

| | ESSENTIAL PLAN 1 | ESSENTIAL PLAN 1 AI/AN | ESSENTIAL PLAN 1 (DV) | ESSENTIAL PLAN 1 AI/AN (DV) | ESSENTIAL PLAN 2 | ESSENTIAL PLAN 2 AI/AN | ESSENTIAL PLAN 2 (DV) | ESSENTIAL PLAN 2 AI/AN (DV) | ESSENTIAL PLAN 3 | ESSENTIAL PLAN 4 |
|--|--|--|--|--|--|--|--|--|--|--|
| COST-SHARING | | | | | | | | | | |
| Deductible ■ Individual | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Out-of-Pocket Limit | **** | | 4 | •- | 4 | | | | | |
| Individual OFFICE VISITS | \$2,000 | \$0 | \$2,000 | \$0 | \$200 | \$ 0 | \$200 | \$0 | \$200 | \$0 |
| Primary Care Office Visits (or Home Visits) | \$15 | \$ 0 | \$ 15 | \$ 0 | \$ 0 | \$0 | \$ 0 | \$ 0 | \$ 0 | \$ 0 |
| Specialist Office Visits (or Home Visits) | \$25 | \$0 | \$25 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| PREVENTIVE CARE | | | | | | | | | | |
| Adult Annual Physical Examinations* Adult Immunizations* | 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 Covered in full | Covered in full Covered in full | Covered in full Covered in full |
| Routine Gynecological Services/Well Woman Exams* | Covered in full |
| Mammography Screenings and Diagnostic Imaging for the Detection of | Covered in full |
| Breast Cancer Sterilization Procedures for Women* | Covered in full |
| Vasectomy | Covered in full |
| Bone Density Testing* | Covered in full |
| Screening for Prostate Cancer Performed in PCP Office Performed in PCP Office | \$ 15 | \$0 | \$15 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Performed in Specialist Office | \$25 | \$0 \$0 | \$25 | \$0 \$0 | \$0 \$0 | \$0 | \$0 \$0 | \$0 | \$0 \$0 | \$0 |
| All other preventive services required by USPSTF and HRSA | Covered in full |
| | Use Cost-Sharing for appropriate service (Primary Care Office | Use Cost-Sharing for appropriate service (Primary Care Office | Use Cost-Sharing for appropriate service (Primary Care Office | Use Cost-Sharing for appropriate service (Primary Care Office | Use Cost-Sharing for appropriate service (Primary Care Office | Use Cost-Sharing for appropriate service (Primary Care Office | Use Cost-Sharing for appropriate service (Primary Care Office | Use Cost-Sharing for appropriate service (Primary Care Office | Use Cost-Sharing for appropriate service (Primary Care Office | Use Cost-Sharing for appropriate service (Primary Care Office |
| *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA | Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) |
| EMERGENCY CARE | | | | | | | | | | |
| Pre-Hospital Emergency Medical Services | \$75 | \$0 | \$75 | \$ 0 | \$0 | \$0 | \$ 0 | \$0 | \$0 | \$ 0 |
| (Ambulance Services) | · | | · | • | | · | • | | · | |
| Non-Emergency Ambulance Services Preauthorization Required | \$75 | \$0 | \$75 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Emergency Department | \$75 | \$0 | \$75 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| [Copayment / Coinsurance waived if Hospital admission] | • | • | ••• | • | • | • | • | • | • | • |
| Urgent Care Center | \$25 | \$0 | \$25 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| PROFESSIONAL SERVICES and OUTPATIENT CARE Advanced Imaging Services | | | | | | | | | | |
| Performed in a Freestanding Radiology Facility or Office Setting Performed as Outpatient Hospital Services | \$25 \$25 | \$0 \$0 | \$25 \$25 | \$0 \$0 |
| Preauthorization Required | | | | | | | | | | |
| Allergy Testing and Treatment Performed in a PCP Office | \$ 15 | \$0 | \$15 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Performed in a Specialist Office | \$25 | \$0 | \$25 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Ambulatory Surgical Center Facility Fee Anesthesia Services (all settings) Preauthorization Required | \$50 Covered in full | \$0 Covered in full | \$50 Covered in full | \$0 Covered in full | \$0 Covered in full | \$0 Covered in full | \$0 Covered in full | \$0 Covered in full | \$0 Covered in full | \$0 Covered in full |
| Autologous Blood Banking | 5% coinsurance | Covered in full | 5% coinsurance | Covered in full |
