# Section XXVI
# Schedule of Benefits
# EmblemHealth Gold

| COST-SHARING | Participating Provider Member Responsibility for Cost-Sharing | **Non-Participating Provider Member Responsibility for Cost-Sharing** | |
|---|---|---|---|
| Deductible<br>• Individual<br>• Family | $600<br>$1,200 | None<br>None | |
| Out-of-Pocket Limit<br>• Individual<br>• Family | $4,000<br>$8,000 | Non-Participating Provider services are not Covered except as required for emergency care | |
| OFFICE VISITS | Participating Provider Member Responsibility for Cost-Sharing | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| Primary Care Office Visits (or Home Visits) | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Specialist Office Visits (or Home Visits)<br><br>**Referral Required** | $40 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |

| PREVENTIVE CARE | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|---|
| • Well Child Visits and Immunizations* | Covered in full | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| • Adult Annual Physical Examinations* | Covered in full | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Adult Immunizations* | Covered in full | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Routine Gynecological Services/Well Woman Exams* | Covered in full | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer* | Covered in full | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Sterilization Procedures for Women* | Covered in full | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Vasectomy | See Surgical Services Cost-Sharing | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Bone Density Testing* | Covered in full | Non-Participating Provider services are not Covered and You pay the full cost | |

| **PREVENTIVE CARE – Continued** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
|---|---|---|---|
| • Screening for Prostate Cancer | Covered in full | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| • All other preventive services required by USPSTF and HRSA | Covered in full | Non-Participating Provider services are not Covered and You pay the full cost | |
| • *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA | Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | Non-Participating Provider services are not Covered and You pay the full cost | |
| **EMERGENCY CARE** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| Pre-Hospital Emergency Medical Services (Ambulance Services) | $150 Copayment after Deductible | $150 Copayment after Deductible | See benefit for description |
| Non-Emergency Ambulance Services<br><br>**Preauthorization Required** | $150 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Emergency Department<br><br>Copayment waived if admitted Hospital | $150 Copayment after Deductible<br><br>Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing | $150 Copayment after Deductible | See benefit for description |
| Urgent Care Center | $60 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |

| PROFESSIONAL SERVICES and OUTPATIENT CARE | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|---|
| Advanced Imaging Services<br><br>• Performed in a Specialist Office<br><br>• Performed in a Freestanding Radiology Facility<br><br>• Performed as Outpatient Hospital Services*<br><br>**Preauthorization Required** | <br><br>$40 Copayment after Deductible<br><br>$40 Copayment after Deductible<br><br>$40 Copayment after Deductible | <br><br>Non-Participating Provider services are not Covered and You pay the full cost<br><br>Non-Participating Provider services are not Covered and You pay the full cost<br><br>Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Allergy Testing and Treatment<br><br>• Performed in a PCP Office<br><br>• Performed in a Specialist Office<br><br>**Referral Required** | <br><br>$25 Copayment after Deductible<br><br>$40 Copayment after Deductible | <br><br>Non-Participating Provider services are not Covered and You pay the full cost<br><br>Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Ambulatory Surgical Center Facility Fee<br><br>**Preauthorization Required** | $100 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Anesthesia Services (all settings) | Covered in full | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Autologous Blood Banking | 20% Coinsurance after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |

| PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|---|
| Cardiac and Pulmonary Rehabilitation | | | See benefit for description |
| • Performed in a Specialist Office | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed as Outpatient Hospital Services | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed as Inpatient Hospital Services | Included as part of inpatient Hospital service Cost-Sharing | Included as part of inpatient Hospital service Cost-Sharing | |
| **Preauthorization Required** | | | |
| Chemotherapy | | | See benefit for description |
| • Performed in a PCP Office | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed in a Specialist Office | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed as Outpatient Hospital Services | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| **Preauthorization Required** | | | |
| Chiropractic Services | $40 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Clinical Trials<br><br>**Preauthorization Required** | Use Cost-Sharing for appropriate service | Use Cost-Sharing for appropriate service | See benefit for description |

