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SUMMARY OF BENEFITS

Essential Plan 1 Plus

COST-SHARING	COMMENTS / LIMITATIONS	IN-NETWORK
Deductible Individual		$0 per plan year
Family		Not Applicable
Prescription Drug Deductible		$0 per plan year
Out-of-Pocket Maximum Individual		$2,000 per plan year
Family		Not Applicable
OFFICE VISITS		
Primary Care Physician Office Visit		$15 copayment
Specialist Care Physician Office Visit	PCP referral required	$25 copayment
Telemedicine Physician		$0 copayment
Dietician		$0 copayment
PREVENTIVE CARE SERVICES		
Adult Annual Physical Checkup and Adult Immunizations		Covered in full
Routine Gynecological Services/Well Woman Exams, Mammography Screenings		Covered in full
Vasectomy		See surgical services below
All other preventive services required by USPSTF and HRSA		Covered in full
EMERGENCY CARE		
Emergency Room Department	Cost-sharing waived if admitted to hospital	$75 copayment
Urgent Care Center		$25 copayment
Ambulance		$75 copayment
PROFESSIONAL SERVICES and OUTPATIENT CARE		
Advanced Imaging	Referral required	$25 copayment
Allergy Care Performed in PCP Office		$15 copayment
Performed in Specialist Office	PCP referral required	$25 copayment
Ambulatory Surgical Facility	Preauthorization required	$50 copayment
Anesthesia Services (all settings)		Covered in full
Cardiac and Pulmonary Rehabilitation	Preauthorization required	$25 copayment
Chemotherapy (all settings)	Referral required to see specialist	$15 copayment
Chiropractic Services		$25 copayment
Diagnostic Testing Performed in PCP Office		$15 copayment
Performed in Specialist Office	PCP referral required	$25 copayment

Dialysis	Referral required to see specialist	$15 copayment
Habilitation and Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	Preauthorization required. Combined 60 visits/condition/plan year, combined therapies	$15 copayment
Home Health Care	Preauthorization required. 40 visits per plan year	$15 copayment
Laboratory Procedures Performed in PCP Office Performed in Specialist Office		 $15 copayment $25 copayment
Maternity and Newborn Care Inpatient Hospital and Birthing Center) Prenatal Care Postnatal Care	Preauthorization required	 $150 copayment $0 copayment Included in physician and midwife services for delivery cost-sharing
Preadmission Testing	Preauthorization required	$0 copayment

PROFESSIONAL SERVICES and OUTPATIENT CARE (Continued)		
Diagnostic Radiology Services Performed in PCP Office Performed in Specialist Office	 PCP referral required	 $15 copayment $25 copayment
Second Opinions on the Diagnosis of Cancer, Surgery and Other	Referral required	$25 copayment
Surgical Services Surgical Services in In-Patient/Out-Patient Facility PCP Office Surgery Specialist Office Surgery	Preauthorization required	 $50 copayment $15 copayment $25 copayment
ADDITIONAL SERVICES, EQUIPMENT and DEVICES		
Diabetic Equipment, Supplies and Insulin	Preauthorization required for insulin pump. 30-day; Up to a 90-day supply	$15 copayment
Durable Medical Equipment	Preauthorization required. One external prosthetic device per limb per lifetime. No orthotics	5% coinsurance
External Hearing Aids	Preauthorization required. Single purchase, one or both ears, (including repair/replacement) every 3 years	5% coinsurance
Inpatient Hospice Care	Preauthorization required. 210 days per plan year	$150 copayment
INPATIENT SERVICES and FACILITIES		
Inpatient Hospital Service	Preauthorization required, except for emergency admissions	$150 copayment
Skilled Nursing Facility Care	Preauthorization required. 200 days per plan year	$150 copayment
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	Preauthorization required. 60 days per plan year, combined therapies. Speech and physical therapy are only covered following a hospital stay or surgery	$150 copayment
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES		
Inpatient Mental Health Care	Preauthorization required, except for emergency admissions	$150 copayment
Outpatient Mental Health Care		$15 copayment

Inpatient Substance Use Services	Preauthorization required, except for emergency admissions or for Participating OASAS-certified Facilities	$150 copayment
Outpatient Substance Use Services	Up to 20 visits per plan year may be used for family counseling	$15 copayment
PRESCRIPTION DRUGS		
Retail Pharmacy	30 day supply	
Tier 1		$6 copayment
Tier 2		$15 copayment
Tier 3		$30 copayment
Mail Order Pharmacy	90 day supply	
Tier 1		$15 copayment
Tier 2		$37.50 copayment
Tier 3		$75 copayment
WELLNESS BENEFIT		
Gym Reimbursement	Gym reimbursement benefit does not apply towards the OOP max	Reimbursed up to $200 for completion of 50 exercise facility visits in each six month period
VISION CARE		
Exams	One exam per 12 month period per plan year	$15 copayment
Lenses and Frames	One set of lenses & frames per plan year	10% coinsurance
Contact Lenses	One set of contacts per plan year. Referral Required	10% coinsurance
DENTAL CARE		
Preventive Dental Care	One dental exam and cleaning per 6 month period	$15 copayment
Routine Dental Care	Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing xrays at 6 to 12 month intervals	$15 copayment
Major Dental (Endodontics, Periodontics, and Prosthodontics)	Referral required	$15 copayment

This summary is provided for information only; it does not contain complete details or limitations of the Plan which are available only in the Contract or Certificate of Coverage/Insurance, and it does not constitute an agreement.

Second opinions on diagnosis of cancer are covered at Participating Cost Sharing for Non-Participating Specialist when a Referral is obtained.