

STANDARD BENEFIT DESIGN COST SHARING DESCRIPTION CHART (5-6-2013)

NOTE: The standard plan design descriptions are based on current understanding of HHS Regulations and the Actuarial Value Calculator (Feb 2013 final versions) and NYS laws/regulations.

****Note: The Catastrophic plan design was revised to reflect the official OOP maximum of \$6,350 (single) for calendar year 2014**

TYPE OF SERVICE	Platinum (AV = 0.88 to 0.92)	Gold (AV = 0.78 to 0.82)	Silver (AV = 0.68 to 0.72)	Silver - CSR Versions			Bronze (AV = 0.58 to 0.62)	Catastrophic	sharing variation Less than or equal to 300% FPL
				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	\$2,000	\$1,750	\$250	\$0	\$3,000	\$6,350	\$0
MAXIMUM OUT OF POCKET LIMIT (single) Includes the deductible	\$2,000	\$4,000	\$5,500	\$4,000	\$2,000	\$1,000	\$6,350	\$6,350	\$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	0% cost sharing	0% cost sharing
Outpatient Facility-Surgery, including freestanding surgicenters	\$100	\$100	\$100	\$100	\$75	\$25	50% cost sharing	0% cost sharing	0% cost sharing
Surgeon - Inpatient facility, outpatient facility, including freestanding surgicenters	\$100	\$100	\$100	\$100	\$75	\$25	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 hospital outpatient facility setting, including freestanding surgicenters, not to office surgery. See also "Maternity delivery and post natal care-physician/midwife" under "physician services".								
PCP	\$15	\$25	\$30	\$30	\$15	\$10	50% cost sharing	0% cost sharing	0% cost sharing
Specialist	\$35	\$40	\$50	\$50	\$35	\$20	50% cost sharing	0% cost sharing	0% cost sharing
PT/OT/ST - rehabilitative & habilitative therapies	\$25	\$30	\$30	\$30	\$25	\$15	50% cost sharing	0% cost sharing	0% cost sharing
ER	\$100	\$150	\$150	\$150	\$75	\$50	50% cost sharing	0% cost sharing	0% cost sharing
Ambulance	\$100	\$150	\$150	\$150	\$75	\$50	50% cost sharing	0% cost sharing	0% cost sharing
Urgent Care	\$55	\$60	\$70	\$70	\$50	\$30	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	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	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	0% cost sharing	0% cost sharing
INPATIENT HOSPITAL SERVICES									
Observation stay/observation care unit	ER copay per case, copay is waived if direct transfer from outpatient surgery setting to an observation care unit						50% cost sharing	0% cost sharing	0% cost sharing
Hospital services - non-maternity	Inpatient Facility copay per admission #						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	0% cost sharing	0% cost sharing
Mental health/Behavioral health care	Inpatient Facility copay per admission #						50% cost sharing	0% cost sharing	0% cost sharing
Detoxification	Inpatient Facility copay per admission #						50% cost sharing	0% cost sharing	0% cost sharing
Substance abuse disorder services	Inpatient Facility copay per admission #						50% cost sharing	0% cost sharing	0% cost sharing
Skilled nursing facility	Inpatient Facility copay per admission #						50% cost sharing	0% cost sharing	0% cost sharing
	Indicated copay per admission is waived if direct transfer from hospital inpatient setting to skilled nursing facility								
Hospice (inpatient)	Inpatient Facility copay per admission #						50% cost sharing	0% cost sharing	0% cost sharing
	Indicated copay per admission is waived if direct transfer from hospital inpatient setting or skilled nursing facility to hospice facility								
EMERGENCY MEDICAL SERVICES									
Facility charge - Emergency Room	ER copay per case - copay is waived if patient is admitted as an inpatient (including as an observation stay or to an observation care unit) directly from the emergency room						50% cost sharing	0% cost sharing	0% cost sharing

