

**NY State of Health - Standard SILVER Plan
Cost-Sharing Reduction Variation (100-150% FPL)
Schedule of Benefits**

COST-SHARING	Member Cost-Sharing Responsibility for Services from Participating Providers*
Deductible • Individual • Family	NONE NONE
Out-of-Pocket Limit • Individual • Family	\$1,000 \$2,000

OFFICE VISITS	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits**
Primary Care Office Visits (or Home Visits)	\$10 Copayment	
Specialist Office Visits (or Home Visits)	\$20 Copayment	

PREVENTIVE CARE	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
• Well Child Visits and Immunizations*	Covered in full	
• Adult Annual Physical Examinations*	Covered in full	
• Adult Immunizations*	Covered in full	
Routine Gynecological Services/Well Woman Exams*	Covered in full	
• Mammography Screenings*	Covered in full	
• Sterilization Procedures for Women*	Covered in full	
• Vasectomy	\$10 Copayment (PCP) \$20 Copayment (Specialist)	
• Bone Density Testing*	Covered in full	
• Screening for Prostate Cancer	Covered in full	
• All other preventive services required by USPSTF and HRSA.	Covered in full	
• *Preventive services that are provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA are covered in full. Preventive services that are provided outside of these guidelines may be subject to cost-sharing.	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	

EMERGENCY CARE	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	\$50 Copayment (for services provided from both participating and non-participating providers)	
Non-Emergency Ambulance Services	\$50 Copayment Preauthorization Required	
Emergency Department Coinsurance waived if Hospital admission	\$50 Copayment (for services provided from both participating and non-participating providers)	
Urgent Care Center	\$30 Copayment	

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PROFESSIONAL SERVICES AND OUTPATIENT CARE	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting	\$20 Copayment	
Advanced Imaging Services • Performed as Outpatient Hospital Services	\$20 Copayment Preauthorization Required	
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures) Preauthorization Required	
Ambulatory Surgical Center Facility Fee	\$25 Copayment Preauthorization Required	
Anesthesia Services (all settings)	Covered in Full Preauthorization Required	
Autologous Blood Banking	5% Coinsurance Preauthorization Required	
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office	\$10 Copayment	
Cardiac & Pulmonary Rehabilitation • Performed as Outpatient Hospital Services	\$10 Copayment	
Cardiac & Pulmonary Rehabilitation • Performed as Inpatient Hospital Services	Included as part of Inpatient Hospital Service Cost Sharing Preauthorization Required	
Chemotherapy • Performed in a PCP Office	\$10 Copayment	
Chemotherapy • Performed in a Specialist Office	\$10 Copayment	
Chemotherapy • Performed as Outpatient Hospital Services	\$10 Copayment Preauthorization Required	
Chiropractic Services	\$20 Copayment Preauthorization Required	
Diagnostic Testing • Performed in a PCP Office	\$10 Copayment	
Diagnostic Testing • Performed in a Specialist office	\$20 Copayment	
Diagnostic Testing • Performed as Outpatient Hospital Services	\$20 Copayment Preauthorization Required	
Dialysis • Performed in a PCP Office	\$10 Copayment (for services provided from both participating and non-participating providers)	Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Dialysis • Performed in a Freestanding Center or Specialist Office Setting	\$10 Copayment (for services provided from both participating and non-participating providers)	
Dialysis • Performed as Outpatient Hospital Services	\$10 Copayment Preauthorization Required (for services provided from both participating and non-participating providers)	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	\$15 Copayment Preauthorization Required	60 visits per condition, per lifetime combined therapies
Home Health Care	\$10 Copayment Preauthorization Required	40 Visits per Plan Year
Infertility Services	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) Preauthorization Required	
Infusion Therapy • Performed in a PCP Office	\$10 Copayment	Home Infusion counts towards Home Health Care Visit Limits
Infusion Therapy • Performed in Specialist Office	\$10 Copayment	
Infusion Therapy • Performed as Outpatient Hospital Services	\$10 Copayment	
Infusion Therapy • Home Infusion Therapy	\$10 Copayment Preauthorization Required	
Inpatient Medical Visits	\$0 Copayment after Deductible not covered in full	

