ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (5/12/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	Limits
Deductible • Individual • Family	None None	$600 $1,200	$2,100 $4,200	$1,925 $3,850	$275 $550	None None	$4,600 $9,200	$6,100 $12,200	$9,450 $18,900	
Out-of-Pocket Limit • Individual • Family	$2,000 $4,000	$5,900 $11,800	$9,450 $18,900	$7,550 $15,100	$3,150 $6,300	$1,000 $2,000	$9,450 $18,900	$7,150 $14,300	$9,450 $18,900	
OFFICE VISITS										
Primary Care Office Visits (or Home Visits)	$15 Copayment	$25 Copayment after Deductible	$30 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $30 Copayment after Deductible for additional visits	$30 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $30 Copayment after Deductible for additional visits	$15 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $15 Copayment after Deductible for additional visits	$10 Copayment	$50 Copayment not subject to Deductible (and does not count towards the Deducible) for first 3 visits (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, outpatient MH/SUD or any combination thereof); $50 Copayment after Deductible for additional visits	50% Coinsurance after Deductible	$0 Copayment not subject to Deductible for first 3 visits (PCP, outpatient MH/SUD or any combination); 0% Coinsurance after Deductible for additional visits	See benefit for description
Specialist Office Visits (or Home Visits)	$35 Copayment	$40 Copayment after Deductible	$65 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services,	$65 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services,	$35 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services,	$20 Copayment	$75 Copayment not subject to Deductible (and does not count towards the Deducible) for first 3 visits (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (5/12/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	Limits
[[Preauthorization; Referral] required]			Second Opinions, ABA Treatment, or outpatient MH/SUD) $65 Copayment after Deductible for additional visits	Second Opinions, ABA Treatment, or outpatient MH/SUD) $65 Copayment after Deductible for additional visits	Second Opinions, ABA Treatment, or outpatient MH/SUD) $35 Copayment after Deductible for additional visits		Opinions, ABA Treatment, outpatient MH/SUD or any combination thereof); $75 Copayment after Deductible for additional visits			
PREVENTIVE CARE										**Limits**
• Well Child Visits and Immunizations*	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	
• Adult Annual Physical Examinations*	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	
• Adult Immunizations*	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	
• Routine Gynecological Services/Well Woman Exams*	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	
• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	
• Sterilization Procedures for Women*	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	
• Vasectomy	See Surgical Services Cost-Sharing	See Surgical Services Cost-Sharing	See Surgical Services Cost-Sharing	See Surgical Services Cost-Sharing	See Surgical Services Cost-Sharing	See Surgical Services Cost-Sharing	See Surgical Services Cost-Sharing	See Surgical Services Cost-Sharing	See Surgical Services Cost-Sharing	
• Bone Density Testing*	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	
• Screening for Prostate Cancer	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	
• Colon Cancer Screening	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	
• All other preventive	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	Limits
services required by USPSTF and HRSA										
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA **[Referral required]**	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	
EMERGENCY CARE										**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	$100 Copayment	$150 Copayment after Deductible	$150 Copayment after Deductible	$150 Copayment after Deductible	$75 Copayment after Deductible	$50 Copayment	$300 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Non-Emergency Ambulance Services **[[Preauthorization; Referral] required]**	$100 Copayment	$150 Copayment after Deductible	$150 Copayment after Deductible	$150 Copayment after Deductible	$75 Copayment after Deductible	$50 Copayment	$300 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Emergency Department [Cost-Sharing; Copayment; Coinsurance] waived if admitted to Hospital	$100 Copayment Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	$150 Copayment after Deductible Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	$500 Copayment after Deductible Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	$275 Copayment after Deductible Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	$75 Copayment after Deductible Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	$50 Copayment Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	$500 Copayment after Deductible Health care forensic examinations performed under Public Health Law § 2805-i are not subject to[Cost-Sharing	50% Coinsurance after Deductible Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Coinsurance	0% Coinsurance after Deductible Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Coinsurance	See benefit for description
Urgent Care Center	$55 Copayment	$60 Copayment	$70 Copayment	$70 Copayment	$50 Copayment	$30 Copayment	$75 Copayment	50% Coinsurance	0% Coinsurance	See benefit