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Physician charge - Emergency Room visit			\$0 copay per visit				50% cost sharing	0% cost sharing	0% cost sharing
Facility charge - Freestanding urgent care center			Urgent Care copay per visit				50% cost sharing	0% cost sharing	0% cost sharing
Physician charge - Free standing urgent care center visit			\$0 copay per visit				50% cost sharing	0% cost sharing	0% cost sharing
Prehospital emergency services/ transportation, includes air ambulance			Ambulance copay per case				50% cost sharing	0% cost sharing	0% cost sharing

OUTPATIENT HOSPITAL/FACILITY SERVICES

Outpatient facility surgery - hospital facility charge, including freestanding surgicenters			Outpatient Facility-Surgery copay per case				50% cost sharing	0% cost sharing	0% cost sharing
Pre-admission/pre-operative testing			\$0 copay				50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine laboratory and pathology			Specialist copay per visit				50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine imaging services including Xray; excluding CAT/PET scans, MRI			Specialist copay per visit				50% cost sharing	0% cost sharing	0% cost sharing
Imaging: CAT/PET scans, MRI			Specialist copay				50% cost sharing	0% cost sharing	0% cost sharing
Chemotherapy			PCP copay per visit				50% cost sharing	0% cost sharing	0% cost sharing
Radiation therapy			PCP copay per visit				50% cost sharing	0% cost sharing	0% cost sharing
Hemodialysis/Renal dialysis			PCP copay per visit				50% cost sharing	0% cost sharing	0% cost sharing
Mental health/Behavioral health care			PCP copay per visit				50% cost sharing	0% cost sharing	0% cost sharing
Substance abuse disorder services			PCP copay per visit				50% cost sharing	0% cost sharing	0% cost sharing
Covered therapies (PT, OT, ST) - rehabilitative & habilitative			PT/OT/ST copay per visit				50% cost sharing	0% cost sharing	0% cost sharing
Home care			PCP copay per visit				50% cost sharing	0% cost sharing	0% cost sharing
Hospice			PCP copay per visit				50% cost sharing	0% cost sharing	0% cost sharing

PREVENTIVE & PRIMARY CARE SERVICES

Bone density testing									
Cervical cytology									
Colonoscopy screening									
Gynecological exams									
Immunizations									
Mammography									
Prenatal maternity care									
Prostate cancer screening									
Routine exams									
Women's preventive health services									
NOTE: For preventive care visits/services as defined in section 2713 of ACA no deductible or cost sharing applies. Otherwise the cost sharing indicated below applies to all services in this benefit service category.									
			PCP/Specialist copay per visit (based on type of physician performing the service)				50% cost sharing	0% cost sharing	0% cost sharing

PHYSICIAN/PROFESSIONAL SERVICES

Inpatient hospital surgery - surgeon			Surgeon copay per case				50% cost sharing	0% cost sharing	0% cost sharing
Outpatient hospital and freestanding surgicenter - surgeon			Surgeon copay per case				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	0% cost sharing	0% cost sharing
Anesthesia (any setting)			Covered in full, no deductible and no cost sharing applies				50% cost sharing	0% cost sharing	0% cost sharing
Covered therapies (PT, OT, ST) - rehabilitative & habilitative			PT/OT/ST copay per visit				50% cost sharing	0% cost sharing	0% cost sharing
Additional surgical opinion			Specialist copay per visit				50% cost sharing	0% cost sharing	0% cost sharing