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PROFESSIONAL SERVICES AND OUTPATIENT CARE (cont'd)	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Laboratory Procedures • Performed in a PCP Office	50% Coinsurance after Deductible	
Laboratory Procedures • Performed in a Freestanding Laboratory Facility or Specialist Office	\$10 Copayment	
Laboratory Procedures • Performed as Outpatient Hospital Services	\$20 Copayment	
Maternity & Newborn Care • Prenatal Care	\$20 Copayment	
Maternity & Newborn Care • Inpatient Hospital Services and Birthing Center	Covered in Full	1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
Maternity & Newborn Care • Physician and Nurse Midwife Services for Delivery	\$100 per admission	
Maternity & Newborn Care • Breast Pump	\$25 Copayment	Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge	Covered in Full Preauthorization Required	
Preadmission Testing	\$25 Copayment Preauthorization Required	
Diagnostic Radiology Services • Performed in a PCP Office	\$0 Copayment Preauthorization Required	
Diagnostic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office	\$10 Copayment	
Diagnostic Radiology Services • Performed as Outpatient Hospital Services	\$20 Copayment	
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office	\$10 Copayment	
Therapeutic Radiology Services • Performed as Outpatient Hospital Services	\$10 Copayment Preauthorization Required	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	\$15 Copayment Preauthorization Required	60 visits per condition, per lifetime combined therapies Speech and Physical Therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	\$20 Copayment	
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery	\$25 Copayment	
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Outpatient Hospital Surgery	\$25 Copayment	
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Surgery Performed at an Ambulatory Surgical Center	\$25 Copayment	
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Office Surgery	\$20 Copayment (Specialist) \$10 Copayment (PCP) Preauthorization Required	

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Schedule of Benefits

ADDITIONAL SERVICES, EQUIPMENT & DEVICES	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
ABA Treatment for Autism Spectrum Disorder	\$10 Copayment Preauthorization Required	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	\$10 Copayment	
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply)	\$10 Copayment	
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Education	\$10 Copayment Preauthorization Required	
Durable Medical Equipment & Braces	5% Coinsurance Preauthorization Required for Items Above \$100	
External Hearing Aids	5% Coinsurance Preauthorization Required	Single Purchase Once Every 3 Years
Cochlear Implants	5% Coinsurance Preauthorization Required	One Per Ear Per Time Covered
Hospice Care • Inpatient	\$100 per admission	210 Days per Plan Year 5 Visits for Family Bereavement Counseling
Hospice Care • Outpatient	\$10 Copayment	
Medical Supplies	5% Coinsurance Preauthorization Required for Items Above \$100	
Prosthetic Devices • External	5% Coinsurance	One prosthetic device, per limb, per lifetime
Prosthetic Devices • Internal	5% Coinsurance Preauthorization Required	Unlimited

INPATIENT SERVICES & FACILITIES	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	\$100 per admission Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.	
Observation Stay	\$50 Copayment Preauthorization Required	
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	\$100 per admission Preauthorization Required	200 Days Per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	\$100 per admission Preauthorization Required	60 Consecutive Days Per Condition, Per Lifetime

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	\$100 Copayment Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.	
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	\$10 Copayment	
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	\$100 Copayment Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.	
Outpatient Substance Use Services	\$10 Copayment after Deductible	Unlimited; Up to 20 Visits a Plan Year May Be Used For Family Counseling

PRESCRIPTION DRUGS	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Retail Pharmacy 30 Day Supply Tier 1 Tier 2 Tier 3	\$6 Copayment \$15 Copayment \$30 Copayment	

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Schedule of Benefits

WELLNESS BENEFITS	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Gym Reimbursement	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse, not subject to Deductible	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse

PEDIATRIC DENTAL & VISION CARE***	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Pediatric Dental Care • Preventive/Routine Dental Care	\$10 Copayment	One Dental Exam & Cleaning Per 6 Month Period
Pediatric Dental Care • Major Dental (Endodontics & Prosthodontics)	\$10 Copayment Orthodontia & Major Dental Require Preauthorization	
Pediatric Dental Care • Orthodontia	\$10 Copayment Orthodontia & Major Dental Require Preauthorization	
Pediatric Vision Care • Exams	\$10 Copayment	One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12 Month Period
Pediatric Vision Care • Lenses & Frames	5% Coinsurance	
Pediatric Vision Care • Contact Lenses	5% Coinsurance Contact Lenses Require Preauthorization	

