

**Section XXVI**

**Schedule of Benefits  
EmblemHealth Platinum D**

<p><b>COST-SHARING</b></p> <p><b>Deductible</b></p> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul> <p><b>Out-of-Pocket Limit</b></p> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul>	<p><b>Participating Provider Member Responsibility for Cost-Sharing</b></p> <p>\$0 \$0</p> <p>\$2,000 \$4,000</p>	<p><b>Non-Participating Provider Member Responsibility for Cost-Sharing</b></p> <p>None None</p> <p>Non-Participating Provider services are not Covered except as required for emergency care</p>	
<p><b>OFFICE VISITS</b></p>	<p><b>Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Non-Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Limits</b></p>
<p>Primary Care Office Visits (or Home Visits)</p>	<p>\$15 Copayment</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Specialist Office Visits (or Home Visits)</p> <p><b>Referral Required</b></p>	<p>\$35 Copayment</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>

<b>PREVENTIVE CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<ul style="list-style-type: none"> <li>Well Child Visits and Immunizations*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<ul style="list-style-type: none"> <li>Adult Annual Physical Examinations*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Adult Immunizations*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Routine Gynecological Services/Well Woman Exams*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Sterilization Procedures for Women*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Vasectomy</li> </ul>	See Surgical Services Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Bone Density Testing*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	

<b>PREVENTIVE CARE – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<ul style="list-style-type: none"> <li>Screening for Prostate Cancer <ul style="list-style-type: none"> <li>Performed in PCP Office</li> <li>Performed in Specialist Office</li> </ul> </li> <li>All other preventive services required by USPSTF and HRSA</li> <li>*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> </ul>	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	See benefit for description
<b>EMERGENCY CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Pre-Hospital Emergency Medical Services (Ambulance Services)	\$100 Copayment	\$100 Copayment	See benefit for description
Non-Emergency Ambulance Services <b>Preauthorization Required</b>	\$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Emergency Department  Copayment waived if admitted to Hospital	\$100 Copayment  Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	\$100 Copayment	See benefit for description
Urgent Care Center	\$55 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

<b>PROFESSIONAL SERVICES and OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<p>Advanced Imaging Services</p> <ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> <li>Performed in a Freestanding Radiology Facility</li> <li>Performed as Outpatient Hospital Services</li> </ul> <p><b>Referral Required</b></p>	<p>\$35 Copayment</p> <p>\$35 Copayment</p> <p>\$35 Copayment</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	See benefit for description
<p>Allergy Testing and Treatment</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> </ul> <p><b>Referral Required</b></p>	<p>\$15 Copayment</p> <p>\$35 Copayment</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	See benefit for description
<p>Ambulatory Surgical Center Facility Fee</p> <p><b>Preauthorization Required</b></p>	\$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<p>Anesthesia Services (all settings)</p>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<p>Autologous Blood Banking</p> <p><b>Preauthorization Required</b></p>	10% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

<b>PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Cardiac and Pulmonary Rehabilitation <ul style="list-style-type: none"> <li>• Performed in a Specialist Office</li> <li>• Performed as Outpatient Hospital Services</li> <li>• Performed as Inpatient Hospital Services</li> </ul> <p><b>Preauthorization Required</b></p>	\$15 Copayment  \$15 Copayment  Included as part of inpatient Hospital service Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost  Included as part of inpatient Hospital service Cost-Sharing	See benefit for description
Chemotherapy <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> <li>• Performed in a Specialist Office</li> <li>• Performed as Outpatient Hospital Services</li> </ul> <p><b>Referral Required</b></p>	\$15 Copayment  \$15 Copayment  \$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Chiropractic Services	\$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Clinical Trials <p><b>Preauthorization Required</b></p>	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description

<b>PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Diagnostic Testing <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> <li>• Performed in a Specialist Office <b>Referral Required</b></li> <li>• Performed as Outpatient Hospital Services <b>Referral Required</b></li> </ul>	\$15 Copayment  \$35 Copayment  \$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Dialysis <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> <li>• Performed in a Specialist Office <b>Referral Required</b></li> <li>• Performed in a Freestanding Center <b>Referral Required</b></li> <li>• Performed as Outpatient Hospital Services <b>Referral Required</b></li> </ul>	\$15 Copayment  \$15 Copayment  \$15 Copayment  \$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description  Dialysis performed by Non-Participating Providers is limited to 10 visits per calendar year <b>Preauthorization Required</b>

<b>PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> <li>• Performed in a Specialist Office</li> <li>• Performed in an Outpatient Facility</li> </ul> <p style="text-align: center;"><b>Preauthorization Required</b></p>	\$25 Copayment  \$25 Copayment  \$25 Copayment	Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost	Sixty (60) visits per condition per Plan Year. Combined therapies
Home Health Care  <b>Preauthorization Required</b>	\$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	Forty (40) visits per Plan Year

