ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (4/23/2025)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
Deductible • Individual • Family	None None	$775 $1,550	$2,450 $4,900	$2,160 $4,320	$450 $900	None None	$4,125 $8,250	$5,500 $11,000	$10,150 $20,300	None None	
Out-of-Pocket Limit • Individual • Family	$2,000 $4,000	$10,150 $20,300	$10,150 $20,300	$8,100 $16,200	$3,350 $6,700	$1,275 $2,550	$10,150 $20,300	$8,050 $16,100	$10,150 $20,300	$0 $0	
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	$0 Copayment	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	$65 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic	$35 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic	$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	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (4/23/2025)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
[[Preauthorization; Referral] required]			Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $65 Copayment after Deductible for additional visits	Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $65 Copayment after Deductible for additional visits	Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $35 Copayment after Deductible for additional visits		Services, Second 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	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	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	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	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	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	Covered in full	

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (4/23/2025)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
• 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	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	Covered in full	
• Prostate 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	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	Covered in full	
• All other preventive services required 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	Covered in full	
• *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)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	
EMERGENCY CARE											**Limits**
Emergency Ambulance Transportation (Pre-Hospital Emergency	$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	$0 Copayment	See benefit for description

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (4/23/2025)

	Platinum	**Gold**	**Silver**	**Silver 73**	**Silver 87**	**Silver 94**	**Bronze**	**Bronze HSA**	**Catastrophic**	**AI/AN CSR 100-300% FPL**	**Limits**
Medical Services and Emergency Transportation including Air Ambulance)											
Non-Emergency Ambulance Services (Ground and Air Ambulance) **[[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	$0 Copayment	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	$0 Copayment	See benefit for description
Urgent Care Center **[Preauthorization required for out-of-network Urgent Care; Referral required]**	$55 Copayment	$60 Copayment after Deductible	$70 Copayment after Deductible	$70 Copayment after Deductible	$50 Copayment after Deductible	$30 Copayment	$75 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description
PROFESSIONAL SERVICES and OUTPATIENT CARE											**Limits**
Advanced Imaging Services											See benefit for

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (4/23/2025)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
• 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	$0 Copayment	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	$0 Copayment	
• 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	$0 Copayment	
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 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) after 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	$0 Copayment	See benefit for description
• Performed in a	$35 Copayment	$40 Copayment	$65 Copayment	$65 Copayment	$35 Copayment	$20 Copayment	$75 Copayment not	50% Coinsurance	0% Coinsurance	$0	

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (4/23/2025)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
Specialist Office **[[Preauthorization; Referral] required]**		after Deductible	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	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	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		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	after Deductible	after Deductible	Copayment	
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	$0 Copayment	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	$0 Copayment	See benefit for description
Cardiac and Pulmonary Rehabilitation • 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	$0 Copayment	See benefit for description

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (4/23/2025)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	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	$0 Copayment	
• 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	$0 Copayment	
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	$0 Copayment	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	$0 Copayment	
• 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	$0 Copayment	
• [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	$0 Copayment	
Chiropractic Services	$35 Copayment	$40 Copayment after Deductible	$65 Copayment not subject to Deductible (and does not count towards the Deducible) for	$65 Copayment not subject to Deductible (and does not count towards the Deducible) for	$35 Copayment not subject to Deductible (and does not count towards the Deducible) for	$20 Copayment	$75 Copayment not subject to Deductible (and does not count towards the Deducible) for first	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (4/23/2025)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
[[Preauthorization; Referral] required]			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	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	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		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				
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	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	$0 Copayment	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	$0 Copayment	
• 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	$0 Copayment	
Dialysis • Performed in a	$15 Copayment	$25 Copayment	$30 Copayment	$30 Copayment	$15 Copayment	$10 Copayment	$50 Copayment	50% Coinsurance	0% Coinsurance	$0	See benefit for

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (4/23/2025)