**NOTE: Unless otherwise noted, non-participating provider services are not covered and you pay the full cost*

***NOTE: Additional limits may apply. Complete benefit descriptions are available from insurers upon effectuation of coverage.*

****NOTE: Not all Standard Plans offer Pediatric Dental Benefits. A Stand-Alone Dental Plan may need to be purchased to receive these benefits. Please refer to the plan details on our website to see if this is included or discuss further with a navigator, broker, or customer service representative.*

**NY State of Health - Standard SILVER Plan
Cost-Sharing Reduction Variation (150-200%FPL)
Schedule of Benefits**

COST-SHARING	Member Cost-Sharing Responsibility for Services from Participating Providers*
Deductible	
• Individual	\$250
• Family	\$500
Out-of-Pocket Limit	
• Individual	\$2,000
• Family	\$4,000

OFFICE VISITS	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits**
Primary Care Office Visits (or Home Visits)	\$15 Copayment after Deductible	
Specialist Office Visits (or Home Visits)	\$35 Copayment after Deductible	

PREVENTIVE CARE	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
• Well Child Visits and Immunizations*	Covered in full	
• Adult Annual Physical Examinations*	Covered in full	
• Adult Immunizations*	Covered in full	
Routine Gynecological Services/Well Woman Exams*	Covered in full	
• Mammography Screenings*	Covered in full	
• Sterilization Procedures for Women*	Covered in full	
• Vasectomy	\$15 Copayment after Deductible (PCP) \$35 Copayment after Deductible (Specialist)	
• Bone Density Testing*	Covered in full	
• Screening for Prostate Cancer	Covered in full	
• All other preventive services required by USPSTF and HRSA.	Covered in full	
• *Preventive services that are provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA are covered in full. Preventive services that are provided outside of these guidelines may be subject to cost-sharing.	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	

EMERGENCY CARE	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	\$75 Copayment after Deductible (for services provided from both participating and non-participating providers)	
Non-Emergency Ambulance Services	\$75 Copayment after Deductible Preauthorization Required	
Emergency Department Coinsurance waived if Hospital admission	\$75 Copayment after Deductible (for services provided from both participating and non-participating providers)	
Urgent Care Center	\$50 Copayment after Deductible	

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PROFESSIONAL SERVICES AND OUTPATIENT CARE	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting	\$35 Copayment after Deductible	
Advanced Imaging Services • Performed as Outpatient Hospital Services	\$35 Copayment after Deductible Preauthorization Required	
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures) Preauthorization Required	
Ambulatory Surgical Center Facility Fee	\$75 Copayment after Deductible Preauthorization Required	
Anesthesia Services (all settings)	Covered in Full Preauthorization Required	
Autologous Blood Banking	10% Coinsurance after Deductible Preauthorization Required	
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office	\$15 Copayment after Deductible	
Cardiac & Pulmonary Rehabilitation • Performed as Outpatient Hospital Services	\$15 Copayment after Deductible	
Cardiac & Pulmonary Rehabilitation • Performed as Inpatient Hospital Services	Included as part of Inpatient Hospital Service Cost Sharing Preauthorization Required	
Chemotherapy • Performed in a PCP Office	\$15 Copayment after Deductible	
Chemotherapy • Performed in a Specialist Office	\$15 Copayment after Deductible	
Chemotherapy • Performed as Outpatient Hospital Services	\$15 Copayment after Deductible Preauthorization Required	
Chiropractic Services	\$35 Copayment after Deductible Preauthorization Required	
Diagnostic Testing • Performed in a PCP Office	\$15 Copayment after Deductible	
Diagnostic Testing • Performed in a Specialist office	\$35 Copayment after Deductible	
Diagnostic Testing • Performed as Outpatient Hospital Services	\$35 Copayment after Deductible Preauthorization Required	
Dialysis • Performed in a PCP Office	\$15 Copayment (for services provided from both participating and non-participating providers)	Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Dialysis • Performed in a Freestanding Center or Specialist Office Setting	\$15 Copayment after Deductible (for services provided from both participating and non-participating providers)	
Dialysis • Performed as Outpatient Hospital Services	\$15 Copayment after Deductible Preauthorization Required (for services provided from both participating and non-participating providers)	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	\$25 Copayment after Deductible Preauthorization Required	60 visits per condition, per lifetime combined therapies
Home Health Care	\$15 Copayment after Deductible Preauthorization Required	40 Visits per Plan Year
Infertility Services	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) Preauthorization Required	
Infusion Therapy • Performed in a PCP Office	\$15 Copayment after Deductible	Home Infusion counts towards Home Health Care Visit Limits
Infusion Therapy • Performed in Specialist Office	\$15 Copayment after Deductible	
Infusion Therapy • Performed as Outpatient Hospital Services	\$15 Copayment after Deductible	
Infusion Therapy • Home Infusion Therapy	\$15 Copayment after Deductible Preauthorization Required	
Inpatient Medical Visits	\$0 Copayment after Deductible not covered in full	

