ✓	$40 ✓	**$50** ✓
Laboratory Outpatient and Professional Services		$25 ✓	**$50** ✓	$25 ✓	**$50** ✓
X-rays and Diagnostic Imaging		$25 ✓	**$50** ✓	$25 ✓	**$50** ✓
High-Cost Imaging		$500 ✓	$500 ✓	$500 ✓	$500 ✓
Outpatient Surgery: Ambulatory Surgery Center		$750 ✓	**$500** ✓	$500 ✓	$500 ✓
Outpatient Surgery: Physician/Surgical Services		$0 ✓	$0 ✓	$0 ✓	$0 ✓
Prescription Drug	Retail Tier 1	$20	**$25**	$20 ✓	**$25** ✓
	Retail Tier 2	$60 ✓	**$50** ✓	$40 ✓	**$50** ✓
	Retail Tier 3	$90 ✓	**$100** ✓	$60 ✓	**$100** ✓
	Mail Tier 1	$40	**$50**	$40 ✓	**$50** ✓
	Mail Tier 2	$120 ✓	**$100** ✓	$80 ✓	**$100** ✓
	Mail Tier 3	$270 ✓	**$300** ✓	$180 ✓	**$300** ✓
Federal Actuarial Value Calculator		64.84%	**64.99%**	64.88%	**64.98%**

Bold indicates changes from 2018.
A check mark (✓) indicates that the benefit is subject to the annual deductible.
**The out-of-pocket maximum for this plan may need to be revised upon the publication of the 2019 OOP max for HSA plans.*

Qualified Dental Plans: 2019 Standard Plan Designs

Plan Feature/ Service	Family High	Family Low	Pediatric-only
Plan Year Deductible	$50/$150	$50/$150	$50
Deductible Applies to	Major and Minor Restorative	Major and Minor Restorative	Major and Minor Restorative
Plan Year Max (>=19 only)	$1,250	$750	N/A
Plan Year MOOP <19 Only	$350 (1 child) $700 (2+ children)	$350 (1 child) $700 (2+ children)	$350 (1 child)
Preventive & Diagnostic Co-Insurance (In/out-of-Network)	0%/20%	0%/20%	0%/20%
Minor Restorative Co-Insurance (In/out-of-Network)	25%/45%	25%/45%	25%/45%
Major Restorative Co-Insurance (In/out-of-Network)	50%/70%	50%/70% No Major Restorative >=19	50%/70%
Medically Necessary Orthodontia, <19 only (In/out-of-Network)	50%/70%	50%/70%	50%/70%
Non-Medically Necessary Orthodontia, <19 only (In/out-of-Network)	N/A	N/A	N/A

Note: Standard QDP designs are unchanged from 2018.

2019 Health Plan Product Shelf: Other Requirements

Frozen Plans (Nongroup)

- *New* Carriers may not propose any nongroup silver tier plans to be frozen for 2019
- Carriers may continue to propose other plans offered in 2018 for "Frozen" status in 2019. Frozen plans will not count against a carrier's plan submission limits for 2019

Standardized Plan Design Parameters (Nongroup & Small Group Requirement)

- We do not expect to change the number of standardized cost-sharing features from those defined in 2018

Pediatric Vision Coverage (Nongroup & Small Group Requirement)

- Embedded pediatric vision essential health benefit (EHB) coverage will remain a requirement for all health plans in accordance with federal requirements

Pediatric Dental Coverage (Nongroup & Small Group Requirement)

- Embedded pediatric dental EHB coverage will remain a requirement for all health plans

Plan Marketing Names (Nongroup & Small Group Requirement)

- We will maintain the defined plan marketing name requirements to improve the shopping and comparison process for consumers

Network Flag (Nongroup & Small Group Requirement)

- We will maintain the existing formalized "Network Flag" rules for plans with smaller or tiered networks

2019 Dental Plan Product Shelf: Other Requirements

Frozen Plans (nongroup & Small Group Requirement)

- Carriers may continue to propose any dental plan offered in 2018 for "Frozen" status in 2019. Frozen plans will not count against a carrier's plan submission limits for 2018
  - Frozen plans may be offered outside of the Health Connector as frozen or for sale to new/renewing members

Plan Marketing Names (nongroup & Small Group Requirement)

- We will continue to follow plan marketing name requirements to improve the shopping and comparison process for consumers

Network Flag (nongroup & Small Group Requirement)

- We will use the existing formalized "Network Flag" rules for plans with smaller or tiered networks