| Preauthorization Required Cardiac and Pulmonary Rehabilitation | | | | | | | | | | |
| Performed in a Specialist Office | \$25 | \$0 | \$25 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Performed as Outpatient Hospital Services | \$25 | \$0 | \$25 | \$0 | \$0 | \$0 | \$0 | \$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 | 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 |
| Preauthorization Required | cost-snanny | cost-snanny | Cost-snanny | COSC-SHAIIIIY | oost-snanny | Cost-snanny | cost-snanny | cost-snanny | COSE-SHAIIIIY | |
| Chemotherapy | | ** | ^ | | 40 | ** | * | ** | 40 | ** |
| Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services | \$15 \$15 \$15 | \$0 \$0 \$0 | \$15 \$15 \$15 | \$0 \$0 \$0 |
| Preauthorization Requiredm (preauthorizaion not required for injectables and infusions) | | | | | | | | | | |



| | ESSENTIAL PLAN 1 | ESSENTIAL PLAN 1 AI/AN | ESSENTIAL PLAN 1 (DV) | ESSENTIAL PLAN 1 AI/AN (DV) | ESSENTIAL PLAN 2 | ESSENTIAL PLAN 2 AI/AN | ESSENTIAL PLAN 2 (DV) | ESSENTIAL PLAN 2 Al/AN (DV) | ESSENTIAL PLAN 3 | ESSENTIAL PLAN 4 |
|---|------------------------------|------------------------------|------------------------------|--------------------------------|------------------------------|------------------------------|------------------------------|--------------------------------|---------------------------|---------------------------|
| Chiropractic Services | \$25 | \$0 | \$25 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Preauthorization Required | | | | | | | | | | |
| Clinical Trials | Use Cost-Sharing for | Use Cost-Sharing for | Use Cost-Sharing for | Use Cost-Sharing for | Use Cost-Sharing for | Use Cost-Sharing for | Use Cost-Sharing for | Use Cost-Sharing for | Use Cost-Sharing for | Use Cost-Sharing for |
| | appropriate service | appropriate service | appropriate service | appropriate service | appropriate service | appropriate service | appropriate service | appropriate service | appropriate service | appropriate service |
| Preauthorization Required | | | | | | | | | | |
| Diagnostic Testing Performed in a PCP Office | \$15 | \$0 | \$ 15 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Performed in a PCP Office Performed in a Specialist Office | \$25 | \$0 \$0 | \$15 \$25 | \$0 | Φ0 \$0 | \$0 \$0 | \$0 \$0 | \$0 | \$0 \$0 | \$0 \$0 |
| Performed in a Specialist Office Performed as Outpatient Hospital Services | \$25 \$25 | \$0 \$0 | \$25 \$25 | \$0 | \$0 \$0 | \$0 \$0 | \$0 \$0 | \$0 | \$0 \$0 | \$0 \$0 |
| Dialysis | Ψ23 | ΨΟ | ΨΖΟ | ΨΟ | ΨΟ | ΨΟ | ΨΟ | Ψ0 | Ψ0 | ΨΟ |
| Performed in a PCP Office | \$15 | \$0 | \$15 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Performed in a Freestanding Center or Specialist Office Setting | \$15 | \$0 | \$15 | \$0 | \$0 \$0 | \$0 | \$0 \$0 | \$0 | \$0 \$0 | \$0 \$0 |
| Performed as Outpatient Hospital Services | \$15 | \$0 \$0 | \$15 | \$0 | \$0 \$0 | \$0 | \$0 | \$0 | \$0 \$0 | \$0 \$0 |
| Preauthorization required with first encounter and after 12 visits | ψ10 | Ψ | Ψ10 | ΨΟ | ΨΟ | Ψΰ | ΨΟ | Ψ0 | ΨΟ | ΨΟ |
| Habilitation Services | \$15 | \$0 | \$15 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| (Physical Therapy, Occupational Therapy or Speech Therapy) | 1 | | 4.5 | + • | 4 • | T | Ψ* | | 4 • | 4.0 |
| (· · · · · · · · · · · · · · · · · · · | 60 visits per condition, per | 60 visits per condition, per | 60 visits per condition, per | 60 visits per condition, per | 60 visits per condition, per | 20 visits per therapy per | 20 visits per therapy per |
| | | | | | | | | lifetime combined therapies | Plan Year | Plan Year |
| Preauthorization required after 6 visits | • | 1 | | 1 | • | | 1 | 1 | | |
| Home Health Care | \$15 | \$0 | \$15 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| 40 visits Per Plan Year | · | · · | · · | · | · | · | , | · | · | · |
| Preauthorization required | | | | | | | | | | |
| • | Use Cost-Sharing for | Use Cost-Sharing for | Use Cost-Sharing for | Use Cost-Sharing for | Use Cost-Sharing for | Use Cost-Sharing for | Use Cost-Sharing for | Use Cost-Sharing for | Use Cost-Sharing for | Use Cost-Sharing for |
