

The Essential Plan Summary of Benefits

DESCRIPTION OF BENEFITS		eBenefits Essential Plan
<i>All plan benefits shown as a percentage of Eligible Charge.</i>		
PLAN PROVISIONS		Participating Providers
		Member Pays
MEDICAL SERVICES		
Annual Medical Deductible		\$3,000 Individual / \$6,000 Family
Annual Medical Out of Pocket Maximum		\$8,700 Individual / \$17,400 Family
Services from Participating Providers		For Participating Providers, the contract generally prohibits the provider from charging more than the amounts established in their Participating Provider agreement for covered services. However, the Member will be responsible for the Deductible, Copayments, and Coinsurance.
Services from Non-Participating Providers		Eligible expenses as defined in Plan Benefits Document will be covered out-of-network when a network provider is not available within 50 mile radius. The Maximum Allowable Charge for services from non-network providers will be limited to 150% of the equivalent Medicare Allowed amount.
Lifetime Maximum		None
Dependent Coverage		To age 26
PHYSICIAN SERVICES		Participating Providers
		Member Pays
Virtual Primary Care	No	\$0 Copayment <i>Limited to Specific Telemedicine Vendor</i>
Primary Care Office Visits Limited to 3 Visits per calendar year	No	20% Coinsurance after Deductible
Primary Care Office Visits In excess of 3 Visits per calendar year	No	Not Covered
Physician Office Visits (Specialist) Limited to 3 Visits per calendar year	No	20% Coinsurance After Deductible
Physician Office Visits (Specialist) In excess of 3 Specialist visits		Not Covered
Urgent Care Limited to 3 Visits per calendar year	No	20% Coinsurance after Deductible
Urgent Care In excess of 3 Visits per calendar year	No	Not Covered
PREVENTIVE CARE - NOT COVERED IF PERFORMED IN A HOSPITAL		
BENEFITS FOR CHILDREN - NOT COVERED IF PERFORMED IN A HOSPITAL		
Newborn Circumcision	No	No Copayment
Well Child Care Office Visits 7 visits Birth to 12 months 3 visits During age 1 2 visits During age 2 1 visit During age 3 through 21	No	No Copayment
Well Child Care Immunization (as recommended by Bright Futures project)	No	No Copayment
Well Child Care Lab Tests (as recommended by Bright Futures project)	No	No Copayment

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ADULT PREVENTIVE SCREENING/TESTING - NOT COVERED IF PERFORMED IN A HOSPITAL		
Adults, one (1) physical exam per benefit year to obtain recommended preventive and diagnostic services	No	No Copayment
Immunizations - doses, recommended ages, and recommended populations vary per the recommendations of the Advisory Committee for Immunization Practices (ACIP)	No	No Copayment
Prostate Specific Antigen (Men, one per CY, age ≥ 50)	No	No Copayment
Screenings such as; Obesity, Blood Pressure, Cholesterol, Colorectal Cancer, HIV, Alcohol Misuse (Colorectal Cancer Screening (i.e., Colonoscopy) Limited to Ambulatory Surgical Center locations only. Not covered if performed in a Hospital.)	No	No Copayment
Counseling such as; Alcohol Misuse, Sexually Transmitted Infection (STI) Prevention, Nutritional Counseling, Tobacco Use	No	No Copayment
WOMEN'S PREVENTIVE CARE SERVICES - NOT COVERED IF PERFORMED IN A HOSPITAL		
Prescribed contraceptive methods, sterilization procedures and patient education. (Supply and administration of Contraceptive IUDs, Implants and Injectables); (Pharmacy - birth control pills, diaphragms, emergency contraceptive pill through your Pharmacy Benefits)	No	No Copayment
Well Woman exam to obtain recommended preventive and diagnostic services (Subject to all Limitations as described under Covered Medical Benefits)	No	No Copayment
Screenings such as Pap Smears, Mammography, Domestic and interpersonal violence screening, Osteoporosis screening (Subject to all Limitations as described under Covered Medical Benefits)	No	No Copayment
Counseling such as Contraception, BRCA, Breast Cancer Chemoprevention, Folic Acid Supplements	No	No Copayment
Services for Pregnant Women including but not limited to Anemia Screening, Rh Incompatibility Screening, Breastfeeding, Hepatitis B Screening. Breastfeeding: Comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women. (Reimbursement of Non-Participating breastfeeding supplies up to the amount of \$200).	No	No Copayment



