PROPOSED 2020 PATIENT-CENTERED BENEFIT PLAN DESIGNS

Benefit	Platinum Coins		Platinum Cop		Individual-only Gold Coinsurance		Individual-only Gold Copay		CCSB-only Gold Coins Plan		CCSB-only Gold Copay Plan		Individual-only Silver		Silver 73		Silver 87		Silver 94		CCSB-only Silver Coinsurance		CCSB-only Silver Copay		CCSB-only Silver HDHP		Bronze		Bronze HDHP	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible																										$2,500				$6,950
Medical Deductible										$250		$250		$4,000		$3,700		$1,400		$75		$2,250		$2,250				$6,300		
Drug Deductible										$0		$0		$300		$275		$100		$0		$300		$300				$500		
Coinsurance (Member)		10%		10%		20%		20%		20%		20%		20%		20%		15%		10%		20%		20%		20%		40%		100%
MOOP		$4,500		$4,500		$7,850		$7,850		$7,850		$7,850		$7,850		$6,550		$2,700		$1,000		$7,850		$7,850		$6,850		$7,850		$6,950
ED Facility Fee		$150		$150		$350		$350	X	$250	X	$250		$400		$400		$150		$50	X	$400	X	$400	X	20%	X	40%	X	100%
Inpatient Facility Fee		10%		$250		20%		$600	X	20%	X	$600	X	20%	X	20%	X	15%	X	10%	X	20%	X	20%	X	20%	X	40%	X	100%
Inpatient Physician Fee		10%		---		20%		---	X	20%		--		20%		20%		15%		10%	X	20%		20%	X	20%	X	40%	X	100%
Primary Care Visit		$15		$15		$30		$30		$25		$25		$40		$35		$15		$5		$50		$50	X	20%	X	$65	X	100%
Specialist Visit		$30		$30		$60		$60		$50		$50		$80		$75		$25		$8		$85		$85	X	20%	X	$95	X	100%
MH/SU Outpatient Services		$15		$15		$30		$30		$25		$25		$40		$35		$15		$5		$50		$50	X	20%	X	$65	X	100%
Imaging (CT/PET Scans, MRIs)		10%		$75		20%		$275		20%		$275		$325		$325		$100		$50		20%		$300	X	20%	X	40%	X	100%
Speech Therapy		$15		$15		$30		$30		$25		$25		$40		$35		$15		$5		$50		$50	X	20%		$65	X	100%
Occupational and Physical Therapy		$15		$15		$30		$30		$25		$25		$40		$35		$15		$5		$50		$50	X	20%		$65	X	100%
Laboratory Services		$15		$15		$40		$40		$25		$25		$40		$40		$20		$8		$40		$40	X	20%		$40	X	100%
X-rays and Diagnostic Imaging		$30		$30		$75		$75		$65		$65		$85		$85		$40		$8		$85		$85	X	20%	X	40%	X	100%
Skilled Nursing Facility		10%		$150		20%		$300	X	20%	X	$300	X	20%	X	20%	X	15%	X	10%	X	20%	X	20%	X	20%	X	40%	X	100%
Outpatient Facility Fee		10%		$100		20%		$300		20%		$300		20%		20%		15%		10%		20%		20%	X	20%	X	40%	X	100%
Outpatient Physician Fee		10%		$25		20%		$40		20%		$40		20%		20%		15%		10%		20%		20%	X	20%	X	40%	X	100%
Tier 1 (Generics)		$5		$5		$15		$15		$15		$15	X	$16	X	$16		$5		$3	X	$17	X	$17	X	20%	X	$18	X	100%
Tier 2 (Preferred Brand)		$15		$15		$55		$55		$50		$50	X	$60	X	$55	X	$25		$10	X	$65	X	$65	X	20%	X	40%	X	100%
Tier 3 (Nonpreferred Brand)		$25		$25		$80		$80		$80		$80	X	$90	X	$85	X	$45		$15	X	$90	X	$90	X	20%	X	40%	X	100%
Tier 4 (Specialty)		10%		10%		20%		20%		20%		20%	X	20%	X	20%	X	15%		10%	X	20%	X	20%	X	20%	X	40%	X	100%
Tier 4 Maximum Coinsurance	$250		$250		$250		$250		$250		$250		$250		$250		$150		$150		$250		$250		$250*		$500*			
Maximum Days for charging IP copay			5				5				5																			
Begin PCP deductible after # of copays																											3 visits			
Actuarial Value																														
2020 AV (DRAFT 2020 AVC)	**91.71**		**89.07**		**81.90**		**78.29**		**78.05**		**79.65**		**71.73†**		**73.82†**		**87.70†**		**94.54**		**70.47†**		**70.15†**		**71.34**		**61.29**		**61.97**	
Actuarial Value (2019)	**91.73**		**88.90**		**81.80**		**78.06**		**N/A**		**N/A**		**71.84†**		**73.90†**		**87.85†**		**94.21**		**71.90†**		**71.57†**		**70.47**		**60.94**		**61.62**	
Additive adjustment (†)													**0.30**		**0.30**		**0.10**				**0.30**		**0.30**							

KEY:		
	X	Subject to deductible
	*	Drug cap applies to all drug tiers
	†	Additive adjustment (included in AV)
		Increased member cost from 2019
		Decreased member cost from 2019
		Does not meet AV
		Within .5 of de minimis
		Securely within AV