COST-SHARING

Deductibles
- Individual
- $0
- $0
- $0
- $0
- $0
- $0
- $0
- $0
- $0
- $0

Out-of-Pocket Limit
- Individual
- Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a Plan Year basis.
- $2,000
- $0
- $2,000
- $0
- $200
- $0
- $200
- $0
- $0
- $0

OFFICE VISIT

Primary Care Office Visits (or Home Visits)
- $15
- $0
- $15
- $0
- $0
- $0
- $0
- $0
- $0
- $0

Specialized Office Visits (or Home Visits)
- $25
- $0
- $25
- $0
- $0
- $0
- $0
- $0
- $0
- $0

PREVENTIVE CARE

- Adult Annual Physical Examinations*
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - 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
  - 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
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full

- Mammography Screenings and Diagnostic Imaging for the Detection of Breast Cancer
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full

- Sterilization Procedures for Women*
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full

- Vaccinations
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full

- Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge)
  - See Surgical Services Section
  - See Surgical Services Section
  - See Surgical Services Section
  - See Surgical Services Section
  - See Surgical Services Section
  - See Surgical Services Section
  - See Surgical Services Section
  - See Surgical Services Section
  - See Surgical Services Section
  - See Surgical Services Section

- Bone Density Testing*
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full

- Screening for Prostate Cancer:
  - Performed in PCP Office
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full
  - Covered in full

- All other preventive services required by USPSTF and HRSA
  - 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
  - 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

  *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA

EMERGENCY CARE

Pre-Hospital Emergency Medical Services (Ambulance Services)
- $75
- $0
- $75
- $0
- $0
- $0
- $0
- $0
- $0

Non-Emergency Ambulance Services
- $75
- $0
- $75
- $0
- $0
- $0
- $0
- $0

Preauthorization Required

Emergency Department (Copies waived if hospital admission)
- $75
- $0
- $75
- $0
- $0
- $0
- $0

Urgent Care Center
- $25
- $0
- $25
- $0
- $0
- $0
- $0

Preauthorization required for out-of-network Urgent Care

PROFESSIONAL SERVICES AND OUTPATIENT CARE

Advanced Imaging Services
- Performed in a Freestanding Radiology Facility or Office Setting
  - $25
  - $0
  - $25
  - $0
  - $0
  - $0
  - $0
  - $0
  - $0

- Performed in a specialist office
  - $25
  - $0
  - $25
  - $0
  - $0
  - $0
  - $0
  - $0
  - $0

- Performed as Outpatient Hospital Services
  - $25
  - $0
  - $25
  - $0
  - $0
  - $0
  - $0
  - $0
  - $0

Preauthorization Required

Allergy Testing and Treatment
- Performed in a PCP Office
  - $15
  - $0
  - $15
  - $0
  - $0
  - $0
  - $0
  - $0
  - $0

- Performed in a specialist Office
  - $25
  - $0
  - $25
  - $0
  - $0
  - $0
  - $0
  - $0
  - $0

Preauthorization Required

Ambulatory Surgical Center Facility Fee
- $50
- $0
- $50
- $0
- $0
- $0
- $0
- $0

Preauthorization Required

Anesthesia services (all settings)

Preauthorization Required

Antigenic Blood Banking

Preauthorization Required

Cardiac and Pulmonary Rehabilitation
- Performed in a specialist office
  - $25
  - $0
  - $25
  - $0
  - $0
  - $0
  - $0
  - $0
  - $0

- Performed as Inpatient Hospital Services
  - Included as part of inpatient Hospital service cost-sharing
  - Included as part of inpatient Hospital service cost-sharing
  - Included as part of inpatient Hospital service cost-sharing
  - Included as part of inpatient Hospital service cost-sharing
  - Included as part of inpatient Hospital service cost-sharing
  - Included as part of inpatient Hospital service cost-sharing
  - Included as part of inpatient Hospital service cost-sharing
  - Included as part of inpatient Hospital service cost-sharing

Preauthorization Required

Chemotherapy Administration
- Performed in a PCP Office
  - $15
  - $0
  - $15
  - $0
  - $0
  - $0
  - $0
  - $0
  - $0