	Platinum	**Gold**	**Silver**	**Silver 73**	**Silver 87**	**Silver 94**	**Bronze**	**Bronze HSA**	**Catastrophic**	**AI/AN CSR 100-300% FPL**	**Limits**
PCP Office • Performed in a Specialist Office • Performed in a Freestanding Center • Performed as Outpatient Hospital Services • [Performed at Home] **[[Preauthorization; Referral] required]**	$15 Copayment $15 Copayment $15 Copayment $15 Copayment	after Deductible $25 Copayment after Deductible $25 Copayment after Deductible $25 Copayment after Deductible $25 Copayment after Deductible	after Deductible $30 Copayment after Deductible $30 Copayment after Deductible $30 Copayment after Deductible $30 Copayment after Deductible	after Deductible $30 Copayment after Deductible $30 Copayment after Deductible $30 Copayment after Deductible $30 Copayment after Deductible	after Deductible $15 Copayment after Deductible $15 Copayment after Deductible $15 Copayment after Deductible $15 Copayment after Deductible	 $10 Copayment $10 Copayment $10 Copayment $10 Copayment	after Deductible $50 Copayment after Deductible $50 Copayment after Deductible $50 Copayment after Deductible $50 Copayment after Deductible	after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	Copayment $0 Copayment $0 Copayment $0 Copayment $0 Copayment	description [Dialysis performed by Non-Participating 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.]
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	$0 Copayment	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	$0 Copayment	40 visits per Plan Year
Infertility Services	Use Cost-Sharing for appropriate service (Office	Use Cost-Sharing for appropriate service (Office	Use Cost-Sharing for appropriate service (Office	Use Cost-Sharing for appropriate service (Office	Use Cost-Sharing for appropriate service (Office	Use Cost-Sharing for appropriate service (Office	Use Cost-Sharing for appropriate service (Office	Use Cost-Sharing for appropriate service (Office	Use Cost-Sharing for appropriate service (Office	Use Cost-Sharing for appropriate	See benefit for description

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (4/23/2025)

	Platinum	**Gold**	**Silver**	**Silver 73**	**Silver 87**	**Silver 94**	**Bronze**	**Bronze HSA**	**Catastrophic**	**AI/AN CSR 100-300% FPL**	**Limits**
[[Preauthorization; Referral] required]	Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy **[[Preauthorization; Referral] required]**	$15 Copayment $15 Copayment $15 Copayment $15 Copayment	$25 Copayment after Deductible $25 Copayment after Deductible $25 Copayment after Deductible $25 Copayment after Deductible	$30 Copayment after Deductible $30 Copayment after Deductible $30 Copayment after Deductible $30 Copayment after Deductible	$30 Copayment after Deductible $30 Copayment after Deductible $30 Copayment after Deductible $30 Copayment after Deductible	$15 Copayment after Deductible $15 Copayment after Deductible $15 Copayment after Deductible $15 Copayment after Deductible	$10 Copayment $10 Copayment $10 Copayment $10 Copayment	$50 Copayment after Deductible $50 Copayment after Deductible $50 Copayment after Deductible $50 Copayment after Deductible	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	$0 Copayment $0 Copayment $0 Copayment $0 Copayment	See benefit for description Home infusion counts toward home health care visit limits
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	$0 Copayment	See benefit for description
Interruption of											See benefit

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (4/23/2025)

	Platinum	**Gold**	**Silver**	**Silver 73**	**Silver 87**	**Silver 94**	**Bronze**	**Bronze HSA**	**Catastrophic**	**AI/AN CSR 100-300% FPL**	**Limits**
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	Covered in full	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	$0 Copayment	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	$0 Copayment	
• 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	$0 Copayment	
• 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	$0 Copayment	
Maternity and Newborn Care • 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	Covered in full	See benefit for description
• Prenatal Care	Use Cost-Sharing	Use Cost-Sharing	Use Cost-Sharing	Use Cost-Sharing	Use Cost-Sharing	Use Cost-Sharing	Use Cost-Sharing	Use Cost-Sharing	Use Cost-Sharing	Use Cost-	

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory	
• 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	$0 Copayment	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	$0 Copayment	Covered for duration of breast feeding
• 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 in full	
• Postnatal Care											
• Postnatal Care provided in Accordance with the comprehensive guidelines	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 in full	

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (4/23/2025)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
supported by USPSTF and HRSA											
• Postnatal 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	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing	
• Outpatient Donor Breast Milk **[Preauthorization required] [for inpatient services; breast pump]**	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	$0 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	$0 Copayment	See benefit for description
Preadmission Testing	$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	$0 Copayment	See benefit for

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (4/23/2025)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
[[Preauthorization; Referral] required]											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	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	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	$0 Copayment	
Diagnostic Radiology Services											See benefit for description
• 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	$0 Copayment	
• 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	$0 Copayment	
• Performed in a Freestanding Radiology	$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	$0 Copayment	

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	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
Facility • Performed as Outpatient Hospital Services **[[Preauthorization; Referral] required]**	$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	$0 Copayment	
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	$0 Copayment	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	$0 Copayment	
• Performed as Outpatient Hospital Services **[[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	$0 Copayment	
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	$0 Copayment	60 visits per condition, per Plan Year combined therapies Speech and physical therapy are only

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	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
[[Preauthorization; Referral] required]											Covered following a Hospital stay or surgery
[Retail Health Clinic Care) **[[Preauthorization; Referral] required]**	Optional	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	$0 Copayment	See benefit for description
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants) • 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	$0 Copayment	See benefit for description **[All transplants must be performed at [Centers of**

