

ESSENTIAL PLAN

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 200-250	ESSENTIAL PLAN 1	ESSENTIAL PLAN 2	ESSENTIAL PLAN 3	ESSENTIAL PLAN 4
Deductible <ul style="list-style-type: none"> Individual 	\$0	\$0	\$0	\$0	\$0
Out-of-Pocket Limit <ul style="list-style-type: none"> Individual 	\$2,000	\$360	\$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	\$15	\$0	\$0	\$0

Essential Plan | 2025

Specialist Office Visits (or Home Visits)	\$25	\$25	\$0	\$0	\$0
PREVENTATIVE CARE					
<ul style="list-style-type: none"> Adult Annual Physical Examinations* Adult Immunizations* Routine Gynecological Services/Well Woman Exams* Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer Sterilization Procedures for Women* Vasectomy 	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>See Surgical Services Section</p> <p>Covered in full</p>	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>See Surgical Services Section</p> <p>Covered in full</p>	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>See Surgical Services Section</p> <p>Covered in full</p>	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>See Surgical Services Section</p> <p>Covered in full</p>	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>See Surgical Services Section</p> <p>Covered in full</p>

Essential Plan | 2025

<ul style="list-style-type: none"> Bone Density Testing* Screening for Prostate Cancer Screening for Colon Cancer All other preventive services required by USPSTF and HRSA *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA 	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
	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)	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	\$75	\$0	\$0	\$0

Essential Plan | 2025

Non-Emergency Ambulance Services	\$75	\$75	\$0	\$0 See Contract on how to use this service	\$0 See Contract on how to use this service
Emergency Department Copayment waived if admitted to Hospital	\$75 Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Copayment	\$75 Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Copayment	\$0	\$0	\$0
Urgent Care Center	\$25	\$25	\$0	\$0	\$0
PROFESSIONAL SERVICES and OUTPATIENT CARE					
Advanced Imaging Services					
• Performed in a Freestanding Radiology Facility or Office Setting	\$25	\$25	\$0	\$0	\$0
• Performed in a Specialist Office	\$25	\$25	\$0	\$0	\$0
• Performed as Outpatient	\$25	\$25	\$0	\$0	\$0

Essential Plan | 2025

Hospital Services					
Allergy Testing and Treatment					
• Performed in a PCP Office	\$15	\$15	\$0	\$0	\$0
• Performed in a Specialist Office	\$25	\$25	\$0	\$0	\$0
Ambulatory Surgical Center Facility Fee	\$50	\$50	\$0	\$0	\$0
Anesthesia Services (all settings)	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
Cardiac and Pulmonary Rehabilitation					
• Performed in a Specialist Office	\$25	\$25	\$0	\$0	\$0
• Performed as Outpatient Hospital Services	\$25	\$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	Included as part of inpatient Hospital service cost-sharing
Chemotherapy and Immunotherapy					
• Administration					

Essential Plan | 2025

<ul style="list-style-type: none"> Performed in a PCP Office 	\$15	\$15	\$0	\$0	\$0
<ul style="list-style-type: none"> Performed in a Specialist Office 	\$15	\$15	\$0	\$0	\$0
<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	\$15	\$15	\$0	\$0	\$0
<ul style="list-style-type: none"> Chemotherapy and Immunotherapy Medications 	\$15	\$15	\$0	\$0	\$0
Chiropractic Services	\$25	\$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	Use Cost-Sharing for appropriate service
Diagnostic Testing <ul style="list-style-type: none"> Performed in a PCP Office 	\$15	\$15	\$0	\$0	\$0
<ul style="list-style-type: none"> Performed in a Specialist Office 	\$25	\$25	\$0	\$0	\$0