| | appropriate service | appropriate service | appropriate service | appropriate service | appropriate service | appropriate service | appropriate service | appropriate service | appropriate service | appropriate service |
| Infertility Services | (Office Visit; Diagnostic | (Office Visit; Diagnostic | (Office Visit; Diagnostic | (Office Visit; Diagnostic | (Office Visit; Diagnostic | (Office Visit; Diagnostic | (Office Visit; Diagnostic | (Office Visit; Diagnostic | (Office Visit; Diagnostic | (Office Visit; Diagnostic |
| | Radiology Services; | Radiology Services; | Radiology Services; | Radiology Services; | Radiology Services; | Radiology Services; | Radiology Services; | Radiology Services; | Radiology Services; | Radiology Services; |
| | Surgery; Laboratory & | Surgery; Laboratory & | Surgery; Laboratory & | Surgery; Laboratory & | Surgery; Laboratory & | Surgery; Laboratory & | Surgery; Laboratory & | Surgery; Laboratory & | Surgery; Laboratory & | Surgery; Laboratory & |
| Preauthorization Required | Diagnostic Procedures) | Diagnostic Procedures) | Diagnostic Procedures) | Diagnostic Procedures) | Diagnostic Procedures) | Diagnostic Procedures) | Diagnostic Procedures) | Diagnostic Procedures) | Diagnostic Procedures) | Diagnostic Procedures) |
| Infusion Therapy | | | | | | | | | | |
| Performed in a PCP Office | \$15 | \$0 | \$15 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Performed in Specialist Office | \$15 | \$0 | \$15 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Performed as Outpatient Hospital Services | \$15 | \$0 | \$15 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Home Infusion Therapy | \$15 | \$0 | \$15 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| (Home infusion counts toward home health care visit limits) | | | | | | | | | | |
| Preauthorization required for first encounter and beyond 6 encounters | | | | | | | | | | |
| Inpatient Medical Visits | \$0 per admission | \$0 per admission | \$0 per admission | \$0 per admission | \$0 per admission | \$0 per admission | \$0 per admission | \$0 per admission | \$0 per admission | \$0 per admission |
| Preauthorization Required | | | | | | | | | | |
| Laboratory Procedures | | | | | | | | | | |
| Performed in a PCP Office | \$15 | \$0 | \$15 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Performed in a Freestanding Laboratory Facility or Specialist Office | \$25 | \$0 | \$25 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Performed as Outpatient Hospital Services | \$25 | \$0 | \$25 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Maternity and Newborn Care | | | | | | | | | | |
| Prenatal Care | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Inpatient Hospital Services | \$150 Per Admission | \$0 | \$150 Per Admission | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Physician and Midwife Services for Delivery | \$50 | \$0 | \$50 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Breast Pump | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| | Included in Physician and | Included in Physician and | Included in Physician and | Included in Physician and | Included in Physician and | Included in Physician and | Included in Physician and |
| Postnatal Care | Midwife Services for | Midwife Services for | Midwife Services for | Midwife Services for | Midwife Services for | Midwife Services for | Midwife Services for | Midwife Services for | Midwife Services for | Midwife Services for |
| | Delivery Cost-Sharing | Delivery Cost-Sharing | Delivery Cost-Sharing | Delivery Cost-Sharing | Delivery Cost-Sharing | Delivery Cost-Sharing | Delivery Cost-Sharing | Delivery Cost-Sharing | Delivery Cost-Sharing | Delivery Cost-Sharing |
| Proputhorization required at initial visit than at 26 weeks | | ' | | | , , | | | | | , , |
| Preauthorization required at initial visit then at 36 weeks | 1 | I | I | 1 | I | I | | 1 | I | |



