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 1	ESSENTIAL PLAN 2	ESSENTIAL PLAN 3	ESSENTIAL PLAN 4	ESSENTIAL PLAN 200-250
Deductible • Individual	$0	$0	$0	$0	$0
Out-of-Pocket Limit • Individual	$360	$200	$200	$0	$2,000
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	$15

Specialist Office Visits (or Home Visits)	$25	$0	$0	$0	$25
PREVENTIVE CARE					
• Adult Annual Physical Examinations*	Covered in full	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	Covered in full
• Routine Gynecological Services/Well Woman Exams*	Covered in full	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	Covered in full
• Sterilization Procedures for Women*	See Surgical Services Section	See Surgical Services Section	See Surgical Services Section	See Surgical Services Section	See Surgical Services Section
• Vasectomy	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full

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• Bone Density Testing*	Covered in full	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	Covered in full
• Screening for Colon Cancer	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full
• 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	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	$0	$0	$0	$75

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

Hospital Services					
Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office	$15 $25	$0 $0	$0 $0	$0 $0	$15 $25
Ambulatory Surgical Center Facility Fee	$50	$0	$0	$0	$50
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 • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	$25 $25 Included as part of inpatient Hospital service cost-sharing	$0 $0 Included as part of inpatient Hospital service cost-sharing	$0 $0 Included as part of inpatient Hospital service cost-sharing	$0 $0 Included as part of inpatient Hospital service cost-sharing	$25 $25 Included as part of inpatient Hospital service cost-sharing
Chemotherapy and Immunotherapy • Administration • Performed in a PCP Office	$15	$0	$0	$0	$15

• Performed in a Specialist Office	$15	$0	$0	$0	$15
• Performed as Outpatient Hospital Services	$15	$0	$0	$0	$15
• Chemotherapy and Immunotherapy Medications	$15	$0	$0	$0	$15
Chiropractic Services	$25	$0	$0	$0	$25
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 • Performed in a PCP Office	$15	$0	$0	$0	$15
• Performed in a Specialist Office	$25	$0	$0	$0	$25

• Performed as Outpatient Hospital Services	$25	$0	$0	$0	$25
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services	$15 $15 $15	$0 $0 $0	$0 $0 $0	$0 $0 $0	$15 $15 $15
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$15 60 visits per condition, per Plan Year combined therapies	$0 60 visits per condition, per Plan Year combined therapies	$0	$0	$15 60 visits per condition, per Plan Year combined therapies
Home Health Care 40 visits Per Plan Year	$15	$0	$0	$0	$15
Infertility Services	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery;	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery;	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)

	& Diagnostic Procedures)	Laboratory & Diagnostic Procedures)	& Diagnostic Procedures)	Laboratory & Diagnostic Procedures)	
Infusion Therapy • Performed in a PCP Office	$15	$0	$0	$0	$15
• Performed in a Specialist Office	$15	$0	$0	$0	$15
• Performed as Outpatient Hospital Services	$15	$0	$0	$0	$15
• Home Infusion Therapy (Home infusion counts toward home health care visit limits)	$15	$0	$0	$0	$15
Inpatient Medical Visits	$0 per admission	$0 per admission	$0 per admission	$0 per admission	$0 per admission
Interruption of Pregnancy • Abortion Services	Covered in Full	Covered in Full	Covered in Full	Covered in Full	Covered in Full
Laboratory Procedures • Performed in a PCP Office	$15	$0	$0	$0	$15

• Performed in a Specialist Office	$25	$0	$0	$0	$25
• Performed in a Freestanding Laboratory Facility or Specialist Office	$25	$0	$0	$0	$25
• Performed as Outpatient Hospital Services	$25	$0	$0	$0	$25
Maternity and Newborn Care					
• Prenatal Care	$0	$0	$0	$0	$0
• Inpatient Hospital Services and Birthing Center	$150 per admission	$0	$0	$0	$150 per admission
• Physician and Midwife Services for Delivery	$50	$0	$0	$0	$50
• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps	$0	$0	$0	$0	$0

*Covered for duration of breast feeding • 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	Included in Physician and Midwife Services for Delivery Cost-Sharing
Outpatient Hospital Surgery Facility Charge	$50	$0	$0	$0	$50
Preadmission Testing	$0	$0	$0	$0	$0
Prescription Drugs Administered in Office or Outpatient Facilities					
• Performed in a PCP Office	$15	$0	$0	$0	$15
• Performed in Specialist Office	$25	$0	$0	$0	$25
• Performed in Outpatient Facilities	$25	$0	$0	$0	$25
• Prescription Drug Cost-Sharing	$15	$0	$0	$0	$15