Essential Plan | 2025

<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	\$25	\$25	\$0	\$0	\$0
Dialysis					
<ul style="list-style-type: none"> Performed in a PCP Office 	\$15	\$15	\$0	\$0	\$0
<ul style="list-style-type: none"> Performed in a Freestanding Center or Specialist Office Setting 	\$15	\$15	\$0	\$0	\$0
<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	\$15	\$15	\$0	\$0	\$0
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	\$15	\$15	\$0	\$0	\$0
	60 visits per condition, per Plan Year combined therapies	60 visits per condition, per Plan Year combined therapies	60 visits per condition, per Plan Year combined therapies		
Home Health Care	\$15	\$15	\$0	\$0	\$0
40 visits Per Plan Year					
Infertility Services	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic

Essential Plan | 2025

	Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Radiology Services; Surgery; Laboratory & Diagnostic Procedures)
Infusion Therapy <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services Home Infusion Therapy (Home infusion counts toward home health care visit limits)	\$15	\$15	\$0	\$0	\$0
	\$15	\$15	\$0	\$0	\$0
	\$15	\$15	\$0	\$0	\$0
	\$15	\$15	\$0	\$0	\$0
Inpatient Medical Visits	\$0 per admission	\$0 per admission	\$0 per admission	\$0 per admission	\$0 per admission
Interruption of Pregnancy <ul style="list-style-type: none"> Abortion Services 	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Laboratory Procedures					

Essential Plan | 2025

<ul style="list-style-type: none"> Performed in a PCP Office 	\$15	\$15	\$0	\$0	\$0
<ul style="list-style-type: none"> Performed in a Specialist Office 	\$25	\$25	\$0	\$0	\$0
<ul style="list-style-type: none"> Performed in a Freestanding Laboratory Facility or Specialist Office 	\$25	\$25	\$0	\$0	\$0
<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	\$25	\$25	\$0	\$0	\$0
Maternity and Newborn Care					
<ul style="list-style-type: none"> Prenatal Care 	\$0	\$0	\$0	\$0	\$0
<ul style="list-style-type: none"> Inpatient Hospital Services and Birthing Center 	\$150 per admission	\$150 per admission	\$0	\$0	\$0
<ul style="list-style-type: none"> Physician and Midwife Services for Delivery 	\$0	\$0	\$0	\$0	\$0
<ul style="list-style-type: none"> Breastfeeding Support, Counseling and Supplies, 	\$0	\$0	\$0	\$0	\$0

Essential Plan | 2025

<p>Including Breast Pumps</p> <p>*Covered for duration of breast feeding</p> <ul style="list-style-type: none"> Postnatal Care 	<u>Included in Physician and Midwife Services for Delivery Cost-Sharing</u>	<u>Included in Physician and Midwife Services for Delivery Cost-Sharing</u>	<u>Included in Physician and Midwife Services for Delivery Cost-Sharing</u>	<u>Included in Physician and Midwife Services for Delivery Cost-Sharing</u>	<u>Included in Physician and Midwife Services for Delivery Cost-Sharing</u>
Outpatient Hospital Surgery Facility Charge	\$50	\$50	\$0	\$0	\$0
Preadmission Testing	\$0	\$0	\$0	\$0	\$0
<p>Prescription Drugs Administered in Office or Outpatient Facilities</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in Specialist Office Performed in Outpatient Facilities Prescription Drug Cost-Sharing 	<p>\$15</p> <p>\$25</p> <p>\$25</p> <p>\$15</p>	<p>\$15</p> <p>\$25</p> <p>\$25</p> <p>\$15</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p>

Essential Plan | 2025

See note 6 below on page 31 regarding Cost-Sharing for Covered Prescription Drugs for the treatment of diabetes.					
Diagnostic Radiology Services					
• Performed in a PCP Office	\$15	\$15	\$0	\$0	\$0
• Performed in a Specialist Office	\$25	\$25	\$0	\$0	\$0
• Performed in a Freestanding Radiology Facility	\$25	\$25	\$0	\$0	\$0
• Performed as Outpatient Hospital Services	\$25	\$25	\$0	\$0	\$0
Therapeutic Radiology Services					
• Performed in a Specialist Office	\$15	\$15	\$0	\$0	\$0
• Performed in a Freestanding	\$15	\$15	\$0	\$0	\$0