| Processing Processor to the registration for the controlling of the | | ESSENTIAL PLAN 1 | ESSENTIAL PLAN 1 AI/AN | ESSENTIAL PLAN 1 (DV) | ESSENTIAL PLAN 1 AI/AN (DV) | ESSENTIAL PLAN 2 | ESSENTIAL PLAN 2 AI/AN | ESSENTIAL PLAN 2 (DV) | ESSENTIAL PLAN 2 Al/AN (DV) | ESSENTIAL PLAN 3 | ESSENTIAL PLAN 4 |
|---|---|--|---------------------------|--------------------------|--------------------------------|--------------------------|---------------------------|--------------------------|--------------------------------|---------------------------|---------------------------|
| Note Proceedings Procedure Procedu | Outpatient Hospital Surgery Facility Charge | \$50 | \$0 | \$50 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Find transfer of the CPUTONIC 150 15 | Preauthorization Required for hospital (not for freestanding) Preadmission Testing | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Production of a incorporary processory depended from 15 to | Diagnostic Radiology Services | 045 | # 0 | C4. | ФО. | ¢o. | ФО. | ФО. | ФО. | ФО | # 0 |
| The control of a positive of the control of the c | | | | | - | · | | | | Ŧ - | \$0 \$0 |
| Prisonal prison for executing includes you find you find you for the prison of the p | | | | | - | r - | | | | • - | \$0 |
| The final following is a Company in Proceed and Company in Compa | Therapeutic Radiology Services | | | | | | | | | | |
| Part | | | | | | | | | | | |
| Part | Preauthorization Required | V 10 | Ψΰ | Ψ10 | Ψ | Ψ0 | Ψ0 | Ψ | Ψΰ | Ψ | Ψ" |
| Disable provided for \$ views Disable provided for \$ views | Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech | \$15 | \$0 | \$15 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Part Year Part Part Part Part Part Part Part Part Part Part | Therapy) see also Habilitation | 60 visits per condition, | 60 visits per condition, | 60 visits per condition, | 60 visits per condition, | 60 visits per condition, | 60 visits per condition, | 60 visits per condition, | 60 visits per condition, | 20 visite per therepy per | 20 visite per therepy per |
| Presentations required after a visits Comment Comme | | • | l · | per Plan Year combined | 1 · | · | 1 · | 1 · | per Plan Year combined | | |
| Secured Children on the Registered of Discusses. Suppose Proceedings Suppose Content Suppose Co | Preauthorization required after 6 visits | tnerapies | tnerapies | tnerapies | tnerapies | therapies | tnerapies | tnerapies | therapies | | |
| Present protection of the Control of Supply of Supply Supp | Second Opinions on the Diagnosis of Cancer, | \$25 | \$0 | \$25 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Support devices (Support, Reconstructive Support, College Reco | Surgery and Other | | | | | | | | | | |
| Possible processed supply of the reconstruction and concentrate during the reconstruction and concentrate during the registered of Registering of Register | | | | | | | | | | | |
| All transpolent must be performed at designated Facilities - Output Production Suggery - Output Produ | (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive | | | | | | | | | | |
| Injusted Houseling Surgery | | | | | | | | | | | |
| Supply Informacy at an Amouston's Surgical Center Sign | | | \$0 | | \$0 | \$0 | | \$0 | \$0 | \$0 | \$0 |
| From the Company 15 6 wines predictioned at PDP of Design 15 15 15 15 15 15 15 1 | Outpatient Hospital Surgery | The state of the s | | • | | • | · | - | | \$0 | ¥ * |
| Presult-orientation Required ABO-Trivenery Internation Required Regular Re | | · | · | + | | , - | · | · | · | \$0 | ** |
| Present for stant or five Septiminary and DEVICES, Septiminary Section Disorder Septiminary Section Disorder Section Disorder Septiminary Section Disorder Section Disorder | Office Surgery | | \$0 | PCP office) | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| ## Presult incitation Required | | • | | | | | | | | | |
| ADDITIONALS SERVICES, DOLUMENT and DEVICES ADDITIONALS SERVICES, DOLUMENT AND SERVICES ADDITIONALS SERVICES, DOLUMENT AND SERVICES, DO | Preauthorization Required | specialist office | | specialist office | | | | | | | |
