**Attachment C STANDARD BENEFIT WITH 3 PCP VISITS DESIGN COST SHARING DESCRIPTION CHART (04-10-2020)**

**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 2021) 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 | | |
|---|---|---|---|---|---|
| | Gold | Silver | 200 - 250% FPL | 150 - 200% FPL | 100 - 150% FPL |
| TYPE OF SERVICE | AV = 0.76 to 0.82 | AV = 0.70 to 0.72 | AV = 0.72 to 0.74 | AV = 0.86 to 0.88 | AV = 0.93 to 0.95 |
| DEDUCTIBLE (single) | $650 | $1,875 | $1,725 | $400 | $0 |
| MAXIMUM OUT OF POCKET LIMIT (single) Includes the deductible | $5,000 | $8,500 | $6,625 | $2,300 | $1,000 |
| 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 |
| Outpatient facility – surgery, including freestanding surgicenters | $100 | $150 | $150 | $75 | $25 |
| Surgeon – inpatient facility, outpatient facility, including freestanding surgicenters | $100 | $150 | $150 | $75 | $25 |
| | 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". | | | | |
| PCP | $25 | $35 | $35 | $15 | $10 |
| Specialist | $40 | $55 | $55 | $35 | $20 |
| PT/OT/ST – rehabilitative & habilitative therapies | $30 | $35 | $35 | $25 | $15 |
| ER | $150 | $300 | $250 | $75 | $50 |
| Ambulance | $150 | $150 | $150 | $75 | $50 |
| Urgent care | $60 | $70 | $70 | $50 | $30 |
| DME/Medical supplies | 20% cost sharing | 30% cost sharing | 25% cost sharing | 10% cost sharing | 5% cost sharing |
| Hearing aids | 20% cost sharing | 30% cost sharing | 25% cost sharing | 10% cost sharing | 5% cost sharing |
| Eyewear | 20% cost sharing | 30% cost sharing | 25% cost sharing | 10% cost sharing | 5% 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. | | | | |
| Hospital services – non-maternity | Inpatient facility copay per admission # | | | | |
| Maternity care stay (covers mother and well newborn combined) | Inpatient facility copay per admission # | | | | |
| Mental/Behavioral 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. | | | | |
| 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. | | | | |
| Physician charge – emergency room visit | $0 copay per visit | | | | |
| Facility charge – freestanding urgent care center | Urgent care copay per visit | | | | |
| Physician charge – freestanding urgent care visit | $0 copay per visit | | | | |
| Pre-hospital emergency services, transportation, includes air ambulance | Ambulance copay per case | | | | |
| COST SHARING – OUTPATIENT HOSPITAL/FACILITY SERVICES | | | | | |
| Outpatient facility surgery – hospital facility charge, including freestanding surgicenters | Outpatient facility - surgery copay per case | | | | |
| Pre-admission/Pre-operative testing | $0 copay | | | | |
| Diagnostic and routine laboratory and pathology | Specialist copay per visit | | | | |
| Diagnostic and routine imaging services, including X-ray, excluding CAT/PET scans, MRI | Specialist copay per visit | $75 | Specialist copay per visit | | |
| Imaging: CAT/PET scans, MRI | Specialist copay per visit | $75 | Specialist copay per visit | | |
| Chemotherapy | PCP copay per visit | | | | |
| Radiation therapy | PCP copay per visit | | | | |
| Hemodialysis/Renal dialysis | PCP copay per visit | | | | |
| Mental/Behavioral health care | PCP copay per visit | | | | |
| Substance abuse disorder services | PCP copay per visit | | | | |
| Covered therapies (PT, OT, ST) – rehabilitative & habilitative | PT/OT/ST copay per visit | | | | |
| Home care | PCP copay per visit | | | | |
| Hospice | PCP copay per visit | | | | |

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**Each of these plans allows 3 visits to a primary care provider that are not subject to the deductible/coinsurance.**

