PY2025 PATIENT-CENTERED BENEFIT DESIGNS – INDIVIDUAL & FAMILY

Benefit	Individual-only Platinum Coinsurance		Individual-only Platinum Copay		Individual-only Gold Coinsurance		Individual-only Gold Copay		Individual-only Silver		CA Enhanced CSR Silver 73		CA Enhanced CSR Silver 87		CA Enhanced CSR 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																				$6,650
Medical Deductible										$5,400		$0		$0		$0		$5,800		
Drug Deductible										$50		$0		$0		$0		$450		
Coinsurance (Member)		10%		10%		20%		20%		30%		30%		20%		10%		40%		0%
MOOP		$4,500		$4,500		$8,700		$8,700		$8,700		$6,100		$3,000		$1,150		$8,850		$6,650
ED Facility Fee		$150		$150		$330		$330		$400		$350		$150		$50	X	40%	X	0%
Inpatient Facility Fee		10%		$225		30%		$350	X	30%		30%		20%		10%	X	40%	X	0%
Inpatient Physician Fee		10%		---		30%		---		30%		30%		20%		10%	X	40%	X	0%
Primary Care Visit		$15		$15		$35		$35		$50		$35		$15		$5		$60	X	0%
Specialist Visit		$30		$30		$65		$65		$90		$85		$25		$8	X	$95	X	0%
MH/SU Outpatient Services		$15		$15		$35		$35		$50		$35		$15		$5		$60	X	0%
Imaging (CT/PET Scans, MRIs)		10%		$75		25%		$75		$325		$325		$100		$50	X	40%	X	0%
Speech Therapy		$15		$15		$35		$35		$50		$35		$15		$5		$60	X	0%
Occupational and Physical Therapy		$15		$15		$35		$35		$50		$35		$15		$5		$60	X	0%
Laboratory Services		$15		$15		$40		$40		$50		$50		$20		$8		$40	X	0%
X-rays and Diagnostic Imaging		$30		$30		$75		$75		$95		$95		$40		$8	X	40%	X	0%
Skilled Nursing Facility		10%		$125		30%		$150	X	30%		30%		20%		10%	X	40%	X	0%
Outpatient Facility Fee		10%		$75		30%		$130		30%		30%		20%		10%	X	40%	X	0%
Outpatient Physician Fee		10%		$20		30%		$60		30%		30%		20%		10%	X	40%	X	0%
Tier 1 (Generics)		$7		$7		$15		$15		$18		$15		$5		$3		$19	X	0%
Tier 2 (Preferred Brand)		$16		$16		$60		$60	X	$60		$55		$25		$10	X	40%	X	0%
Tier 3 (Nonpreferred Brand)		$25		$25		$85		$85	X	$90		$85		$45		$15	X	40%	X	0%
Tier 4 (Specialty)		10%		10%		20%		20%	X	20%		20%		15%		10%	X	40%	X	0%
Tier 4 Maximum Coinsurance		$250		$250		$250		$250		$250		$250		$150		$150		$500*		
Maximum Days for charging IP copay				5				5												
Begin Specialist deductible after # of copays																		3		
Actuarial Value																				
2025 AV (Draft 2025 AVC)		**91.90**		**91.58**		**81.46**		**81.64**		**71.59†**		**79.22**		**88.86**		**95.07**		**63.61†**		**64.88**

KEY		
	X	Subject to deductible
	*	Drug cap applies to all drug tiers
	†	Additive adjustment included in AV
	(light orange)	Increased member cost from 2024
	(light green)	Decreased member cost from 2024
	(blue)	Enhanced member cost
	(red)	Does not meet AV
	(yellow/orange)	Within .5 of upper de minimis
	(green)	Securely within AV

PY2025 BENEFIT DESIGNS - CCSB

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														$2,850
Medical Deductible						$350		$250		$2,500		$2,500		
Drug Deductible						$0		$0		$300		$300		
Coinsurance (Member)		10%		10%		20%		20%		35%		35%		25%
MOOP		$4,500		$4,500		$7,800		$7,800		$8,600		$8,750		$7,500
ED Facility Fee		$200		$150	X	20%	X	$250	X	35%	X	35%	X	25%
Inpatient Facility Fee		10%		$250	X	20%	X	$600	X	35%	X	35%	X	25%
Inpatient Physician Fee		10%		---	X	20%		--	X	35%		35%	X	25%
Primary Care Visit		$15		$20		$25		$35		$55		$55	X	25%
Specialist Visit		$30		$30		$50		$55		$90		$90	X	25%
MH/SU Outpatient Services		$15		$20		$25		$35		$55		$55	X	25%
Imaging (CT/PET Scans, MRIs)		10%		$100		20%	X	$250	X	35%	X	$300	X	25%
Speech Therapy		$15		$20		$25		$35		$55		$55	X	25%
Occupational and Physical Therapy		$15		$20		$25		$35		$55		$55	X	25%
Laboratory Services		$15		$20		$25		$35		$55		$55	X	25%
X-rays and Diagnostic Imaging		$30		$30		$65		$55		$90		$90	X	25%
Skilled Nursing Facility		10%		$150	X	20%	X	$300	X	35%	X	35%	X	25%
Outpatient Facility Fee		10%		$100		20%	X	$300	X	35%	X	35%	X	25%
Outpatient Physician Fee		10%		$25		20%		$35		35%		35%	X	25%
Tier 1 (Generics)		$10		$5		$15		$15		$20		$19	X	25%
Tier 2 (Preferred Brand)		$25		$20		$50		$40	X	$75	X	$85	X	25%
Tier 3 (Nonpreferred Brand)		$40		$30		$80		$70	X	$105	X	$110	X	25%
Tier 4 (Specialty)		10%		10%		20%		20%	X	30%	X	30%	X	25%
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														
2025 AV (Draft 2025 AVC)	**91.27**		**90.47**		**79.08**		**80.52**		**69.45†**		**69.07†**		**71.21**	

KEY		
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	†	Additive adjustment included in AV
	(light orange)	Increased member cost from 2024
	(light green)	Decreased member cost from 2024
	(red)	Does not meet AV
	(yellow)	Within .5 of upper de minimis
	(green)	Securely within AV