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (5/12/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	Limits
[Preauthorization required for out-of-network Urgent Care; Referral required]		after Deductible	after Deductible	after Deductible	after Deductible		after Deductible	after Deductible	after Deductible	for description
PROFESSIONAL SERVICES and OUTPATIENT CARE										**Limits**
Advanced Imaging Services • Performed in a Specialist Office	$35 Copayment	$40 Copayment after Deductible	$175 Copayment after Deductible	$175 Copayment after Deductible	$35 Copayment after Deductible	$20 Copayment	$175 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
• Performed in a Freestanding Radiology Facility	$35 Copayment	$40 Copayment after Deductible	$175 Copayment after Deductible	$175 Copayment after Deductible	$35 Copayment after Deductible	$20 Copayment	$175 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services **[[Preauthorization; Referral] required]**	$35 Copayment	$40 Copayment after Deductible	$175 Copayment after Deductible	$175 Copayment after Deductible	$35 Copayment after Deductible	$20 Copayment	$175 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
Allergy Testing and Treatment • Performed in a PCP Office	$15 Copayment	$25 Copayment after Deductible	$30 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient	$30 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient	$15 Copayment not subject to Deductible (and does not count towards the Deducible) after first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient	$10 Copayment	$50 Copayment not subject to Deductible (and does not count towards the Deducible) for first 3 visits (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, outpatient MH/SUD or any	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (5/12/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	Limits
			MH/SUD) $30 Copayment after Deductible for additional visits	MH/SUD) $30 Copayment after Deductible for additional visits	MH/SUD) $15 Copayment after Deductible for additional visits		combination thereof); $50 Copayment after Deductible for additional visits			
• Performed in a Specialist Office **[[Preauthorization; Referral] required]**	$35 Copayment	$40 Copayment after Deductible	$65 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $65 Copayment after Deductible for additional visits	$65 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $65 Copayment after Deductible for additional visits	$35 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, or Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $35 Copayment after Deductible for additional visits	$20 Copayment	$75 Copayment not subject to Deductible (and does not count towards the Deducible) for first 3 visits (PCP, Specialist, outpatient MH/SUD or any combination thereof); $75 Copayment after Deductible for additional visits	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
Ambulatory Surgical Center Facility Fee **[[Preauthorization; Referral] required]**	$100 Copayment	$100 Copayment after Deductible	$150 Copayment after Deductible	$150 Copayment after Deductible	$75 Copayment after Deductible	$25 Copayment	$150 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings) **[[Preauthorization; Referral] required]**	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Cardiac and Pulmonary Rehabilitation										See benefit for

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (5/12/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	Limits
• Performed in a Specialist Office	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	description
• Performed as Outpatient Hospital Services	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
• Performed as Inpatient Hospital Services **[[Preauthorization; Referral] required]**	Included as part of inpatient Hospital service Cost-Sharing	Included as part of inpatient Hospital service Cost-Sharing	Included as part of inpatient Hospital service Cost-Sharing	Included as part of inpatient Hospital service Cost-Sharing	Included as part of inpatient Hospital service Cost-Sharing	Included as part of inpatient Hospital service Cost-Sharing	Included as part of inpatient Hospital service Cost-Sharing	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
Chemotherapy and Immunotherapy • Performed in a PCP Office	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
• [Performed at Home] **[[Preauthorization; Referral] required]**	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
Chiropractic Services	$35 Copayment	$40 Copayment after Deductible	$65 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing	$65 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing	$35 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing	$20 Copayment	$75 Copayment not subject to Deductible (and does not count towards the Deducible) for first 3 visits (PCP, Specialist, Allergy Testing and	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (5/12/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	Limits
[[Preauthorization; Referral] required]			and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $65 Copayment after Deductible for additional visits	and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $65 Copayment after Deductible for additional visits	and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $35 Copayment after Deductible for additional visits		Treatment, Chiropractic Services, Second Opinions, ABA Treatment, outpatient MH/SUD or any combination thereof); $75 Copayment after Deductible for additional visits			
Clinical Trials **[[Preauthorization; Referral] required]**	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description
Diagnostic Testing • Performed in a PCP Office	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office	$35 Copayment	$40 Copayment after Deductible	$50 Copayment after Deductible	$50 Copayment after Deductible	$35 Copayment after Deductible	$20 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services **[[Preauthorization; Referral] required]**	$35 Copayment	$40 Copayment after Deductible	$50 Copayment after Deductible	$50 Copayment after Deductible	$35 Copayment after Deductible	$20 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
Dialysis • Performed in a PCP Office	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	[Dialysis performed by Non-Participating

