PROPOSED 2019 PATIENT-CENTERED BENEFIT PLAN DESIGNS

Benefit	Platinum Coins		Platinum Cop		Gold Coins		Gold Copay		Silver		Silver 73		Silver 87		Silver 94		CCSB Silver Coin		CCSB Silver Cop		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
Deductible																						$2,500				$6,000
Medical Deductible										$2,500		$2,200		$650		$75		$2,000		$2,000				$6,300		
Drug Deductible										$200		$175		$50		$0		$200		$200				$500		
Coinsurance (Member)		10%		10%		20%		20%		20%		20%		15%		10%		20%		20%		20%		100%		40%
MOOP		$3,350		$3,350		$7,200		$7,200		$7,550		$6,300		$2,600		$1,000		$7,550		$7,550		$6,650		$7,550		$6,650
ED Facility Fee		$150		$150		$325		$325		$350		$350		$100		$50		$350		$350	X	20%	X	100%	X	40%
Inpatient Facility Fee		10%		$250		20%		$600	X	20%	X	20%	X	15%	X	10%	X	20%	X	20%	X	20%	X	100%	X	40%
Inpatient Physician Fee		10%		---		20%		---		20%		20%		15%		10%	X	20%		20%	X	20%	X	100%	X	40%
Primary Care Visit		$15		$15		$30		$30		$40		$35		$15		$5		$45		$45	X	20%	X	$75	X	40%
Specialist Visit		$30		$30		$55		$55		$80		$75		$25		$8		$80		$80	X	20%	X	$105	X	40%
MH/SU Outpatient Services		$15		$15		$30		$30		$40		$35		$15		$5		$45		$45	X	20%	X	$75	X	40%
Imaging (CT/PET Scans, MRIs)		10%		$75		20%		$275		$300		$300		$100		$50		20%		$300	X	20%	X	100%	X	40%
Speech Therapy		$15		$15		$30		$30		$40		$35		$15		$5		$45		$45	X	20%		$75	X	40%
Occupational and Physical Therapy		$15		$15		$30		$30		$40		$35		$15		$5		$45		$45	X	20%		$75	X	40%
Laboratory Services		$15		$15		$35		$35		$35		$35		$15		$8		$40		$40	X	20%		$40	X	40%
X-rays and Diagnostic Imaging		$30		$30		$55		$55		$75		$75		$30		$8		$75		$75	X	20%	X	100%	X	40%
Skilled Nursing Facility		10%		$150		20%		$300	X	20%	X	20%	X	15%	X	10%	X	20%	X	20%	X	20%	X	100%	X	40%
Outpatient Facility Fee		10%		$100		20%		$300		20%		20%		15%		10%		20%		20%	X	20%	X	100%	X	40%
Outpatient Physician Fee		10%		$25		20%		$40		20%		20%		15%		10%		20%		20%	X	20%	X	100%	X	40%
Tier 1 (Generics)		$5		$5		$15		$15	X	$15	X	$15		$5		$3	X	$15	X	$15	X	20%	X	100%	X	40%
Tier 2 (Preferred Brand)		$15		$15		$55		$55	X	$55	X	$50	X	$20		$10	X	$55	X	$55	X	20%	X	100%	X	40%
Tier 3 (Nonpreferred Brand)		$25		$25		$75		$75	X	$80	X	$75	X	$35		$15	X	$85	X	$85	X	20%	X	100%	X	40%
Tier 4 (Specialty)		10%		10%		20%		20%	X	20%	X	20%	X	15%		10%	X	20%	X	20%	X	20%	X	100%	X	40%
Tier 4 Maximum Coinsurance		$250		$250		$250		$250		$250		$250		$150		$150		$250		$250		$250*		$500*		$500*
Maximum Days for charging IP copay				5				5																		
Begin PCP deductible after # of copays																								3 visits		
Actuarial Value																										
2019 AV (FINAL 2019 AVC)		**91.73**		**88.90**		**81.80**		**78.06**		**71.84†**		**73.90†**		**87.85†**		**94.21**		**71.90†**		**71.57†**		**70.47**		**60.94**		**61.62**
Actuarial Value (2018)		**91.23**		**88.11**		**81.85**		**78.40**		**71.90†**		**73.88†**		**87.98†**		**93.94**		**71.85†**		**71.42†**		**71.66**		**60.75**		**61.38**
Additive adjustment (†)										**0.40**		**0.40**		**0.10**				**0.40**		**0.40**						

KEY:		
	X	Subject to deductible
	*	Drug cap applies to all drug tiers
	†	Additive adjustment (included in AV)
		Increased member cost from 2018
		Decreased member cost from 2018
		Does not meet AV
		Within .5 of de minimis
		Securely within AV