Attachment B STANDARD BENEFIT DESIGN COST SHARING DESCRIPTION CHART - FINAL AV CALCULATOR (7/13/2022)

NOTE: Standard plan design descriptions are based on current HHS Regulations and the Actuarial Value Calculator (Final for 2023) and NY Laws/Regulations.

Non-HSA Compliant Bronze plan allows a total of three primary care or specialist visits before the deductible (PCP/Specialist copayment applies).

The Standard Silver and Silver CSR 73 and 87 plans allow one primary care or specialist visit before the deductible (PCP/Specialist copayment applies).

TYPE OF SERVICE	Platinum AV = 0.88 to 0.92	Gold AV = 0.78 to 0.82	Silver AV = 0.70 to 0.72	Silver CSR 200 - 250% FPL AV = 0.73 to 0.74	Silver CSR 150 - 200% FPL AV = 0.87 to 0.88	Silver CSR 100 - 150% FPL AV = 0.94 to 0.95	Bronze AV = 0.58 to 0.65	Bronze HSA Compliant* AV = 0.58 to 0.65	Catastrophic	AI/AN CSR 100 - 300% FPL $0 Cost Sharing
DEDUCTIBLE (single)	$0	$600	$1,750	$1,625	$250	$0	$4,700	$6,100	$9,100	$0
MAXIMUM OUT OF POCKET LIMIT (single) Includes the deductible	$2,000	$4,750	$9,100	$7,250	$2,800	$1,000	$8,700	$6,900	$9,100	$0
COST SHARING – MEDICAL SERVICES										
Inpatient facility/SNF/Hospice	$500 per admission	$1,000 per admission	$1,500 per admission	$1,500 per admission	$250 per admission	$100 per admission	$1,500 per admission	50% coinsurance	0% cost sharing	0% cost sharing
Outpatient facility – surgery, including freestanding am/surg centers	$100	$100	$150	$150	$75	$25	$150	50% coinsurance	0% cost sharing	0% cost sharing
Surgeon – inpatient facility, outpatient facility, including freestanding am/surg centers	$100	$100	$150	$150	$75	$25	$150	50% coinsurance	0% cost sharing	0% cost sharing
	One such copay per surgery and applies only to surgery performed in a hospital inpatient or a hospital outpatient facility setting, including freestanding am/surg centers, not to office surgery. See also "Maternity delivery and post-natal care - physician/midwife" under "physician services".									
PCP	$15	$25	$30	$30	$15	$10	$50	50% coinsurance	0% cost sharing	0% cost sharing
Specialist	$35	$40	$65	$65	$35	$20	$75	50% coinsurance	0% cost sharing	0% cost sharing
PT/OT/ST – rehabilitative & habilitative therapies	$25	$30	$30	$30	$25	$15	$50	50% coinsurance	0% cost sharing	0% cost sharing
ER	$100	$150	$500	$275	$75	$50	$500	50% coinsurance	0% cost sharing	0% cost sharing
Ambulance	$100	$150	$150	$150	$75	$50	$300	50% coinsurance	0% cost sharing	0% cost sharing
Urgent care	$55	$60	$70	$70	$50	$30	$75	50% coinsurance	0% cost sharing	0% cost sharing