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	Limits
• Performed in a Freestanding Center	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	Providers is limited to 10 visits per calendar year. Cost-Sharing for the visits is the same as for a Participating Provider. See benefit description for more information.]
• Performed as Outpatient Hospital Services	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
• [Performed at Home] **[[Preauthorization; Referral] required]**	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **[[Preauthorization; Referral] required]**	$25 Copayment	$30 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$25 Copayment after Deductible	$15 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	60 visits per condition, per Plan Year combined therapies
Home Health Care **[[Preauthorization; Referral] required]**	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	40 visits per Plan Year
Infertility Services **[[Preauthorization; Referral] required]**	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See benefit for description
Infusion Therapy • Performed in a PCP Office	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (5/12/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	Limits
• Performed in Specialist Office	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	Home infusion counts toward home health care visit limits
• Performed as Outpatient Hospital Services	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
• Home Infusion Therapy **[[Preauthorization; Referral] required]**	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
Inpatient Medical Visits **[[Preauthorization; Referral] required]**	$0 Copayment	$0 Copayment after Deductible	$0 Copayment after Deductible	$0 Copayment after Deductible	$0 Copayment after Deductible	$0 Copayment	$0 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Interruption of Pregnancy • Abortion Services	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full after Deductible	Covered in full after Deductible	See benefit for description
Laboratory Procedures • Performed in a PCP Office	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office	$35 Copayment	$40 Copayment after Deductible	$50 Copayment after Deductible	$50 Copayment after Deductible	$35 Copayment after Deductible	$20 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
• Performed in a Freestanding Laboratory Facility	$35 Copayment	$40 Copayment after Deductible	$50 Copayment after Deductible	$50 Copayment after Deductible	$35 Copayment after Deductible	$20 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	$35 Copayment	$40 Copayment after Deductible	$50 Copayment after Deductible	$50 Copayment after Deductible	$35 Copayment after Deductible	$20 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (5/12/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	Limits
[[Preauthorization; Referral] required]										
Maternity and Newborn Care										See benefit for description
• Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	
• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)]	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	
• Inpatient Hospital Services [and Birthing Center]	$500 Copayment per admission	$1,000 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$250 Copayment after Deductible per admission	$100 Copayment per admission	$1,500 Copayment after Deductible per admission	50% Coinsurance after Deductible	0% Coinsurance after Deductible	One (1) home care visit[s] is Covered at no Cost-Sharing if mother is discharged from Hospital early
• Physician and Midwife Services for Delivery	$100 Copayment	$100 Copayment after Deductible	$150 Copayment after Deductible	$150 Copayment after Deductible	$75 Copayment after Deductible	$25 Copayment	$150 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered for duration of breast feeding

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (5/12/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	Limits
• Postnatal Care **[Preauthorization required] [for inpatient services; breast pump]**	Included in Physician and Midwife Services for Delivery Copayment	Included in Physician and Midwife Services for Delivery Copayment	Included in Physician and Midwife Services for Delivery Copayment	Included in Physician and Midwife Services for Delivery Copayment	Included in Physician and Midwife Services for Delivery Copayment	Included in Physician and Midwife Services for Delivery Copayment	Included in Physician and Midwife Services for Delivery Copayment	Included in Physician and Midwife Services for Delivery Copayment	Included in Physician and Midwife Services for Delivery Copayment	
Outpatient Hospital Surgery Facility Charge **[[Preauthorization; Referral] required]**	$100 Copayment	$100 Copayment after Deductible	$150 Copayment after Deductible	$150 Copayment after Deductible	$75 Copayment after Deductible	$25 Copayment	$150 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Preadmission Testing **[[Preauthorization; Referral] required]**	$0 Copayment	$0 Copayment after Deductible	$0 Copayment after Deductible	$0 Copayment after Deductible	$0 Copayment after Deductible	$0 Copayment after Deductible	$0 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Prescription Drugs Administered in Office [or Outpatient Facilities]										See benefit for description
• Performed in a PCP Office	Included as part of the PCP office visit Cost-Sharing	Included as part of the PCP office visit Cost-Sharing	Included as part of the PCP office visit Cost-Sharing	Included as part of the PCP office visit Cost-Sharing	Included as part of the PCP office visit Cost-Sharing	Included as part of the PCP office visit Cost-Sharing	Included as part of the PCP office visit Cost-Sharing	Included as part of the PCP office visit Cost-Sharing	Included as part of the PCP office visit Cost-Sharing	
• Performed in Specialist Office	Included as part of the Specialist office visit Cost-Sharing	Included as part of the Specialist office visit Cost-Sharing	Included as part of the Specialist office visit Cost-Sharing	Included as part of the Specialist office visit Cost-Sharing	Included as part of the Specialist office visit Cost-Sharing	Included as part of the Specialist office visit Cost-Sharing	Included as part of the Specialist office visit Cost-Sharing	Included as part of the Specialist office visit Cost-Sharing	Included as part of the Specialist office visit Cost-Sharing	
• [Performed in Outpatient Facilities] **[[Preauthorization; Referral] required]**	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
Diagnostic Radiology										See benefit