| **PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
|---|---|---|---|
| Diagnostic Testing | | | See benefit for description |
| • Performed in a PCP Office | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed in a Specialist Office **Referral Required** | $40 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed as Outpatient Hospital Services **Preauthorization Required** | $40 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| Dialysis | | | See benefit for description<br><br>Dialysis performed by Non-Participating Providers is limited to 10 visits per calendar year **Preauthorization Required** |
| • Performed in a PCP Office | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed in a Specialist Office **Referral Required** | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed in a Freestanding Center **Referral Required** | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed as Outpatient Hospital Services **Referral Required** | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |

| **PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
|---|---|---|---|
| Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) | | | Sixty (60) visits per condition per Plan Year. Combined therapies |
| • Performed in a PCP Office | $30 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed in a Specialist Office | $30 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed in an Outpatient Facility | $30 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| **Preauthorization Required** | | | |
| Home Health Care<br><br>**Preauthorization Required** | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | Forty (40) visits per Plan Year |

| **PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
|---|---|---|---|
| Infertility Services<br><br>**Preauthorization Required** | 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 | | | See benefit for description |
| • Performed in a PCP Office | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed in a Specialist Office **Referral Required** | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed as Outpatient Hospital Services **Preauthorization Required** | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Home Infusion Therapy **Preauthorization Required** | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | Home infusion counts toward home health care visit limits |
| Inpatient Medical Visits | $0 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |

| PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|---|
| Interruption of Pregnancy | | | |
| • Medically Necessary Abortions | Covered in full | Non-Participating Provider services are not Covered and You pay the full cost | Unlimited |
| • Elective Abortions<br><br>**Preauthorization Required** | $100 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | One (1) procedure per calendar Year |
| Laboratory Procedures | | | See benefit for description |
| • Performed in a PCP Office | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed in a Specialist Office | $40 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed in a Freestanding Laboratory Facility | $40 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed as Outpatient Hospital Services **Preauthorization Required** | $40 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |

| PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|---|
| Maternity and Newborn Care<br><br>• Prenatal Care<br>• Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA<br>• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA<br><br>• Inpatient Hospital Services and Birthing Center<br><br>• Physician and Midwife Services for Delivery<br><br>• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps<br><br>• Postnatal Care<br><br>**Preauthorization Required for Inpatient Services** | Covered in full<br><br>Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)<br><br>$1,000 Copayment per admission after Deductible<br><br>$100 Copayment after Deductible<br><br>Covered in full<br><br>Included in Physician and Midwife Services for Delivery Cost-Sharing | Non-Participating Provider services are not Covered and You pay the full cost<br><br>Non-Participating Provider services are not Covered and You pay the full cost<br><br>Non-Participating Provider services are not Covered and You pay the full cost<br><br>Non-Participating Provider services are not Covered and You pay the full cost<br><br>Non-Participating Provider services are not Covered and You pay the full cost<br><br>Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description<br><br>One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early<br><br>Covered for duration of breast feeding |
| Outpatient Hospital Surgery Facility Charge<br><br>**Preauthorization Required** | $100 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |

| PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|---|
| Preadmission Testing<br><br>**Preauthorization Required** | $0 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Prescription Drugs Administered in Office | | | See benefit for description |
| • Performed in a PCP Office | Included as part of the PCP office visit Cost-Sharing | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed in Specialist Office | Included as part of the Specialist office visit Cost-Sharing | Non-Participating Provider services are not Covered and You pay the full cost | |
| Diagnostic Radiology Services | | | See benefit for description |
| • Performed in a PCP Office | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed in a Specialist Office **Preauthorization Required** | $40 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed in a Freestanding Radiology Facility **Preauthorization Required** | $40 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed as Outpatient Hospital Services **Preauthorization Required** | $40 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |