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HOSPITAL/FACILITY SERVICES		
Inpatient Room & Care – semi-private room rate; unlimited number of days (including scheduled Maternity Care & Nursery stays beyond a mother's discharge) in an Acute or Skilled Nursing Facility setting	No	Not Covered
Inpatient Room & Care (Mental/Behavioral Health/Substance Abuse) – semi-private room rate	No	Not Covered
Outpatient / Ambulatory Surgery Services & Birthing Centers	No	Not Covered
Other Outpatient Hospital Services (such as Cardiac, Pulmonary, PT/OT/ST)	No	Not Covered
Emergency Room Services	No	Not Covered
DIAGNOSTIC SERVICES		
Laboratory, Radiology Limited to 5 services by date of service	No	20% Coinsurance after Deductible
Laboratory, Radiology In excess of 5 services per calendar year	No	Not Covered
Radiation Oncology Services	No	Not Covered
Advanced Diagnostic Imaging, MRI/CT/MRA/PET	No	Not Covered

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MENTAL HEALTH/BEHAVIORAL HEALTH/SUBSTANCE ABUSE DISORDER		
INPATIENT		
Hospital & Facility Services; semi-private room rate	No	Not Covered
Psychiatrist & Psychologist Services	No	Not Covered
OUTPATIENT		
Psychiatrist & Psychologist Services	No	Not Covered
Psychological Testing	No	Not Covered
OTHER SERVICES		
Allergy Testing (including serums, injections, and administration)	No	Not Covered
Ground Ambulance	No	Not Covered
Air Ambulance	No	Not Covered
Chemotherapy	No	Not Covered
Dialysis and Supplies	No	Not Covered
Durable Medical Equipment (including Orthotics/Prosthetics)	No	Not Covered
Enteral Nutrition Therapy	No	Not Covered
Hearing Aids	No	Not Covered
Evaluations for the Use of Hearing Aids	No	Not Covered
Home Health Services	No	Not Covered
Home Infusion Services	No	Not Covered
Hospice Services	No	Not Covered
Human Growth Hormone, Genetic Testing/Counseling, Other	No	Not Covered
Physical/Occupational/Speech Therapy (Non Hospital Based)	No	Not Covered
ALTERNATIVE CARE SERVICES		
Acupuncture	No	Not Covered
Chiropractic Care	No	Not Covered
Naturopathy	No	Not Covered
Massage Therapy	No	Not Covered
Prior Authorization is required for certain services (noted above). Please refer to the Plan Document for Prior Authorization requirements.		



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PHARMACY PROVISIONS (Please refer to ID Card for Pharmacy Benefit Information)		Participating Pharmacies
PHARMACY BENEFITS		Member Pays
Annual Deductible		\$0 Per Person \$0 Per Family
Annual Out of Pocket Maximum		\$0 Per Person \$0 Per Family
Lifetime Maximum		None
Preventive Prescription Services		
<u>Mandatory Generic Only - Preventive Prescription Services as defined by PPACA.</u>		
In order for preventive medications to be covered at 100%, a prescription is required from your physician, including over-the-counter (OTC) drugs. If a generic is available and you choose to receive the brand name drug you will pay the difference between the brand name drug and the generic drug. (This is referred to as the Dispense As Written Penalty.)		
Prescription Drugs Pharmacy Retail - up to a 31 day supply		Generic - \$0 Copayment
Prescription Drugs Pharmacy Retail - 90 Day Supply		Generic - \$0 Copayment
Specialty Drugs		Not Covered
Non-Preventive Prescription Services		
All prescriptions will be dispensed as Generic unless otherwise prescribed by your Physician.		
Prescription Drugs Pharmacy Retail - up to a 31 day supply		Up to 75% off FDA approved medications
Prescription Drugs Pharmacy Retail - 90 Day Supply		
Prescription Drugs Pharmacy Mail Order - 90 Day Supply		
Specialty Drugs		
This summary provides a condensed explanation of plan benefits. Certain limitations, restrictions and exclusions may apply. Please refer to the Plan Document for complete information on benefits. In the case of discrepancy between this summary and the language contained in the Benefits Plan Document, the latter will take precedence.		