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	Platinum	**Gold**	**Silver**	**Silver 73**	**Silver 87**	**Silver 94**	**Bronze**	**Bronze HSA**	**Catastrophic**	**AI/AN CSR 100-300% FPL**	**Limits**
• 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	$0 Copayment	**Excellence; Hospitals]**
• 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	$0 Copayment	
• 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	$0 Copayment	
[Telemedicine Program]	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	[See benefit for description]
ADDITIONAL BENEFITS, EQUIPMENT and DEVICES											**Limits**
Diabetic Equipment, Supplies and Self-Management Education • Diabetic Equipment and Supplies (30-day supply)	$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	$0 Copayment	See benefit for description
• Diabetic Insulin	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	0% Coinsurance	Covered in	

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	Platinum	**Gold**	**Silver**	**Silver 73**	**Silver 87**	**Silver 94**	**Bronze**	**Bronze HSA**	**Catastrophic**	**AI/AN CSR 100-300% FPL**	**Limits**
• 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	after Deductible 0% Coinsurance after Deductible	full $0 Copayment	
Durable Medical Equipment and Braces **[[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	$0 Copayment	See benefit for description
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]	$0 Copayment	Single purchase once every three (3) years [Describe limits for OTC hearing aids]
Cochlear Implants	[10% Coinsurance] [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-	[20% Coinsurance after Deductible] [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-	[30% Coinsurance after Deductible] [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for appropriate service (Surgical	[25% Coinsurance after Deductible] [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for	[10% Coinsurance after Deductible] [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for	[5% Coinsurance] [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for appropriate	[50% Coinsurance after Deductible] See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for appropriate service (Surgical	[50% Coinsurance after Deductible] [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for appropriate service (Surgical	[0% Coinsurance after Deductible] [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for appropriate	$0 Copayment	One (1) per ear per time Covered

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (4/23/2025)

	Platinum	**Gold**	**Silver**	**Silver 73**	**Silver 87**	**Silver 94**	**Bronze**	**Bronze HSA**	**Catastrophic**	**AI/AN CSR 100-300% FPL**	**Limits**
[[Preauthorization; Referral] required]	Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]	Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]	Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]	appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]	appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]	service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]	Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge)]	Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge)]	service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge)]		
Hospice Care • Inpatient	$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	$0 Copayment	210 days per Plan Year]
• Outpatient **[[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	$0 Copayment	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	$0 Copayment	See benefit for description
Prosthetic Devices • External	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	$0 Copayment	One (1) prosthetic device, per limb, per lifetime with coverage for repairs

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	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
• Internal **[[Preauthorization; Referral] required]**	Included as part of inpatient Hospital Cost-Sharing	Included as part of inpatient Hospital Cost-Sharing	Included as part of inpatient Hospital Cost-Sharing	Included as part of inpatient Hospital Cost-Sharing	Included as part of inpatient Hospital Cost-Sharing	Included as part of inpatient Hospital Cost-Sharing	Included as part of inpatient Hospital Cost-Sharing	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	and replacements Unlimited; See benefit for description
INPATIENT SERVICES											**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	$0 Copayment	See benefit for description
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care) **[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions or services provided**	$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	$0 Copayment	See benefit for description

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	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
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	$0 Copayment	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	$0 Copayment	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	$0 Copayment	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	$0 Copayment	60 days per Plan Year combined therapies Speech and physical therapy are only Covered following a Hospital

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	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
[[Preauthorization; Referral] required]											stay or surgery
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES											**Limits**
Inpatient Mental Health Care for a continuous confinement when in a Hospital or Residential Facility **[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions or for admissions at participating Hospitals or crisis residential facilities licensed or operated by OMH.]**	$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	$0 Copayment	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	$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	$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	$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	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	$0 Copayment	See benefit for description

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (4/23/2025)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
[[Preauthorization; Referral] required However, Preauthorization is not required for participating crisis stabilization centers licensed by OMH.]			Opinions, ABA Treatment, or outpatient MH/SUD) $30 Copayment after Deductible for additional visits	Opinions, ABA Treatment, or outpatient MH/SUD) $30 Copayment after Deductible for additional visits	Opinions, ABA Treatment, or outpatient MH/SUD) $15 Copayment after Deductible for additional visits		Opinions, ABA Treatment, outpatient MH/SUD or any combination thereof); $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	$0 Copayment	See benefit for description

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (4/23/2025)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
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	$0 Copayment	See benefit for description
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment) **[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions or for participating Facilities licensed, certified or otherwise authorized by OASAS.]**	$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	$0 Copayment	See benefit for description
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted	$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,	$30 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment,	$15 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment,	$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,	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	$0 Copayment	Unlimited; Up to [20] visits per Plan Year may be used for family counseling

