ATTACHMENT G EP BENEFITS AND COST SHARING GRID

TYPE OF SERVICE	*Essential 200 - 250 200 – 250% FPL	Essential Plan 1 150 - 200% FPL	Essential Plan 2 138 - 150% FPL	Essential Plan 3 100 - 138% FPL	Essential Plan 4 Below 100% FPL
DEDUCTIBLE (single)	$0	$0	$0	$0	$0
MAXIMUM OUT OF POCKET LIMIT (single) Includes the deductible	$2,000	**$360	$200	$200	$0
COST SHARING - MEDICAL SERVICES					
Inpatient Facility/SNF/Hospice	$150 per admission	$150 per admission	$0 per admission	$0 per admission	$0 per admission
Outpatient Facility-Surgery, including freestanding surgicenters	$50	$50	$0	$0	$0
Surgeon - Inpatient facility, outpatient facility, including freestanding surgicenters	$50	$50	$0	$0	$0
	One such copay per surgery and applies only to surgery performed in a hospital inpatient or hospital outpatient				
PCP	$15	$15	$0	$0	$0
Specialist	$25	$25	$0	$0	$0
PT/OT/ST - rehabilitative & habilitative therapies	$15	$15	$0	$0	$0
ER	$75	$75	$0	$0	$0
Ambulance	$75	$75	$0	$0	$0
Urgent Care	$25	$25	$0	$0	$0
DME/Medical supplies	5% cost sharing	5% cost sharing	$0	$0	$0
Hearing aids	5% cost sharing	5% cost sharing	$0	$0	$0
Non-emergency transportation	N/A	N/A	N/A	$0	$0
Non-prescription drugs	N/A	N/A	N/A	$.50	$0
Adult dental (Preventive Dental Care; Routine Dental Care and Major Dental Care)	$0	$0	$0	$0	$0
Vision care - Exams	$0	$0	$0	$0	$0
Vision care - Lenses and Frames	$0	$0	$0	$0	$0
Vision care - Contact Lenses	$0	$0	$0	$0	$0

INPATIENT HOSPITAL SERVICES

Observation stay/observation care unit	ER copay per case, copay is waived if direct transfer from outpatient surgery setting to an observation care unit
Hospital services- non-maternity	Inpatient Facility copay per admission#
Maternity care stay (covers mother & Well newborn combined)	Inpatient Facility copay per admission#
Mental health/Behavioral healthcare	Inpatient Facility copay per admission#
Detoxification	Inpatient Facility copay per admission#
Substance use disorder services	Inpatient Facility copay per admission#
Skilled nursing facility	Indicated copay per admission is waived if direct transfer from hospital inpatient setting to skilled nursing facility
Hospice (inpatient)	Indicated copay per admission is waived if direct transfer from hospital inpatient setting or skilled nursing facility to hospice facility

EMERGENCY MEDICAL SERVICES

Facility charge - Emergency room	ER copay per case - copay is waived if patient is admitted as an inpatient (including as an observation care unit) directly from the emergency room
Physician charge - Emergency room visit	$0 copay per visit
Facility charge - Freestanding urgent care	Urgent care copay per visit
Physician charge - Urgent care	$0 copay per visit
Prehospital emergency services/ transportation, includes air ambulance	Ambulance copay per case

ATTACHMENT G EP BENEFITS AND COST SHARING GRID

TYPE OF SERVICE	*Essential 200 - 250 200 – 250% FPL	Essential Plan 1 150 - 200% FPL	Essential Plan 2 138 - 150% FPL	Essential Plan 3 100-138% FPL	Essential Plan 4 Below 100% FPL
OUTPATIENT HOSPITAL/FACILITY SERVICES					
Outpatient facility surgery - hospital facility charge, including freestanding surgicenters	Outpatient Facility-Surgery copay per case				
Pre-admission/pre-operative testing	$0 copay				
Diagnostic and routine laboratory and pathology	Specialist copay per visit				
Diagnostic and routine imaging services including Xray; excluding CAT/PET scans, MRI	Specialist copay per visit				
Imaging: CAT/PET scans, MRI	Specialist copay				
Chemotherapy	PCP copay per visit				
Radiation therapy	PCP copay per visit				
Hemodialysis/Renal dialysis	PCP copay per visit				
Mental health/Behavioral health care	PCP copay per visit				
Substance use disorder services	PCP copay per visit				
Covered therapies (PT, OT, ST) – rehabilitative & habilitative	PT/OT/ST copay per visit				
Home care	PCP copay per visit				
Hospice	PCP copay per visit				
PREVENTIVE & PRIMARY CARE SERVICES					
Bone density testing	NOTE: For preventive case visits/services as defined in section 2713 of ACA no deductible or cost sharing applies. Otherwise, the cost sharing indicated below applies to all services				
Cervical cytology					
Colonoscopy screening					
Gynecological exams					
Immunizations	PCP/Specialist copay per visit (based on type of physician performing the service)				
Mammography					
Prenatal maternity care					
Prostate cancer screening					
Routine exams					
Women's preventive health services					