Essential Plan | 2025

Radiology Facility <ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	\$15	\$15	\$0	\$0	\$0
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	60 visits per condition, per Plan Year combined therapies Speech and physical therapy are only Covered following a Hospital stay or surgery	60 visits per condition, per Plan Year combined therapies Speech and physical therapy are only Covered following a Hospital stay or surgery	60 visits per condition, per Plan Year combined therapies 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	\$25	\$0	\$0	\$0
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery;					

Essential Plan | 2025

Other Reconstructive and Corrective Surgery; and Transplants)					
All transplants must be performed at designated Facilities					
• Inpatient Hospital Surgery	\$50	\$50	\$0	\$0	\$0
• Outpatient Hospital Surgery	\$50	\$50	\$0	\$0	\$0
• Surgery Performed at an Ambulatory Surgical Center	\$50	\$50	\$0	\$0	\$0
• Office Surgery	\$15 (when performed at PCP office) \$25 (when performed at specialist office)	\$15 (when performed at PCP office) \$25 (when performed at specialist office)	\$0	\$0	\$0
ADDITIONAL SERVICES,					

Essential Plan | 2025

EQUIPMENT and DEVICES					
Diabetic Equipment, Supplies and Self-Management Education <ul style="list-style-type: none"> Diabetic Equipment, Supplies and Insulin (30-day; Up to a 90 supply) <p>Diabetes Initiative - Upon federal approval, starting in 2025 to make services more accessible and affordable, NY State of Health will cover the in-network cost-sharing such as copayments, and coinsurance for Essential Plan enrollees who have a primary diagnosis of diabetes. See note 6 below on page 31.</p> <ul style="list-style-type: none"> Diabetic Education 	\$15	\$15	\$0	\$0	\$0
	\$15	\$15	\$0	\$0	\$0

Essential Plan | 2025

Durable Medical Equipment and Braces	5% cost-sharing	5% cost-sharing	\$0	\$0	\$0
External Hearing Aids <ul style="list-style-type: none"> Prescription Hearing Aids (Single purchase one every three (3) years)	5% cost-sharing	5% cost-sharing	\$0	\$0	\$0
Cochlear Implants (One (1) per ear per time Covered)	5% cost-sharing	5% cost-sharing	\$0	\$0	\$0
Hospice Care <ul style="list-style-type: none"> Inpatient Outpatient 210 days per Plan Year Five (5) visits for family bereavement counseling	\$150 \$15	\$150 \$15	\$0 \$0	\$0 \$0	\$0 \$0
Medical Supplies	5% coinsurance	5% coinsurance	\$0	\$0	\$0
Prosthetic Devices					

Essential Plan | 2025

<ul style="list-style-type: none"> External <p>One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements</p> <ul style="list-style-type: none"> Internal 	5% coinsurance	5% coinsurance	\$0	\$0	\$0
	Included as part of Inpatient Hospital Cost-sharing	Included as part of Inpatient Hospital Cost-sharing	Included as part of Inpatient Hospital Cost-sharing	Included as part of Inpatient Hospital Cost-sharing	Included as part of Inpatient Hospital Cost-sharing
INPATIENT SERVICES and FACILITIES					
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	\$150	\$150	\$0	\$0	\$0
Autologous Blood Banking Services	5% co-insurance	5% co-insurance	\$0	\$0	\$0

Essential Plan | 2025

Observation Stay	\$75 Copay waived if direct transfer from outpatient surgery setting to observation	\$75 Copay waived if direct transfer from outpatient surgery setting to observation	\$0	\$0	\$0
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) 200 days per Plan Year	\$150 Copay waived for each admission if directly transferred from hospital inpatient setting to skilled nursing facility	\$150 Copay waived for each admission if directly transferred from hospital inpatient setting to skilled nursing facility	\$0	\$0	\$0
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)	\$150 60 days per Plan Year combined therapies	\$150 60 days per Plan Year combined therapies	\$0 60 days per Plan Year combined therapies	\$0	\$0
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	\$150 60 per Plan Year combined therapies	\$150 60 per Plan Year combined therapies	\$0 60 per Plan Year combined therapies	\$0	\$0
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES					
Inpatient Mental Health Care for a continuous	\$150	\$150	\$0	\$0	\$0