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Second medical opinion for cancer				Specialist copay per visit			50% cost sharing	0% cost sharing	0% cost sharing	
Maternity delivery and post natal care - physician or midwife	Surgeon copay per case for delivery and post natal care services combined (only one such copay per pregnancy)						50% cost sharing	0% cost sharing	0% cost sharing	
In-hospital physician visits				\$0 copay per visit			50% cost sharing	0% cost sharing	0% cost sharing	
Diagnostic office visits		PCP/Specialist copay per visit (based on type of physician performing the service)						50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine laboratory and pathology				PCP/Specialist copay per visit			50% cost sharing	0% cost sharing	0% cost sharing	
Diagnostic and routine imaging services including Xray; excluding CAT/PET scans, MRI				PCP/Specialist copay per visit			50% cost sharing	0% cost sharing	0% cost sharing	
Imaging: CAT/PET scans, MRI				Specialist copay per visit			50% cost sharing	0% cost sharing	0% cost sharing	
Allergy testing				PCP/Specialist copay per visit			50% cost sharing	0% cost sharing	0% cost sharing	
Allergy shots				PCP/Specialist copay per visit			50% cost sharing	0% cost sharing	0% cost sharing	
Office/outpatient consultations		PCP/Specialist copay per visit (based on type of physician performing the service)						50% cost sharing	0% cost sharing	0% cost sharing
Mental health/Behavioral health care				PCP copay per visit			50% cost sharing	0% cost sharing	0% cost sharing	
Substance abuse disorder services				PCP copay per visit			50% cost sharing	0% cost sharing	0% cost sharing	
Chemotherapy				PCP copay per visit			50% cost sharing	0% cost sharing	0% cost sharing	
Radiation therapy				PCP copay per visit			50% cost sharing	0% cost sharing	0% cost sharing	
Hemodialysis/Renal dialysis				PCP copay per visit			50% cost sharing	0% cost sharing	0% cost sharing	
Chiropractic care				Specialist copay per visit			50% cost sharing	0% cost sharing	0% cost sharing	

ADDITIONAL BENEFITS/SERVICES

ABA treatment for Autism Spectrum Disorder				PCP copay per visit			50% cost sharing	0% cost sharing	0% cost sharing	
Assistive Communication Devices for Autism Spectrum Disorder				PCP copay per device			50% cost sharing	0% cost sharing	0% cost sharing	
Durable medical equipment and medical supplies		DME/Medical supplies coinsurance cost sharing applies						50% cost sharing	0% cost sharing	0% cost sharing
Hearing evaluations/testing				Specialist copay per visit			50% cost sharing	0% cost sharing	0% cost sharing	
Hearing aids				Hearing aid coinsurance cost sharing applies			50% cost sharing	0% cost sharing	0% cost sharing	
Diabetic drugs and supplies				PCP copay per 30 days supply			50% cost sharing	0% cost sharing	0% cost sharing	
Diabetic education and self-management				PCP copay per visit			50% cost sharing	0% cost sharing	0% cost sharing	
Home care				PCP copay per visit			50% cost sharing	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.									

PEDIATRIC DENTAL SERVICES

Dental office visit				PCP copay per visit			50% cost sharing	0% cost sharing	0% cost sharing
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PEDIATRIC VISION SERVICES

Eye exam visit				PCP copay per visit			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	0% cost sharing	0% cost sharing
Contact lenses				Eyewear coinsurance cost sharing applies			50% cost sharing	0% cost sharing	0% cost sharing	

PRESCRIPTION DRUGS

Generic or Tier 1	\$10	\$10	\$10	\$10	\$9	\$6	\$10	0% cost sharing	0% cost sharing
Formulary Brand or Tier 2	\$30	\$35	\$35	\$35	\$20	\$15	\$35	0% cost sharing	0% cost sharing
Non-Formulary Brand or Tier 3	\$60	\$70	\$70	\$70	\$40	\$30	\$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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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.

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.

If the copay payable is more than the allowed amount (or remainder of the allowed amount), the copay payable is reduced to the allowed amount (or to the remainder of the allowed amount).

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.

The deductible is over a calendar year for individual products and over the calendar year or plan year (option of insurer) for small group products.

For the 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).

No deductible or cost sharing applies to the preventive care visits/services defined in section 2713 of ACA.

Per ACA the 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).

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

Note: 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.

****Note: IRS Revenue Procedure 2013-25 provides the calendar year 2014 maximum out of pocket limit.**

The maximum out of pocket limit for calendar year 2014 is \$6,350 for self only coverage, and \$12,700 for family coverage.

Plans will need to amend the individual rate filing to reflect the revised catastrophic plan design.

Plans that submitted any plan design with a maximum out of pocket limit exceeding the official maximums will need to submit an amendment to the filing to revise such out of pocket limit.