| TYPE OF SERVICE | Gold AV = 0.76 to 0.82 | Silver AV = 0.70 to 0.72 | Silver CSR 200 - 250% FPL AV = 0.72 to 0.74 | Silver CSR 150 - 200% FPL AV = 0.86 to 0.88 | Silver CSR 100 - 150% FPL AV = 0.93 to 0.95 |
|---|---|---|---|---|---|
| **COST SHARING – PREVENTIVE AND PRIMARY CARE SERVICES** | | | | | |
| Bone density Testing<br>Cervical cytology<br>Colonoscopy screening<br>Gynecological exams<br>Immunizations<br>Mammography<br>Prenatal maternity care<br>Prostate cancer screening<br>Routine exams<br>Women's preventive health services | NOTE: For preventive care visits/services as defined in section 2713 of ACA, no deductible or cost sharing applies; otherwise, the cost sharing indicated below applies to all services in this benefit service category. | | | | |
| | PCP/Specialist copay per visit (based on type of physician performing the service) | | | | |
| **COST SHARING – PHYSICIAN/PROFESSIONAL SERVICES** | | | | | |
| Inpatient hospital surgery - surgeon | Surgeon copay per case | | | | |
| Outpatient hospital and freestanding surgicenters – surgeon | Surgeon copay per case | | | | |
| Office surgery | PCP/Specialist copay per visit (based on type of physician performing the service) | | | | |
| Anesthesia (any setting) | Covered in full, no deductible and no cost sharing applies | | | | |
| Covered therapies (PT, OT, ST) – rehabilitative and habilitative | PT/OT/ST copay per visit | | | | |
| Additional surgical opinion | Specialist copay per visit | | | | |
| Second medical opinion for cancer | Specialist copay per visit | | | | |
| 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) | | | | |
| In-hospital physician visits | $0 copay per visit | | | | |
| Diagnostic office visits | PCP/Specialist copay per visit (based on type of physician performing the service) | | | | |
| Diagnostic and routine laboratory and pathology | PCP/Specialist copay per visit | | | | |
| Diagnostic and routine imaging services, including X-ray, excluding CAT/PET scans, MRI | PCP/Specialist copay per visit | $75 | PCP/Specialist copay per visit | | |
| Imaging: CAT/PET scans, MRI | Specialist copay per visit | $75 | Specialist copay per visit | | |
| Allergy testing | PCP/Specialist copay per visit | | | | |
| Allergy shots | PCP/Specialist copay per visit | | | | |
| Office/Outpatient consultations | PCP/Specialist copay per visit (based on type of physician performing the service) | | | | |
| Mental/Behavioral health care | PCP copay per visit | | | | |
| Substance abuse disorder services | PCP copay per visit | | | | |
| Chemotherapy | PCP copay per visit | | | | |
| Radiation therapy | PCP copay per visit | | | | |
| Hemodialysis/Renal dialysis | PCP copay per visit | | | | |
| Chiropractic care | Specialist copay per visit | | | | |
| **COST SHARING – ADDITIONAL BENEFITS/SERVICES** | | | | | |
| ABA treatment for Autism Spectrum Disorder | PCP copay per visit | | | | |
| Assistive communication devices for Autism Spectrum Disorder | PCP copay per device | | | | |
| Durable medical equipment and medical supplies | DME/Medical supplies coinsurance cost sharing applies | | | | |
| Hearing evaluations/testing | Specialist copay per visit | | | | |
| Hearing aids | Hearing aid coinsurance cost sharing applies | | | | |
| Diabetic drugs and supplies | PCP copay per 30-day supply | | | | |
| Diabetic education and self-management | PCP copay per visit | | | | |
| Home care | PCP copay per visit | | | | |
| Exercise facility reimbursements | | | | | |
| **COST SHARING – PEDIATRIC DENTAL SERVICES** | | | | | |
| Dental office visit | PCP copay per visit | | | | |
| **COST SHARING – PEDIATRIC VISION SERVICES** | | | | | |
| Eye exam visit | PCP copay per visit | | | | |
| Prescribed lenses and frames | Eyewear coinsurance cost sharing applies to combined cost of lenses and frames | | | | |
| Contact lenses | Eyewear coinsurance cost sharing applies | | | | |

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|---|---|---|---|---|---|
| | Gold | Silver | 200 - 250% FPL | 150 - 200% FPL | 100 - 150% FPL |
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| COST SHARING – PRESCRIPTION DRUGS | | | | | |
| Generic or Tier 1 | $10 | $10 | $10 | $9 | $6 |
| Formulary brand or Tier 2 | $40 | $40 | $40 | $20 | $15 |
| Non-formulary brand or Tier 3 | $80 | $80 | $80 | $40 | $30 |
| 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. For purposes of using these 3 PCP visits not subject to the deductible/coinsurance, a PCP 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. Additional services, like laboratory tests, which are delivered during these 3 PCP visits may be subject to deductible or cost sharing. After the first 3 visits, the applicability of the deductible/coinsurance and the cost sharing copay will adhere to the guideline in Item #2.

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.

7. No deductible or cost sharing applies to the preventive care visits/services defined in section 2713 of ACA but additional services, like laboratory tests, which are delivered at the preventive care visit may be subject to the deductible or cost sharing.

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.