# ESSENTIAL PLAN PROGRAM

## INDEPENDENT HEALTH SCHEDULE OF BENEFITS

**See Benefit Description in Contract for More Details*

Non-Participating Provider services are not Covered for any services other than those related to emergency care and You pay the full cost for services performed by a non-participating provider except in cases related to emergency care.

| COST-SHARING | ESSENTIAL PLAN 1 | ESSENTIAL PLAN 2 | ESSENTIAL PLAN 3 | ESSENTIAL PLAN 4 |
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| **Deductible**<br>• Individual | $0 | $0 | $0 | $0 |
| **Out-of-Pocket Limit**<br>• Individual | $2,000 | $200 | $200 | $0 |
| Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a Plan Year basis. | | | For covered prescription drugs, the Maximum Out-of-Pocket Limit is $50 per calendar quarter. | |
| **OFFICE VISITS** | | | | |
| Primary Care Office Visits (or Home Visits) | $15 | $0 | $0 | $0 |
| Specialist Office Visits (or Home Visits) | $25 | $0 | $0 | $0 |

| PREVENTIVE CARE | | | | |
|---|---|---|---|---|
| • Adult Annual Physical Examinations* | Covered in full | Covered in full | Covered in full | Covered in full |
| • Adult Immunizations* | Covered in full | Covered in full | Covered in full | Covered in full |
| • Routine Gynecological Services/Well Woman Exams* | Covered in full | Covered in full | Covered in full | Covered in full |
| • Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer | Covered in full | Covered in full | Covered in full | Covered in full |
| • Sterilization Procedures for Women* | Covered in full | Covered in full | Covered in full | Covered in full |
| • Vasectomy | See Surgical Services Section | See Surgical Services Section | See Surgical Services Section | See Surgical Services Section |
| • Bone Density Testing* | Covered in full | Covered in full | Covered in full | Covered in full |
| • Screening for Prostate Cancer | Covered in full | Covered in full | Covered in full | Covered in full |
| • All other preventive services required by USPSTF and HRSA | Covered in full | Covered in full | Covered in full | Covered in full |

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| • *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA | Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) |
| **EMERGENCY CARE** | | | | |
| Pre-Hospital Emergency Medical Services (Ambulance Services) | $75 | $0 | $0 | $0 |
| Non-Emergency Ambulance Services | $75 | $0 | $0<br><br>**See Contract on how to use this service** | $0<br><br>**See Contract on how to use this service** |
| Emergency Department<br><br>Copayment waived if admitted to Hospital | $75<br><br>Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Copayment | $0 | $0 | $0 |
| Urgent Care Center | $25 | $0 | $0 | $0 |

| PROFESSIONAL SERVICES and OUTPATIENT CARE | | | | |
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| Advanced Imaging Services<br>• Performed in a Freestanding Radiology Facility or Office Setting<br>• Performed in a Specialist Office<br>• Performed as Outpatient Hospital Services | $25<br>$25<br>$25 | $0<br>$0<br>$0 | $0<br>$0<br>$0 | $0<br>$0<br>$0 |
| Allergy Testing and Treatment<br>• Performed in a PCP Office<br>• Performed in a Specialist Office | $15<br>$25 | $0<br>$0 | $0<br>$0 | $0<br>$0 |
| Ambulatory Surgical Center Facility Fee | $50 | $0 | $0 | $0 |
| Anesthesia Services (all settings) | Covered in full | Covered in full | Covered in full | Covered in full |

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| Cardiac and Pulmonary Rehabilitation | | | | |
| • Performed in a Specialist Office | $25 | $0 | $0 | $0 |
| • Performed as Outpatient Hospital Services | $25 | $0 | $0 | $0 |
| • Performed as Inpatient Hospital Services | Included as part of inpatient Hospital service cost-sharing | Included as part of inpatient Hospital service cost-sharing | Included as part of inpatient Hospital service cost-sharing | Included as part of inpatient Hospital service cost-sharing |
| Chemotherapy and Immunotherapy | | | | |
| • Performed in a PCP Office | $15 | $0 | $0 | $0 |
| • Performed in a Specialist Office | $15 | $0 | $0 | $0 |
| • Performed as Outpatient Hospital Services | $15 | $0 | $0 | $0 |
| • Chemotherapy and Immunotherapy Medications | $15 | $0 | $0 | $0 |