| ABA Treatment for Autism Securium Disorder \$15 | | | | | | | | | | | |
| Assistate Communication Devices for Authors Spectrum Disorder Preauthorization Required Disorder Equipment, Supplies and Self-Management Education Solidada ysupply Solidada ysu | ABA Treatment for Autism Spectrum Disorder | \$15 | \$0 | \$15 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Presultorization Required (or greater than cost of \$500 Presultorization required (or greater than cost of \$500 Presultorization required Presultorization required (or greater than cost of \$500 Presultorization required (or greater than cost of \$500 Presultorization required Presultorization required (or greater than cost of \$500 Presultorization required (or gr | | Φ4 <i>E</i> | ФО. | Ф4 <i>Б</i> | ФО | ФО | ФО. | ФО | ФО | ФО | \$ 0 |
| Diabetic Equipment Supplies and Self-Management Education S15 S0 \$15 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$ | · | \$15 | Φ0 | \$10 | Φυ | Φ0 | Φ0 | Φ0 | Φ0 | ФО | Φ0 |
| \$30-day supply \$15 | Diabetic Equipment, Supplies and Self-Management Education | | | | | | | | | | |
| ■ Disable Education required for insulin pump Durable Medicinal Equipment required for insulin pump Stock extending \$0 \$15 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$ | | \$15 | \$0 | \$15 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Preauthorization required for insulin pump Durable Medical Equipment and Braces 5% cost-sharing \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$ | | \$15 | \$0 | \$15 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Presention required for DME items greater than cost of \$500 (NY Medicar a retrocluse) Sw cost-sharing \$0 \$5% cost-sharing \$0 \$5% cost-sharing \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$ | Preauthorization required for insulin pump | *** | ** | *** | ** | ¥ 3 | ** | ** | ** | Ψ. | ** |
| Medical Supplies Sw. cost-sharing \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$ | Durable Medical Equipment and Braces | 5% cost-sharing | \$0 | 5% cost-sharing | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| External Hearing Aids Single purchase one every three (3) years) Single purchase one every three (3) years one years of purchase one every three (3) years of the purchase one years of purch | • | | | | | | | | | | |
| Preauthorization required Cochlear Implants Conce (1) per ear per time Covered) Preauthorization required Social Socia | External Hearing Aids | 5% cost-sharing | \$0 | 5% cost-sharing | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Cochlear Implants (One (1) per a per time Covered) Preauthorization required Hospica Care S 150 S 0 S 150 S 0 S 0 S 0 S 0 S 0 S 0 S 0 S 0 S 0 S | (Single purchase one every three (3) years) | | | | | | | | | | |
| (One (1) per ear per time Covered) Preauthorization required Hospice Care Included as part of Inpatient Hospital Cost-sharing Included Included Inpatient Hospital Cost-sharing Included Included Inpatient Hospital Cost-Inpatient Hospital Cost-Inpatient Hospital Cost-Inpatient Ho | · | 5% cost-sharing | \$0 | 5% cost-sharing | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Hospice Care Inpatient Included as part of Inspitant Hospital Costsharing Inspitant Ho | (One (1) per ear per time Covered) | 0 70 oost snaming | ΨΟ | 070 000t onaring | ΨΟ | Ψ | Ψ | ΨΟ | ΨΟ | ΨΟ | Ψ0 |
| Included as part of Inpatient Hospital Cost-sharing sharing sh | Preauthorization required | | | | | | | | ļ | | |
