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

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

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

For all the standard plan designs, the deductible must be met first, and then the cost sharing copay or coinsurance is applied to the remainder of the allowed amount until the maximum out of pocket limit is reached.

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

The maximum out of pocket limit is an aggregate over all covered services (medical, pediatric dental, pediatric vision, and prescription drugs), and includes the deductible.

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

For the Platinum, Gold, Silver and Silver-CSR Plans the deductible applies only to medical, pediatric dental, and pediatric vision services (including lenses/frames), and does not apply to prescription drugs.

For the Bronze and Catastrophic Plans the deductible applies to all services combined (medical, pediatric dental, pediatric vision (including lenses/frames), and prescription drugs).

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

Per ACA the Catastrophic Plan must include 3 primary care visits per calendar year to which the deductible does not apply.

These 3 primary care visits are in addition to the ACA mandated preventive services for which no cost sharing can apply.

These 3 primary care visits are covered in full by the insurance plan (i.e., no deductible and no cost sharing).

The family deductible is two times the single deductible and the family out-of-pocket limit is two times the single maximum out-of-pocket limit. The plan designs below are non-HSA plan designs and

each family member is subject to a maximum deductible equal to the single deductible and to a maximum out-of-pocket limit equal to the single out-of-pocket limit. Once all members of the

family in aggregate meet the family deductible amount (or family out-of-pocket limit amount) then no family member needs to accumulate any more dollars towards the deductible (or out-of-pocket limit).

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

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

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

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

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

TYPE OF SERVICE	Platinum (AV = 0.88 to 0.92)	Gold (AV = 0.78 to 0.82)	Silver (AV = 0.68 to 0.72)	200 - 250 % FPL (AV = 0.72 to 0.74)	Silver - CSR Versions 150 - 200% FPL (AV = 0.86 to 0.88)	100 - 150% FPL (AV = 0.93 to 0.95)	Bronze (AV = 0.58 to 0.62)	Revised** Catastrophic	Zero cost sharing variation Less than or equal to 300% FPL
THE OF SERVICE	(AV = 0.00 to 0.52)	(AV = 0.70 to 0.02)	(AV = 0.00 to 0.72)	(AV = 0.72 to 0.74)	(AV = 0.00 to 0.00)	(AV = 0.55 to 0.55)	(AV = 0.30 to 0.02)		10 30070111
DEDUCTIBLE (single)	\$0	\$600	\$2,000	\$1,750	\$250	\$0	\$3,000	\$6,350	\$0
MAXIMUM OUT OF POCKET LIMIT (single) Includes the deductible	\$2,000	\$4,000	\$5,500	\$4,000	\$2,000	\$1,000	\$6,350	\$6,350	\$0
COST SHARING - MEDICAL SERVICES									
Inpatient Facility/SNF/Hospice	\$500 per admission	\$1,000 per admission	\$1,500 per admission	\$1,500 per admission	\$250 per admission	\$100 per admission	50% cost sharing	0% cost sharing	0% cost sharing

The following applies to the Platinum, Gold, Silver and Silver-CSR Plans:

For an inpatient admission the only copay that applies during an inpatient stay is the inpatient facility per admission

copay, and if surgery is performed a surgeon copay, and if a maternity delivery is performed a maternity delivery copay

which is the same as the surgeon copay if this copay has not already been collected as part of another maternity related claim.

There are no additional copays for diagnostic tests, medical supplies, in-hospital physician visits, anesthesia, assistant surgeon, other staff doctors, etc.

For a maternity stay the inpatient per admission copay covers charges for the mother and a well newborn.

The inpatient facility copay per admission is waived for a re-admission within 90 days of a previous discharge for the same or a related condition.

Outpatient Facility-Surgery, including	\$100	\$100	\$100	\$100	\$75	\$25	50% cost sharing	0% cost sharing	0% cost sharing
freestanding surgicenters									
Surgeon - Inpatient facility,	\$100	\$100	\$100	\$100	\$75	\$25	50% cost sharing	0% cost sharing	0% cost sharing
outpatient facility, including freestanding	One such	copay per surgery and	applies only to surgery	performed in a hospit	al inpatient or hospital	outpatient			
surgicenters		facility settin	g, including freestandi	ng surgicenters, not to	office surgery.				
	Se	ee also "Maternity deliv	ery and post natal car	e-physician/midwife" u	nder "physician service	s".			
PCP	\$15	\$25	\$30	\$30	\$15	\$10	50% cost sharing	0% cost sharing	0% cost sharing
Specialist	\$35	\$40	\$50	\$50	\$35	\$20	50% cost sharing	0% cost sharing	0% cost sharing

