Attachment C STANDARD BENEFIT WITH 3 PCP VISITS DESIGN COST SHARING DESCRIPTION CHART (04-06-2017)

NOTE: Standard benefit with 3 PCP visits plan design descriptions are based on current understanding of HHS Regulations and the Actuarial Value Calculator (Final version for 2018) and NYS Laws/Regulations.
Each of these plans allows 3 visits to a primary care provider that are not subject to the deductible/coinsurance.

			Silver CSR			
TYPE OF SERVICE	Gold AV = 0.76 to 0.82	Silver AV = 0.66 to 0.72	200 - 250% FPL AV = 0.72 to 0.74	150 - 200% FPL AV = 0.86 to 0.88	100 - 150% FPL AV = 0.93 to 0.95	Expanded Bronze AV = 0.56 to 0.65
DEDUCTIBLE (single)	$650	$2,350	$2,000	$400	$0	$4,000
MAXIMUM OUT OF POCKET LIMIT (single) Includes the deductible	$5,000	$7,150	$5,700	$2,000	$1,000	$7,150
COST SHARING – MEDICAL SERVICES						
Inpatient facility/SNF/Hospice	$1,000 per admission	$1,500 per admission	$1,500 per admission	$250 per admission	$100 per admission	50% cost sharing
Outpatient facility – surgery, including freestanding surgicenters	$100	$100	$100	$75	$25	50% cost sharing
Surgeon – inpatient facility, outpatient facility, including freestanding surgicenters	$100 One such copay per surgery and applies only to surgery performed in a hospital inpatient or a hospital outpatient facility setting, including freestanding surgicenters, not to office surgery. See also "Maternity delivery and post natal care - physician/midwife" under "physician services".	$100	$100	$75	$25	50% cost sharing
PCP	$25	$35	$35	$15	$10	50% cost sharing
Specialist	$40	$55	$55	$35	$20	50% cost sharing
PT/OT/ST – rehabilitative & habilitative therapies	$30	$35	$35	$25	$15	50% cost sharing
ER	$150	$250	$250	$75	$50	50% cost sharing
Ambulance	$150	$150	$150	$75	$50	50% cost sharing
Urgent care	$60	$70	$70	$50	$30	50% cost sharing
DME/Medical supplies	20% cost sharing	30% cost sharing	25% cost sharing	10% cost sharing	5% cost sharing	50% cost sharing
Hearing aids	20% cost sharing	30% cost sharing	25% cost sharing	10% cost sharing	5% cost sharing	50% cost sharing
Eyewear	20% cost sharing	30% cost sharing	25% cost sharing	10% cost sharing	5% cost sharing	50% cost sharing
COST SHARING – INPATIENT HOSPITAL SERVICES						
Observation stay/care unit	ER copay per case; copay is waived if direct transfer from outpatient surgery setting to an observation care unit.					50% cost sharing
Hospital services – non-maternity	Inpatient facility copay per admission #					50% cost sharing
Maternity care stay (covers mother and well newborn combined)	Inpatient facility copay per admission #					50% cost sharing
Mental/Behavioral health care	Inpatient facility copay per admission #					50% cost sharing
Detoxification	Inpatient facility copay per admission #					50% cost sharing
Substance abuse disorder services	Inpatient facility copay per admission #					50% cost sharing
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.					50% cost sharing
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.					50% cost sharing
COST SHARING – EMERGENCY MEDICAL SERVICES						
Facility charge – emergency room	ER copay per case; copay is waived if patient is admitted as an inpatient (including as an observation stay or to an observation care unit) directly from the emergency room.					50% cost sharing
Physician charge – emergency room visit	$0 copay per visit					50% cost sharing
Facility charge – freestanding urgent care center	Urgent care copay per visit					50% cost sharing
Physician charge – freestanding urgent care visit	$0 copay per visit					50% cost sharing
Pre-hospital emergency services, transportation, includes air ambulance	Ambulance copay per case					50% cost sharing
COST SHARING – OUTPATIENT HOSPITAL/FACILITY SERVICES						
Outpatient facility surgery – hospital facility charge, including freestanding surgicenters	Outpatient facility - surgery copay per case					50% cost sharing
Pre-admission/Pre-operative testing	$0 copay					50% cost sharing
Diagnostic and routine laboratory and pathology	Specialist copay per visit					50% cost sharing
Diagnostic and routine imaging services, including X-ray, excluding CAT/PET scans, MRI	Specialist copay per visit					50% cost sharing
Imaging: CAT/PET scans, MRI	Specialist copay					50% cost sharing
Chemotherapy	PCP copay per visit					50% cost sharing
Radiation therapy	PCP copay per visit					50% cost sharing
Hemodialysis/Renal dialysis	PCP copay per visit					50% cost sharing
Mental/Behavioral health care	PCP copay per visit					50% cost sharing
Substance abuse disorder services	PCP copay per visit					50% cost sharing
Covered therapies (PT, OT, ST) – rehabilitative & habilitative	PT/OT/ST copay per visit					50% cost sharing
Home care	PCP copay per visit					50% cost sharing
Hospice	PCP copay per visit					50% cost sharing