| Outpatient 210 days per Plan Year Preauthorization required Medical Supplies Presuthorization required for greater than cost of \$500 Prosthetic Devices External One (1) prosthetic devices and its parts Included as part of Included as part of Inpatient Hospital Costsharing Inletient Hospital Costsharing Inletient Hospital Costsharing Inpatient Hospital Costsharing Inpatient Hospital Costsharing So Stoinsurance So Stoinsurance So S | · · | \$150 | \$0 | \$150 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Preauthorization required Medical Supplies Presuthorization required for greater than cost of \$500 Presuthorization required for greater than cost of \$500 Prosthetic Devices External Once (1) prosthetic device, per limb, per lifetime, and the cost of repair and replacement of the prosthetic devices and its parts Included as part of Included as part of Inpatient Hospital Costsharing Sharing Included as part of Inpatient Hospital Costsharing | · | | | | | · | | · | | T - | \$0 |
| Medical Supplies Preauthorization required for greater than cost of \$500 Prosthetic Devices • External One (1) prosthetic device, per limb, per lifetime, and the cost of repair and replacement of the prosthetic devices and its parts • Included as part of Inpatient Hospital Costsharing • Internal Included as part of Inpatient Hospital Costsharing • Internal Included as part of Inpatient Hospital Costsharing • So coinsurance \$0 \$5% coinsurance \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$ | 210 days per Plan Year | | | | | | | | | | |
| Medical Supplies Preauthorization required for greater than cost of \$500 Prosthetic Devices • External One (1) prosthetic device, per limb, per lifetime, and the cost of repair and replacement of the prosthetic devices and its parts • Included as part of Inpatient Hospital Costsharing • Internal Included as part of Inpatient Hospital Costsharing • Internal Included as part of Inpatient Hospital Costsharing • So coinsurance \$0 \$5% coinsurance \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$0 \$ | Preauthorization required | | | | | | | | | | |
| • External Some (1) prosthetic device, per limb, per lifetime, and the cost of repair and replacement of the prosthetic devices and its parts Included as part of Inpatient Hospital Costsharing Included as part of Inpatient H | Medical Supplies Preauthorization required for greater than cost of \$500 | 5% coinsurance | \$0 | 5% coinsurance | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| One (1) prosthetic device, per limb, per lifetime, and the cost of repair and replacement of the prosthetic devices and its parts Included as part of Inpatient Hospital Cost-sharing Include | Prosthetic Devices | 50/ | 4.5 | 50/ | | 4.5 | 4.5 | * | * | | |
| replacement of the prosthetic devices and its parts Included as part of Included as part of Included as part of Inpatient Hospital Costsharing Included as part of Inpatient Hospital Costsharing Included as part of Included as part of Inpatient Hospital Costsharing Included as part of Included as part of Inpatient Hospital Costsharing Inpat | | 5% coinsurance | \$0 | 5% coinsurance | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Included as part of Includ | replacement of the prosthetic devices and its parts | | | | | | | | | | |
| sharing sharing sharing sharing sharing sharing sharing sharing sharing | | • | | | - | | • | • | • | - | |
| | • Internal | ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' | · ' | | | • | · | · ' | • • | | |
| | Preauthorization required for greater than cost of \$500 | onanng | onaring | | onaring | | | onaring | - Graining | onanng | onaning |



| | ESSENTIAL PLAN 1 | ESSENTIAL PLAN 1 Al/AN | ESSENTIAL PLAN 1 (DV) | ESSENTIAL PLAN 1 AI/AN (DV) | ESSENTIAL PLAN 2 | ESSENTIAL PLAN 2 AI/AN | ESSENTIAL PLAN 2 (DV) | ESSENTIAL PLAN 2 AI/AN (DV) | ESSENTIAL PLAN 3 | ESSENTIAL PLAN 4 |
|---|------------------|---------------------------|--------------------------|--------------------------------|------------------|---------------------------|--------------------------|--------------------------------|------------------|------------------|