Indian CSR

## Fig. \$100 \$150 \$150 \$150 \$150 \$775 \$50 \$50 \$500 \$500 \$501 \$150 \$150 \$150 \$775 \$50 \$500 \$5	Indian CSR									
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PT/CVFT - rehabilitative & habilitative & \$25	Less than or equal	Catastrophic	Bronze	100 - 150% FPL	150 - 200% FPL	200 - 250 % FPL	Silver	Gold	Platinum	
therapies ER 5100 \$150 \$150 \$150 \$5150 \$550 \$50 \$500 \$50	to 300% FPL		(AV = 0.58 to 0.62)	(AV = 0.93 to 0.95)	(AV = 0.86 to 0.88)	(AV = 0.72 to 0.74)	(AV = 0.68 to 0.72)	(AV = 0.78 to 0.82)	(AV = 0.88 to 0.92)	YPE OF SERVICE
Ambulance \$1,00 \$15.0 \$15.0 \$15.0 \$5.0 \$5.0 \$5.0 \$5.0 \$5.0 \$5.0 \$5.0 \$	0% cost sharing	0% cost sharing	50% cost sharing	\$15	\$25	\$30	\$30	\$30	\$25	
Urgent Care	0% cost sharing	0% cost sharing	50% cost sharing	\$50	\$75	\$150	\$150	\$150	\$100	ER
DMM_Medical supplies 10% cost sharing 20% cost sharing 20	0% cost sharing	0% cost sharing	50% cost sharing	\$50	\$75	\$150	\$150	\$150	\$100	Ambulance
Hearing aids	0% cost sharing	0% cost sharing	50% cost sharing	\$30	\$50	\$70	\$70	\$60	\$55	Urgent Care
Eyewear 10% cost sharing 20% cost sharing 50% cost sharing 5	0% cost sharing	0% cost sharing	50% cost sharing	5% cost sharing	10% cost sharing	25% cost sharing	30% cost sharing	20% cost sharing	10% cost sharing	DME/Medical supplies
PATIENT HOSPITAL SERVICES Observation care unit ER copay per case, copay is waived if direct transfer from outpatient surgery setting to an observation care unit 50% cost sharing 0% cost s	0% cost sharing	0% cost sharing	50% cost sharing	5% cost sharing	10% cost sharing	25% cost sharing	30% cost sharing	20% cost sharing	10% cost sharing	Hearing aids
Disservation stay/observation care unit ER copay per case, copay is waived if direct transfer from outpatient surgery setting to an observation care unit 50% cost sharing 0% cost shari	0% cost sharing	0% cost sharing	50% cost sharing	5% cost sharing	10% cost sharing	25% cost sharing	30% cost sharing	20% cost sharing	10% cost sharing	Eyewear
Maternity care stay (covers mother and well newborn combined) Mental health/Jehavorial health care Inpatient Facility copay per admission # Substance abuse disorder services Inpatient Facility (copay per admission # Substance abuse disorder services Inpatient Facility (copay per admission # Substance abuse disorder services Substance abuse disorder services Inpatient Facility (copay per admission # Solv cost sharing Solv cost sharing Officest sha	0% cost sharing	0% cost sharing	50% cost sharing	ı care unit	tting to an observation	n outpatient surgery se	ed if direct transfer fror	per case, copay is waiv	ER copay	
Maternity care stay (covers mother and well newborn combined) Mental health/Behavorial health care Inpatient Facility copay per admission # Sol% cost sharing Detoxification Inpatient Facility copay per admission # Sol% cost sharing Ox co	0% cost sharing	0% cost sharing	50% cost sharing			nay per admission #	Innationt Facility co.			Hospital services - non-maternity
well newborn combined) Mental health/Behavorial health care inpatient Facility copay per admission # 50% cost sharing O% cost sharing Detoxification inpatient Facility copay per admission # 50% cost sharing O% cost sharing						, ,				
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care center visit Prehospital emergency services/ transportation, includes air ambulance DITPATIENT HOSPITAL/FACILITY SERVICES Outpatient facility surgery - hospital facility charge, including freestanding surgicenters Outpatient Facility-Surgery copay per case Pre-admission/pre-operative testing Diagnostic and routine laboratory and pathology Ambulance copay per case 50% cost sharing 0% cost sharing	0% cost sharing	0% cost sharing	50% cost sharing			per visit	\$0 copay			
Prehospital emergency services/ transportation, includes air ambulance DTPATIENT HOSPITAL/FACILITY SERVICES Outpatient facility surgery - hospital facility charge, including freestanding surgicenters Pre-admission/pre-operative testing Diagnostic and routine laboratory and pathology Ambulance copay per case Outpatient Facility-Surgery copay per case 50% cost sharing 0% cost sharing			9				, ,			
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Diagnostic and routine laboratory and Specialist copay per visit 50% cost sharing o% cost sharing pathology										charge, including freestanding surgicenters
pathology		0% cost sharing								
Diameter and another transfer and in the contract of the contr	0% cost sharing	0% cost sharing	50% cost sharing			pay per visit	Specialist co			
Diagnostic and routine imaging services Specialist copay per visit 50% cost sharing 0% cost sharing 0% cost sharing	0% cost sharing	0% cost sharing	50% cost sharing			pay per visit	Specialist co			Diagnostic and routine imaging services
including Xray; excluding CAT/PET scans, MRI										
	0% cost sharing	0% cost sharing	50% cost sharing			et conav	Specialie			
		0% cost sharing								
		0% cost sharing								

