

# “Essential Copay” Outline

Healthcare services are managed by a combination of two plans. “Essential” is the ShareWELL Health Share for medical bills that exceed an Unshared Amount. “Copay” is a plan that offers 100% coverage for preventive care and copays for common services when conducted at a PPO Multiplan/PHCS network provider

*Description of Benefits*

*Member payment responsibilities*

<b>Unshared Amount</b> <b>1500/3000/6000</b>	Eligible bills are shared 100% after Unshared Amount, per Sharing Request basis, with a safeguard limit of two maximum in 12 months. No cap on sharing limit per Sharing Request
<b>Copays</b>	In-network services covered with a flat copay and maximum payment. No deductible or Unshared Amount requirement.
<b>Preventive Care</b>	Covered at 100% at in-network providers
<b>ShareWELL Health Share network</b>	<i>Present as a self-pay patient at providers for non-preventive services and expenses that are not covered by a copay. No network restrictions.</i>
<b>Copay Plan network</b>	<i>For Participating Providers, see copay amount and max payment in this outline. The Maximum charges paid for services from non-network providers will be limited to 150% of the equivalent Medicare Allowed amount.</i>

<b>Physician Services</b>	<b>Participating providers member pays</b>
<b>Virtual Primary &amp; Urgent Care</b>	\$0 copay, Download the Recuro Health app for access
<b>Primary Care Office Visits</b>	<i>\$20 copay, unlimited visits, \$200 maximum per visit.</i>
<b>Specialist Visit</b>	<i>\$50 copay, unlimited visits, \$300 maximum per visit.</i>
<b>Urgent Care</b>	<i>\$50 copay, limit 3 per calendar year</i>
<b>Preventive Care</b>	<b>Participating providers member pays Not covered if performed at a hospital</b>
<b>Newborn circumcision</b>	<i>100% covered, No copayment</i>
<b>Well Child Care Office Visits</b> <i>7 visits birth to 12 months 3 visits during age 1 2 visits during age 2 1 visit from age 3 through 21</i>	<i>100% covered, No copayment</i>
<b>Well Child Care Immunizations (as recommended by Bright Futures project)</b>	<i>100% covered, No copayment</i>
<b>Well Child Care Lab Tests (as recommended by Bright Futures project)</b>	<i>100% covered, No copayment</i>
<b>Adult Preventive Screening/Testing</b>	<b>Participating providers member pays Not covered if performed in a hospital</b>
<b>Adults, one physical exam per benefit year to obtain recommended and diagnostic services</b>	<i>100% covered, No copayment</i>
<b>Immunizations- doses, recommended ages, and recommended populations vary per the recommendations of the Advisory Committee for Immunization Practices (ACIP)</b>	<i>100% covered, No copayment</i>
<b>Prostate-specific antigen (Men, one per CY, age &gt; 49)</b>	<i>100% covered, No copayment</i>

<p>Screenings such as; obesity, blood pressure, cholesterol, colorectal cancer, HIV, and alcohol misuse. <i>Colorectal Cancer Screening (i.e.. Colonoscopy) Limited to Ambulatory Surgical Center locations only. Not covered if performed in a Hospital.)</i></p>	<p>100% covered, No copayment</p>
<p>Counseling such as alcohol misuse, sexually transmitted infection (STI) prevention, nutritional counseling, and tobacco use</p>	<p>100% covered, No copayment</p>
<p><b>Women's Preventive Care Services</b></p>	<p>Participating providers member pays Not covered if performed at a hospital</p>
<p>Prescribed contraceptive methods, sterilization procedures, and patient education. <i>(Supply and admin of contraceptives IUDs, implants and injectables); (Pharmacy- birth control pills, diaphragms, emergency contraceptive pill through your pharmacy benefit)</i></p>	<p>100% covered, No copayment</p>
<p>Well-woman exam to obtain recommended preventive and diagnostic services</p>	<p>100% covered, No copayment</p>
<p>Screenings such as pap smears, mammography, domestic and interpersonal violence screening, osteoporosis screening,</p>	<p>100% covered, No copayment</p>
<p>Counseling such as contraception, BRCA, breast cancer chemoprevention, folic acid supplements</p>	<p>100% covered, No copayment</p>
<p>Services for pregnant women including but not limited to anemia screening, rh incompatibility screening, breastfeeding, and hepatitis B screening; Breastfeeding: comprehensive support, and counseling from trained providers as well as access to breastfeeding supplies for pregnant and nursing women. <i>(Participating breastfeeding supplies up to the amount of \$200)</i></p>	<p>100% covered, No copayment</p>
<p><b>Hospital &amp; Facility Services</b></p>	<p>Member pays</p>
<p>Inpatient room &amp; care- semi private room rate; unlimited number of days in acute or skilled nursing</p>	<p>Meet Unshared Amount</p>

