Attachment C STANDARD BENEFIT WITH 3 PCP VISITS DESIGN COST SHARING DESCRIPTION CHART (04-07-2016)

NOTE: The standard with 3 pcp visits plan design descriptions are based on current understanding of HHS Regulations and the Actuarial Value Calculator (Final version for 2017) and NYS Laws/Regulations.
Each of these plans allow 3 visits to a primary care provider that are not subject to the deductible.

			Silver CSR		
	Gold	Silver	200 - 250 % FPL	150 - 200 % FPL	100 - 150 % FPL
TYPE OF SERVICE	(AV = 0.78 to 0.82)	(AV = 0.68 to 0.72)	(AV = 0.72 to 0.74)	(AV = 0.86 to 0.88)	(AV = 0.93 to 0.95)
DEDUCTIBLE (single)	$650	$2,350	$2,000	$400	$0
MAXIMUM OUT OF POCKET LIMIT (single) Includes the deductible	$5,000	$7,150	$5,700	$2,000	$1,000
COST SHARING - MEDICAL SERVICES					
Inpatient Facility/SNF/Hospice	$1,000 per admission	$1,500 per admission	$1,500 per admission	$250 per admission	$100 per admission
Outpatient Facility - Surgery, including freestanding surgicenters	$100	$100	$100	$75	$25
Surgeon - Inpatient facility, outpatient facility, including freestanding surgicenters	$100	$100	$100	$75	$25
	One such copay per surgery and applies only to surgery performed in a hospital inpatient or hospital outpatient facility setting, including freestanding surgicenters, not to office surgery. See also "Maternity delivery and post natal care-physician/midwife" under "physician services".				
PCP	$25	$35	$35	$15	$10
Specialist	$40	$55	$55	$35	$20
PT/OT/ST - rehabilitative & habilitative therapies	$30	$35	$35	$25	$15
ER	$150	$250	$250	$75	$50
Ambulance	$150	$150	$150	$75	$50
Urgent Care	$60	$70	$70	$50	$30
DME/Medical supplies	20% cost sharing	30% cost sharing	25% cost sharing	10% cost sharing	5% cost sharing
Hearing aids	20% cost sharing	30% cost sharing	25% cost sharing	10% cost sharing	5% cost sharing
Eyewear	20% cost sharing	30% cost sharing	25% cost sharing	10% cost sharing	5% cost sharing
INPATIENT HOSPITAL SERVICES					
Observation stay/observation care unit	ER copay per case, copay is waived if direct transfer from outpatient surgery setting to an observation care unit				
Hospital services - non-maternity	Inpatient Facility copay per admission #				
Maternity care stay (covers mother and well newborn combined)	Inpatient Facility copay per admission #				
Mental health/Behavorial health care	Inpatient Facility copay per admission #				
Detoxification	Inpatient Facility copay per admission #				
Substance abuse disorder services	Inpatient Facility copay per admission #				
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				
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				
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				
Physician charge - Emergency Room visit	$0 copay per visit				
Facility charge - Freestanding urgent care center	Urgent Care copay per visit				
Physician charge - Free standing urgent care center visit	$0 copay per visit				
Prehospital emergency services/ transportation, includes air ambulance	Ambulance copay per case				