- Performed in a specialist office
  - $15
  - $0
  - $15
  - $0
  - $0
  - $0
  - $0
  - $0
  - $0

Chemotherapy Medication

Preauthorization Required (preauthorization not required for injectables and infusions)

12/6/2019
<table>
<thead>
<tr>
<th>Preauthorization Required</th>
<th>Essential Plan 2020 Schedule of Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic Testing</strong></td>
<td></td>
</tr>
<tr>
<td>- Performed in a PIN Office</td>
<td>$15</td>
</tr>
<tr>
<td>- Performed in a Specialist Office</td>
<td>$15</td>
</tr>
<tr>
<td>- Performed in an Outpatient Hospital Services</td>
<td>$15</td>
</tr>
<tr>
<td><strong>Obstetrics</strong></td>
<td></td>
</tr>
<tr>
<td>- Performed in a PIN Office</td>
<td>$15</td>
</tr>
<tr>
<td>- Performed in a Feasibly Center or Specialist Office Setting</td>
<td>$15</td>
</tr>
<tr>
<td>- Performed in an Outpatient Hospital Services</td>
<td>$15</td>
</tr>
<tr>
<td><strong>Preauthorization required at first encounter and after 12 visits</strong></td>
<td>$15</td>
</tr>
<tr>
<td><strong>Laboratory Procedures</strong></td>
<td></td>
</tr>
<tr>
<td>- Performed in a PIN Office</td>
<td>$15</td>
</tr>
<tr>
<td>- Performed in a Specialist Office</td>
<td>$15</td>
</tr>
<tr>
<td>- Performed in an Outpatient Hospital Services</td>
<td>$15</td>
</tr>
<tr>
<td><strong>Preauthorization required at initial visit then at 36 weeks</strong></td>
<td>$50</td>
</tr>
<tr>
<td><strong>Outpatient Hospital Surgery Facility Charge</strong></td>
<td>$50</td>
</tr>
<tr>
<td><strong>Preauthorization Required for hospital (not for freestanding)</strong></td>
<td>$50</td>
</tr>
</tbody>
</table>

**Chiropractic Services**
- Preauthorization Required
  - Use Cost-Sharing for applicable service
  - Use Cost-Sharing for applicable service
  - Use Cost-Sharing for applicable service
  - Use Cost-Sharing for applicable service
  - Use Cost-Sharing for applicable service
  - Use Cost-Sharing for applicable service
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  - Use Cost-Sharing for applicable service
  - Use Cost-Sharing for applicable service
  - Use Cost-Sharing for applicable service
  - Use Cost-Sharing for applicable service

**Infertility Services**
- Preauthorization Required
  - Use Cost-Sharing for applicable service
  - Use Cost-Sharing for applicable service
  - Use Cost-Sharing for applicable service
  - Use Cost-Sharing for applicable service
  - Use Cost-Sharing for applicable service
  - Use Cost-Sharing for applicable service
  - Use Cost-Sharing for applicable service
  - Use Cost-Sharing for applicable service
  - Use Cost-Sharing for applicable service

**Inpatient Medical Visits**
- $0 per admission
- $0 per admission
- $0 per admission
- $0 per admission
- $0 per admission
- $0 per admission
- $0 per admission
- $0 per admission
- $0 per admission

**Interuption of Pregnancy**
- Medically Necessary Abortions (Unlimited)
- Elective Abortions (One (1) procedure per Plan Year)
- Covered in full See Surgical Services Cost-Sharing
- Covered in full See Surgical Services Cost-Sharing
- Covered in full See Surgical Services Cost-Sharing
- Covered in full See Surgical Services Cost-Sharing
- Covered in full See Surgical Services Cost-Sharing
- Covered in full See Surgical Services Cost-Sharing
- Covered in full See Surgical Services Cost-Sharing
- Covered in full See Surgical Services Cost-Sharing
- Covered in full See Surgical Services Cost-Sharing

**Laboratory Procedures**
- Performed in a PIN Office
- Performed in a Specialist Office
- Performed in an Outpatient Hospital Services
- Performed in a Freestanding Laboratory Facility or Specialist Office
- Performed in an Outpatient Hospital Services

