ATTACHMENT F - BHP PRODUCT OFFERING AND COST-SHARING
Cost Sharing Chart

TYPE OF SERVICE	BHP Cost-Sharing 2 150 - 200% FPL (AV =)	BHP Cost-Sharing 1 100 - 150% FPL (AV =)
DEDUCTIBLE (single)	$0	$0
MAXIMUM OUT OF POCKET LIMIT (single) Includes the deductible	$2,000	$200
COST SHARING - MEDICAL SERVICES		
Inpatient Facility/SNF/Hospice	$150 per admission	$0 per admission
Outpatient Facility-Surgery, including freestanding surgicenters	$50	$0
Surgeon - Inpatient facility, outpatient facility, including freestanding surgicenters	$50 One such copay per surgery and applies only to surgery performed in a hospital inpatient or hospital outpatient facility setting, including freestanding surgicenters, not to office surgery. See also "Maternity delivery and post natal care-physician/midwife" under "physician services".	$0
PCP	$15	$0
Specialist	$25	$0
PT/OT/ST - rehabilitative & habilitative therapies	$15	$0
ER	$75	$0
Ambulance	$75	$0
Urgent Care	$25	$0
DME/Medical supplies	5% cost sharing	$0
Hearing aids	5% cost sharing	$0
Eyewear	5% cost sharing	$0
Non-emergency transportation	N/A	$0
Non-prescription drugs	N/A	$1
Adult dental (Preventive Dental Care; Routine Dental Care and Major Dental Care)	$15	$0
Vision care - Exams	$15	$0
Vision care - Lenses and Frames	10% Coinsurance	$0
Vision care - Contact Lenses	10% Coinsurance	$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/Behavorial 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 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 oberservation care unit) directly from the emergency room	

TYPE OF SERVICE	BHP 150 - 200% FPL	100 - 150% FPL
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/Behavorial 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/servics as defined in section 2713 of ACA no deductible or cost sharing applies. Otherwise the cost sharing indicated below applies to all services in this benefit service category.
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	
	BHP	
TYPE OF SERVICE	150 - 200% FPL (AV = 0.86 to 0.88)	100 - 150% FPL (AV = 0.93 to 0.95)
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/Behavorial 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	

ATTACHMENT F - BHP PRODUCT OFFERING AND COST-SHARING
Cost Sharing Chart

ADDITIONAL BENEFITS/SERVICES	
ABA treatment for Autism Specturm Disorder	PCP copay per visit
Assistive Communiciation 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	Duductible does not apply. $200/$100 reimbursement every six months for member/spouse. * Partial reimbursement for facility fees every six months if member attains at least 50 visits.

PRESCRIPTION DRUGS		
Generic or Tier 1	$6	$1
Formulary Brand or Tier 2	$15	$3
Non-Formulary Brand or Tier 3	$30	$3
Above are retail copay amounts; mail order copays are 2.5 times retail (except for Catastrophic Plans) 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 to Medicaid due to immigration status

* 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, pediatric dental, pediatric vision, and prescription drugs).

*No cost sharing applies to the preventive care visits/services defined in section 2713 of ACA.