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| Chiropractic Services | $25 | $0 | $0 | $0 |
| Clinical Trials | Use Cost-Sharing for appropriate service | Use Cost-Sharing for appropriate service | Use Cost-Sharing for appropriate service | Use Cost-Sharing for appropriate service |
| Diagnostic Testing | | | | |
| • Performed in a PCP Office | $15 | $0 | $0 | $0 |
| • Performed in a Specialist Office | $25 | $0 | $0 | $0 |
| • Performed as Outpatient Hospital Services | $25 | $0 | $0 | $0 |
| Dialysis | | | | |
| • Performed in a PCP Office | $15 | $0 | $0 | $0 |
| • Performed in a Freestanding Center or Specialist Office Setting | $15 | $0 | $0 | $0 |
| • Performed as Outpatient Hospital Services | $15 | $0 | $0 | $0 |

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| Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) | $15<br><br>60 visits per condition, per Plan Year combined therapies | $0<br><br>60 visits per condition, per Plan Year combined therapies | $0 | $0 |
| Home Health Care<br><br>40 visits Per Plan Year | $15 | $0 | $0 | $0 |
| Infertility Services | Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) | Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) | Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) | Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) |
| Infusion Therapy<br>• Performed in a PCP Office<br>• Performed in a Specialist Office<br>• Performed as Outpatient Hospital Services<br>• Home Infusion Therapy<br><br>(Home infusion counts toward home health care visit limits) | <br>$15<br>$15<br>$15<br>$15 | <br>$0<br>$0<br>$0<br>$0 | <br>$0<br>$0<br>$0<br>$0 | <br>$0<br>$0<br>$0<br>$0 |

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| Inpatient Medical Visits | $0 per admission | $0 per admission | $0 per admission | $0 per admission |
| Interruption of Pregnancy<br><br>• Medically Necessary Abortions<br><br>(Unlimited)<br><br>• Elective Abortions<br><br>(One (1) procedure per Plan Year) | <br><br>Covered in Full<br><br><br><br>See Surgical Services Cost-Sharing | <br><br>Covered in Full<br><br><br><br>$0 | <br><br>Covered in Full<br><br><br><br>$0 | <br><br>Covered in Full<br><br><br><br>$0 |
| Laboratory Procedures<br><br>• Performed in a PCP Office<br><br>• Performed in a Specialist Office<br><br>• Performed in a Freestanding Laboratory Facility or Specialist Office<br><br>• Performed as Outpatient Hospital Services | <br><br>$15<br><br>$25<br><br>$25<br><br>$25 | <br><br>$0<br><br>$0<br><br>$0<br><br>$0 | <br><br>$0<br><br>$0<br><br>$0<br><br>$0 | <br><br>$0<br><br>$0<br><br>$0<br><br>$0 |

| Maternity and Newborn Care | | | | |
|---|---|---|---|---|
| • Prenatal Care | $0 | $0 | $0 | $0 |
| • Inpatient Hospital Services and Birthing Center | $150 per admission | $0 | $0 | $0 |
| • Physician and Midwife Services for Delivery | $50 | $0 | $0 | $0 |
| • Breastfeeding Support, Counseling and Supplies, Including Breast Pumps<br><br>Covered for duration of breast feeding | $0 | $0 | $0 | $0 |
| • Postnatal Care | Included in Physician and Midwife Services for Delivery Cost-Sharing | Included in Physician and Midwife Services for Delivery Cost-Sharing | Included in Physician and Midwife Services for Delivery Cost-Sharing | Included in Physician and Midwife Services for Delivery Cost-Sharing |
| Outpatient Hospital Surgery Facility Charge | $50 | $0 | $0 | $0 |
| Preadmission Testing | $0 | $0 | $0 | $0 |

| Prescription Drugs Administered in Office or Outpatient Facilities | | | | |
|---|---|---|---|---|
| • Performed in a PCP Office | $15 | $0 | $0 | $0 |
| • Performed in Specialist Office | $25 | $0 | $0 | $0 |
| • Performed in Outpatient Facilities | $25 | $0 | $0 | $0 |
| • Prescription Drug Cost-Sharing | $15 | $0 | $0 | $0 |
| Diagnostic Radiology Services | | | | |
| • Performed in a PCP Office | $15 | $0 | $0 | $0 |
| • Performed in a Specialist Office | $25 | $0 | $0 | $0 |
| • Performed in a Freestanding Radiology Facility | $25 | $0 | $0 | $0 |
| • Performed as Outpatient Hospital Services | $25 | $0 | $0 | $0 |