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OUTPATIENT HOSPITAL/FACILITY SERVICES					
Outpatient facility surgery - hospital facility charge, including freestanding surgicenters	Outpatient Facility-Surgery copay per case				
Pre-admission/pre-operative testing	$0 copay				
Diagnostic and routine laboratory and pathology	Specialist copay per visit				
Diagnostic and routine imaging services including Xray; excluding CAT/PET scans, MRI	Specialist copay per visit				
Imaging: CAT/PET scans, MRI	Specialist copay				
Chemotherapy	PCP copay per visit				
Radiation therapy	PCP copay per visit				
Hemodialysis/Renal dialysis	PCP copay per visit				
Mental health/Behavorial health care	PCP copay per visit				
Substance abuse disorder services	PCP copay per visit				
Covered therapies (PT, OT, ST) - rehabilitative & habilitative	PT/OT/ST copay per visit				
Home care	PCP copay per visit				
Hospice	PCP copay per visit				
PREVENTIVE & PRIMARY CARE SERVICES					
Bone density testing	NOTE: For preventive care visits/services as defined in section 2713 of ACA no deductible or cost sharing applies.				
Cervical cytology	Otherwise the cost sharing indicated below applies to all services in this benefit service category.				
Colonoscopy screening					
Gynecological exams					
Immunizations	PCP/Specialist copay per visit (based on type of physician performing the service)				
Mammography					
Prenatal maternity care					
Prostate cancer screening					
Routine exams					
Women's preventive health services					
PHYSICIAN/PROFESSIONAL SERVICES					
Inpatient hospital surgery - surgeon	Surgeon copay per case				
Outpatient hospital and freestanding surgicenter - surgeon	Surgeon copay per case				
Office surgery	PCP/Specialist copay per visit (based on type of physician performing the service)				
Anesthesia (any setting)	Covered in full, no deductible and no cost sharing applies				
Covered therapies (PT, OT, ST) - rehabilitative & habilitative	PT/OT/ST copay per visit				
Additional surgical opinion	Specialist copay per visit				
Second medical opinion for cancer	Specialist copay per visit				
Maternity delivery and post natal care - physician or midwife	Surgeon copay per case for delivery and post natal care services combined (only one such copay per pregnancy)				
In-hospital physician visits	$0 copay per visit				
Diagnostic office visits	PCP/Specialist copay per visit (based on type of physician performing the service)				
Diagnostic and routine laboratory and pathology	PCP/Specialist copay per visit				
Diagnostic and routine imaging services including Xray; excluding CAT/PET scans, MRI	PCP/Specialist copay per visit				
Imaging: CAT/PET scans, MRI	Specialist copay per visit				
Allergy testing	PCP/Specialist copay per visit				
Allergy shots	PCP/Specialist copay per visit				
Office/outpatient consultations	PCP/Specialist copay per visit (based on type of physician performing the service)				
Mental health/Behavorial health care	PCP copay per visit				
Substance abuse disorder services	PCP copay per visit				
Chemotherapy	PCP copay per visit				
Radiation therapy	PCP copay per visit				
Hemodialysis/Renal dialysis	PCP copay per visit				
Chiropractic care	Specialist copay per visit				

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ADDITIONAL BENEFITS/SERVICES					
ABA treatment for Autism Spectrum Disorder	PCP copay per visit				
Assistive Communiciation Devices for Autism Spectrum Disorder	PCP copay per device				
Durable medical equipment and medical supplies	DME/Medical supplies coinsurance cost sharing applies				
Hearing evaluations/testing	Specialist copay per visit				
Hearing aids	Hearing aid coinsurance cost sharing applies				
Diabetic drugs and supplies	PCP copay per 30 days supply				
Diabetic education and self-management	PCP copay per visit				
Home care	PCP copay per visit				
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.				
PEDIATRIC DENTAL SERVICES					
Dental office visit	PCP copay per visit				
PEDIATRIC VISION SERVICES					
Eye exam visit	PCP copay per visit				
Prescribed lenses and frames	Eyewear coinsurance cost sharing applies to combined cost of lenses and frames				
Contact lenses	Eyewear coinsurance cost sharing applies				
PRESCRIPTION DRUGS					
Generic or Tier 1	$10	$10	$10	$9	$6
Formulary Brand or Tier 2	$40	$40	$40	$20	$15
Non-Formulary Brand or Tier 3	$80	$80	$80	$40	$30
Above are retail copay amounts; mail order copays are 2.5 times retail (except for Catastrophic Plans) for a 90 day supply					

Additional Instructions:

There is no Platinum and AI/AN <= 300% FPL versions of this design because these plan designs do not have a deductible.
There is no Bronze version of this design because it did not meet the required actuarial value per 2017 CMS actuarial value calculator.

1. The following applies to the Gold, Silver and Silver-CSR Plans:
   For an inpatient admission the only copay that applies during 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 a well newborn.
   # The inpatient facility copay per admission is waived for a re-admission within 90 days of a previous discharge for the same or a related condition.
2. For all the standard plan designs, the deductible must be met first, and then the cost sharing copay or coinsurance is applied to the remainder of the allowed amount until the maximum out of pocket limit is reached.
3. For all standard plans with 3 PCP visits not subject to the deductible, the cost sharing copay is still applicable to the first 3 visits. After the first 3 visits, the applicability of the deductible and the cost sharing copay will adhere to the guideline in Item #2. PCP visits are defined as visits to provider whose primary specialty is in family medicine, internal medicine, pediatric medicine, obstetrics/gynecology or outpatient mental health services.
4. If the copay payable is more than the allowed amount (or remainder of the allowed amount), the copay payable is reduced to the allowed amount (or to the remainder of the allowed amount).
5. 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.
6. The deductible is over a calendar year for individual products and over the calendar year or plan year (option of insurer) for small group products.
   For the 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.
7. No deductible or cost sharing applies to the preventive care visits/services defined in section 2713 of ACA.
8. The family deductible is two times the single deductible and the family out-of-pocket limit is two times the single maximum out-of-pocket limit. The plan designs below are non-HSA plan designs and 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 towards the deductible (or out-of-pocket limit).
9. 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 will have its own deductible and cost sharing arrangements and associated premium.