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Cost-Sharing Reduction Variation (150-200%FPL)
Schedule of Benefits**

PROFESSIONAL SERVICES AND OUTPATIENT CARE (cont'd)	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Laboratory Procedures • Performed in a PCP Office	\$15 Copayment after Deductible	
Laboratory Procedures • Performed in a Freestanding Laboratory Facility or Specialist Office	\$35 Copayment after Deductible	
Laboratory Procedures • Performed as Outpatient Hospital Services	\$35 Copayment after Deductible	
Maternity & Newborn Care • Prenatal Care	Covered in Full	
Maternity & Newborn Care • Inpatient Hospital Services and Birthing Center	\$250 per admission after Deductible	1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
Maternity & Newborn Care • Physician and Nurse Midwife Services for Delivery	\$75 Copayment after Deductible	
Maternity & Newborn Care • Breast Pump	Covered in Full Preauthorization Required	Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge	\$75 Copayment after Deductible Preauthorization Required	
Preadmission Testing	\$0 Copayment after Deductible Preauthorization Required	
Diagnostic Radiology Services • Performed in a PCP Office	\$15 Copayment after Deductible	
Diagnostic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office	\$35 Copayment after Deductible	
Diagnostic Radiology Services • Performed as Outpatient Hospital Services	\$35 Copayment after Deductible Preauthorization Required	
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office	\$15 Copayment after Deductible	
Therapeutic Radiology Services • Performed as Outpatient Hospital Services	\$15 Copayment after Deductible Preauthorization Required	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	\$25 Copayment after Deductible Preauthorization Required	60 visits per condition, per lifetime combined therapies Speech and Physical Therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	\$35 Copayment after Deductible	
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery	\$75 Copayment after Deductible	
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Outpatient Hospital Surgery	\$75 Copayment after Deductible	
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Surgery Performed at an Ambulatory Surgical Center	\$75 Copayment after Deductible	
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Office Surgery	\$35 Copayment after Deductible (Specialist) \$15 Copayment after Deductible (PCP) Preauthorization Required	

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Cost-Sharing Reduction Variation (150-200%FPL)
Schedule of Benefits**

ADDITIONAL SERVICES, EQUIPMENT & DEVICES	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
ABA Treatment for Autism Spectrum Disorder	\$15 Copayment after Deductible Preauthorization Required	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	\$15 Copayment after Deductible	
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply)	\$15 Copayment after Deductible	
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Education	\$15 Copayment after Deductible Preauthorization Required	
Durable Medical Equipment & Braces	10% Coinsurance after Deductible Preauthorization Required for Items Above \$100	
External Hearing Aids	10% Coinsurance after Deductible Preauthorization Required	Single Purchase Once Every 3 Years
Cochlear Implants	10% Coinsurance after Deductible Preauthorization Required	One Per Ear Per Time Covered
Hospice Care • Inpatient	\$250 per admission after Deductible	210 Days per Plan Year 5 Visits for Family Bereavement Counseling
Hospice Care • Outpatient	\$15 Copayment after Deductible	
Medical Supplies	10% Coinsurance after Deductible Preauthorization Required	
Prosthetic Devices • External	10% Coinsurance after Deductible	One prosthetic device, per limb, per lifetime
Prosthetic Devices • Internal	10% Coinsurance after Deductible Preauthorization Required	Unlimited