<b>PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Infertility Services  <p style="text-align: center;"><b>Preauthorization Required</b></p>	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and Diagnostic Procedures)	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Infusion Therapy <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> <li>• Performed in a Specialist Office <b>Referral Required</b></li> <li>• Performed as Outpatient Hospital Services <b>Referral Required</b></li> <li>• Home Infusion Therapy <b>Preauthorization Required</b></li> </ul>	\$15 Copayment  \$15 Copayment  \$15 Copayment  \$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description    Home infusion counts toward home health care visit limits
Inpatient Medical Visits	\$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description



<b>PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Interruption of Pregnancy <ul style="list-style-type: none"> <li>• Medically Necessary Abortions</li> <li>• Elective Abortions</li> </ul>	Covered in full  \$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost	Unlimited  One (1) procedure per calendar Year
Laboratory Procedures <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> <li>• Performed in a Specialist Office</li> <li>• Performed in a Freestanding Laboratory Facility</li> <li>• Performed as Outpatient Hospital Services</li> </ul>	\$15 Copayment  \$35 Copayment  \$35 Copayment  \$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

<b>PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<p>Maternity and Newborn Care</p> <ul style="list-style-type: none"> <li>• Prenatal Care <ul style="list-style-type: none"> <li>• Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> <li>• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> </ul> </li> <li>• Inpatient Hospital Services and Birthing Center</li> <li>• Physician and Midwife Services for Delivery</li> <li>• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps</li> <li>• Postnatal Care</li> </ul> <p><b>Preauthorization Required for Inpatient Services; Breast Pump</b></p>	<p>Covered in full</p> <p>Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)</p> <p>\$500 Copayment</p> <p>\$100 Copayment</p> <p>Covered in full</p> <p>Included in Physician and Midwife Services for Delivery Cost-Sharing</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p> <p>One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early</p> <p>Covered for duration of breast feeding</p>
<p>Outpatient Hospital Surgery Facility Charge</p> <p><b>Preauthorization Required</b></p>	<p>\$100 Copayment</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>

<b>PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Preadmission Testing  <b>Preauthorization Required</b>	\$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Prescription Drugs Administered in Office  <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in Specialist Office</li> </ul>	<p>Included as part of the PCP office visit Cost-Sharing</p> <p>Included as part of the Specialist office visit Cost-Sharing</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	See benefit for description
Diagnostic Radiology Services <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> </ul> <b>Preauthorization Required</b> <ul style="list-style-type: none"> <li>Performed in a Freestanding Radiology Facility</li> </ul> <b>Preauthorization Required</b> <ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul> <b>Preauthorization Required</b>	<p>\$15 Copayment</p> <p>\$35 Copayment</p> <p>\$35 Copayment</p> <p>\$35 Copayment</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	See benefit for description

<b>PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Therapeutic Radiology Services <ul style="list-style-type: none"> <li>• Performed in a Specialist Office</li> <li>• Performed in a Freestanding Radiology Facility</li> <li>• Performed as Outpatient Hospital Services</li> </ul> <p><b>Referral Required</b></p>	\$15 Copayment  \$15 Copayment  \$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <ul style="list-style-type: none"> <li>• Performed in a PCP office</li> <li>• Performed in a Specialist office</li> <li>• Performed in an Outpatient Facility)</li> </ul> <p><b>Preauthorization Required</b></p>	\$25 Copayment  \$25 Copayment  \$25 Copayment	Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost	Sixty (60) visits per condition per Plan Year. Combined therapies. Speech and physical therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery and Other <p><b>Referral Required</b></p>	\$35 Copayment	Non-Participating Provider services are not covered and You pay the full cost  Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained.	See benefit for description

<b>PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<p>Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants)</p> <ul style="list-style-type: none"> <li>• Inpatient Hospital Surgery</li> <li>• Outpatient Hospital Surgery</li> <li>• Surgery Performed at an Ambulatory Surgical Center</li> <li>• Office Surgery <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> <li>• Performed in a Specialist Office</li> </ul> </li> </ul> <p><b>Preauthorization Required</b></p>	<p>\$100 Copayment</p> <p>\$100 Copayment</p> <p>\$100 Copayment</p> <p>\$15 Copayment</p> <p>\$35 Copayment</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p> <p><b>All transplants must be performed at designated Facilities</b></p>
<p>Telemedicine Program</p> <ul style="list-style-type: none"> <li>• Provided by a Telemedicine Physician</li> </ul>	<p>\$0 Copayment</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>

<b>ADDITIONAL SERVICES, EQUIPMENT and DEVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
ABA Treatment for Autism Spectrum Disorder  <b>Preauthorization Required</b>	\$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder  <b>Preauthorization Required</b>	\$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education <ul style="list-style-type: none"> <li>• Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply)</li> <li>• Diabetic Education</li> </ul> <b>Preauthorization Required</b>	\$15 Copayment  \$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