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COST SHARING – PREVENTIVE AND PRIMARY CARE SERVICES						
Bone density testing	NOTE: For preventive care visits/services as defined in section 2713 of ACA, no deductible or cost sharing applies; otherwise, the cost sharing indicated below applies to all services in this benefit service category.					
Cervical cytology						
Colonoscopy screening						
Gynecological exams						
Immunizations	PCP/Specialist copay per visit (based on type of physician performing the service)					50% cost sharing
Mammography						
Prenatal maternity care						
Prostate cancer screening						
Routine exams						
Women's preventive health services						
COST SHARING – PHYSICIAN/PROFESSIONAL SERVICES						
Inpatient hospital surgery - surgeon	Surgeon copay per case					50% cost sharing
Outpatient hospital and freestanding surgicenters – surgeon	Surgeon copay per case					50% cost sharing
Office surgery	PCP/Specialist copay per visit (based on type of physician performing the service)					50% cost sharing
Anesthesia (any setting)	Covered in full, no deductible and no cost sharing applies					50% cost sharing
Covered therapies (PT, OT, ST) – rehabilitative and habilitative	PT/OT/ST copay per visit					50% cost sharing
Additional surgical opinion	Specialist copay per visit					50% cost sharing
Second medical opinion for cancer	Specialist copay per visit					50% cost sharing
Maternity delivery and post natal care – physician or midwife	Surgeon copay per case for delivery and post natal care services combined (only one such copay per pregnancy)					50% cost sharing
In-hospital physician visits	$0 copay per visit					50% cost sharing
Diagnostic office visits	PCP/Specialist copay per visit (based on type of physician performing the service)					50% cost sharing
Diagnostic and routine laboratory and pathology	PCP/Specialist copay per visit					50% cost sharing
Diagnostic and routine imaging services, including X-ray, excluding CAT/PET scans, MRI	PCP/Specialist copay per visit					50% cost sharing
Imaging: CAT/PET scans, MRI	Specialist copay per visit					50% cost sharing
Allergy testing	PCP/Specialist copay per visit					50% cost sharing
Allergy shots	PCP/Specialist copay per visit					50% cost sharing
Office/Outpatient consultations	PCP/Specialist copay per visit (based on type of physician performing the service)					50% cost sharing
Mental/Behavioral health care	PCP copay per visit					50% cost sharing
Substance abuse disorder services	PCP copay per visit					50% cost sharing
Chemotherapy	PCP copay per visit					50% cost sharing
Radiation therapy	PCP copay per visit					50% cost sharing
Hemodialysis/Renal dialysis	PCP copay per visit					50% cost sharing
Chiropractic care	Specialist copay per visit					50% cost sharing
COST SHARING – ADDITIONAL BENEFITS/SERVICES						
ABA treatment for Autism Spectrum Disorder	PCP copay per visit					50% cost sharing
Assistive communication devices for Autism Spectrum Disorder	PCP copay per device					50% cost sharing
Durable medical equipment and medical supplies	DME/Medical supplies coinsurance cost sharing applies					50% cost sharing
Hearing evaluations/testing	Specialist copay per visit					50% cost sharing
Hearing aids	Hearing aid coinsurance cost sharing applies					50% cost sharing
Diabetic drugs and supplies	PCP copay per 30-day supply					50% cost sharing
Diabetic education and self-management	PCP copay per visit					50% cost sharing
Home care	PCP copay per visit					50% cost sharing
Exercise facility reimbursements	Deductible does not apply. $200/$100 reimbursement every six months for member/spouse. Partial reimbursement for facility fees every six months if member attains at least 50 visits.					
COST SHARING – PEDIATRIC DENTAL SERVICES						
Dental office visit	PCP copay per visit					50% cost sharing
COST SHARING – PEDIATRIC VISION SERVICES						
Eye exam visit	PCP copay per visit					50% cost sharing
Prescribed lenses and frames	Eyewear coinsurance cost sharing applies to combined cost of lenses and frames					50% cost sharing
Contact lenses	Eyewear coinsurance cost sharing applies					50% cost sharing

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COST SHARING – PRESCRIPTION DRUGS						
Generic or Tier 1	$10	$10	$10	$9	$6	$10
Formulary brand or Tier 2	$40	$40	$40	$20	$15	$35
Non-formulary brand or Tier 3	$80	$80	$80	$40	$30	$70
Above are retail copay amounts; mail order copays are 2.5 times retail (except for Catastrophic plans) for a 90-day supply.						

ADDITIONAL INSTRUCTIONS:

There are no Platinum and AI/AN CSR (100 – 300% FPL) versions of this design because these plan designs do not have a deductible (that is deductible = $0).

1. The following applies to 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/coinsurance, the cost sharing copay is still applicable to the first 3 visits. After the first 3 visits, the applicability of the deductible/coinsurance and the cost sharing copay will adhere to the guideline in Item #2. PCP visits are defined as visits to a provider whose primary specialty is in family medicine, internal medicine, pediatric medicine, obstetrics/gynecology, outpatient mental health or substance use services.

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

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 (an option of the insurer) for small group products.
   For Gold, Silver and Silver CSR plans, the deductible applies only to medical, pediatric dental, and pediatric vision services (including lenses/frames), and does not apply to prescription drugs.
   For Bronze plan, the deductible applies to all services combined (medical, pediatric dental, pediatric vision (including lenses/frames), and 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; the family out-of-pocket limit is two times the single maximum out-of-pocket limit. The plan designs below are non-HSA plan designs and each family member is subject to a maximum deductible equal to the single deductible and to a maximum out-of-pocket limit equal to the single out-of-pocket limit. Once all members of the family in aggregate meet the family deductible amount (or family out-of-pocket limit amount), then no family member needs to accumulate any more dollars toward the deductible (or out-of-pocket limit).

9. The pediatric dental cost sharing indicated is when pediatric dental is included as part of the standard design medical QHP plan. A stand-alone pediatric dental plan will have its own deductible and cost sharing arrangements and associated premium.