INPATIENT SERVICES & FACILITIES	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	\$250 per admission after Deductible Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.	
Observation Stay	\$75 Copayment after Deductible Preauthorization Required	
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	\$250 per admission after Deductible Preauthorization Required	200 Days Per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	\$250 per admission after Deductible Preauthorization Required	60 Consecutive Days Per Condition, Per Lifetime

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	\$250 Copayment after Deductible Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.	
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	\$15 Copayment after Deductible	
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	\$250 Copayment after Deductible Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.	
Outpatient Substance Use Services	\$15 Copayment after Deductible	Unlimited; Up to 20 Visits a Plan Year May Be Used For Family Counseling

PRESCRIPTION DRUGS	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Retail Pharmacy 30 Day Supply Tier 1 Tier 2 Tier 3	\$9 Copayment \$20 Copayment \$40 Copayment	

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Schedule of Benefits**

WELLNESS BENEFITS	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Gym Reimbursement	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse, not subject to Deductible	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse

PEDIATRIC DENTAL & VISION CARE***	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Pediatric Dental Care • Preventive/Routine Dental Care	\$15 Copayment after Deductible	One Dental Exam & Cleaning Per 6 Month Period
Pediatric Dental Care • Major Dental (Endodontics & Prosthodontics)	\$15 Copayment after Deductible Orthodontia & Major Dental Require Preauthorization	
Pediatric Dental Care • Orthodontia	\$15 Copayment after Deductible Orthodontia & Major Dental Require Preauthorization	
Pediatric Vision Care • Exams	\$15 Copayment after Deductible	One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12 Month Period
Pediatric Vision Care • Lenses & Frames	10% Coinsurance after Deductible	
Pediatric Vision Care • Contact Lenses	10% Coinsurance after Deductible Contact Lenses Require Preauthorization	

**NOTE: Unless otherwise noted, non-participating provider services are not covered and you pay the full cost*

***NOTE: Additional limits may apply. Complete benefit descriptions are available from insurers upon effectuation of coverage.*

****NOTE: Not all Standard Plans offer Pediatric Dental Benefits. A Stand-Alone Dental Plan may need to be purchased to receive these benefits. Please refer to the plan details on our website to see if this is included or discuss further with a navigator, broker, or customer service representative.*

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Cost-Sharing Reduction Variation (200-250% FPL)
Schedule of Benefits

COST-SHARING	Member Cost-Sharing Responsibility for Services from Participating Providers*
Deductible	
• Individual	\$1,750
• Family	\$3,500
Out-of-Pocket Limit	
• Individual	\$4,000
• Family	\$8,000

OFFICE VISITS	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits**
Primary Care Office Visits (or Home Visits)	\$30 Copayment after Deductible	
Specialist Office Visits (or Home Visits)	\$50 Copayment after Deductible	

PREVENTIVE CARE	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
• Well Child Visits and Immunizations*	Covered in full	
• Adult Annual Physical Examinations*	Covered in full	
• Adult Immunizations*	Covered in full	
Routine Gynecological Services/Well Woman Exams*	Covered in full	
• Mammography Screenings*	Covered in full	
• Sterilization Procedures for Women*	Covered in full	
• Vasectomy	\$30 Copayment after Deductible (PCP) \$50 Copayment after Deductible (Specialist)	
• Bone Density Testing*	Covered in full	
• Screening for Prostate Cancer	Covered in full	
• All other preventive services required by USPSTF and HRSA.	Covered in full	
• *Preventive services that are provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA are covered in full. Preventive services that are provided outside of these guidelines may be subject to cost-sharing.	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	

EMERGENCY CARE	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	\$150 Copayment after Deductible (for services provided from both participating and non-participating providers)	
Non-Emergency Ambulance Services	\$150 Copayment after Deductible Preauthorization Required	
Emergency Department Coinsurance waived if Hospital admission	\$150 Copayment after Deductible (for services provided from both participating and non-participating providers)	
Urgent Care Center	\$70 Copayment after Deductible	