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (5/12/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	Limits
Services • Performed in a PCP Office	$35 Copayment	$40 Copayment after Deductible	$75 Copayment after Deductible	$75 Copayment after Deductible	$35 Copayment after Deductible	$20 Copayment	$75 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	for description
• Performed in a Specialist Office	$35 Copayment	$40 Copayment after Deductible	$75 Copayment after Deductible	$75 Copayment after Deductible	$35 Copayment after Deductible	$20 Copayment	$75 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
• Performed in a Freestanding Radiology Facility	$35 Copayment	$40 Copayment after Deductible	$75 Copayment after Deductible	$75 Copayment after Deductible	$35 Copayment after Deductible	$20 Copayment	$75 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	$35 Copayment	$40 Copayment after Deductible	$75 Copayment after Deductible	$75 Copayment after Deductible	$35 Copayment after Deductible	$20 Copayment	$75 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
[[Preauthorization; Referral] required]										
Therapeutic Radiology Services • Performed in a Specialist Office	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
• Performed in a Freestanding Radiology Facility	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
[[Preauthorization; Referral] required]										
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$25 Copayment	$30 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$25 Copayment after Deductible	$15 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	60 visits per condition, per Plan Year combined therapies Speech and physical therapy are

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (5/12/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	Limits
[[Preauthorization; Referral] required]										only Covered following a Hospital stay or surgery
[Retail Health Clinic Care) **[[Preauthorization; Referral] required]**	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	[See benefit for description]
Second Opinions on the Diagnosis of Cancer, Surgery and Other **[[Preauthorization; Referral] required]**	$35 Copayment	$40 Copayment after Deductible	$65 Copayment not subject to Deductible for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $65 Copayment after Deductible for additional visits	$65 Copayment not subject to Deductible for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $65 Copayment after Deductible for additional visits	$35 Copayment not subject to Deductible for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $35 Copayment after Deductible for additional visits	$20 Copayment	$75 Copayment not subject to Deductible for first 3 visits (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, outpatient MH/SUD or any combination thereof); $75 Copayment after Deductible for additional visits	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants)										See benefit for description
• Inpatient Hospital Surgery	$100 Copayment	$100 Copayment after Deductible	$150 Copayment after Deductible	$150 Copayment after Deductible	$75 Copayment after Deductible	$25 Copayment	$150 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	**[All transplants must be performed at designated Facilities]**
• Outpatient Hospital Surgery	$100 Copayment	$100 Copayment after Deductible	$150 Copayment after Deductible	$150 Copayment after Deductible	$75 Copayment after Deductible	$25 Copayment	$150 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (5/12/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	Limits
• Surgery Performed at an Ambulatory Surgical Center	$100 Copayment	$100 Copayment after Deductible	$150 Copayment after Deductible	$150 Copayment after Deductible	$75 Copayment after Deductible	$25 Copayment	$150 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
• Office Surgery **[[Preauthorization; Referral] required]**	$15 Copayment when performed by PCP; $35 Copayment when performed by Specialist	$25 Copayment after Deductible when performed by PCP; $40 Copayment after Deductible when performed by Specialist	$30 Copayment after Deductible when performed by PCP; $65 Copayment after Deductible when performed by Specialist	$30 Copayment after Deductible when performed by PCP; $65 Copayment after Deductible when performed by Specialist	$15 Copayment after Deductible when performed by PCP; $35 Copayment after Deductible when performed by Specialist	$10 Copayment when performed by PCP; $20 Copayment when performed by Specialist	$50 Copayment after Deductible when performed by PCP; $75 Copayment after Deductible when performed by Specialist	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
[Telemedicine Program]	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	[See benefit for description]
ADDITIONAL SERVICES, EQUIPMENT and DEVICES										**Limits**
Diabetic Equipment, Supplies and Self-Management Education										See benefit for description
• Diabetic Equipment, Supplies and Insulin (30-day supply)	$15 Copayment	$25 Copayment after Deductible but no more than $100 (including before the Deductible) for a 30-day supply of insulin	$30 Copayment after Deductible but no more than $100 (including before the Deductible) for a 30-day supply of insulin	$30 Copayment after Deductible but no more than $100 (including before the Deductible) for a 30-day supply of insulin	$15 Copayment after Deductible but no more than $100 (including before the Deductible) for a 30-day supply of insulin	$10 Copayment	$50 Copayment after Deductible but no more than $100 (including before the Deductible) for a 30-day supply of insulin	50% Coinsurance after Deductible but no more than $100 (including before the Deductible) for a 30-day supply of insulin	0% Coinsurance after Deductible	
• Diabetic Education **[[Preauthorization; Referral] required] [for insulin pump]**	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
Durable Medical Equipment and Braces	10% Coinsurance	20% Coinsurance after Deductible	30% Coinsurance after Deductible	25% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance	50% Coinsurance after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (5/12/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	Limits
[[Preauthorization; Referral] required]										
External Hearing Aids • Prescription Hearing Aids • [Over-the-Counter Hearing Aids] **[[Preauthorization; Referral] required]**	10% Coinsurance [Optional]	20% Coinsurance after Deductible [Optional]	30% Coinsurance after Deductible [Optional]	25% Coinsurance after Deductible [Optional]	10% Coinsurance after Deductible [Optional]	5% Coinsurance [Optional]	50% Coinsurance after Deductible [Optional]	50% Coinsurance after Deductible [Optional]	0% Coinsurance after Deductible [Optional]	Single purchase once every three (3) years [Describe limits for OTC hearing aids]
Cochlear Implants **[[Preauthorization; Referral] required]**	[10% Coinsurance] [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]	[20% Coinsurance after Deductible] [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]	[30% Coinsurance after Deductible] [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]	[25% Coinsurance after Deductible] [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]	[10% Coinsurance after Deductible] [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]	[5% Coinsurance] [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]	[50% Coinsurance after Deductible] See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge)]	[50% Coinsurance after Deductible] [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge)]	[0% Coinsurance after Deductible] [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge)]	One (1) per ear per time Covered
Hospice Care • Inpatient	$500 Copayment per admission	$1,000 Copayment after Deductible per	$1,500 Copayment after Deductible per	$1,500 Copayment after Deductible per	$250 Copayment after Deductible	$100 Copayment per admission	$1,500 Copayment after Deductible per	50% Coinsurance after Deductible	0% Coinsurance after Deductible	210 days per Plan Year]