Indian CSR

	Platinum	Gold	Silver	200 - 250 % FPL	Silver - CSR Versions 150 - 200% FPL	100 - 150% FPL	Bronze	Revised** Catastrophic	Indian CSR Zero cost sharing variation Less than or equal
TYPE OF SERVICE	(AV = 0.88 to 0.92)	(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)	(AV = 0.58 to 0.62)		to 300% FPL
Hemodialysis/Renal dialysis				ıy per visit			50% cost sharing	0% cost sharing	0% cost sharing
Mental health/Behavorial health care				y per visit			50% cost sharing	0% cost sharing	0% cost sharing
Substance abuse disorder services				y per visit			50% cost sharing	0% cost sharing	0% cost sharing
Covered therapies (PT, OT, ST) -			PT/OT/ST co	opay per visit			50% cost sharing	0% cost sharing	0% cost sharing
rehabilitative & habilitative Home care			PCP cona	ny per visit			50% cost sharing	0% cost sharing	0% cost sharing
Hospice				y per visit			50% cost sharing	0% cost sharing	0% cost sharing
riospice			тег сори	ly per visit			30% cost sharing	070 COSC 31101111g	ove cost sharing
PREVENTIVE & PRIMARY CARE SERVICES		_							
Bone density testing		Ŋ	·	re visits/services as def			•		
Cervical cytology			Otherwise the o	ost sharing indicated be	elow applies to all service	es in this benefit servi	ce category.		
Colonoscopy screening									
Gynecological exams		_					1		
Immunizations		PCP/Specialist co	pay per visit (based on	type of physician perfo	rming the service)		50% cost sharing	0% cost sharing	0% cost sharing
Mammography									
Prenatal maternity care									
Prostate cancer screening									
Routine exams									
Women's preventive health services									
PHYSICIAN/PROFESSIONAL SERVICES Inpatient hospital surgery - surgeon Outpatient hospital and freestanding surgicenter - surgeon			Surgeon co	pay per case pay per case			50% cost sharing 50% cost sharing	0% cost sharing 0% cost sharing	0% cost sharing 0% cost sharing
Office surgery				type of physician perfo			50% cost sharing	0% cost sharing	0% cost sharing
Anesthesia (any setting)		Cove	red in full, no deductibl	le and no cost sharing a	pplies		50% cost sharing	0% cost sharing	0% cost sharing
Covered therapies (PT, OT, ST) - rehabilitative & habilitative			PT/OT/ST co	opay per visit			50% cost sharing	0% cost sharing	0% cost sharing
Additional surgical opinion			Specialist co	pay per visit			50% cost sharing	0% cost sharing	0% cost sharing
Second medical opinion for cancer				ppay per visit			50% cost sharing	0% cost sharing	0% cost sharing
Maternity delivery and post natal care -	Surgeon c	opay per case for deliv		services combined (on	ly one such copay per p	regnancy)	50% cost sharing	0% cost sharing	0% cost sharing
physician or midwife		.,,,,,	.,,		,	-07,	,	3	
In-hospital physician visits			\$0 copay	y per visit			50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic office visits		PCP/Specialist co	pay per visit (based on	type of physician perfo	rming the service)		50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine laboratory and pathology			PCP/Specialist	copay per visit			50% cost sharing	0% cost sharing	0% cost sharing
Diagnostic and routine imaging services			DCD/Specialist	copay per visit			50% cost sharing	0% cost sharing	0% cost sharing
including Xray; excluding CAT/PET scans,			r Cr/Specialist	copay per visit			30% COSt Sharing	070 COSt Sharing	070 COSt Straining
MRI									
Imaging: CAT/PET scans, MRI			Specialist co	ppay per visit			50% cost sharing	0% cost sharing	0% cost sharing
Allergy testing				copay per visit			50% cost sharing	0% cost sharing	0% cost sharing
			, i	copay per visit			50% cost sharing		
Allergy shots Office/outpatient consultations		PCP/Specialist co		type of physician perfo	rming the service)		50% cost sharing	0% cost sharing 0% cost sharing	0% cost sharing 0% cost sharing
Mental health/Behavorial health care		r Cr/ Specialist CO		rype of physician perior	ining the service)		50% cost sharing	0% cost sharing	0% cost sharing
Substance abuse disorder services				ay per visit			50% cost sharing	0% cost sharing	0% cost sharing
Chemotherapy				ay per visit			50% cost sharing	0% cost sharing	0% cost sharing
Radiation therapy				ny per visit			50% cost sharing	0% cost sharing	0% cost sharing
Hemodialysis/Renal dialysis				ay per visit			50% cost sharing	0% cost sharing	0% cost sharing
Chiropractic care				opay per visit			50% cost sharing	0% cost sharing	0% cost sharing
Ciliopractic care			Specialist CC	phay her visit			JU/0 COSE SHALLING	U/U CUSE SHAITING	U/U CUST SHALING