DME/Medical supplies	10% coinsurance	20% coinsurance	30% coinsurance	25% coinsurance	10% coinsurance	5% coinsurance	50% coinsurance	50% coinsurance	0% cost sharing	0% cost sharing
Hearing aids	10% coinsurance	20% coinsurance	30% coinsurance	25% coinsurance	10% coinsurance	5% coinsurance	50% coinsurance	50% coinsurance	0% cost sharing	0% cost sharing
Eyewear	10% coinsurance	20% coinsurance	30% coinsurance	25% coinsurance	10% coinsurance	5% coinsurance	50% coinsurance	50% coinsurance	0% cost sharing	0% cost sharing
COST SHARING – INPATIENT HOSPITAL SERVICES										
Observation stay/care unit	ER copay per case; copay is waived if direct transfer from outpatient surgery setting to an observation care unit.							50% coinsurance	0% cost sharing	0% cost sharing
Hospital services – non-maternity	Inpatient facility copay per admission #							50% coinsurance	0% cost sharing	0% cost sharing
Maternity care stay (covers mother and newborn combined)	Inpatient facility copay per admission #							50% coinsurance	0% cost sharing	0% cost sharing
Mental/Behavioral health care	Inpatient facility copay per admission #							50% coinsurance	0% cost sharing	0% cost sharing
Substance abuse disorder services	Inpatient facility copay per admission #							50% coinsurance	0% cost sharing	0% cost sharing
Skilled nursing facility	Inpatient facility copay per admission # Indicated copay per admission is waived if direct transfer from hospital inpatient setting to skilled nursing facility.							50% coinsurance	0% cost sharing	0% cost sharing
Hospice (inpatient)	Inpatient facility copay per admission # Indicated copay per admission is waived if direct transfer from hospital inpatient setting or skilled nursing facility to hospice facility.							50% coinsurance	0% cost sharing	0% cost sharing
COST SHARING – EMERGENCY MEDICAL SERVICES										
Facility charge – emergency room	ER copay per case; copay is waived if patient is admitted as an inpatient (including as an observation stay or to an observation care unit) directly from the emergency room.							50% coinsurance	0% cost sharing	0% cost sharing
Physician charge – emergency room visit	$0 copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Facility charge – freestanding urgent care center	Urgent care copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Physician charge – freestanding urgent care visit	$0 copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Pre-hospital emergency services, transportation, includes air ambulance	Ambulance copay per case							50% coinsurance	0% cost sharing	0% cost sharing