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (5/12/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	Limits
• Outpatient **[[Preauthorization; Referral] required]**	admission $15 Copayment	admission $25 Copayment after Deductible	admission $30 Copayment after Deductible	admission $30 Copayment after Deductible	per admission $15 Copayment after Deductible	 $10 Copayment	admission $50 Copayment after Deductible	 50% Coinsurance after Deductible	 0% Coinsurance after Deductible	Five (5) visits for family bereavement counseling
Medical Supplies **[[Preauthorization; Referral] required]**	10% Coinsurance	20% Coinsurance after Deductible	30% Coinsurance after Deductible	25% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance	50% Coinsurance after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Prosthetic Devices • External • Internal **[[Preauthorization; Referral] required]**	10% Coinsurance Included as part of inpatient Hospital Cost-Sharing	20% Coinsurance after Deductible Included as part of inpatient Hospital Cost-Sharing	30% Coinsurance after Deductible Included as part of inpatient Hospital Cost-Sharing	25% Coinsurance after Deductible Included as part of inpatient Hospital Cost-Sharing	10% Coinsurance after Deductible Included as part of inpatient Hospital Cost-Sharing	5% Coinsurance Included as part of inpatient Hospital Cost-Sharing	50% Coinsurance after Deductible Included as part of inpatient Hospital Cost-Sharing	50% Coinsurance after Deductible 50% Coinsurance after Deductible	0% Coinsurance after Deductible 0% Coinsurance after Deductible	One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements Unlimited; See benefit for description
INPATIENT SERVICES and FACILITIES										**Limits**
Autologous Blood Banking **[[Preauthorization; Referral] required [in outpatient settings]]**	10% Coinsurance	20% Coinsurance after Deductible	30% Coinsurance after Deductible	25% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance	50% Coinsurance after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary	$500 Copayment per admission	$1,000 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$250 Copayment after Deductible per admission	$100 Copayment per admission	$1,500 Copayment after Deductible per admission	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (5/12/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	Limits
Rehabilitation, and End of Life Care) **[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions or services provided in a neonatal intensive care unit of a Hospital certified pursuant to Article 28 of the Public Health Law.]]**										
Observation Stay	$100 Copayment	$150 Copayment after Deductible	$500 Copayment after Deductible	$275 Copayment after Deductible	$75 Copayment after Deductible	$50 Copayment	$500 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) **[[Preauthorization; Referral] required]**	$500 Copayment per admission	$1,000 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$250 Copayment after Deductible per admission	$100 Copayment per admission	$1,500 Copayment after Deductible per admission	50% Coinsurance after Deductible	0% Coinsurance after Deductible	200 days per Plan Year]
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) **[[Preauthorization; Referral] required]**	$500 Copayment per admission	$1,000 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$250 Copayment after Deductible per admission	$100 Copayment per admission	$1,500 Copayment after Deductible per admission	50% Coinsurance after Deductible	0% Coinsurance after Deductible	60 days per Plan Year combined therapies
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	$500 Copayment per admission	$1,000 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$250 Copayment after Deductible per admission	$100 Copayment per admission	$1,500 Copayment after Deductible per admission	50% Coinsurance after Deductible	0% Coinsurance after Deductible	60 days per Plan Year combined therapies Speech and physical therapy are only