facility	
Inpatient room & care (mental/behavioral health/substance abuse) Semi private room rate	<i>Meet Unshared Amount</i>
Outpatient/Ambulatory surgery services & birthing centers	<i>Meet Unshared Amount</i>
Other outpatient hospital services (such as cardiac, pulmonary, PT/OT/ST)	<i>Meet Unshared Amount</i>
Emergency room services	<i>Meet Unshared Amount</i>
<b>Diagnostic Services</b>	<b>Member Pays</b>
Diagnostic X-ray	\$50 copay, \$250 max benefit per x-ray
Laboratory Work	\$10 copay, \$100 max benefit paid per date of service
Radiation Oncology services	<i>Meet Unshared Amount</i>
Advanced diagnostic imaging, MRI/CT/MRA/PET/Ultra Sound	<i>\$200 copay, maximum 2 tests per calendar year</i>
<b>Mental Health/Behavioral Health/Substance Abuse Disorder (Inpatient)</b>	<b>Member pays</b>
Hospital & facility services; semi private room rate	Not covered
Psychiatrist & psychologist service	Not covered
<b>Outpatient</b>	<b>Member pays</b>
Psychiatrist & psychologist services	Not covered
Psychological testing	Not covered
<b>Other Services</b>	<b>Member pays</b>
Allergy testing (including serums, injections, and administration)	<i>Meet Unshared Amount, limits apply, see Member Guidelines for details</i>

<b>Ground ambulance</b>	<i>Meet Unshared Amount</i>
<b>Air ambulance</b>	<i>Meet Unshared Amount</i>
<b>Chemotherapy</b>	<i>Meet Unshared Amount</i>
<b>Dialysis and supplies</b>	<i>Meet Unshared Amount</i>
<b>Durable medical equipment (including orthotics/prosthetics)</b>	<i>Meet Unshared Amount, limits apply, see Member Guidelines for details</i>
<b>Enteral nutritional therapy</b>	Not covered
<b>Hearing aids</b>	Not covered
<b>Evaluations for the use of hearing aids</b>	Not covered
<b>Home health services</b>	<i>Meet Unshared Amount</i>
<b>Home infusion services</b>	<i>Meet Unshared Amount, limits apply, see Member Guidelines for details</i>
<b>Hospice services</b>	Not covered
<b>Human growth hormone, genetic testing/counseling, other</b>	<i>Meet Unshared Amount, limits apply, see Member Guidelines for details</i>
<b>Physical/occupational/ speech therapy (non hospital based)</b>	<i>Meet Unshared Amount, limits apply, see "Recovery Allowance" in the Member Guidelines for details</i>
<b>Alternative care services</b>	<b>Member pays</b>
<b>Acupuncture</b>	<i>Meet Unshared Amount, limits apply, see "Recovery Allowance" in the Member Guidelines for details</i>
<b>Chiropractic care</b>	<i>Meet Unshared Amount, limits apply, see "Recovery Allowance" in the Member Guidelines for details</i>

<b>Naturopathy, Functional Medicine, and other alternative medicines</b>	<i>Meet Unshared Amount, limits apply, see Member Guidelines for details</i>
<b>Massage Therapy</b>	<i>Meet Unshared Amount, limits apply, see "Recovery Allowance" in the Member Guidelines for details</i>
<b>Pharmacy Benefits</b> <i>(refer to ID card for pharmacy benefits)</i>	Member pays  The outline below applies to the copay portion of the plan. Eligible costs beyond the copay amount exceeding the Unshared Amount are eligible for sharing with ShareWELL. International and Prescription Assistance programs available.
<b>132 common acute medications &amp; ACA preventive medications</b>	\$0 copay
<b>Tier 1- Generics</b>	\$15 in-store or \$30 mail order 90-day supply
<b>Tier 2- Preferred brands</b>	\$40 in store or \$80 mail order 90 day supply
<b>Tier 3- Non-preferred brand</b>	\$65 in-store or \$130 mail order 90-day supply
<b>Brand specialty</b>	Member pays discounted price
<b>Monthly maximum allowance</b>	\$200 in store and \$600 mail order
<b>Prescription Assistance Program</b>	Member pays a \$60 processing fee if approved by the manufacturer

## Network Providers

Your PPO Network is:

Private Healthcare Systems – PHCS Practitioner and Ancillary To locate a provider:

<https://www.multiplan.com/webcenter/portal/ProviderSearch>

Be sure to select “PHCS” then “Practitioner and Ancillary” on the left side

Your Pharmacy Benefit Manager (Prescription Drug PPO) is:

Rx Valet <https://www.myrxvalet.com> 1-855-798-2538

Your Telemedicine Provider is:

Recuro <https://recurohealth.com>