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (4/23/2025)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
Treatment)			Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $30 Copayment after Deductible for additional visits	Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $30 Copayment after Deductible for additional visits	Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $15 Copayment after Deductible for additional visits		Chiropractic Services, Second Opinions, ABA Treatment, outpatient MH/SUD or any combination thereof); $50 Copayment after Deductible for additional visits		for additional visits		
Opioid Treatment Programs **[[Preauthorization; Referral] required. However, Preauthorization is not required for participating Facilities licensed certified or otherwise authorized by OASAS.]**	Covered in full	Covered in full after Deductible	$0 Copayment not subject to Deductible (and does not count towards the Deductible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) Covered in full after Deductible for additional visits	$0 Copayment not subject to Deductible (and does not count towards the Deductible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) Covered in full after Deductible for additional visits	$0 Copayment not subject to Deductible (and does not count towards the Deductible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) Covered in full after Deductible for additional visits	Covered in full	$0 Copayment not subject to Deductible (and does not count towards the Deductible) for first 3 visits (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) Covered in full after Deductible for additional visits	Covered in full after Deductible	$0 Copayment not subject to Deductible for first 3 visits (PCP, outpatient MH/SUD or any combination); Covered in full after Deductible for additional visits	$0 Copayment	
PRESCRIPTION DRUGS *Certain Prescription Drugs are not subject to Cost-Sharing when provided in											**Limits**

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (4/23/2025)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
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											See benefit for description
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	$0 Copayment	
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	$0 Copayment	
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	$0 Copayment	
Preauthorization is not required for Covered Prescription Drugs for the treatment or prevention of HIV or AIDS and Prescription Drugs used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose	Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Calendar Year.	Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Calendar Year.	Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Calendar Year.	Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Calendar Year.	Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Calendar Year.	Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Calendar Year.	Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Calendar Year.	Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Calendar Year after Deductible.			

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (4/23/2025)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
reversal.											
[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	$0 Copayment	[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	$0 Copayment	
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	$0 Copayment	
	Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Calendar Year.	Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Calendar Year.	Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Calendar Year.	Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Calendar Year.	Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Calendar Year.	Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Calendar Year.	Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Calendar Year.	Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Calendar Year 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	$0 Copayment	The mail order pharmacy Cost-Sharing will apply to
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	$0 Copayment	Prescription Drugs obtained at a retail
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	$0 Copayment	Participating Pharmacy that agrees to the same reimburse
	Cost-Sharing for epinephrine auto-	Cost-Sharing for epinephrine auto-	Cost-Sharing for epinephrine auto-	Cost-Sharing for epinephrine auto-	Cost-Sharing for epinephrine auto-	Cost-Sharing for epinephrine auto-	Cost-Sharing for epinephrine auto-	Cost-Sharing for epinephrine auto-			

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (4/23/2025)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
	injector devices shall not exceed $100 per Calendar Year.	injector devices shall not exceed $100 per Calendar Year.	injector devices shall not exceed $100 per Calendar Year.	injector devices shall not exceed $100 per Calendar Year.	injector devices shall not exceed $100 per Calendar Year.	injector devices shall not exceed $100 per Calendar Year.	injector devices shall not exceed $100 per Calendar Year.	injector devices shall not exceed $100 per Calendar Year after Deductible.			ment amount as the mail order Pharmacy.
[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	$0 Copayment	[See benefit for description] The mail order pharmacy Cost-Sharing will apply to
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	$0 Copayment	
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	$0 Copayment	Prescription Drugs obtained at a retail Participating Pharmacy that agrees to the same reimbursement amount as the mail order Pharmacy.
	Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Calendar Year.	Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Calendar Year.	Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Calendar Year.	Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Calendar.	Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Calendar Year.	Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Calendar Year.	Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Calendar Year.	Cost-Sharing for epinephrine auto-injector devices shall not exceed $100 per Calendar Year 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	$0 Copayment	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	$0 Copayment	
Tier 3	$60 Copayment	$70 Copayment not subject to	$75 Copayment not subject to	$75 Copayment not subject to	$40 Copayment not subject to	$30 Copayment	$70 Copayment after Deductible	$70 Copayment after Deductible	0% Coinsurance after Deductible	$0 Copayment	

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (4/23/2025)

	Platinum	**Gold**	**Silver**	**Silver 73**	**Silver 87**	**Silver 94**	**Bronze**	**Bronze HSA**	**Catastrophic**	**AI/AN CSR 100-300% FPL**	**Limits**
		Deductible	Deductible	Deductible	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	$0 Copayment	[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	$0 Copayment	
• [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	$0 Copayment	[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	$0 Copayment	
[Orthodontics and											

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (4/23/2025)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
major dental require [Preauthorization; Referral]]											
Pediatric Vision Care • Exams	$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	$0 Copayment	One (1) 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	$0 Copayment	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	$0 Copayment	

{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 (4/23/2025)

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 an 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).