**Maternity and Newborn Care**
- Prenatal Care
- Inpatient Hospital Services
- One (1) home care visit is covered at no cost-sharing if mother is discharged from hospital early
- Physician and Midwife Services for Delivery
- Breathing Support, Counseling and Supplies, Including Breast Pumps (Covered for duration of breast feeding)
- Postnatal Care

**Preauthorization required at initial visit then at 36 weeks**
- $50

**Pregnancy Testing**
- $0

**Surgical Services**
- 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
- 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

**Wellness Program**
- $0

**Dialysis**
- Medically Necessary Abortions (Unlimited)
- Breastfeeding Support, Counseling and Supplies, Including Breast Pumps (Covered for duration of breast feeding)

**Essential Plan 1**
- Covered in full

**Essential Plan 2**
- Covered in full

**Essential Plan 3**
- Covered in full

**Essential Plan 4**
- Covered in full
### Essential Plan 2020 Schedule of Benefits

<table>
<thead>
<tr>
<th>Service Description</th>
<th>ESSENTIAL PLAN 1</th>
<th>ESSENTIAL PLAN 1</th>
<th>ESSENTIAL PLAN 1</th>
<th>ESSENTIAL PLAN 1</th>
<th>ESSENTIAL PLAN 2</th>
<th>ESSENTIAL PLAN 2</th>
<th>ESSENTIAL PLAN 2</th>
<th>ESSENTIAL PLAN 3</th>
<th>ESSENTIAL PLAN 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prescription Drugs Administered in Office (or Out Patient facility)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Administration</td>
<td>$15</td>
<td>$0</td>
<td>$15</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td> Performed in a PCP Office</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td> Performed in a Specialist Office</td>
<td>$25</td>
<td>$0</td>
<td>$25</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td> Performed in Outpatient Facilities</td>
<td>$25</td>
<td>$0</td>
<td>$25</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td> Prescription Drug Cost Sharing</td>
<td>$15</td>
<td>$0</td>
<td>$15</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td><strong>Diagnostic Radiology Services</strong></td>
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<tr>
<td> Performed in a PCP Office</td>
<td>$15</td>
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<tr>
<td> Performed in a Specialist Office</td>
<td>$25</td>
<td>$0</td>
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<td>$0</td>
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<tr>
<td> Performed in a Freestanding Radiology Facility</td>
<td>$25</td>
<td>$0</td>
<td>$25</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td> Performed as Outpatient Hospital Services</td>
<td>$25</td>
<td>$0</td>
<td>$25</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td><strong>Therapeutic Radiology Services</strong></td>
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<tr>
<td> Performed in a Specialist Office</td>
<td>$15</td>
<td>$0</td>
<td>$15</td>
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<tr>
<td> Performed in a Freestanding Radiology Facility</td>
<td>$15</td>
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<td>$15</td>
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<td>$0</td>
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</tr>
<tr>
<td> Performed as Outpatient Hospital Services</td>
<td>$15</td>
<td>$0</td>
<td>$15</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>Preauthorization Required</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</strong></td>
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<td></td>
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<tr>
<td> Performed in a PCP Office</td>
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<td>$15</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td> Performed in a Specialist Office</td>
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<td>$0</td>
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</tr>
<tr>
<td> Performed in Outpatient Facilities</td>
<td>$15</td>
<td>$0</td>
<td>$15</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
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<tr>
<td>Speech and physical therapy are only Covered following a Hospital stay or surgery</td>
<td></td>
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<tr>
<td>Preauthorization required after 6 visits</td>
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<tr>
<td><strong>Retail Health Clinic Care</strong></td>
<td>$25</td>
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<td>$25</td>
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<td>$0</td>
<td>$0</td>
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<tr>
<td>Second Opinions on the Diagnosis of Cancer, Surgery and Other</td>
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<tr>
<td>Preauthorization Required</td>
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<td><strong>Dental Services</strong></td>
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<tr>
<td>All transplants must be performed at designated Facilities</td>
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<td> Surgery performed at an Ambulatory Surgical Center</td>
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<tr>
<td> Office Surgery</td>
<td>$15 (when performed at PCP office)</td>
<td>$0</td>
<td>$15 (when performed at specialist office)</td>
<td>$0</td>
<td>$0</td>
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<td>$0</td>
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</tr>
<tr>
<td> $25 (when performed at specialist office)</td>
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<td>$0</td>
<td>$25</td>
<td>$0</td>
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<tr>
<td><strong>ADDITIONAL SERVICES, EQUIPMENT and DEVICES</strong></td>
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<td><strong>Audiometric Testing for Autism Spectrum Disorder</strong></td>
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<td></td>
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<tr>
<td><strong>Dialytic Equipment, Supplies and Self-Management Education</strong></td>
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<tr>
<td> Dialytic Equipment, Supplies and Insulin</td>
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<tr>
<td> Dialytic Education</td>
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<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Preauthorization required for insulin pump</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Durable Medical Equipment and Braces</strong></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Preauthorization required for DME items greater than cost of $500 (NY Medicare rate/cost schedule)</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td><strong>External Hearing Aids</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Single purchase one every three (3) years)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preauthorization required</td>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>** Cochlear Implant**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(One (1) per ear per time Covered)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Preauthorization required</td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospital Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td> Inpatient</td>
<td>$150</td>
<td>$0</td>
<td>$150</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td> Outpatient</td>
<td>$15</td>
<td>$0</td>
<td>$15</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td> 2/3 days per Plan Year</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preauthorization required</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medical Supplies</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Preauthorization required for greater than cost of $500</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Prosthetic Devices</strong></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td> External</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>One (1) prosthetic device, per limb, per lifetime, with coverage for repairs and replacements</td>
<td>$50</td>
<td>$0</td>
<td>$50</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td> Internal</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Preauthorization required for greater than cost of $500</td>
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<td></td>
<td></td>
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</tr>
</tbody>
</table>
## 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.