PHYSICIAN/PROFESSIONAL SERVICES	
Inpatient hospital surgery - surgeon	Surgeon copay per case
Outpatient hospital and freestanding surgicenter - surgeon	Surgeon copay per case
Office surgery	PCP/Specialist copay per visit (based on type of physician performing the service)
Anesthesia (any setting)	Covered in full, no deductible and no cost sharing applies
Covered therapies (PT, OT, ST) - Rehabilitative & habilitative	PT/OT/ST copay per visit
Additional surgical opinion	Specialist copay per visit
Second medical opinion for cancer	Specialist copay per visit
Maternity delivery and post-natal care - physician or midwife	Surgeon copay per case for delivery and post natal care services combined (only one such copay per pregnancy)
In-hospital physician visits	$0 copay per visit
Diagnostic office visits	PCP/Specialist copay per visit (based on type of physician performing the service)
Diagnostic and routine laboratory and pathology	PCP/Specialist copay per visit
Diagnostic and routine imaging services including Xray; excluding CAT/PET scans, MRI	PCP/Specialist copay per visit
Imaging: CAT/PET scans, MRI	Specialist copay per visit
Allergy testing	PCP/Specialist copay per visit
Allergy shots	PCP/Specialist copay per visit
Office/outpatient consultations	PCP/Specialist copay per visit (based on type of physician performing the service)
Mental health/Behavioral healthcare	PCP copay per visit
Substance use disorder services	PCP copay per visit
Chemotherapy	PCP copay per visit
Radiation therapy	PCP copay per visit
Hemodialysis/Renal dialysis	PCP copay per visit
Chiropractic care	Specialist copay per visit

ATTACHMENT G EP BENEFITS AND COST SHARING GRID

TYPE OF SERVICE	*Essential Plan 200 – 250% 200 – 250 % FPL	Essential Plan 1 150 - 200% FPL	Essential Plan 2 138 - 150% FPL	Essential Plan 3 100-138% FPL	Essential Plan 4 Below 100% FPL
ADDITIONAL BENEFITS/SERVICES					
ABA treatment for Autism Spectrum Disorder			PCP copay per visit		
Assistive Communication Devices for Autism Spectrum Disorder			PCP copay per visit		
Durable medical equipment and medical supplies			DME/Medical supplies coinsurance cost sharing applies		
Hearing evaluations/testing			Specialist copay per visit		
Hearing aids			Hearing aid coinsurance cost sharing applies		
Diabetic drugs and supplies			PCP Copay per 30 days supply		
Diabetic education and self-management			PCP copay per visit		
Home care			PCP copay per visit		
Exercise facility reimbursements	$200/$100 reimbursement every six months for member. Partial reimbursement for facility fees every six months if member attains at least 50				
PRESCRIPTION DRUGS					
Generic or Tier 1	$6	$6	$1	$1	$0
Formulary Brand or Tier 2	$15	$15	$3	$3	$0
Non-Formulary Brand or Tier 3	$30	$30	$3	$3	$0
Above are retail copay amounts; mail order copays are 2.5 times retail for a 90-day supply					

Additional Instructions:

- ✓ For an inpatient admission the only copay that applies during an inpatient stay is the inpatient facility per admission copay, and if surgery is performed a surgeon copay, and if a maternity delivery is performed a maternity delivery which is the same as the surgeon copy if this copay has not already been collected as part of another maternity related claim
- ✓ There are no additional copays for diagnostic tests, medical supplies, in-hospital physician visits, anesthesia, assistant surgeon, other staff doctors, etc.
- ✓ For a maternity stay the inpatient per admission copay covers charges for the mother and a well newborn.
- ✓ The inpatient facility copay per admission is waived for a re-admission within 90 days of a previous discharge for the same or a related condition.
- ✓ If the copay payable is more than the allowed amount (or remainder of the allowed amount), the copay payable is reduced to the allowed amount (or to the remainder of the allowed amount).
- ✓ The maximum out of pocket limit is an aggregate over all covered services (medical and prescription drugs).
- ✓ No cost sharing applies to the preventive care visits/services defined in section 2713 of ACA.

* Pending Federal Waiver approval
** Maximum out of pocket changed from $2000 to $360 effective 1/1/2024