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (5/12/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	Limits
[[Preauthorization; Referral] required]										Covered following a Hospital stay or surgery
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES										**Limits**
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment) **[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions or for admissions at Participating OHM-licensed Facilities for Members under 18.]**	$500 Copayment per admission	$1,000 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$250 Copayment after Deductible per admission	$100 Copayment per admission	$1,500 Copayment after Deductible per admission	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	$15 Copayment	$25 Copayment after Deductible	$30 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $30 Copayment	$30 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $30 Copayment	$15 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $15 Copayment	$10 Copayment	$50 Copayment not subject to Deductible (and does not count towards the Deducible) for first 3 visits (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, outpatient MH/SUD or any combination thereof);	50% Coinsurance after Deductible	$0 Copayment not subject to Deductible for first 3 visits (PCP, outpatient MH/SUD or any combination); 0% Coinsurance after Deductible for additional visits	See benefit for description

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (5/12/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	Limits
[[Preauthorization; Referral] required]			after Deductible for additional visits	after Deductible for additional visits	after Deductible for additional visits		$50 Copayment after Deductible for additional visits			
ABA Treatment for Autism Spectrum Disorder **[[Preauthorization; Referral] required]**	$15 Copayment	$25 Copayment after Deductible	$30 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $30 Copayment after Deductible for additional visits	$30 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $30 Copayment after Deductible for additional visits	$15 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $15 Copayment after Deductible for additional visits	$10 Copayment	$50 Copayment not subject to Deductible (and does not count towards the Deducible) for first 3 visits (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, outpatient MH/SUD or any combination thereof); $50 Copayment after Deductible for additional visits	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder **[[Preauthorization; Referral] required]**	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment) **[[Preauthorization; Referral] required.**	$500 Copayment per admission	$1,000 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$250 Copayment after Deductible per admission	$100 Copayment per admission	$1,500 Copayment after Deductible per admission	50% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (5/12/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	Limits
However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.]										
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)	$15 Copayment	$25 Copayment after Deductible	$30 Copayment not subject to Deductible (and does not count towards the Deducible) for first visits (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $30 Copayment after Deductible for additional visits	$30 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $30 Copayment after Deductible for additional visits	$15 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $30 Copayment after Deductible for additional visits	$10 Copayment	$50 Copayment not subject to Deductible (and does not count towards the Deducible) for first 3 visits (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, outpatient MH/SUD or any combination thereof); $50 Copayment after Deductible for additional visits	50% Coinsurance after Deductible	$0 Copayment not subject to Deductible for first 3 visits (PCP, outpatient MH/SUD or any combination); 0% Coinsurance after Deductible for additional visits	Unlimited; Up to [20] visits per Plan Year may be used for family counseling
Opioid Treatment Programs **[[Preauthorization; Referral] required. However, Preauthorization is not required for Participating OASAS-certified Facilities.]**	Covered in full	Covered in full	Covered in full after Deductible	Covered in full after Deductible	Covered in full after Deductible	Covered in full	Covered in full after Deductible	Covered in full after Deductible	Covered in full after Deductible	
PRESCRIPTION DRUGS *Certain Prescription										**Limits**

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (5/12/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	Limits
Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an “A” or “B” rating from the USPSTF [and obtained at a participating pharmacy].										
Retail Pharmacy										
30-day supply Tier 1	$10 Copayment	$10 Copayment not subject to Deductible	$15 Copayment not subject to Deductible	$15 Copayment not subject to Deductible	$9 Copayment not subject to Deductible	$6 Copayment	$10 Copayment after Deductible	$10 Copayment after Deductible	0% Coinsurance after Deductible	See benefit for description
Tier 2	$30 Copayment	$35 Copayment not subject to Deductible	$40 Copayment not subject to Deductible	$40 Copayment not subject to Deductible	$20 Copayment not subject to Deductible	$15 Copayment	$35 Copayment after Deductible	$35 Copayment after Deductible	0% Coinsurance after Deductible	
Tier 3 Preauthorization is not required for a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.	$60 Copayment	$70 Copayment not subject to Deductible	$75 Copayment not subject to Deductible	$75 Copayment not subject to Deductible	$40 Copayment not subject to Deductible	$30 Copayment	$70 Copayment after Deductible	$70 Copayment after Deductible	0% Coinsurance after Deductible	
[Up to a 90-day supply for Maintenance Drugs] [Tier 1	$30 Copayment	$30 Copayment not subject to Deductible	$45 Copayment not subject to Deductible	$45 Copayment not subject to Deductible	$27 Copayment not subject to Deductible	$18 Copayment	$30 Copayment after Deductible	$30 Copayment after Deductible	0% Coinsurance after Deductible	[See benefit for description]
Tier 2	$90 Copayment	$105 Copayment not subject to Deductible	$120 Copayment not subject to Deductible	$120 Copayment not subject to Deductible	$60 Copayment not subject to Deductible	$45 Copayment	$105 Copayment after Deductible	$105 Copayment after Deductible	0% Coinsurance after Deductible	

