PROPOSED 2020 PATIENT-CENTERED BENEFIT PLAN DESIGNS

					Indiv	idual-only	Indiv	vidual-only	cc	SB-only	CC	SB-only	Indi	vidual-only							CC	SB-only	C	CSB-only	C	CSB-only				
Benefit	Plat	inum Coins	Pla	tinum Cop	Gold (Coinsurance	Go	ld Copay		Coins Plan	Gold (Copay Plan		Silver	s	ilver 73	Si	ilver 87	5	Silver 94	Silver	Coinsurance		ver Copay	Sil	ver HDHP		Bronze	Bro	nze 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			1							\$250		\$250		\$4,000		\$3,700		\$1,400		\$75		\$2,250		\$2,250	1		1	\$6,300		
Drug Deductible			1							\$0		\$0		\$300		\$275		\$100		\$0		\$300		\$300			1	\$500		
Coinsurance (Member)		10%	1	10%		20%		20%		20%		20%		20%		20%		15%		10%		20%		20%	1	20%	1	40%	1	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	Х	\$250	Х	\$250		\$400		\$400		\$150		\$50	Х	\$400	Х	\$400	Х	20%	Х	40%	Х	100%
Inpatient Facility Fee		10%		\$250		20%		\$600	Χ	20%	Х	\$600	Χ	20%	Χ	20%	Χ	15%	Χ	10%	Х	20%	Х	20%	Χ	20%	Х	40%	Х	100%
Inpatient Physician Fee		10%				20%			Χ	20%				20%		20%		15%		10%	Х	20%		20%	Χ	20%	Х	40%	Χ	100%
Primary Care Visit		\$15		\$15		\$30		\$30		\$25		\$25		\$40		\$35		\$15		\$5		\$50		\$50	Х	20%	Х	\$65	Χ	100%
Specialist Visit		\$30		\$30		\$60		\$60		\$50		\$50		\$80		\$75		\$25		\$8		\$85		\$85	Χ	20%	Х	\$95	Χ	100%
MH/SU Outpatient Services		\$15		\$15		\$30		\$30		\$25		\$25		\$40		\$35		\$15		\$5		\$50		\$50	Χ	20%	Х	\$65	Χ	100%
Imaging (CT/PET Scans, MRIs)		10%		\$75		20%		\$275		20%		\$275		\$325		\$325		\$100		\$50		20%		\$300	Χ	20%	Х	40%	Χ	100%
Speech Therapy		\$15		\$15		\$30		\$30		\$25		\$25		\$40		\$35		\$15		\$5		\$50		\$50	Χ	20%		\$65	Χ	100%
Occupational and Physical Therapy		\$15		\$15		\$30		\$30		\$25		\$25		\$40		\$35		\$15		\$5		\$50		\$50	Х	20%		\$65	Χ	100%
Laboratory Services		\$15		\$15		\$40		\$40		\$25		\$25		\$40		\$40		\$20		\$8		\$40		\$40	Χ	20%		\$40	Χ	100%
X-rays and Diagnostic Imaging		\$30		\$30		\$75		\$75		\$65		\$65		\$85		\$85		\$40		\$8		\$85		\$85	Χ	20%	Х	40%	Χ	100%
Skilled Nursing Facility		10%		\$150		20%		\$300	Χ	20%	Х	\$300	Х	20%	Χ	20%	Χ	15%	Χ	10%	Х	20%	Χ	20%	Χ	20%	Х	40%	Χ	100%
Outpatient Facility Fee		10%		\$100		20%		\$300		20%		\$300		20%		20%		15%		10%		20%		20%	Χ	20%	Х	40%	Χ	100%
Outpatient Physician Fee		10%		\$25		20%		\$40		20%		\$40		20%		20%		15%		10%		20%		20%	Х	20%	Х	40%	Х	100%
Tier 1 (Generics)		\$5		\$5		\$15		\$15		\$15		\$15	Х	\$16	Х	\$16		\$5		\$3	Х	\$17	Х	\$17	Х	20%	Х	\$18	Х	100%
Tier 2 (Preferred Brand)		\$15		\$15		\$55		\$55		\$50		\$50	Х	\$60	Χ	\$55	Х	\$25		\$10	Х	\$65	Х	\$65	Χ	20%	Χ	40%	Χ	100%
Tier 3 (Nonpreferred Brand)		\$25		\$25		\$80		\$80		\$80		\$80	Х	\$90	Χ	\$85	Х	\$45		\$15	Х	\$90	Х	\$90	Χ	20%	Х	40%	Χ	100%
Tier 4 (Specialty)		10%		10%		20%		20%		20%		20%	Х	20%	Х	20%	Х	15%		10%	Х	20%	Х	20%	Х	20%	Х	40%	Х	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	8	31.90		78.29		78.05	7	9.65		71.73†	7	73.82†	8	37.70†		94.54	7	0.47†	7	70.15†		71.34		51.29		61.97
Actuarial Value (2019)		91.73		88.90	8	31.80		78.06		N/A		N/A		71.84†	7	73.90†	8	37.85†		94.21	7	1.90†		71.57†		70.47		50.94		61.62
Additive adjustment (†)														0.30		0.30		0.10				0.30		0.30						

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