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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>	\$15 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	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 <b>Preauthorization required</b></li> <li>• Performed in a Freestanding Radiology Facility <b>Preauthorization required</b></li> <li>• Performed as Outpatient Hospital Services <b>Preauthorization required</b></li> </ul>	\$15 Copayment  \$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  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 CARE</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> <b>Preauthorization required</b>	\$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)  <b>Preauthorization required</b>	\$15 Copayment	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.

<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>Second Opinions on the Diagnosis of Cancer, Surgery and Other</p> <p><b>Referral required</b></p>	\$25 Copayment	<p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained.</p>	See benefit for description
<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>\$50 Copayment</p> <p>\$50 Copayment</p> <p>\$50 Copayment</p> <p>\$15 Copayment</p> <p>\$25 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>



<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>
Telemedicine Program <ul style="list-style-type: none"> <li>• Provided by a Telemedicine Physician</li> </ul>	\$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<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 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>	5% 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>	5% 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>	5% 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>	\$150 Copayment per admission  \$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	Two hundred ten (210) days per Plan Year  Five (5) visits for family bereavement counseling
Medical Supplies  <b>Preauthorization required</b>	5% 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> <b>Preauthorization required</b>	5% 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)  <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>	\$150 Copayment per admission	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Observation Stay	\$75 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	Copay waived if direct transfer from outpatient surgery setting to observation













<b>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>
<b>Dental Care</b> <ul style="list-style-type: none"> <li>• Preventive Dental Care</li> <li>• Routine Dental Care</li> <li>• Major Dental (Endodontics, Periodontics and Prosthodontics)</li> </ul> <b>Endodontics, Periodontics &amp; Prosthodontics Require Preauthorization</b>	\$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	One (1) dental exam and cleaning Per six (6)-Month Period Full mouth X-rays or panoramic X-rays at thirty-six (36)-month intervals and bitewing X-rays at six (6) to twelve (12)-month intervals
<b>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>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 Plan Year

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 Contract, You will be responsible for the full cost of the services.