| 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) Preauthorization required. However, Preauthorization is not required for emergency admissions. | \$150 | \$0 | \$150 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Observation Stay Preathorization Required. Copay waived if direct transfer from outpatient surgery setting to observation | \$75 | \$0 | \$75 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) 200 days per Plan Year Copay waived for each admission if directly transferred from hospital inpatient setting to skilled nursing facility Preauthorization required | \$150 | \$0 | \$150 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) 60 days per Plan Year combined therapies Preauthorization required | \$150 | \$0 | \$150 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) 60 days per Plan Year combined therapies Preauthorization required | \$150 | \$0 | \$150 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES | | | | | | | | | | |
| Inpatient Mental Health Care (for a continuous confinement when in a Hospital) Preauthorization required. However, Preauthorization is not required for | \$150 | \$0 | \$150 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| emergency admissions. Outpatient Mental Health Care | \$15 | \$0 | \$15 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| (including Partial Hospitalization and Intensive Outpatient Program Services) Preauthorization required | | | | | | | | | | |
| Inpatient Substance Use Services (for a continuous confinement when in a Hospital) Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities. | \$150 | \$0 | \$150 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| Outpatient Substance Use Services Up to 20 visits per Plan Year may be used for family counseling | \$15 | \$0 | \$15 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 | \$0 |
| *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 Tier 1 | \$6 | \$0 | \$6 | \$0 | \$1 | \$0 | \$1 | \$0 | \$1 | \$0 |
| Tier 2 | \$15 | \$0 | \$15 | \$0 | \$3 | \$0 | \$3 | \$0 | \$3 | \$0 |
| Tier 3 | \$30 | \$0 | \$30 | \$0 | \$3 | \$0 | \$3 | \$0 | \$3 | \$0 |
| Mail Order Pharmacy Up to a 90-day supply for Maintenance Drugs (2.5x copay) Tier 1 | \$15 | \$0 | \$15 | \$0 | \$2.50 | \$0 | \$2.50 | \$0 | \$2.50 | \$0 |
| Tier 2 | \$37.50 | \$0 | \$37.50 | \$0 | \$7.50 | \$0 \$0 | \$7.50 | \$0 | \$7.50 | \$0 |
| Tier 3 NON-PRESCRIPTION DRUGS | \$75 | \$0 | \$75 | \$0 | \$7.50 | \$0 | \$7.50 | \$0 | \$7.50 | \$0 |
| (only include for Essential Plans 3 & 4) | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A | \$0.50 | \$0 |



| | ESSENTIAL PLAN 1 | ESSENTIAL PLAN 1 AI/AN | ESSENTIAL PLAN 1 | ESSENTIAL PLAN 1 | ESSENTIAL PLAN 2 | ESSENTIAL PLAN 2 AI/AN | ESSENTIAL PLAN 2 | ESSENTIAL PLAN 2 | ESSENTIAL PLAN 3 | ESSENTIAL PLAN 4 |
|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| WELLNESS BENEFITS | | Al/AN | (DV) | AVAN (DV) | | AVAN | (DV) | Al/AN (DV) | | |
| Gym Reimbursement | Up to \$200 per six (6)- |
| | month period |
| Breast cancer screening (Women ages 50 and up) Diabetes - eye exam Flu Vaccinations Complete annual visit with PCP | \$25 Gift Card |
| | \$25 Gift Card |
| | \$25 Gift Card |
| | \$25 Gift Card |
| | \$10, or \$15,or \$25 Gift |
| Colorectal Screening (Men ages 50 and up) Complete health risk assessment Sign-up for Affinity newsletter | Card |
| | \$25 Gift Card |
| | \$10 Gift Card |
| Asthma medicine maintenance | \$25 Gift Card at 6 |
| | months and 12 months |
| DENTAL and VISION CARE | | | | | | | | | | |
| Dental Care Preventive Dental Care Routine Dental Care Major Dental (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 Orthodontics and major dental require Preauthorization | N/A | N/A | \$15 | \$0 | N/A | N/A | \$0 | \$0 | \$0 | \$0 |
| | N/A | N/A | \$15 | \$0 | N/A | N/A | \$0 | \$0 | \$0 | \$0 |
| | N/A | N/A | \$15 | \$0 | N/A | N/A | \$0 | \$0 | \$0 | \$0 |
| Vision Care Exams Lenses and Frames Contact Lenses One (1) exam per [12-month period; Plan Year One (1) prescribed lenses and frames per Plan Year Contact lenses require Preauthorization | N/A | N/A | \$15 | \$0 | N/A | N/A | \$0 | \$0 | \$0 | \$0 |
| | N/A | N/A | 10% Coinsurance | \$0 | N/A | N/A | \$0 | \$0 | \$0 | \$0 |
| | N/A | N/A | 10% Coinsurance | \$0 | N/A | N/A | \$0 | \$0 | \$0 | \$0 |