Attachment B STANDARD BENEFIT DESIGN COST SHARING DESCRIPTION CHART - FINAL AV CALCULATOR (7/13/2022)

NOTE: Standard plan design descriptions are based on current HHS Regulations and the Actuarial Value Calculator (Final for 2023) and NY Laws/Regulations.

Non-HSA Compliant Bronze plan allows a total of three primary care or specialist visits before the deductible (PCP/Specialist copayment applies).

The Standard Silver and Silver CSR 73 and 87 plans allow one primary care or specialist visit before the deductible (PCP/Specialist copayment applies).

TYPE OF SERVICE	Platinum AV = 0.88 to 0.92	Gold AV = 0.78 to 0.82	Silver AV = 0.70 to 0.72	Silver CSR 200 - 250% FPL AV = 0.73 to 0.74	Silver CSR 150 - 200% FPL AV = 0.87 to 0.88	Silver CSR 100 - 150% FPL AV = 0.94 to 0.95	Bronze AV = 0.58 to 0.65	Bronze HSA Compliant* AV = 0.58 to 0.65	Catastrophic	AI/AN CSR 100 - 300% FPL $0 Cost Sharing
COST SHARING – OUTPATIENT HOSPITAL/FACILITY SERVICES										
Outpatient facility surgery – facility charge, including freestanding am/surg centers	Outpatient facility - surgery copay per case							50% coinsurance	0% cost sharing	0% cost sharing
Pre-admission/Pre-operative testing	$0 copay							50% coinsurance	0% cost sharing	0% cost sharing
Diagnostic and routine laboratory and pathology	Specialist copay per visit		$50	$50	Specialist copay per visit		$50	50% coinsurance	0% cost sharing	0% cost sharing
Diagnostic and routine imaging services, including X-ray, excluding CAT/PET scans, MRI	$35	$40	$75	$75	$35	$20	$75	50% coinsurance	0% cost sharing	0% cost sharing
Imaging: CAT/PET scans, MRI	$35	$40	$175	$175	$35	$20	$175	50% coinsurance	0% cost sharing	0% cost sharing
Chemotherapy	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Radiation therapy	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Hemodialysis/Renal dialysis	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Mental/Behavioral health care	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Substance use disorder services	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Covered therapies (PT, OT, ST) – rehabilitative & habilitative	PT/OT/ST copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Home care	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Hospice	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
COST SHARING – PREVENTIVE AND PRIMARY CARE SERVICES	NOTE: For preventive care visits/services as defined in 42 USC § 300gg-13 or as required by state law, no cost-sharing (including deductible) applies. Such preventive care visits/services include, but are not limited to, those found in this section.									
Bone mineral density testing										
Gynecological exams / cervical cancer screening										
Immunizations										
Mammograms / breast cancer screening										
Prostate cancer screening										
Routine / annual exams										
Women's preventive health, including prenatal care										
COST SHARING – PHYSICIAN/PROFESSIONAL SERVICES										
Inpatient hospital surgery - surgeon	Surgeon copay per case							50% coinsurance	0% cost sharing	0% cost sharing
Outpatient hospital and freestanding am/surg centers – surgeon	Surgeon copay per case							50% coinsurance	0% cost sharing	0% cost sharing
Office surgery	PCP/Specialist copay per visit (based on type of physician performing the service)							50% coinsurance	0% cost sharing	0% cost sharing
Anesthesia (any setting)	Covered in full, no deductible and no cost sharing apply							50% coinsurance	0% cost sharing	0% cost sharing
Covered therapies (PT, OT, ST) – rehabilitative and habilitative	PT/OT/ST copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Additional surgical opinion	Specialist copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Second medical opinion for cancer	Specialist copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Maternity delivery and post natal care – physician or midwife	Surgeon copay per case for delivery and post-natal care services combined (only one copay per pregnancy)							50% coinsurance	0% cost sharing	0% cost sharing
In-hospital physician visits	$0 copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Diagnostic office visits	PCP/Specialist copay per visit (based on type of physician performing the service)							50% coinsurance	0% cost sharing	0% cost sharing
Diagnostic and routine laboratory and pathology	PCP/Specialist copay per visit (based on type of physician performing the service)		PCP copay if performed by PCP/ $50	PCP copay if performed by PCP/ $50	PCP/Specialist copay per visit (based on type of physician performing the service)		$50	50% coinsurance	0% cost sharing	0% cost sharing

Attachment B STANDARD BENEFIT DESIGN COST SHARING DESCRIPTION CHART - FINAL AV CALCULATOR (7/13/2022)

NOTE: Standard plan design descriptions are based on current HHS Regulations and the Actuarial Value Calculator (Final for 2023) and NY Laws/Regulations.

Non-HSA Compliant Bronze plan allows a total of three primary care or specialist visits before the deductible (PCP/Specialist copayment applies).

The Standard Silver and Silver CSR 73 and 87 plans allow one primary care or specialist visit before the deductible (PCP/Specialist copayment applies).