**NY State of Health - Standard SILVER Plan
Cost-Sharing Reduction Variation (200-250% FPL)
Schedule of Benefits**

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting	\$50 Copayment after Deductible	
Advanced Imaging Services • Performed as Outpatient Hospital Services	\$50 Copayment after Deductible Preauthorization Required	
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures) Preauthorization Required	
Ambulatory Surgical Center Facility Fee	\$100 Copayment after Deductible Preauthorization Required	
Anesthesia Services (all settings)	Covered in Full Preauthorization Required	
Autologous Blood Banking	25% Coinsurance after Deductible Preauthorization Required	
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office	\$30 Copayment after Deductible	
Cardiac & Pulmonary Rehabilitation • Performed as Outpatient Hospital Services	\$30 Copayment after Deductible	
Cardiac & Pulmonary Rehabilitation • Performed as Inpatient Hospital Services	Included as part of Inpatient Hospital Service Cost Sharing Preauthorization Required	
Chemotherapy • Performed in a PCP Office	\$30 Copayment after Deductible	
Chemotherapy • Performed in a Specialist Office	\$30 Copayment after Deductible	
Chemotherapy • Performed as Outpatient Hospital Services	\$30 Copayment after Deductible Preauthorization Required	
Chiropractic Services	\$50 Copayment after Deductible Preauthorization Required	
Diagnostic Testing • Performed in a PCP Office	\$30 Copayment after Deductible	
Diagnostic Testing • Performed in a Specialist office	\$50 Copayment after Deductible	
Diagnostic Testing • Performed as Outpatient Hospital Services	\$50 Copayment after Deductible Preauthorization Required	
Dialysis • Performed in a PCP Office	\$30 Copayment after Deductible (for services provided from both participating and non-participating providers)	Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Dialysis • Performed in a Freestanding Center or Specialist Office Setting	\$30 Copayment after Deductible (for services provided from both participating and non-participating providers)	
Dialysis • Performed as Outpatient Hospital Services	\$30 Copayment after Deductible Preauthorization Required (for services provided from both participating and non-participating providers)	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	\$30 Copayment after Deductible Preauthorization Required	60 visits per condition, per lifetime combined therapies
Home Health Care	\$30 Copayment after Deductible Preauthorization Required	40 Visits per Plan Year
Infertility Services	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) Preauthorization Required	
Infusion Therapy • Performed in a PCP Office	\$30 Copayment after Deductible	Home Infusion counts towards Home Health Care Visit Limits
Infusion Therapy • Performed in Specialist Office	\$30 Copayment after Deductible	
Infusion Therapy • Performed as Outpatient Hospital Services	\$30 Copayment after Deductible	
Infusion Therapy • Home Infusion Therapy	\$30 Copayment after Deductible Preauthorization Required	
Inpatient Medical Visits	\$0 Copayment after Deductible not covered in full	

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PROFESSIONAL SERVICES AND OUTPATIENT CARE (cont'd)	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Laboratory Procedures • Performed in a PCP Office	\$30 Copayment after Deductible	
Laboratory Procedures • Performed in a Freestanding Laboratory Facility or Specialist Office	\$50 Copayment after Deductible	
Laboratory Procedures • Performed as Outpatient Hospital Services	\$50 Copayment after Deductible	
Maternity & Newborn Care • Prenatal Care	Covered in Full	
Maternity & Newborn Care • Inpatient Hospital Services and Birthing Center	\$1,500 per admission after Deductible	1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
Maternity & Newborn Care • Physician and Nurse Midwife Services for Delivery	\$100 Copayment after Deductible	
Maternity & Newborn Care • Breast Pump	Covered in Full Preauthorization Required	Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge	\$100 Copayment after Deductible Preauthorization Required	
Preadmission Testing	\$0 Copayment after Deductible Preauthorization Required	
Diagnostic Radiology Services • Performed in a PCP Office	\$30 Copayment after Deductible	
Diagnostic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office	\$50 Copayment after Deductible	
Diagnostic Radiology Services • Performed as Outpatient Hospital Services	\$50 Copayment after Deductible Preauthorization Required	
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office	\$30 Copayment after Deductible	
Therapeutic Radiology Services • Performed as Outpatient Hospital Services	\$30 Copayment after Deductible Preauthorization Required	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	\$30 Copayment after Deductible Preauthorization Required	60 visits per condition, per lifetime combined therapies Speech and Physical Therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	\$50 Copayment after Deductible	
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery	\$100 Copayment after Deductible	
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Outpatient Hospital Surgery	\$100 Copayment after Deductible	
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Surgery Performed at an Ambulatory Surgical Center	\$100 Copayment after Deductible	
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Office Surgery	\$50 Copayment after Deductible (Specialist) \$30 Copayment after Deductible (PCP) Preauthorization Required	