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (5/12/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	Limits
Tier 3]	$180 Copayment	$210 Copayment not subject to Deductible	$225 Copayment not subject to Deductible	$225 Copayment not subject to Deductible	$120 Copayment not subject to Deductible	$90 Copayment	$210 Copayment after Deductible	$210 Copayment after Deductible	0% Coinsurance after Deductible	
[Mail Order Pharmacy]										
[Up to a 30-day supply										
Tier 1	$10 Copayment	$10 Copayment not subject to Deductible	$15 Copayment not subject to Deductible	$15 Copayment not subject to Deductible	$9 Copayment not subject to Deductible	$6 Copayment	$10 Copayment after Deductible	$10 Copayment after Deductible	0% Coinsurance after Deductible	
Tier 2	$30 Copayment	$35 Copayment not subject to Deductible	$40 Copayment not subject to Deductible	$40 Copayment not subject to Deductible	$20 Copayment not subject to Deductible	$15 Copayment	$35 Copayment after Deductible	$35 Copayment after Deductible	0% Coinsurance after Deductible	
Tier 3]	$60 Copayment	$70 Copayment not subject to Deductible	$75 Copayment not subject to Deductible	$75 Copayment not subject to Deductible	$40 Copayment not subject to Deductible	$30 Copayment	$70 Copayment after Deductible	$70 Copayment after Deductible	0% Coinsurance after Deductible	
[Up to a 90-day supply Tier 1	$25 Copayment	$25 Copayment not subject to Deductible	$37.50 Copayment not subject to Deductible	$37.50 Copayment not subject to Deductible	$22.50 Copayment not subject to Deductible	$15 Copayment	$25 Copayment after Deductible	$25 Copayment after Deductible	0% Coinsurance after Deductible	[See benefit for description]
Tier 2	$75 Copayment	$87.50 Copayment not subject to Deductible	$100 Copayment not subject to Deductible	$100 Copayment not subject to Deductible	$50 Copayment not subject to Deductible	$37.50 Copayment	$87.50 Copayment after Deductible	$87.50 Copayment after Deductible	0% Coinsurance after Deductible	
Tier 3]	$150 Copayment	$175 Copayment not subject to Deductible	$187.50 Copayment not subject to Deductible	$187.50 Copayment not subject to Deductible	$100 Copayment not subject to Deductible	$75 Copayment	$175 Copayment after Deductible	$175 Copayment after Deductible	0% Coinsurance after Deductible	
Enteral Formulas Tier 1	$10 Copayment	$10 Copayment not subject to Deductible	$15 Copayment not subject to Deductible	$15 Copayment not subject to Deductible	$9 Copayment not subject to Deductible	$6 Copayment	$10 Copayment after Deductible	$10 Copayment after Deductible	0% Coinsurance after Deductible	See benefit for description
Tier 2	$30 Copayment	$35 Copayment not subject to Deductible	$40 Copayment not subject to Deductible	$40 Copayment not subject to Deductible	$20 Copayment not subject to Deductible	$15 Copayment	$35 Copayment after Deductible	$35 Copayment after Deductible	0% Coinsurance after Deductible	
Tier 3	$60 Copayment	$70 Copayment	$75 Copayment	$75 Copayment	$40 Copayment	$30 Copayment	$70 Copayment	$70 Copayment	0% Coinsurance	