Diagnostic Radiology Services					
• Performed in a PCP Office	$15	$0	$0	$0	$15
• Performed in a Specialist Office	$25	$0	$0	$0	$25
• Performed in a Freestanding Radiology Facility	$25	$0	$0	$0	$25
• Performed as Outpatient Hospital Services	$25	$0	$0	$0	$25
Therapeutic Radiology Services					
• Performed in a Specialist Office	$15	$0	$0	$0	$15
• Performed in a Freestanding Radiology Facility	$15	$0	$0	$0	$15
• Performed as Outpatient Hospital Services	$15	$0	$0	$0	$15

Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$15 60 visits per condition, per Plan Year combined therapies Speech and physical therapy are only Covered following a Hospital stay or surgery	$0 60 visits per condition, per Plan Year combined therapies Speech and physical therapy are only Covered following a Hospital stay or surgery	$0	$0	$15 60 visits per condition, per Plan Year combined therapies Speech and physical therapy are only Covered following a Hospital stay or surgery
Second Opinions on the Diagnosis of Cancer, Surgery and Other	$25	$0	$0	$0	$25
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants) **All transplants must be performed at designated Facilities**	$50	$0	$0	$0	$50

• Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery	$50 $50 $15 (when performed at PCP office) $25 (when performed at specialist office)	$0 $0 $0	$0 $0 $0	$0 $0 $0	$50 $50 $15 (when performed at PCP office) $25 (when performed at specialist office)
ADDITIONAL SERVICES, EQUIPMENT and DEVICES					
Diabetic Equipment, Supplies and Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-day; Up to a 90 supply)	$15	$0	$0	$0	$15

• Diabetic Education	$15	$0	$0	$0	$15
Durable Medical Equipment and Braces	5% cost-sharing	$0	$0	$0	5% cost-sharing
External Hearing Aids • Prescription Hearing Aids **(Single purchase one every three (3) years)**	5% cost-sharing	$0	$0	$0	5% cost-sharing
Cochlear Implants **(One (1) per ear per time Covered)**	5% cost-sharing	$0	$0	$0	5% cost-sharing
Hospice Care • Inpatient • Outpatient 210 days per Plan Year Five (5) visits for family bereavement counseling	 $150 $15	 $0 $0	 $0 $0	 $0 $0	 $150 $15
Medical Supplies	5% coinsurance	$0	$0	$0	5% coinsurance

Prosthetic Devices • External One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements • Internal	5% coinsurance Included as part of Inpatient Hospital Cost-sharing	$0 Included as part of Inpatient Hospital Cost-sharing	$0 Included as part of Inpatient Hospital Cost-sharing	$0 Included as part of Inpatient Hospital Cost-sharing	5% coinsurance 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	$0	$0	$0	$150
Autologous Blood Banking Services	5% co-insurance	$0	$0	$0	5% co-insurance

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

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

Program Services, and Medication Assisted Treatment) • Office Visits • All Other Outpatient Services • Opioid Treatment Programs	 $15 $15 $0	 $0 $0 $0	 $0 $0 $0	 $0 $0 $0	 $15 $15 $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.					
Retail Pharmacy					
30-day supply Tier 1 Tier 2 Tier 3	 $6 $15 $30	 $1 $3 $3	 $1 $3 $3	 $0 $0 $0	 $6 $15 $30

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 Tier 2 Tier 3	 $15 $37.50 $75	 $2.50 $7.50 $7.50	 $2.50 $7.50 $7.50	 $0 $0 $0	 $15 $37.50 $75
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

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DENTAL and VISION CARE					
Dental Care • 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 • Exams • Lenses and Frames • Contact Lenses One (1) exam per 12-month period, unless otherwise medically necessary One (1) prescribed	$0 $0 $0	$0 $0 $0	$0 $0 $0	$0 $0 $0	$0 $0 $0

lenses and frames per 12-month period, unless otherwise medically necessary					

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. 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, with the exception of the delivery/hospital stay, for enrollees who become pregnant while having coverage in any Essential Plan. Cost sharing would be waived for PCP, Diagnostic, Prescription/non-prescription drugs, and DME 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. Cost sharing is not waived for the delivery/hospital stay.

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.

* Pending Federal Waiver Approval