Attachment B STANDARD BENEFIT DESIGN COST SHARING DESCRIPTION CHART (05-07-2020)

NOTE: Standard plan design descriptions are based on current understanding of HHS Regulations and the Actuarial Value Calculator (Final version for 2021) and NYS Laws/Regulations. Catastrophic plan design was revised to reflect the official maximum out of pocket limit of $8,550 (single) per Proposed HHS Notice of Benefit and Payment Parameter for calendar year 2021. Non-HSA Compliant Bronze plan allows a total of three visits to primary care providers or specialists before the deductible (PCP/Specialist Copay applies).

				Silver CSR				Bronze		AI/AN CSR
	Platinum	Gold	Silver	200 - 250% FPL	150 - 200% FPL	100 - 150% FPL	Bronze	HSA Compliant*		100 - 300% FPL
TYPE OF SERVICE	AV = 0.86 to 0.92	AV = 0.76 to 0.82	AV = 0.70 to 0.72	AV = 0.72 to 0.74	AV = 0.86 to 0.88	AV = 0.93 to 0.95	AV = 0.56 to 0.65	AV = 0.56 to 0.65	Catastrophic	$0 Cost Sharing
DEDUCTIBLE (single)	$0	$600	$1,300	$1,100	$250	$0	$4,700	$6,100	$8,550	$0
MAXIMUM OUT OF POCKET LIMIT (single)										
Includes the deductible	$2,000	$4,000	$8,500	$6,500	$2,200	$1,000	$8,550	$6,900	$8,550	$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	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Outpatient facility – surgery, including freestanding surgicenters	$100	$100	$150	$150	$75	$25	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Surgeon – inpatient facility, outpatient facility, including freestanding surgicenters	$100	$100	$150	$150	$75	$25	50% cost sharing	50% cost sharing	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 surgicenters, 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% cost sharing	0% cost sharing	0% cost sharing
Specialist	$35	$40	$50	$50	$35	$20	$75	50% cost sharing	0% cost sharing	0% cost sharing
PT/OT/ST – rehabilitative & habilitative therapies	$25	$30	$30	$30	$25	$15	$50	50% cost sharing	0% cost sharing	0% cost sharing
ER	$100	$150	$300	$275	$75	$50	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Ambulance	$100	$150	$150	$150	$75	$50	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Urgent care	$55	$60	$70	$70	$50	$30	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
DME/Medical supplies	10% cost sharing	20% cost sharing	30% cost sharing	25% cost sharing	10% cost sharing	5% cost sharing	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Hearing aids	10% cost sharing	20% cost sharing	30% cost sharing	25% cost sharing	10% cost sharing	5% cost sharing	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Eyewear	10% cost sharing	20% cost sharing	30% cost sharing	25% cost sharing	10% cost sharing	5% cost sharing	50% cost sharing	50% cost sharing	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% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Hospital services – non-maternity	Inpatient facility copay per admission #						50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Maternity care stay (covers mother and well newborn combined)	Inpatient facility copay per admission #						50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Mental/Behavioral health care	Inpatient facility copay per admission #						50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Detoxification	Inpatient facility copay per admission #						50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Substance abuse disorder services	Inpatient facility copay per admission #						50% cost sharing	50% cost sharing	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% cost sharing	50% cost sharing	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% cost sharing	50% cost sharing	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% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Physician charge – emergency room visit	$0 copay per visit						50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Facility charge – freestanding urgent care center	Urgent care copay per visit						50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Physician charge – freestanding urgent care visit	$0 copay per visit						50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Pre-hospital emergency services, transportation, includes air ambulance	Ambulance copay per case						50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing

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TYPE OF SERVICE	Platinum AV = 0.86 to 0.92	Gold AV = 0.76 to 0.82	Silver AV = 0.70 to 0.72	Silver CSR 200 - 250% FPL AV = 0.72 to 0.74	Silver CSR 150 - 200% FPL AV = 0.86 to 0.88	Silver CSR 100 - 150% FPL AV = 0.93 to 0.95	Bronze AV = 0.56 to 0.65	Bronze HSA Compliant* AV = 0.56 to 0.65	Catastrophic	AI/AN CSR 100 - 300% FPL $0 Cost Sharing
COST SHARING – OUTPATIENT HOSPITAL/FACILITY SERVICES										
Outpatient facility surgery – hospital facility charge, including freestanding surgicenters			Outpatient facility - surgery copay per case				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Pre-admission/Pre-operative testing			$0 copay				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine laboratory and pathology			Specialist copay per visit				$50	50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine imaging services, including X-ray, excluding CAT/PET scans, MRI	Specialist copay per visit	Specialist copay per visit	$75	$75	Specialist copay per visit	Specialist copay per visit	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Imaging: CAT/PET scans, MRI	Specialist copay per visit	Specialist copay per visit	$75	$75	Specialist copay per visit	Specialist copay per visit	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Chemotherapy			PCP copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Radiation therapy			PCP copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Hemodialysis/Renal dialysis			PCP copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Mental/Behavioral health care			PCP copay per visit					50% cost sharing	0% cost sharing	0% cost sharing
Substance abuse disorder services			PCP copay per visit					50% cost sharing	0% cost sharing	0% cost sharing
Covered therapies (PT, OT, ST) – rehabilitative & habilitative			PT/OT/ST copay per visit					50% cost sharing	0% cost sharing	0% cost sharing
Home care			PCP copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Hospice			PCP copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
COST SHARING – PREVENTIVE AND PRIMARY CARE SERVICES										
Bone density testing Cervical cytology Colonoscopy screening Gynecological exams Immunizations Mammography Prenatal maternity care Prostate cancer screening Routine exams Women's preventive health services			NOTE: For preventive care visits/services as defined in section 2713 of ACA, no deductible or cost sharing applies; otherwise, the cost sharing indicated below applies to all services in this benefit service category.							
COST SHARING – PHYSICIAN/PROFESSIONAL SERVICES										
Inpatient hospital surgery - surgeon			Surgeon copay per case				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Outpatient hospital and freestanding surgicenters – surgeon			Surgeon copay per case				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Office surgery			PCP/Specialist copay per visit (based on type of physician performing the service)				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Anesthesia (any setting)			Covered in full, no deductible and no cost sharing apply				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Covered therapies (PT, OT, ST) – rehabilitative and habilitative			PT/OT/ST copay per visit					50% cost sharing	0% cost sharing	0% cost sharing
Additional surgical opinion			Specialist copay per visit					50% cost sharing	0% cost sharing	0% cost sharing
Second medical opinion for cancer			Specialist copay per visit					50% cost sharing	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 such copay per pregnancy)				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
In-hospital physician visits			$0 copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic office visits			PCP/Specialist copay per visit (based on type of physician performing the service)					50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine laboratory and pathology			PCP/Specialist copay per visit				$50	50% cost sharing	0% cost sharing	0% cost sharing