TYPE OF SERVICE	Platinum AV = 0.88 to 0.92	Gold AV = 0.78 to 0.82	Silver AV = 0.70 to 0.72	Silver CSR 200 - 250% FPL AV = 0.73 to 0.74	Silver CSR 150 - 200% FPL AV = 0.87 to 0.88	Silver CSR 100 - 150% FPL AV = 0.94 to 0.95	Bronze AV = 0.58 to 0.65	Bronze HSA Compliant* AV = 0.58 to 0.65	Catastrophic	AI/AN CSR 100 - 300% FPL $0 Cost Sharing
COST SHARING – PHYSICIAN/PROFESSIONAL SERVICES (CONTINUED)										
Diagnostic and routine imaging services, including X-ray, excluding CAT/PET scans, MRI	$35	$40	$75	$75	$35	$20	$75	50% coinsurance	0% cost sharing	0% cost sharing
Imaging: CAT/PET scans, MRI	$35	$40	$175	$175	$35	$20	$175	50% coinsurance	0% cost sharing	0% cost sharing
Allergy testing	PCP/Specialist copay per visit(based on type of physician performing the service)							50% coinsurance	0% cost sharing	0% cost sharing
Allergy shots	PCP/Specialist copay per visit (based on type of physician performing the service)							50% coinsurance	0% cost sharing	0% cost sharing
Office/Outpatient consultations	PCP/Specialist copay per visit (based on type of physician performing the service)							50% coinsurance	0% cost sharing	0% cost sharing
Mental/Behavioral health care	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Substance use disorder services	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Chemotherapy	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Radiation therapy	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Hemodialysis/Renal dialysis	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Chiropractic care	Specialist copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
COST SHARING – ADDITIONAL BENEFITS/SERVICES										
ABA treatment for Autism Spectrum Disorder	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Assistive communication devices for Autism Spectrum Disorder	PCP copay per device							50% coinsurance	0% coinsurance	0% cost sharing
Durable medical equipment and medical supplies	DME/Medical supplies coinsurance cost sharing applies							50% coinsurance	0% coinsurance	0% cost sharing
Hearing evaluations/testing	Specialist copay per visit							50% coinsurance	0% coinsurance	0 cost sharing
Hearing aids	Hearing aid coinsurance cost sharing applies							50% coinsurance	0% coinsurance	0% cost sharing
Diabetic drugs and supplies	PCP copay per 30-day supply but no more than $100 (including deductible) paid for a 30-day supply of insulin								0% coinsurance	0% cost sharing
Diabetic self-management education	PCP copay per visit							50% coinsurance	0% coinsurance	0% cost sharing
Home care	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Exercise facility reimbursements	Deductible does not apply. $200/$100 reimbursement every six months for member/spouse. Partial reimbursement for facility fees every six months if member attains at least 50 visits.									
COST SHARING – PEDIATRIC DENTAL SERVICES										
Dental office visit	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
COST SHARING – PEDIATRIC VISION SERVICES										
Eye exam visit	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Prescribed lenses and frames	Eyewear coinsurance cost sharing applies to combined cost of lenses and frames							50% coinsurance	0% cost sharing	0% cost sharing
Contact lenses	Eyewear coinsurance cost sharing applies							50% coinsurance	0% cost sharing	0% cost sharing
COST SHARING – PRESCRIPTION DRUGS										
Generic or Tier 1	$10	$10	$15	$15	$9	$6	$10	$10	0% cost sharing	0% cost sharing
Formulary brand or Tier 2	$30	$35	$40	$40	$20	$15	$35	$35	0% cost sharing	0% cost sharing
Non-formulary brand or Tier 3	$60	$70	$75	$75	$40	$30	$70	$70	0% cost sharing	0% cost sharing

Above are retail copay amounts; mail order copays are 2.5 times retail (except for Catastrophic plans) for a 90-day supply.

Attachment B STANDARD BENEFIT DESIGN COST SHARING DESCRIPTION CHART - FINAL AV CALCULATOR (7/13/2022)

NOTE: Standard plan design descriptions are based on current HHS Regulations and the Actuarial Value Calculator (Final for 2023) and NY Laws/Regulations.

Non-HSA Compliant Bronze plan allows a total of three primary care or specialist visits before the deductible (PCP/Specialist copayment applies).

The Standard Silver and Silver CSR 73 and 87 plans allow one primary care or specialist visit before the deductible (PCP/Specialist copayment applies).

ADDITIONAL INSTRUCTIONS:

1. The following applies to the Platinum, Gold, Silver, Silver CSR, and non-HSA compliant Bronze plans:
   For an inpatient admission, the only copay that applies for an inpatient stay is the inpatient facility per admission copay; and if surgery is performed, a surgeon copay; and if a maternity delivery is performed, a maternity delivery copay (which is the same as the surgeon copay) if this copay has not already been collected as part of another maternity related claim.
   There are no additional copays for diagnostic tests, medical supplies, in-hospital physician visits, anesthesia, assistant surgeon, other staff doctors, etc.
   For a maternity stay, the inpatient per admission copay covers charges for the mother and newborn.
   # The inpatient facility copay per admission is waived for a readmission within 90 days of a previous discharge for the same or a related condition.