### Retail Pharmacy

<table>
<thead>
<tr>
<th>Tier</th>
<th>Days Supply</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>30</td>
<td>$6</td>
<td>$15</td>
<td>$30</td>
<td></td>
</tr>
<tr>
<td>90</td>
<td>$15</td>
<td>$3</td>
<td>$3</td>
<td></td>
</tr>
</tbody>
</table>

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.

### Mail Order Pharmacy

<table>
<thead>
<tr>
<th>Tier</th>
<th>Days Supply</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>90</td>
<td>$15</td>
<td>$32.50</td>
<td>$7.50</td>
<td></td>
</tr>
</tbody>
</table>

## NON-PRESCRIPTION DRUGS

(only include for Essential Plans 3 & 4)

<table>
<thead>
<tr>
<th>Plan</th>
<th>Tier 1</th>
<th>Tier 2</th>
<th>Tier 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>$0.50</td>
<td>$0.50</td>
<td>$0.50</td>
</tr>
</tbody>
</table>

*Note: AI/AN (DV) indicates American Indian/Alaska Native (Domestic Violence) coverage.*
<table>
<thead>
<tr>
<th>WELLNESS BENEFITS</th>
<th>ESSENTIAL PLAN 1</th>
<th>ESSENTIAL PLAN 1</th>
<th>ESSENTIAL PLAN 1</th>
<th>ESSENTIAL PLAN 1</th>
<th>ESSENTIAL PLAN 2</th>
<th>ESSENTIAL PLAN 2</th>
<th>ESSENTIAL PLAN 2</th>
<th>ESSENTIAL PLAN 2</th>
<th>ESSENTIAL PLAN 3</th>
<th>ESSENTIAL PLAN 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gym Reimbursement</td>
<td>Up to $200 per six (6)-month period</td>
<td>Up to $200 per six (6)-month period</td>
<td>Up to $200 per six (6)-month period</td>
<td>Up to $200 per six (6)-month period</td>
<td>Up to $200 per six (6)-month period</td>
<td>Up to $200 per six (6)-month period</td>
<td>Up to $200 per six (6)-month period</td>
<td>Up to $200 per six (6)-month period</td>
<td>Up to $200 per six (6)-month period</td>
<td>Up to $200 per six (6)-month period</td>
</tr>
<tr>
<td>Complete annual physical with PCP and complete gaps in care identified for you throughout the calendar year</td>
<td>Up to $100 in Gift Cards</td>
<td>Up to $100 in Gift Cards</td>
<td>Up to $100 in Gift Cards</td>
<td>Up to $100 in Gift Cards</td>
<td>Up to $100 in Gift Cards</td>
<td>Up to $100 in Gift Cards</td>
<td>Up to $100 in Gift Cards</td>
<td>Up to $100 in Gift Cards</td>
<td>Up to $100 in Gift Cards</td>
<td>Up to $100 in Gift Cards</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DENTAL and VISION CARE</th>
<th>ESSENTIAL PLAN 1</th>
<th>ESSENTIAL PLAN 1</th>
<th>ESSENTIAL PLAN 1</th>
<th>ESSENTIAL PLAN 1</th>
<th>ESSENTIAL PLAN 2</th>
<th>ESSENTIAL PLAN 2</th>
<th>ESSENTIAL PLAN 2</th>
<th>ESSENTIAL PLAN 2</th>
<th>ESSENTIAL PLAN 3</th>
<th>ESSENTIAL PLAN 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Care</td>
<td>N/A</td>
<td>N/A</td>
<td>$15</td>
<td>$0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$0</td>
</tr>
<tr>
<td>Preventive Dental Care</td>
<td>N/A</td>
<td>N/A</td>
<td>$15</td>
