	Essential Plan1	Essential Plan 2	Essential Plan 3	Essential Plan 4		
TYPE OF SERVICE	150 - 200% FPL	138 - 150% FPL	100 - 138% FPL	Below 100% FPL		
DEDUCTIBLE (single)	\$0	\$0	\$0	\$0		
MAXIMUM OUT OF POCKET LIMIT (single) Includes the deductible	\$2,000	\$200	\$200	\$0		
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,	\$50	\$0	\$0	\$0		
outpatient facility, including freestanding surgicenters	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	\$.50	\$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		

	ER copay per case, copay is waived if direct transfer from outpatient surgery setting to a		
Observation stay/observation care unit	observation care unit		
	observation care unit		
Hospital services- non-maternity	Inpatient Facility copay per admission#		
Maternity carestay (covers mother and 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 setti		
	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		
	• • • • • •		
RGENCY MEDICAL SERVICES			
GENCY MEDICAL SERVICES	ED consultations consults waited if nationalist admitted as an innational (including as a		
RGENCY 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		
Facility charge - Emergency room			
	observation care unit) directly from the emergency room		
Facility charge - Emergency room  Physician charge - Emergency room visit	observation care unit) directly from the emergency room \$0 copay per visit		
Facility charge - Emergency room  Physician charge - Emergency room visit  Facility charge - Freestanding urgent care	\$0 copay per visit  Urgent care copay per visit		

	BHP Cost-Sharing1	BHP Cost-Sharing2	BHP Cost-Sharing3	BHP Cost-Sharing 4		
PE OF SERVICE	150 - 200% FPL	139 - 150% FPL	100-138% FPL	Below 100% FPL		
JTPATIENT HOSPITAL/FACILITY SERVICES  Outpatient facility surgery - hospital facility charge, including freestanding surgicenters		Outpatient Facility-Su	rgery 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					
EVENTIVE & PRIMARY CARE SERVICES	NOTE: For preventive	e case visits/servics as d	efined in section 2713	of ACA no deductib		
Bone density testing	NOTE: For preventive case visits/servics as defined in section 2713 of ACA no deductibe or cost sharing applies. Otherwise the cost sharing indicated below applies to all services					
Cervical cytology						
Colonoscopy screening Gynecological exams						
	DCD/Chasialist co.	nav ner visit (based on t	ype of physician perfo	rming the service)		
Immunizations	PCP/Specialist col	ou, per vioit (ouseu oii t				
Immunizations  Mammography	PCP/Specialist col	ou, pe. 1.5.2 (54554 51. 5		, , , , , , , , , , , , , , , , , , , ,		
Mammography	PCP/Specialist co	ou, per 11510 (20000 011 0				
Mammography Prenatal maternity care	PCP/Specialist co	33, per 1310 (33333 511 c		,		
Mammography	PCP/Specialist co	,		······g ······		

### PHYSICIAN/PROFESSIONAL SERVICES

Inpatient hospital surgery - surgeon	Surgeon copay per case		
Outpatient hospital and freestanding	Surgeon copay per case		
surgicenter - surgeon			
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) -	PT/OT/ST copay per visit		
rehabilitative&habilitative	1 1/01/31 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 -	Surgeon copay per case for delivery and post natal care services combined (only one		
physician or midwife	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	PCP/Specialist copay per visit		
pathology	r or / Specialist copuly per visit		
Diagnostic and routine imaging services			
including Xray; excluding CAT/PET scans,	PCP/Specialist copay per visit		
MRI			
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 consult at ions	PCP/Specialist copay per visit (based on type of physician performing the ser		
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		

	BHP Cost-Sharing1	BHP Cost-Sharing2	BHP Cost-Sharing3	BHP Cost-Sharing 4	
TYPE OF SERVICE	150 - 200% FPL	138 - 150% FPL	100-138% FPL	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	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	r copays are 2.5 times r	etail for a 90-day suppl	У		

### Additional Instructions:

<sup>\*</sup>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

<sup>\*</sup> 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

<sup>\*</sup> There are no additional copays for diagnostic tests, medical supplies, in-hospital physician visits, anesthesia, assistant surgeon, other staff doctors, etc.

<sup>\*</sup>For a maternity stay the inpatient per admission copay covers charges for the mother and a well newborn.

<sup>\*</sup>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.

<sup>\*</sup>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).

<sup>\*</sup>The maximum out of pocket limit is an aggregate over all covered services (medical and prescription drugs).

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