Attachment C STANDARD BENEFIT WITH 3 PCP VISITS DESIGN COST SHARING DESCRIPTION CHART (04-07-2016)

NOTE: The standard with 3 pcp visits plan design descriptions are based on current understanding of HHS Regulations and the Actuarial Value Calculator (Final version for 2017) and NYS Laws/Regulations. Each of these plans allow 3 visits to a primary care provider that are not subject to the deductible.

e 11			Silver CSR			
Gold	Silver	200 - 250 % FPL	150 - 200 % FPL	100 - 150 % FPL		
(AV = 0.78 to 0.82)	(AV = 0.68 to 0.72)	(AV = 0.72 to 0.74)	(AV = 0.86 to 0.88)	(AV = 0.93 to 0.95		
\$650	\$2,350	\$2,000	\$400	\$0		
\$5,000	\$7,150	\$5,700	\$2,000	\$1,000		
\$1,000	\$1,500	\$1,500	\$250	\$100		
per admission	per admission	per admission	per admission	per admission		
\$100	\$100	\$100	\$75	\$25		
\$100	\$100	\$100	\$75	\$25		
One such copay per surgery and applies only to surgery performed in a hospital inpatient or						
See also "Maternity delivery and post natal care-physician/midwife" under "physician services".						
\$25	\$35	\$35	\$15	\$10		
\$40	\$55	\$55	\$35	\$20		
\$30	\$35	\$35	\$25	\$15		
\$150	\$250	\$250	\$75	\$50		
\$150	\$150	\$150	\$75	\$50		
\$60	\$70	\$70	\$50	\$30		
20% cost sharing	30% cost sharing	25% cost sharing	10% cost sharing	5% cost sharing		
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well newborn combined)	
Mental health/Behavorial health care	Inpatient Facility copay per admission #
Detoxification	Inpatient Facility copay per admission #
Substance abuse disorder services	Inpatient Facility copay per admission #
Skilled nursing facility	Inpatient Facility copay per admission #
	Indicated copay per admission is waived if direct transfer from hospital inpatient setting to skilled nursing facility
Hospice (inpatient)	Inpatient Facility copay per admission #
	Indicated copay per admission is waived if direct transfer from hospital inpatient setting
	or skilled nursing facility to hospice facility

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

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Hemodialysis/Renal dialysis PCP copay per visit	Radiation therapy			PCP copay per visit		
				PCP copay per visit		
	Chiropractic care			Specialist copay per visit		

Attachment C STANDARD BENEFIT WITH 3 PCP VISITS DESIGN COST SHARING DESCRIPTION CHART (04-07-2016)

				Silver CSR	
	Gold	Silver	200 - 250 % FPL	150 - 200 % FPL	100 - 150 % FPL
YPE OF SERVICE	(AV = 0.78 to 0.82)	(AV = 0.68 to 0.72)	(AV = 0.72 to 0.74)	(AV = 0.86 to 0.88)	(AV = 0.93 to 0.95)
DDITIONAL BENEFITS/SERVICES					
ABA treatment for Autism Spectrum Disorder			PCP copay per visit		
Assistive Communiciation Devices for Autism Spectrum Disorder			PCP copay per device		
Durable medical equipment and medical supplies		DME/M	edical supplies coinsurance cost sharing	g applies	
Hearing evaluations/testing			Specialist copay per visit		
Hearing aids		He	aring aid coinsurance cost sharing appl	ies	
Diabetic drugs and supplies			PCP copay per 30 days supply		
Diabetic education and self-management			PCP copay per visit		
Home care			PCP copay per visit		
Exercise facility reimbursements	Deductible does not apply. \$200/\$100 reimbursement every six months for member/spouse.				
Exercise facility reimbursements		Deductible does not apply.			
Exercise facility reindursements		,	facility fees every six months if member		
Exercise facility reimbursements		,			
		,			
		,			
EDIATRIC DENTAL SERVICES Dental office visit		,	facility fees every six months if member		
DIATRIC DENTAL SERVICES Dental office visit		,	facility fees every six months if member PCP copay per visit		
EDIATRIC DENTAL SERVICES Dental office visit EDIATRIC VISION SERVICES		Partial reimbursement for	facility fees every six months if membe PCP copay per visit PCP copay per visit	er attains at least 50 visits.	
EDIATRIC DENTAL SERVICES Dental office visit EDIATRIC VISION SERVICES Eye exam visit		Partial reimbursement for Eyewear coinsurance	facility fees every six months if member PCP copay per visit	er attains at least 50 visits.	
EDIATRIC DENTAL SERVICES Dental office visit EDIATRIC VISION SERVICES Eye exam visit Prescribed lenses and frames		Partial reimbursement for Eyewear coinsurance	facility fees every six months if membe PCP copay per visit PCP copay per visit cost sharing applies to combined cost	er attains at least 50 visits.	
EDIATRIC DENTAL SERVICES Dental office visit EDIATRIC VISION SERVICES Eye exam visit Prescribed lenses and frames Contact lenses	\$10	Partial reimbursement for Eyewear coinsurance	facility fees every six months if membe PCP copay per visit PCP copay per visit cost sharing applies to combined cost	er attains at least 50 visits.	\$6
EDIATRIC DENTAL SERVICES Dental office visit EDIATRIC VISION SERVICES Eye exam visit Prescribed lenses and frames Contact lenses RESCRIPTION DRUGS	\$10 \$40	Partial reimbursement for Eyewear coinsurance E	Acility fees every six months if member PCP copay per visit PCP copay per visit cost sharing applies to combined cost yewear coinsurance cost sharing applie	of lenses and frames	\$6 \$15

Additional Instructions:

There is no Platinum and Al/AN <= 300% FPL versions of this design because these plan designs do not have a deductible. There is no Bronze version of this design because it did not meet the required actuarial value per 2017 CMS actuarial value calculator.

- 1. The following applies to the Gold, Silver and Silver-CSR Plans:
 - For an inpatient admission the only copay that applies during an inpatient stay is the inpatient facility per admission copay, and if surgery is performed a surgeon copay, and if
 - a maternity delivery is performed a maternity delivery copay which is the same as the surgeon copay if this copay has not already been collected as part of another maternity related claim.
 - There are no additional copays for diagnostic tests, medical supplies, in-hospital physician visits, anesthesia, assistant surgeon, other staff doctors, etc.
 - For a maternity stay the inpatient per admission copay covers charges for the mother and a well newborn.
- # The inpatient facility copay per admission is waived for a re-admission within 90 days of a previous discharge for the same or a related condition.
- 2. For all the standard plan designs, the deductible must be met first, and then the cost sharing copay or coinsurance is applied to the remainder of the allowed amount until the maximum out of pocket limit is reached.
- 3. For all standard plans with 3 PCP visits not subject to the deductible, the cost sharing copay is still applicable to the first 3 visits. After the first 3 visits, the applicability of the deductible and the cost sharing copay will adhere to the guideline in Item #2. <u>PCP visits</u> are defined as visits to provider whose primary specialty is in family medicine, internal medicine, pediatric medicine, obstetrics/gynecology or outpatient mental health services.
- 4. 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).
- 5. The maximum out of pocket limit is an aggregate over all covered services (medical, pediatric dental, pediatric vision, and prescription drugs), and includes the deductible.
- 6. The deductible is over a calendar year for individual products and over the calendar year or plan year (option of insurer) for small group products.
- For the 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.
- 7. No deductible or cost sharing applies to the preventive care visits/services defined in section 2713 of ACA.
- 8. 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).
- 9. The <u>pediatric dental cost sharing</u> 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.