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| Therapeutic Radiology Services<br><br>• Performed in a Specialist Office<br><br>• Performed in a Freestanding Radiology Facility<br><br>• Performed as Outpatient Hospital Services | <br><br>$15<br><br>$15<br><br>$15 | <br><br>$0<br><br>$0<br><br>$0 | <br><br>$0<br><br>$0<br><br>$0 | <br><br>$0<br><br>$0<br><br>$0 |
| Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) | $15<br><br>60 visits per condition, per Plan Year combined therapies<br><br>Speech and physical therapy are only Covered following a Hospital stay or surgery | $0<br><br>60 visits per condition, per Plan Year combined therapies<br><br>Speech and physical therapy are only Covered following a Hospital stay or surgery | $0 | $0 |
| Second Opinions on the Diagnosis of Cancer, Surgery and Other | $25 | $0 | $0 | $0 |

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| Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants<br><br>**All transplants must be performed at designated Facilities** | | | | |
| • Inpatient Hospital Surgery | $50 | $0 | $0 | $0 |
| • Outpatient Hospital Surgery | $50 | $0 | $0 | $0 |
| • Surgery Performed at an Ambulatory Surgical Center | $50 | $0 | $0 | $0 |
| • Office Surgery | $15 (when performed at PCP office)<br><br>$25 (when performed at specialist office) | $0 | $0 | $0 |

| **ADDITIONAL SERVICES, EQUIPMENT and DEVICES** | | | | |
|---|---|---|---|---|
| ABA Treatment for Autism Spectrum Disorder | $15 | $0 | $0 | $0 |
| Assistive Communication Devices for Autism Spectrum Disorder | $15 | $0 | $0 | $0 |
| Diabetic Equipment, Supplies and Self-Management Education | | | | |
| • Diabetic Equipment, Supplies and Insulin (30-day; Up to a 90 supply) | $15 | $0 | $0 | $0 |
| • Diabetic Education | $15 | $0 | $0 | $0 |
| Durable Medical Equipment and Braces | 5% cost-sharing | $0 | $0 | $0 |
| External Hearing Aids<br>**(Single purchase one every three (3) years)** | 5% cost-sharing | $0 | $0 | $0 |
| Cochlear Implants<br>**(One (1) per ear per time Covered)** | 5% cost-sharing | $0 | $0 | $0 |

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| Hospice Care<br><br>• Inpatient<br><br>• Outpatient<br><br>210 days per Plan Year<br><br>Five (5) visits for family bereavement counseling | <br><br>$150<br><br>$15 | <br><br>$0<br><br>$0 | <br><br>$0<br><br>$0 | <br><br>$0<br><br>$0 |
| Medical Supplies | 5% coinsurance | $0 | $0 | $0 |
| Prosthetic Devices<br><br>• External<br><br>One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements<br><br>• Internal | <br><br>5% coinsurance<br><br>Included as part of Inpatient Hospital Cost-sharing | <br><br>$0<br><br>Included as part of Inpatient Hospital Cost-sharing | <br><br>$0<br><br>Included as part of Inpatient Hospital Cost-sharing | <br><br>$0<br><br>Included as part of Inpatient Hospital Cost-sharing |

| INPATIENT SERVICES and FACILITIES | | | | |
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| Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care) | $150 | $0 | $0 | $0 |
| Autologous Blood Banking Services | 5% co-insurance | $0 | $0 | $0 |
| Observation Stay<br><br>Copay waived if direct transfer from outpatient surgery setting to observation | $75 | $0 | $0 | $0 |
| Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)<br><br>200 days per Plan Year<br><br>Copay waived for each admission if directly transferred from hospital inpatient setting to skilled nursing facility | $150 | $0 | $0 | $0 |
| Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) | $150<br><br>60 days per Plan Year combined therapies | $0<br><br>60 days per Plan Year combined therapies | $0 | $0 |