Essential Plan | 2025

confinement when in a Hospital (including Residential Treatment)					
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	\$15	\$15	\$0	\$0	\$0
ABA Treatment for Autism Spectrum Disorder	\$15	\$15	\$0	\$0	\$0
Assistive Communication Devices for Autism Spectrum Disorder	\$15	\$15	\$0	\$0	\$0
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)	\$150	\$150	\$0	\$0	\$0
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services,					

Essential Plan | 2025

and Medication Assisted Treatment) <ul style="list-style-type: none"> • Office Visits • All Other Outpatient Services • Opioid Treatment Programs 	\$15 \$15 \$0	\$15 \$15 \$0	\$0 \$0 \$0	\$0 \$0 \$0	\$0 \$0 \$0
PRESCRIPTION DRUGS *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. See note 6 below on page 31 regarding Cost-Sharing for Covered Prescription					

Essential Plan | 2025

Drugs for the treatment of diabetes.					
Retail Pharmacy 30-day supply					
Tier 1	\$6	\$6	\$1	\$1	\$0
Tier 2	\$15	\$15	\$3	\$3	\$0
Tier 3	\$30	\$30	\$3	\$3	\$0
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.					
Up to a 90-day supply for Maintenance Drugs					
Tier 1	\$15	\$15	\$2.50	\$2.50	\$0
Tier 2	\$37.50	\$37.50	\$7.50	\$7.50	\$0
Tier 3	\$75	\$75	\$7.50	\$7.50	\$0

Essential Plan | 2025

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	Up to \$200 per six (6)-month period
DENTAL and VISION CARE					
Dental Care <ul style="list-style-type: none"> Preventive Dental Care Routine Dental Care Major Dental (Oral Surgery, Endodontics, Periodontics and Prosthodontics) One (1) dental exam and cleaning per six (6)-month period. Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) to 12-month intervals	\$0 \$0 \$0	\$0 \$0 \$0	\$0 \$0 \$0	\$0 \$0 \$0	\$0 \$0 \$0
Vision Care <ul style="list-style-type: none"> Exams Lenses and 	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0	\$0 \$0

Essential Plan | 2025

Frames • Contact Lenses One (1) exam per 12-month period, unless otherwise medically necessary One (1) prescribed lenses and frames per 12-month period, unless otherwise medically necessary	\$0	\$0	\$0	\$0	\$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.

Essential Plan | 2025

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. Upon federal approval, starting in 2025, NY State of Health will cover the in-network cost-sharing such as copayments and coinsurance for Essential Plan enrollees who have a primary diagnosis of diabetes. Additional information regarding the 2025 Diabetes Initiative can be found here - <https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20U%20-%20Revised%20071124%202025%20Cost%20Sharing%20Reduction%20Initiatives.pdf>
7. Abortion services may not be subject to a copayment or coinsurance.
8. Effective June 1, 2021 there shall be no cost-sharing obligations for enrollees for covered dental and vision services.
9. Effective April 1, 2024, there shall be no cost-sharing obligations for enrollees who become pregnant while having coverage in any Essential Plan. Cost sharing would be waived for the duration of the pregnancy, along with one year of postpartum coverage. The 12-month postpartum coverage period will start on the last day of Your pregnancy and end on the last day of the 12th month.
10. Insurance Law §§ 3216(i)(31-b), 3221(l)(7-b), and 4303(l-2) provide that every policy that provides coverage for treatment at an opioid treatment program shall not impose a copayment or coinsurance during the course of treatment on an insured for such treatment. “Opioid treatment program” means a program or practitioner engaged in opioid treatment of individuals with an opioid agonist treatment medication.