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (5/12/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	Limits
		not subject to Deductible	not subject to Deductible	not subject to Deductible	not subject to Deductible		after Deductible	after Deductible	after Deductible	
WELLNESS BENEFITS										
[Gym Reimbursement]	[Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for [Spouse; covered Dependents]] [Not applicable]	[Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for [Spouse; covered Dependents]] [Not applicable]	[Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for [Spouse; covered Dependents]]	[Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for [Spouse; covered Dependents]]	[Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for [Spouse; covered Dependents]]	[Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for [Spouse; covered Dependents]]	[Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for [Spouse; covered Dependents]]	[Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for [Spouse; covered Dependents]]	[Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for [Spouse; covered Dependents]]	[Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for [Spouse; covered Dependents]]
PEDIATRIC [DENTAL and] VISION CARE										**Limits**
[Pediatric Dental Care]										
• [Preventive Dental Care]	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	[One (1) dental exam and cleaning per six (6) month period]
• [Routine Dental Care]	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
• [Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics)]	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	[Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) month intervals]
• [Orthodontics]	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	
[Orthodontics and major dental require [Preauthorization; Referral]]										
Pediatric Vision Care										
• Exams	$15 Copayment	$25 Copayment	$30 Copayment	$30 Copayment	$15 Copayment	$10 Copayment	$50 Copayment	50% Coinsurance	0% Coinsurance	One (1)

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (5/12/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	Limits
		after Deductible	after Deductible	after Deductible	after Deductible		after Deductible	after Deductible	after Deductible	exam per [12-month period; Plan Year; calendar year]
• Lenses and Frames	10% Coinsurance	20% Coinsurance after Deductible	30% Coinsurance after Deductible	25% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance	50% Coinsurance after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	One (1) prescribed lenses and frames per [12-month period; Plan Year; calendar year]
• Contact Lenses **[Contact lenses require [Preauthorization; Referral]]**	10% Coinsurance	20% Coinsurance after Deductible	30% Coinsurance after Deductible	25% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance	50% Coinsurance after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	

{Drafting Note: Insert the provision below regarding eligible American Indians for individual schedules of benefits only if separate schedules of benefits are not used for American Indians over 300% of the federal poverty level (known as the limited cost-sharing plan variation).}
[Eligible American Indians, as determined by the NYSOH, are exempt from Cost-Sharing requirements when Covered Services are rendered by an Indian Health Service, Indian Tribe, Tribal Organization or Urban Indian Organization, or through Referral under contract health services.]

[All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not Covered under the [Certificate; Contract; Policy], You will be responsible for the full cost of the services.]
{Drafting Note: HMOs and gatekeeper EPO products may not impose preauthorization requirements on the member for in-network coverage. Only include preauthorization language if applicable. If plans only require preauthorization for certain services or items (e.g., specific DME items), they must list those specific services or items in the schedule.}

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (5/12/2023)

ADDITIONAL STANDARD PLAN INSTRUCTIONS:

1. **Platinum, Gold, Silver, Silver CSR, and non-HSA Compliant Bronze Plans:**
   - For an inpatient admission, the inpatient facility copayment applies per admission. If surgery is performed, a surgeon copayment applies. If a maternity delivery is performed, a maternity delivery copayment applies (if this copayment has not already been collected as part of another maternity claim). There are no additional copayments for diagnostic tests, medical supplies, in-hospital physician visits, anesthesia, assistant surgeon, other staff doctors, etc. For a maternity stay, the inpatient facility copayment 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. **Gold and HSA Compliant Bronze Plans:** The deductible must be met first, and then the copayment or coinsurance is applied to the remainder of the allowed amount until the out-of-pocket limit is reached.

3. **Non-HSA Compliant Standard Bronze Plan:** Any combination of three visits indicated below are covered before the deductible, subject to the applicable copayments. The copayments paid for the three visits does not count towards the deductible. After the first three visits and for all other services, the deductible must be met, and then the copayment or coinsurance is applied to the remainder of the allowed amount until the 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. **Standard Silver Plan and Silver 73 and 87 CSR Plans:** One visit indicated below is covered before the deductible, subject to the applicable copayment. The copayment paid for the one visit does not count towards the deductible. After the first visit and for all other services, the deductible must be met, and then the copayment or coinsurance is applied to the remainder of the allowed amount until the 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. **Catastrophic Plan:** The plan must include three primary care visits per calendar year not subject to the deducible. 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 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.

6. If the copayment payable is more than the allowed amount, the copayment is reduced to the allowed amount.

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

8. **Deductibles:** The deductible is per calendar year for individual plans and per calendar year or plan year (an option of the insurer) for small group plans.
   - Platinum, Gold, Silver and Silver CSR Plans: The deductible applies to medical, pediatric dental, and pediatric vision services and does not apply to prescription drugs.
   - Bronze and Catastrophic plans: The deductible applies to all services combined (medical, pediatric dental, pediatric vision, and prescription drugs).
   - The family deductible is two times the single deductible; the family out-of-pocket limit is two times the single out-of-pocket limit. For non-HSA compliant plans, each family member is subject to a maximum deductible equal to the single deductible and to a 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).