| **PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| --- | --- | --- | --- |
| Therapeutic Radiology Services<br>• Performed in a Specialist Office<br>• Performed in a Freestanding Radiology Facility<br>• Performed as Outpatient Hospital Services<br>**Preauthorization Required** | $25 Copayment after Deductible<br><br>$25 Copayment after Deductible<br><br>$25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost<br><br>Non-Participating Provider services are not Covered and You pay the full cost<br><br>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)<br>• Performed in a PCP office<br>• Performed in a Specialist office<br>• Performed in an Outpatient Facility)<br>**Preauthorization Required** | $30 Copayment after Deductible<br><br>$30 Copayment after Deductible<br><br>$30 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost<br><br>Non-Participating Provider services are not Covered and You pay the full cost<br><br>Non-Participating Provider services are not Covered and You pay the full cost | 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<br><br>**Referral Required** | $40 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost<br><br>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 |

| **PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
|---|---|---|---|
| Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants)<br><br>• Inpatient Hospital Surgery<br><br>• Outpatient Hospital Surgery<br><br>• Surgery Performed at an Ambulatory Surgical Center<br><br>• Office Surgery<br>  • Performed in a PCP Office<br><br>  • Performed in a Specialist Office<br><br>**Preauthorization Required** | <br><br>$100 Copayment after Deductible<br><br>$100 Copayment after Deductible<br><br>$100 Copayment after Deductible<br><br>$25 Copayment after Deductible<br><br>$40 Copayment after Deductible | <br><br>Non-Participating Provider services are not Covered and You pay the full cost<br><br>Non-Participating Provider services are not Covered and You pay the full cost<br><br>Non-Participating Provider services are not Covered and You pay the full cost<br><br>Non-Participating Provider services are not Covered and You pay the full cost<br><br>Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description<br><br>**All transplants must be performed at designated Facilities** |
| Telemedicine Program<br>• Provided by a Telemedicine Physician | $0 Copayment not subject to Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |

| ADDITIONAL SERVICES, EQUIPMENT and DEVICES | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|---|
| ABA Treatment for Autism Spectrum Disorder<br><br>**Preauthorization Required** | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Assistive Communication Devices for Autism Spectrum Disorder<br><br>**Preauthorization Required** | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Diabetic Equipment, Supplies and Self-Management Education | | | See benefit for description |
| • Diabetic Equipment, Supplies and Insulin (30-day; up to a 90-day supply) | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Diabetic Education<br><br>**Preauthorization Required** | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |

| ADDITIONAL SERVICES, EQUIPMENT and DEVICES (continued) | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|---|
| Durable Medical Equipment and Braces<br><br>**Preauthorization Required** | 20% Coinsurance after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| External Hearing Aids<br><br>**Preauthorization Required** | 20% Coinsurance after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | Single purchase once every three (3) years |
| Cochlear Implants<br><br>**Preauthorization Required** | 20% Coinsurance after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | One (1) per ear per time Covered |
| Hospice Care<br>• Inpatient<br><br>• Outpatient<br><br>**Preauthorization Required** | $1,000 Copayment per admission after Deductible<br><br>$25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost<br><br>Non-Participating Provider services are not Covered and You pay the full cost | 210 days per Plan Year<br><br>Five (5) visits for family bereavement counseling |
| Medical Supplies<br><br>**Preauthorization Required** | 20% Coinsurance after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |

| ADDITIONAL SERVICES, EQUIPMENT and DEVICES – Continued | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|---|
| Prosthetic Devices<br>• External<br>• Internal<br>**Preauthorization Required** | 20% Coinsurance after Deductible<br>Included as part of inpatient Hospital service Cost-Sharing | Non-Participating Provider services are not Covered and You pay the full cost<br>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<br>Unlimited; See benefit for description |
| **INPATIENT SERVICES and FACILITIES** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)<br>**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.** | $1,000 Copayment per admission after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Observation Stay | $150 Copayment after Deductible | 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)<br>**Preauthorization Required** | $1,000 Copayment per admission after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | 200 days per Plan Year |
| Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)<br>**Preauthorization Required** | $1,000 Copayment per admission after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | Sixty (60) days per Plan Year. Combined therapies. |