2. For the Gold and HSA-compliant Bronze plans, the deductible must be met first, and then the copay or coinsurance is applied to the remainder of the allowed amount until the maximum out-of-pocket limit is reached.

3. For the non-HSA compliant standard Bronze plan, any combination of three visits indicated below are covered before the deductible, subject to the applicable copays. The copays paid for the three visits count towards the deductible. After the first three visits and for all other services, the deductible must be met, and then the copay or coinsurance is applied to the remainder of the allowed amount until the maximum out-of-pocket limit is reached. These three visits are in addition to the ACA mandated preventive services for which no cost-sharing can apply. The following visits (or any combination), performed in person or using telehealth, are counted towards the three visits: primary care visits, specialist visits (including allergy visits and visits for second opinions), outpatient mental health visits, outpatient substance use disorder visits, ABA visits, and chiropractic care visits. Urgent care and office surgery do not count towards the three visits.

4. For the standard Silver plan and Silver 73 and 87 CSR plans, one visit indicated below is covered before the deductible, subject to the applicable copay. The copay paid for the one visit counts towards the deductible. After the first visit and for all other services, the deductible must be met, and then the copay or coinsurance is applied to the remainder of the allowed amount until the maximum out-of-pocket limit is reached. This visit is in addition to the ACA mandated preventive services for which no cost-sharing can apply. Any of the following types of visits, performed in person or using telehealth, counts towards the one pre-deductible visit: a primary care visit, specialist visit (including allergy visit and a visit for second opinions), outpatient mental health visit, outpatient substance use disorder visit, ABA visit, or chiropractic care visit. Urgent care and office surgery do not count towards the one visit.

5. If the copay payable is more than the allowed amount, the copay is reduced to the allowed amount.

6. The maximum out-of-pocket limit is an aggregate over all covered services (medical, pediatric dental, pediatric vision, and prescription drugs) and includes the deductible.

7. The deductible is over a calendar year for individual products and over the calendar year or plan year (an option of the insurer) for small group products.
   For the Platinum, Gold, Silver and Silver CSR plans, the deductible applies only to medical, pediatric dental, and pediatric vision services (including lenses/frames) and does not apply to prescription drugs. For the Bronze and Catastrophic plans, the deductible applies to all services combined (medical, pediatric dental, pediatric vision (including lenses/frames) and prescription drugs).

8. No deductible or cost sharing applies to the preventive care visits/services defined in section 2713 of ACA but additional services, like laboratory tests, which are delivered at the preventive care visit may be subject to the deductible or cost sharing.

9. Per ACA, the Catastrophic plan must include three primary care visits per calendar year to which the deductible does not apply. These three primary care visits are in addition to the ACA mandated preventive services for which no cost sharing can apply. These three primary care visits are covered in full (i.e., no deductible and no cost sharing). For purposes of using these three primary care visits to which the deductible does not apply, a primary care visit is defined as a visit to a provider whose primary specialty is in family medicine, internal medicine, pediatric medicine, obstetrics/gynecology, or outpatient mental/behavior health services or substance use disorder services.

10. The family deductible is two times the single deductible; the family out-of-pocket limit is two times the single maximum out-of-pocket limit. For plan designs that are non-HSA plan designs, each family member is subject to a maximum deductible equal to the single deductible and to a maximum out-of-pocket limit equal to the single out-of-pocket limit. Once all members of the family in aggregate meet the family deductible amount (or family out-of-pocket limit amount), then no family member needs to accumulate any more dollars toward the deductible (or out-of-pocket limit).

11. The pediatric dental cost-sharing indicated is when pediatric dental is included as part of the standard design medical QHP plan. A stand-alone pediatric dental plan may have its own deductible , cost-sharing, and associated premium.

* Bronze HSA Compliant plan satisfies the maximum out-of-pocket limit of $7,050 set by IRS for calendar year 2022.