PROPOSED 2017 STANDARD BENEFIT PLAN DESIGN

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Benefit	BRONZE		BRONZE HDHP		SILVER		SILVER 73		SILVER 87		SILVER 94		CCSB SILVER COPAY		CCSB SILVER COINS		CCSB SILVER HDHP		GOLD COPAY		GOLD COINS		PLATINUM COP		PLATINUM COINS	
	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				Amount														$2,000								
Medical Deductible		$6,300				$2,500		$2,200		$650		$75		$2,000		$2,000										
Drug Deductible		$500				$250		$250		$50		$0		$250		$250										
Coinsurance (Member)		100%		40%		20%		20%		15%		10%		20%		20%		20%		20%		20%		10%		10%
MOOP		$6,800		$6,650		$6,800		$5,700		$2,350		$2,350		$6,800		$6,800		$6,650		$6,750		$6,750		$4,000		$4,000
ED Facility Fee	X	100%	X	40%		$350		$350		$100		$50		$350		$350	X	20%		$325		$325		$150		$150
ED Physician Fee		---	X	---		---		---		---		---		---		---	X	---		---		---		---		---
Urgent Care‡	X	$75	X	40%		$35		$30		$10		$5		$45		$45	X	20%		$30		$30		$15		$15
Inpatient Facility Fee	X	100%	X	40%	X	20%	X	20%	X	15%	X	10%	X	20%	X	20%	X	20%		$600/day		20%		$250		10%
Inpatient Physician Fee	X	100%	X	40%	X	20%	X	20%	X	15%	X	10%	X	20%	X	20%	X	20%		$55		20%		$40		10%
Primary Care Visit	X	$75	X	40%		$35		$30		$10		$5		$45		$45	X	20%		$30		$30		$15		$15
Specialist Visit	X	$105	X	40%		$70		$55		$25		$8		$75		$75	X	20%		$55		$55		$40		$40
MH/SU Outpatient Services	X	$75	X	40%		$35		$30		$10		$5		$45		$45	X	20%		$30		$30		$15		$15
Imaging (CT/PET Scans, MRIs)	X	100%	X	40%		$300		$300		$100		$50		$300		20%	X	20%		$275		20%		$150		10%
Rehabilitative Speech Therapy		$75	X	40%		$35		$30		$10		$5		$45		$45	X	20%		$30		$30		$15		$15
Rehabilitative Occupational/PT		$75	X	40%		$35		$30		$10		$5		$45		$45	X	20%		$30		$30		$15		$15
Laboratory Services		$40	X	40%		$35		$35		$15		$8		$40		$40	X	20%		$35		$35		$20		$20
X-rays and Diagnostic Imaging	X	100%	X	40%		$70		$65		$25		$8		$70		$70	X	20%		$55		$55		$40		$40
Skilled Nursing Facility	X	100%	X	40%	X	20%	X	20%	X	15%	X	10%	X	20%	X	20%	X	20%		$300/day		20%		$150/day		10%
Outpatient Facility Fee	X	100%	X	40%		20%		20%		15%		10%		20%		20%	X	20%		$600		20%		$250		10%
Outpatient Physician Fee	X	100%	X	40%		20%		20%		15%		10%		20%		20%	X	20%		$55		20%		$40		10%
Tier 1 (Generics)	X	100%*	X	40%*		$15		$15		$5		$3		$15		$15	X	20%*		$15		$15		$5		$5
Tier 2 (Preferred Brand)	X	100%*	X	40%*	X	$55	X	$50	X	$20		$10	X	$55	X	$55	X	20%*		$55		$55		$15		$15
Tier 3 (Nonpreferred Brand)	X	100%*	X	40%*	X	$80	X	$75	X	$35		$15	X	$85	X	$85	X	20%*		$75		$75		$25		$25
Tier 4 (Specialty)	X	100%*	X	40%*	X	20%	X	20%	X	15%		10%	X	20%	X	20%	X	20%*		20%		20%		10%		10%
Tier 4 Maximum Coinsurance	$500		$500		$250		$250		$150		$150		$250		$250		$250		$250		$250		$250		$250	
Maximum Days for charging IP copay																			5				5			
Begin PCP deductible after # of copays	3 visits																									
Actuarial Value	**61.93**		**61.98**		**71.53**		**73.67**		**87.48**		**94.12**		**71.25**		**71.56**		**71.26**		**81.23**		**80.86**		**90.28**		**89.72**	
AV Δ FROM 2016	**+ 0.06**		**+ 0.92**		**+ 1.08**		**+ 0.84**		**+ 0.64**		**+ 0.28**		**- 0.01**		**- 0.01**		**+ 0.76**		**+ 0.20**		**+ 0.62**		**+ 0.81**		**+ 1.22**	

KEY		
		Increase member cost from 2016
		Decrease member cost from 2016
		Does not meet AV
		Within 0.5 de minimus
		Securely within AV
	*	Drug cap applies to drug tier
	‡	Benefit not included in AV Calculator