<b>ADDITIONAL SERVICES, EQUIPMENT and DEVICES (continued)</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Durable Medical Equipment and Braces  <b>Preauthorization Required</b>	10% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
External Hearing Aids  <b>Preauthorization Required</b>	10% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost	Single purchase once every three (3) years
Cochlear Implants  <b>Preauthorization Required</b>	10% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost	One (1) per ear per time Covered
Hospice Care  <ul style="list-style-type: none"> <li>• Inpatient</li> <li>• Outpatient</li> </ul> <b>Preauthorization Required</b>	\$500 Copayment  \$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost	210 days per Plan Year  Five (5) visits for family bereavement counseling
Medical Supplies  <b>Preauthorization Required</b>	10% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

<b>ADDITIONAL SERVICES, EQUIPMENT and DEVICES – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Prosthetic Devices <ul style="list-style-type: none"> <li>• External</li> <li>• Internal</li> </ul> <p style="text-align: center;"><b>Preauthorization Required</b></p>	10% Coinsurance  Included as part of inpatient Hospital Service Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost	One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements  Unlimited; See benefit for description
<b>INPATIENT SERVICES and FACILITIES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care) <p style="text-align: center;"><b>Preauthorization required. However, Preauthorization is not required for emergency admissions or services provided in a neonatal intensive care unit of a Hospital certified pursuant to Article 28 of the Public Health Law.</b></p>	\$500 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Observation Stay	\$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) <p style="text-align: center;"><b>Preauthorization Required</b></p>	\$500 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	<b>(1)</b> [200, 365] days per Plan Year
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) <p style="text-align: center;"><b>Preauthorization Required</b></p>	\$500 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	Sixty (60) days per Plan Year. Combined therapies



<b>INPATIENT SERVICES and FACILITIES - Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<p>Inpatient Rehabilitation Services (Physical, Speech and Occupational therapy)</p> <p style="text-align: center;"><b>Preauthorization Required</b></p>	\$500 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	<p>Sixty (60) days per Plan Year. Combined therapies</p> <p>Speech and physical therapy are only Covered following a Hospital stay or surgery</p>
<b>MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<p>Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment)</p> <p style="text-align: center;"><b>Preauthorization required. However, Preauthorization is not required for emergency admissions.</b></p>	\$500 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<p>Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)</p> <ul style="list-style-type: none"> <li>• Office Visits</li> <li>• All Other Outpatient Services</li> </ul>	<p>\$15 Copayment</p> <p>\$15 Copayment</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	See benefit for description

<b>MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<p>Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)</p> <p><b>Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.</b></p>	\$500 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<p>Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)</p> <ul style="list-style-type: none"> <li>• Office Visits</li> <li>• All Other Outpatient Services</li> </ul>	<p>\$15 Copayment</p> <p>\$15 Copayment</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	Unlimited; Up to 20 visits per calendar year may be used for family counseling

<b>PRESCRIPTION DRUGS</b>  *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 and obtained at a participating pharmacy.	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<b>Retail Pharmacy</b>  30-day supply Tier 1  Tier 2  Tier 3  If You have an Emergency Condition, Preauthorization is not required for a five (5) day emergency supply of 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.	\$10 Copayment  \$30 Copayment  \$60 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

<b>PRESCRIPTION DRUGS (Continued)</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<b>Mail Order Pharmacy</b>			
Up to a 90-day supply Tier 1	\$25 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	\$75 Copayment		
Tier 3	\$150 Copayment		
Enteral Formulas Tier 1	\$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	\$30 Copayment		
Tier 3	\$60 Copayment		
<b>WELLNESS BENEFITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Gym Reimbursement	Up to \$200 per six (6)-month period; up to an additional \$100 per six (6)-month period for Spouse	Up to \$200 per six (6)-month period; up to an additional \$100 per six (6)-month period for Spouse	Up to \$200 per six (6)-month period; up to an additional \$100 per six (6)-month period for Spouse

<b>PEDIATRIC DENTAL CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<ul style="list-style-type: none"> <li>• Preventive Dental Care</li> <li>• Routine Dental Care</li> <li>• Major Dental Care (Endodontics, Periodontics, Prosthodontics and Oral Surgery)</li> <li>• Orthodontics</li> </ul> <p><b>Major Dental Care and Orthodontics require Preauthorization</b></p>	<p>\$15 Copayment</p> <p>\$15 Copayment</p> <p>\$15 Copayment</p> <p>\$15 Copayment</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>One (1) Dental Exam &amp; Cleaning Per six (6)-Month Period</p> <p>Full mouth X-rays or panoramic X-rays at thirty-six (36) month intervals and bitewing X-rays at six (6) month intervals</p>

<b>PEDIATRIC VISION CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<b>Pediatric Vision Care</b> <ul style="list-style-type: none"> <li>• Exams</li> <li>• Lenses and Frames</li> <li>• Contact Lenses</li> </ul>	\$15 Copayment  10% Coinsurance  10% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost	One (1) exam per 12-month period; One (1) prescribed lenses and frames per 12-month period

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not covered under the Certificate, You will be responsible for the full cost of the services.