					Silver - CSR Versions		1	Revised**	Indian CSR Zero cost sharing variation		
	Platinum	Gold	Silver	200 - 250 % FPL	150 - 200% FPL	100 - 150% FPL	Bronze	Catastrophic	Less than or equal		
TYPE OF SERVICE	(AV = 0.88 to 0.92)	(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)	(AV = 0.58 to 0.62)		to 300% FPL		
ADDITIONAL BENEFITS/SERVICES				ay per visit			1				
ABA treatment for Autism Specturm Disorder			50% cost sharing	0% cost sharing	0% cost sharing						
Assistive Communiciation Devices for			PCP copay	y per device			50% cost sharing	0% cost sharing	0% cost sharing		
Autism Spectrum Disorder											
Durable medical equipment and medical		DME	Medical supplies coin	nsurance cost sharing ap	pplies		50% cost sharing	0% cost sharing	0% cost sharing		
supplies											
Hearing evaluations/testing			Specialist co	opay per visit			50% cost sharing	0% cost sharing	0% cost sharing		
Hearing aids			Hearing aid coinsuran	nce cost sharing applies			50% cost sharing	0% cost sharing	0% cost sharing		
Diabetic drugs and supplies		50% cost sharing	0% cost sharing	0% cost sharing							
Diabetic education and self-management		PCP copay per visit							0% cost sharing		
Home care			•	ay per visit			50% cost sharing	0% cost sharing	0% cost sharing		
Exercise facility reimbursements		Deductible does not apply. \$200/\$100 reimbursement every six months for member/spouse. * Partial reimbursement for facility fees every six months if member attains at least 50 visits.									
PEDIATRIC DENTAL SERVICES											
Dental office visit			PCP copa	ay per visit			50% cost sharing	0% cost sharing	0% cost sharing		
PEDIATRIC VISION SERVICES											
Eye exam visit			PCP copa	ay per visit			50% cost sharing	0% cost sharing	0% cost sharing		
Prescribed lenses and frames		Eyewear coinsura	ance cost sharing applic	es to combined cost of	lenses and frames		50% cost sharing	0% cost sharing	0% cost sharing		
Contact lenses		Eyewear coinsurance cost sharing applies							0% cost sharing		
PRESCRIPTION DRUGS											
Generic or Tier 1	\$10	\$10	\$10	\$10	\$9	\$6	\$10	0% cost sharing	0% cost sharing		
Formulary Brand or Tier 2	\$30	\$35	\$35	\$35	\$20	\$15	\$35	0% cost sharing	0% cost sharing		
Non-Formulary Brand or Tier 3	\$60	\$70	\$70	\$70	\$40	\$30	\$70	0% cost sharing	0% cost sharing		
Above are retail copay amounts; mail order	r copays are 2.5 times r	etail (except for Catastr	ophic Plans) for a 90 da	ay supply		<u> </u>	<u> </u>	·			