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| Inpatient Rehabilitation Services<br>(Physical, Speech and Occupational Therapy)<br><br>60 per Plan Year combined therapies | $150 | $0 | $0 | $0 |
| **MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES** | | | | |
| Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment) | $150 | $0 | $0 | $0 |
| Outpatient Mental Health Care<br>(including Partial Hospitalization and Intensive Outpatient Program Services) | $15 | $0 | $0 | $0 |
| Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment) | $150 | $0 | $0 | $0 |
| Outpatient Substance Use Services<br>(including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) | $15 | $0 | $0 | $0 |

| **PRESCRIPTION DRUGS**<br><br>*Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF and obtained at a participating pharmacy. | | | | |
|---|---|---|---|---|
| **Retail Pharmacy** | | | | |
| 30-day supply<br><br>Tier 1<br><br>Tier 2<br><br>Tier 3<br><br>Preauthorization is not required for a covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal. | <br><br>$6<br><br>$15<br><br>$30 | <br><br>$1<br><br>$3<br><br>$3 | <br><br>$1<br><br>$3<br><br>$3 | <br><br>$0<br><br>$0<br><br>$0 |
| **NON-PRESCRIPTION DRUGS (only include for EP 3 &4)** | | | $.50 | $0 |
| **WELLNESS BENEFITS** | | | | |
| Gym Reimbursement | Up to $200 per six (6)-month period | Up to $200 per six (6)-month period | Up to $200 per six (6)-month period | Up to $200 per six (6)-month period |

| DENTAL and VISION CARE | | | | |
|---|---|---|---|---|
| **Dental Care**<br>• Preventive Dental Care<br>• Routine Dental Care<br>• Major Dental (Oral Surgery, Endodontics, Periodontics and Prosthodontics)<br><br>One (1) dental exam and cleaning per six (6)-month period.<br><br>Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) to 12-month intervals | $0<br>$0<br>$0 | $0<br>$0<br>$0 | $0<br>$0<br>$0 | $0<br>$0<br>$0 |
| **Vision Care**<br>• Exams<br>• Lenses and Frames<br>• Contact Lenses<br>One (1) exam per 12-month period, unless otherwise medically necessary<br><br>One (1) prescribed lenses and frames per 12-month period; unless otherwise medically necessary | $0<br>$0<br>$0 | $0<br>$0<br>$0 | $0<br>$0<br>$0 | $0<br>$0<br>$0 |

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not Covered under the Contract, You will be responsible for the full cost of the services.

Eligible American Indians/Alaska Natives, as determined by NYSOH, are exempt from Cost Sharing requirements, including when Covered Services are rendered by an Indian Health Service, Indian Tribe, Tribal Organization or Urban Indian Organization, or through a Referral under the Purchased/Referred Care (PRC) program, formerly known as the Contract Health Services (CHS).

1. Under state law and the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the financial requirements (deductibles, copayments, coinsurance, and out-of-pocket expenses) and treatment limitations applicable to the mental health or substance use disorder benefits must be no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the plan. Further, if the health plan provides coverage for out-of-network services, then it also must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorders consistent with the MHPAEA.

2. Cost-sharing for services delivered using telehealth shall be at least as favorable to the insured as cost-sharing for the same service when not delivered via telehealth, pursuant to Insurance Law §§ 3217-h(a), 4306-g(a), and Public Health Law § 4406-g(1).

3. Plans have the flexibility to decide when a referral is required on a gated product.

4. The cost-sharing for emergency services in a hospital must be the same for in-network and out-of-network services.

5. The cost-sharing for ABA treatment and assistive communication devices must be the PCP copayment.

6. The cost-sharing for diabetic equipment, supplies, and self-management education must be the PCP copayment.

7. Medically necessary abortions may not be subject to a copayment or coinsurance and may only be subject to a deductible in a high deductible health plan.

8. Effective June 1, 2021 there shall be no cost-sharing obligations for enrollees for covered dental and vision services.