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	Platinum	Gold	Silver	200 - 250% FPL	150 - 200% FPL	100 - 150% FPL	Bronze	HSA Compliant*		AI/AN CSR 100 - 300% FPL
TYPE OF SERVICE	AV = 0.86 to 0.92	AV = 0.76 to 0.82	AV = 0.70 to 0.72	AV = 0.72 to 0.74	AV = 0.86 to 0.88	AV = 0.93 to 0.95	AV = 0.56 to 0.65	AV = 0.56 to 0.65	Catastrophic	$0 Cost Sharing
COST SHARING – PHYSICIAN/PROFESSIONAL SERVICES (CONTINUED)										
Diagnostic and routine imaging services, including X-ray, excluding CAT/PET scans, MRI	PCP/Specialist copay per visit	PCP/Specialist copay per visit	$75	$75	PCP/Specialist copay per visit	PCP/Specialist copay per visit	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Imaging: CAT/PET scans, MRI	Specialist copay per visit	Special copay per visit	$75	$75	Special copay per visit	Specialist copay per visit	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Allergy testing	PCP/Specialist copay per visit							50% cost sharing	0% cost sharing	0% cost sharing
Allergy shots	PCP/Specialist copay per visit							50% cost sharing	0% cost sharing	0% cost sharing
Office/Outpatient consultations	PCP/Specialist copay per visit (based on type of physician performing the service)							50% cost sharing	0% cost sharing	0% cost sharing
Mental/Behavioral health care	PCP copay per visit							50% cost sharing	0% cost sharing	0% cost sharing
Substance use disorder services	PCP copay per visit							50% cost sharing	0% cost sharing	0% cost sharing
Chemotherapy	PCP copay per visit						50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Radiation therapy	PCP copay per visit						50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Hemodialysis/Renal dialysis	PCP copay per visit						50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Chiropractic care	Specialist copay per visit							50% cost sharing	0% cost sharing	0% cost sharing
COST SHARING – ADDITIONAL BENEFITS/SERVICES										
ABA treatment for Autism Spectrum Disorder	PCP copay per visit							50% cost sharing	0% cost sharing	0% cost sharing
Assistive communication devices for Autism Spectrum Disorder	PCP copay per device							50% cost sharing	0% cost sharing	0% cost sharing
Durable medical equipment and medical supplies	DME/Medical supplies coinsurance cost sharing applies							50% cost sharing	0% cost sharing	0% cost sharing
Hearing evaluations/testing	Specialist copay per visit							50% cost sharing	0% cost sharing	0% cost sharing
Hearing aids	Hearing aid coinsurance cost sharing applies							50% cost sharing	0% cost sharing	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							50% cost sharing but no more than $100 (including deductible) paid for a 30-day supply of insulin	0% cost sharing	0% cost sharing
Diabetic education and self-management	PCP copay per visit							50% cost sharing	0% cost sharing	0% cost sharing
Home care	PCP copay per visit						50% cost sharing	50% cost sharing	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% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
COST SHARING – PEDIATRIC VISION SERVICES										
Eye exam visit	PCP copay per visit						50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Prescribed lenses and frames	Eyewear coinsurance cost sharing applies to combined cost of lenses and frames						50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Contact lenses	Eyewear coinsurance cost sharing applies						50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
COST SHARING – PRESCRIPTION DRUGS										
Generic or Tier 1	$10	$10	$10	$10	$9	$6	$10	$10	0% cost sharing	0% cost sharing
Formulary brand or Tier 2	$30	$35	$35	$35	$20	$15	$35	$35	0% cost sharing	0% cost sharing
Non-formulary brand or Tier 3	$60	$70	$70	$70	$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.										

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ADDITIONAL INSTRUCTIONS:

1. The following applies to the Platinum, 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 except the non-HSA-compliant Bronze plan design, 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) 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. If the copay payable is more than the allowed amount, the copay payable is reduced to 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 (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).

7. 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.

8. Per ACA, 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 by the insurance plan (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.

9. 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. 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 toward the deductible (or out-of-pocket limit).

10. 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.

* Bronze HSA Compliant plan satisfies the maximum out-of-pocket limit of $6,900 set by IRS for calendar year 2020.