

# ATTACHMENT G - EP PRODUCT OFFERING AND COST-SHARING

## Cost Sharing Chart

	Essential Plan1	Essential Plan 2	Essential Plan 3	Essential Plan 4
	150 - 200% FPL	138 - 150% FPL	100 - 138% FPL	Below 100% FPL
TYPE OF SERVICE				
DEDUCTIBLE (single)	\$0	\$0	\$0	\$0
MAXIMUM OUT OF POCKET LIMIT (single)	\$2,000	\$200	\$200	\$200
Includes the deductible				
COST SHARING - MEDICAL SERVICES				
Inpatient Facility/SNF/Hospice	\$150 per admission	\$0 per admission	\$0 per admission	\$0 per admission
Outpatient Facility-Surgery, including freestanding surgicenters	\$50	\$0	\$0	\$0
Surgeon - Inpatient facility, outpatient facility, including freestanding surgicenters	\$50	\$0	\$0	\$0
One such copay per surgery and applies only to surgery performed in a hospital inpatient or hospital outpatient				
PCP	\$15	\$0	\$0	\$0
Specialist	\$25	\$0	\$0	\$0
PT/OT/ST - rehabilitative & habilitative therapies	\$15	\$0	\$0	\$0
ER	\$75	\$0	\$0	\$0
Ambulance	\$75	\$0	\$0	\$0
Urgent Care	\$25	\$0	\$0	\$0
DME/Medical supplies	5% cost sharing	\$0	\$0	\$0
Hearing aids	5% cost sharing	\$0	\$0	\$0
Non-emergency transportation	N/A	N/A	\$0	\$0
Non-prescription drugs	N/A	N/A	\$1	\$0
Adult dental (Preventive Dental Care; Routine Dental Care and Major Dental Care)	\$15	\$0	\$0	\$0
Vision care - Exams	\$15	\$0	\$0	\$0
Vision care - Lenses and Frames	10% Coinsurance	\$0	\$0	\$0
Vision care - Contact Lenses	10% Coinsurance	\$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 and well newborn combined)	Inpatient Facility copay per admission#
Mental health/Behavioral health care	Inpatient Facility copay per admission#
Detoxification	Inpatient Facility copay per admission#
Substance abuse 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

### 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 center	Urgent care copay per visit
Physician charge - Free standing urgent care center visit	\$0 copay per visit
Prehospital emergency services/ transportation, includes air ambulance	Ambulance copay per case

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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 abuse 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		
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 health care			PCP copay per visit	
Substance abuse 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	

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TYPE OF SERVICE				
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		Deductible does not apply. \$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	\$1	\$1	\$0
Formulary Brand or Tier 2	\$15	\$3	\$3	\$0
Non-Formulary Brand or Tier 3	\$30	\$3	\$3	\$0
Above are retail copay amounts; mail order copays are 2.5 times retail for a 90 day supply				

### Additional Instructions:

- \*Benefits identified in *italics* are available to individuals who purchase a Standard BHP Plus Vision/Dental and to individuals at or below 138% of FPL not eligible
- \* 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 delivery which is the same as the surgeon copay 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 maximum out of pocket limit).
- \*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.

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≥ to Medicaid due to immigration status  
≥on copay, and if a maternity delivery is performed a maternity

remainder of the allowed amount).