| INPATIENT SERVICES and FACILITIES – Continued | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|---|
| Inpatient Rehabilitation Services<br>(Physical, Speech and Occupational therapy)<br><br>**Preauthorization Required** | $1,000 Copayment per admission after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | Sixty (60) days per Plan Year. Combined therapies.<br><br>Speech and physical therapy are only Covered following a Hospital stay or surgery |
| **MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment)<br><br>**Preauthorization Required. However, Preauthorization is not Required for Emergency Admissions or for admissions at Participating OHM-licensed Facilities for Members under 18** | $1,000 Copayment per admission after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)<br><br>• Office Visits<br><br>• All Other Outpatient Services | <br><br><br>$25 Copayment after Deductible<br><br>$25 Copayment after Deductible | <br><br><br>Non-Participating Provider services are not Covered and You pay the full cost<br><br>Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |

| MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|---|
| Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)<br><br>**Preauthorization Required. However, Preauthorization is not Required for Emergency Admissions or for Participating OASAS-certified Facilities.** | $1,000 Copayment per admission after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) | | | Unlimited; Up to twenty (20) visits per Plan Year may be used for family counseling |
| • Office Visits | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • All Other Outpatient Services | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |

| PRESCRIPTION DRUGS<br><br>*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. | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|---|
| **Retail Pharmacy** | | | |
| 30-day supply<br>Tier 1<br><br><br>Tier 2<br><br><br>Tier 3<br><br>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. | <br>$10.00 Copayment<br>not subject to Deductible<br><br>$35.00 Copayment<br>not subject to Deductible<br><br>$70.00 Copayment<br>not subject to Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |

| PRESCRIPTION DRUGS (Continued) | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|---|
| **Mail Order Pharmacy** | | | |
| Up to a 90-day supply<br>Tier 1<br><br><br>Tier 2<br><br><br>Tier 3 | <br>$25.00 Copayment<br>not subject to Deductible<br><br>$87.50 Copayment<br>not subject to Deductible<br><br>$175.00 Copayment<br>not subject to Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Enteral Formulas<br>Tier 1<br><br><br>Tier 2<br><br><br>Tier 3 | <br>$10.00 Copayment<br>not subject to Deductible<br><br>$35.00 Copayment<br>not subject to Deductible<br><br>$70.00 Copayment<br>not subject to Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| **WELLNESS BENEFITS** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| Gym Reimbursement | $200 per six (6)-month calendar year period; $100 per six (6)-month calendar year period for covered Dependent(s); not subject to Deductible | $200 per six (6)-month calendar year period; $100 per six (6)-month calendar year period for covered Dependent(s); not subject to Deductible. | $200 per six (6)-month calendar year period; $100 per six (6)-month calendar year period for covered Dependent(s) |

| PEDIATRIC DENTAL CARE | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|---|
| • Preventive Dental Care<br><br>• Routine Dental Care<br><br>• Major Dental Care (Endodontics, Periodontics, Prosthodontics and Oral Surgery)<br><br>• Orthodontics<br><br>**Major Dental Care and Orthodontics require Preauthorization** | $25 Copayment after Deductible<br><br>$25 Copayment after Deductible<br><br>$25 Copayment after Deductible<br><br>$25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost<br><br>Non-Participating Provider services are not Covered and You pay the full cost<br><br>Non-Participating Provider services are not Covered and You pay the full cost<br><br>Non-Participating Provider services are not Covered and You pay the full cost | One (1) Dental Exam & Cleaning Per six (6)-Month Period<br><br>Full mouth X-rays or panoramic X-rays at thirty-six (36) month intervals and bitewing X-rays at six (6) month intervals. |

| PEDIATRIC VISION CARE | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|---|
| **Pediatric Vision Care** | | | One (1) exam per 12-month period; One (1) prescribed lenses and frames per 12-month period |
| • Exams | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Lenses and Frames | 20% Coinsurance after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Contact Lenses | 20% Coinsurance after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |

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.