<td>$0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$0</td>
</tr>
<tr>
<td>Routine Dental Care</td>
<td>N/A</td>
<td>N/A</td>
<td>$15</td>
<td>$0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$0</td>
</tr>
<tr>
<td>Major Dental (Endodontics, Periodontics and Prosthodontics)</td>
<td>N/A</td>
<td>N/A</td>
<td>$15</td>
<td>$0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$0</td>
</tr>
<tr>
<td>Orthodontics and major dental require Preauthorization</td>
<td>N/A</td>
<td>N/A</td>
<td>$15</td>
<td>$0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$0</td>
</tr>
<tr>
<td>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</td>
<td>N/A</td>
<td>N/A</td>
<td>$15</td>
<td>$0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$0</td>
</tr>
<tr>
<td>Vision Care</td>
<td>N/A</td>
<td>N/A</td>
<td>$15</td>
<td>$0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$0</td>
</tr>
<tr>
<td>Exams</td>
<td>N/A</td>
<td>N/A</td>
<td>$15</td>
<td>$0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$0</td>
</tr>
<tr>
<td>Lenses and Frames</td>
<td>N/A</td>
<td>N/A</td>
<td>$15</td>
<td>$0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$0</td>
</tr>
<tr>
<td>Contact Lenses</td>
<td>N/A</td>
<td>N/A</td>
<td>$15</td>
<td>$0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$0</td>
</tr>
<tr>
<td>One (1) prescribed lenses and frames per Plan Year</td>
<td>N/A</td>
<td>N/A</td>
<td>$15</td>
<td>$0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$0</td>
</tr>
<tr>
<td>Contact lenses require Preauthorization</td>
<td>N/A</td>
<td>N/A</td>
<td>$15</td>
<td>$0</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$0</td>
</tr>
</tbody>
</table>

| 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 | 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 |
| Wellness Benefits                                                                | Up to $100 in Gift Cards | Up to $100 in Gift Cards | Up to $100 in Gift Cards | Up to $100 in Gift Cards | Up to $100 in Gift Cards | Up to $100 in Gift Cards | Up to $100 in Gift Cards | Up to $100 in Gift Cards | Up to $100 in Gift Cards | Up to $100 in Gift Cards |

**Notes:**
- **Wellness Benefits:** Sign-up for Affinity Member Portal and access Wellness newsletter. Complete annual physical with PCP and complete gaps in care identified for you throughout the calendar year.
- **Dental Care:**
  - Preventive Dental Care: $15
  - Routine Dental Care: $15
  - Major Dental (Endodontics, Periodontics and Prosthodontics): $15
- **Vision Care:**
  - Exams: $15
  - Lenses and Frames: $15
  - Contact Lenses: $15
- **Gym Reimbursement:**
  - Up to $200 per six (6)-month period

**Additional Information:**
- Orthodontics and major dental require Preauthorization.
- Contact lenses require Preauthorization.