PROPOSED 2021 PATIENT-CENTERED BENEFIT PLAN DESIGNS

Benefit	Individual-only Platinum Coinsurance		Individual-only Platinum Copay		Individual-only Gold Coinsurance		Individual-only Gold Copay		Individual-only Silver		Silver 73		Silver 87		Silver 94		Bronze		Bronze HDHP	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible																				$7,000
Medical Deductible										$4,000		$3,700		$1,400		$75		$6,300		
Drug Deductible										$300		$275		$100		$0		$750		
Coinsurance (Member)		10%		10%		20%		20%		20%		20%		15%		10%		40%		100%
MOOP		$4,500		$4,500		$7,950		$7,950		$7,950		$6,500		$2,750		$1,000		$7,950		$7,000
ED Facility Fee		$150		$150		$350		$350		$400		$400		$175		$50	X	40%	X	100%
Inpatient Facility Fee		10%		$250		20%		$600	X	20%	X	20%	X	15%	X	10%	X	40%	X	100%
Inpatient Physician Fee		10%		---		20%		---		20%		20%		15%		10%	X	40%	X	100%
Primary Care Visit		$15		$15		$35		$35		$40		$35		$15		$5	X	$85	X	100%
Specialist Visit		$30		$30		$65		$65		$80		$75		$25		$8	X	$115	X	100%
MH/SU Outpatient Services		$15		$15		$35		$35		$40		$35		$15		$5	X	$85	X	100%
Imaging (CT/PET Scans, MRIs)		10%		$75		20%		$150		$325		$325		$100		$50	X	40%	X	100%
Speech Therapy		$15		$15		$35		$35		$40		$35		$15		$5		$85	X	100%
Occupational and Physical Therapy		$15		$15		$35		$35		$40		$35		$15		$5		$85	X	100%
Laboratory Services		$15		$15		$40		$40		$40		$40		$20		$8	X	$40	X	100%
X-rays and Diagnostic Imaging		$30		$30		$75		$75		$85		$85		$40		$8	X	40%	X	100%
Skilled Nursing Facility		10%		$150		20%		$300	X	20%	X	20%	X	15%	X	10%	X	40%	X	100%
Outpatient Facility Fee		10%		$100		20%		$300		20%		20%		15%		10%	X	40%	X	100%
Outpatient Physician Fee		10%		$25		20%		$40		20%		20%		15%		10%	X	40%	X	100%
Tier 1 (Generics)		$5		$5		$16		$16	X	$16	X	$16		$10		$3	X	$18	X	100%
Tier 2 (Preferred Brand)		$15		$15		$55		$55	X	$60	X	$55	X	$25		$10	X	40%	X	100%
Tier 3 (Nonpreferred Brand)		$25		$25		$80		$80	X	$90	X	$85	X	$45		$15	X	40%	X	100%
Tier 4 (Specialty)		10%		10%		20%		20%	X	20%	X	20%	X	15%		10%	X	40%	X	100%
Tier 4 Maximum Coinsurance		$250		$250		$250		$250		$250		$250		$150		$150		$500*		
Maximum Days for charging IP copay				5				5												
Begin PCP deductible after # of copays																		3 visits		
Actuarial Value																				
2021 AV (Draft 2021 AVC)		**91.59**		**89.25**		**81.88**		**78.07**		**71.02†**		**73.56†**		**87.91†**		**94.09**		**64.85**		**64.60**
2020 AV (Final 2020 AVC)		**91.71**		**89.07**		**81.84**		**78.25**		**71.79†**		**73.88†**		**87.70†**		**94.54**		**61.36**		**62.08**
Additive adjustment (†)										**0.30**		**0.30**		**0.10**						

KEY:		
	X	Subject to deductible
	*	Drug cap applies to all drug tiers
	†	Additive adjustment (included in AV)
		Increased member cost from 2020
		Decreased member cost from 2020
		Does not meet AV
		Within .5 of de minimis
		Securely within AV

PROPOSED 2021 PATIENT-CENTERED BENEFIT PLAN DESIGNS

CCSB-only Plan Designs

Benefit	CCSB-only Platinum Coinsurance‡		CCSB-only Platinum Copay‡		CCSB-only Gold Coinsurance		CCSB-only Gold Copay		CCSB-only Silver Coinsurance		CCSB-only Silver Copay		CCSB-only Silver HDHP	
	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount	Ded	Amount
Deductible														$2,500
Medical Deductible		$250				$500		$250		$2,250		$2,250		
Drug Deductible		$0				$250		$0		$300		$300		
Coinsurance (Member)		10%		10%		20%		20%		35%		35%		20%
MOOP		$4,500		$4,000		$6,400		$7,800		$7,950		$7,950		$6,850
ED Facility Fee	X	$250		$250	X	20%	X	$250	X	35%	X	35%	X	20%
Inpatient Facility Fee	X	10%		$250	X	20%	X	$600	X	35%	X	35%	X	20%
Inpatient Physician Fee	X	10%		---	X	20%		--	X	35%		35%	X	20%
Primary Care Visit		$15		$20		$30		$35		$50		$60	X	20%
Specialist Visit		$30		$30		$50		$55		$85		$90	X	20%
MH/SU Outpatient Services		$15		$20		$30		$35		$50		$60	X	20%
Imaging (CT/PET Scans, MRIs)	X	10%		$150	X	20%	X	$250	X	35%	X	$300	X	20%
Speech Therapy		$15		$20		$30		$35		$50		$60	X	20%
Occupational and Physical Therapy		$15		$20		$30		$35		$50		$60	X	20%
Laboratory Services		$15		$20		$30		$35		$50		$60	X	20%
X-rays and Diagnostic Imaging		$30		$40		$50		$55		$85		$90	X	20%
Skilled Nursing Facility	X	10%		$150	X	20%	X	$300	X	35%	X	35%	X	20%
Outpatient Facility Fee	X	10%		$100	X	20%	X	$300	X	35%	X	35%	X	20%
Outpatient Physician Fee		10%		$25		20%		$35		35%		35%	X	20%
Tier 1 (Generics)		$5		$5		$15		$15		$20		$20	X	20%
Tier 2 (Preferred Brand)		$30		$15	X	$40		$40	X	$70	X	$80	X	20%
Tier 3 (Nonpreferred Brand)		$50		$25	X	$70		$70	X	$100	X	$110	X	20%
Tier 4 (Specialty)		10%		10%	X	20%		20%	X	35%	X	35%	X	20%
Tier 4 Maximum Coinsurance	$250		$250		$250		$250		$250		$250		$250*	
Maximum Days for charging IP copay			5				5							
Begin PCP deductible after # of copays														
Actuarial Value														
2021 AV (Draft 2021 AVC)	**90.57**		**88.08**		**78.07**		**79.44**		**70.16†**		**69.42†**		**71.78**	
2020 AV (Final 2020 AVC)	**91.71**		**89.07**		**78.10**		**79.68**		**70.52†**		**70.21†**		**71.34**	
Additive adjustment (†)									**0.30**		**0.30**			

KEY:		
	X	Subject to deductible
	*	Drug cap applies to all drug tiers
	†	Additive adjustment (included in AV)
	‡	2020 Platinum is basis for changes
		Increased member cost from 2020
		Decreased member cost from 2020
		Does not meet AV
		Within .5 of de minimis
		Securely within AV