

Attachment B STANDARD BENEFIT DESIGN COST SHARING DESCRIPTION CHART (04-24-2019)

NOTE: Standard plan design descriptions are based on current understanding of HHS Regulations and the Actuarial Value Calculator (Final version for 2020) and NYS Laws/Regulations. Catastrophic plan design was revised to reflect the official maximum out of pocket limit of \$8,150 (single) for calendar year 2020. Non-HSA Compliant Bronze plan allows 3 free visits (no cost sharing on the first 3 visits) to primary care providers.

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			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	
				200 - 250% FPL AV = 0.72 to 0.74	150 - 200% FPL AV = 0.86 to 0.88	100 - 150% FPL AV = 0.93 to 0.95					
DEDUCTIBLE (single)	\$0	\$600	\$1,300	\$1,100	\$250	\$0	\$4,425	\$5,500	\$8,150	\$0	
MAXIMUM OUT OF POCKET LIMIT (single) Includes the deductible	\$2,000	\$4,000	\$7,900	\$6,500	\$2,100	\$1,000	\$8,150	\$6,550	\$8,150	\$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”.						50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
PCP	\$15	\$25	\$30	\$30	\$15	\$10	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing	
Specialist	\$35	\$40	\$50	\$50	\$35	\$20	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing	
PT/OT/ST – rehabilitative & habilitative therapies	\$25	\$30	\$30	\$30	\$25	\$15	50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing	
ER	\$100	\$150	\$250	\$250	\$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	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)	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	Gold	Silver	Silver CSR			Bronze	Bronze	AI/AN CSR	
	AV = 0.86 to 0.92	AV = 0.76 to 0.82	AV = 0.70 to 0.72	200 - 250% FPL AV = 0.72 to 0.74	150 - 200% FPL AV = 0.86 to 0.88	100 - 150% FPL AV = 0.93 to 0.95	AV = 0.56 to 0.65	HSA Compliant* AV = 0.56 to 0.65	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% cost sharing	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				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Imaging: CAT/PET scans, MRI			Specialist copay				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	50% cost sharing	0% cost sharing	0% cost sharing
Substance abuse disorder services			PCP copay per visit				50% cost sharing	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	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				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.						
Cervical cytology										
Colonoscopy screening										
Gynecological exams										
Immunizations										
Mammography										
Prenatal maternity care										
Prostate cancer screening										
Routine exams										
Women’s preventive health services										
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 applies				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	50% cost sharing	0% cost sharing	0% cost sharing
Additional surgical opinion			Specialist copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing
Second medical opinion for cancer			Specialist copay per visit				50% cost sharing	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	50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine laboratory and pathology			PCP/Specialist copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing

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				200 - 250% FPL AV = 0.72 to 0.74	150 - 200% FPL AV = 0.86 to 0.88	100 - 150% FPL AV = 0.93 to 0.95					
COST SHARING – PHYSICIAN/PROFESSIONAL SERVICES (CONTINUED)											
Diagnostic and routine imaging services, including X-ray, excluding CAT/PET scans, MRI			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				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing	
Allergy testing			PCP/Specialist copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing	
Allergy shots			PCP/Specialist copay per visit				50% cost sharing	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	50% cost sharing	0% cost sharing	0% cost sharing	
Mental/Behavioral health care			PCP copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing	
Substance abuse disorder services			PCP 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	
Chiropractic care			Specialist copay per visit				50% cost sharing	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	50% cost sharing	0% cost sharing	0% cost sharing	
Assistive communication devices for Autism Spectrum Disorder			PCP copay per device				50% cost sharing	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	50% cost sharing	0% cost sharing	0% cost sharing	
Hearing evaluations/testing			Specialist copay per visit				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing	
Hearing aids		Hearing aid coinsurance cost sharing applies					50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing	
Diabetic drugs and supplies			PCP copay per 30-day supply				50% cost sharing	50% cost sharing	0% cost sharing	0% cost sharing	
Diabetic education and self-management			PCP copay per visit				50% cost sharing	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, the deductible must be met first, and then the cost sharing copay or coinsurance is applied to the remainder of the allowed amount until the maximum out of pocket limit is reached.
3. If the copay payable is more than the allowed amount (or the remainder of the allowed amount), the copay payable is reduced to the allowed amount (or to the remainder of the allowed amount).
4. 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.
5. 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).
6. 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.
7. Non-HSA compliant Bronze plan allows 3 free visits (no cost sharing on the first 3 visits) to primary care providers. These 3 free primary care visits are in addition to the ACA mandated preventive services for which no cost sharing can apply. These 3 free primary care visits are covered in full by the insurance plan (i.e., no deductible and no cost sharing). For purposes of using these 3 free primary care visits, 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.
8. Per ACA, Catastrophic plan must include 3 primary care visits per calendar year to which the deductible does not apply. These 3 primary care visits are in addition to the ACA mandated preventive services for which no cost sharing can apply. These 3 primary care visits are covered in full by the insurance plan (i.e., no deductible and no cost sharing). For purposes of using these 3 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.
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 \$6,750 set by IRS for calendar year 2019.