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ADDITIONAL SERVICES, EQUIPMENT & DEVICES	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
ABA Treatment for Autism Spectrum Disorder	\$30 Copayment after Deductible Preauthorization Required	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	\$30 Copayment after Deductible	
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply)	\$30 Copayment after Deductible	
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Education	\$30 Copayment after Deductible Preauthorization Required	
Durable Medical Equipment & Braces	25% Coinsurance after Deductible Preauthorization Required for Items Above \$100	
External Hearing Aids	25% Coinsurance after Deductible Preauthorization Required	Single Purchase Once Every 3 Years
Cochlear Implants	25% Coinsurance after Deductible Preauthorization Required	One Per Ear Per Time Covered
Hospice Care • Inpatient	\$1,500 per admission after Deductible	210 Days per Plan Year 5 Visits for Family Bereavement Counseling
Hospice Care • Outpatient	\$30 Copayment after Deductible	
Medical Supplies	25% Coinsurance after Deductible Preauthorization Required	
Prosthetic Devices • External	25% Coinsurance after Deductible	One prosthetic device, per limb, per lifetime
Prosthetic Devices • Internal	25% Coinsurance after Deductible Preauthorization Required	Unlimited

INPATIENT SERVICES & FACILITIES	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	\$1,500 per admission after Deductible Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.	
Observation Stay	\$150 Copayment after Deductible Preauthorization Required	
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	\$1,500 per admission after Deductible Preauthorization Required	200 Days Per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	\$1,500 per admission after Deductible Preauthorization Required	60 Consecutive Days Per Condition, Per Lifetime

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	\$1,500 Copayment after Deductible Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.	
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	\$30 Copayment after Deductible	
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	\$1,500 Copayment after Deductible Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.	
Outpatient Substance Use Services	\$30 Copayment after Deductible	Unlimited; Up to 20 Visits a Plan Year May Be Used For Family Counseling

PRESCRIPTION DRUGS	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Retail Pharmacy 30 Day Supply Tier 1 Tier 2 Tier 3	\$10 Copayment after Deductible \$35 Copayment after Deductible \$70 Copayment after Deductible	

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WELLNESS BENEFITS	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Gym Reimbursement	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse, not subject to Deductible	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse

PEDIATRIC DENTAL & VISION CARE***	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Pediatric Dental Care • Preventive/Routine Dental Care	\$30 Copayment after Deductible	One Dental Exam & Cleaning Per 6 Month Period
Pediatric Dental Care • Major Dental (Endodontics & Prosthodontics)	\$30 Copayment after Deductible Orthodontia & Major Dental Require Preauthorization	
Pediatric Dental Care • Orthodontia	\$30 Copayment after Deductible Orthodontia & Major Dental Require Preauthorization	
Pediatric Vision Care • Exams	\$30 Copayment after Deductible	One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12 Month Period
Pediatric Vision Care • Lenses & Frames	25% Coinsurance after Deductible	
Pediatric Vision Care • Contact Lenses	25% Coinsurance after Deductible Contact Lenses Require Preauthorization	

**NOTE: Unless otherwise noted, non-participating provider services are not covered and you pay the full cost*

***NOTE: Additional limits may apply. Complete benefit descriptions are available from insurers upon effectuation of coverage.*

****NOTE: Not all Standard Plans offer Pediatric Dental Benefits. A Stand-Alone Dental Plan may need to be purchased to receive these benefits. Please refer to the plan details on our website to see if this is included or discuss further with a navigator, broker, or customer service representative.*