

**Section XXX**

**EmblemHealth Bronze Value Schedule of Benefits**

<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>\$7,150 \$14,300</p> <p>\$7,150 \$14,300</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>2 visits Covered in full, not subject to Deductible</p> <p>After 2 visits, 0% Coinsurance after Deductible</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>0% Coinsurance after Deductible</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><b>(1)</b>[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><b>(2)</b>[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	
<ul style="list-style-type: none"> <li>Screening for Prostate Cancer <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul> </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>Performed in a Specialist Office</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>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>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>	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)	0% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Non-Emergency Ambulance Services	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<b>Preauthorization required</b>			
Emergency Department	0% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Coinsurance waived if Hospital admission			
Urgent Care Center	0% Coinsurance after Deductible	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>
Acupuncture  <b>Referral required</b>	\$20 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Twelve (12) visits per Plan Year
Advanced Imaging 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>Referral required</b>	0% Coinsurance after Deductible  0% Coinsurance after Deductible  0% Coinsurance after Deductible	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
Allergy Testing and Treatment  <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> </ul> <b>Referral required</b>	0% Coinsurance after Deductible  0% Coinsurance after Deductible	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
Ambulatory Surgical Center Facility Fee  <b>Preauthorization required</b>	0% Coinsurance 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  <b>Preauthorization required</b>	0% Coinsurance after Deductible	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>	0% Coinsurance after Deductible  0% Coinsurance after Deductible  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>	0% Coinsurance after Deductible  0% Coinsurance after Deductible  0% Coinsurance after Deductible	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	0% Coinsurance after Deductible	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>	0% Coinsurance after Deductible  0% Coinsurance after Deductible  0% Coinsurance after Deductible	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>	0% Coinsurance after Deductible  0% Coinsurance after Deductible  0% Coinsurance after Deductible  0% Coinsurance after Deductible	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 ten (10) visits per calendar year <b>Preauthorization required</b>
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <b>Preauthorization required</b>	0% Coinsurance after Deductible	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>	0% Coinsurance after Deductible	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  <b>Preauthorization required</b>	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>	0% Coinsurance after Deductible  0% Coinsurance after Deductible  0% Coinsurance after Deductible  0% Coinsurance after Deductible	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% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
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>	\$20 Copayment, not subject to Deductible  \$20 Copayment, not subject to Deductible  \$20 Copayment, not subject to Deductible  \$20 Copayment, not subject to Deductible	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>0% Coinsurance after Deductible</p> <p>0% Coinsurance after Deductible</p> <p>Covered in full</p> <p>Covered in full</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>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>



<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>
Outpatient Hospital Surgery Facility Charge  <b>Preauthorization required</b>	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preadmission Testing  <b>Preauthorization required</b>	0% Coinsurance, not subject to Deductible	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 a Specialist Office</li> </ul>	Included as part of the PCP office visit Cost-Sharing  Included as part of the Specialist office visit 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	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>	0% Coinsurance after Deductible  0% Coinsurance after Deductible  0% Coinsurance after Deductible  0% Coinsurance after Deductible	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>
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>	0% Coinsurance after Deductible  0% Coinsurance after Deductible  0% Coinsurance after Deductible	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) <p><b>Preauthorization required</b></p>	0% Coinsurance after Deductible	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>	0% Coinsurance after Deductible	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; Transplants; and Interruption of Pregnancy)</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>0% Coinsurance after Deductible</p> <p>0% Coinsurance after Deductible</p> <p>0% Coinsurance after Deductible</p> <p>0% Coinsurance after Deductible</p> <p>0% Coinsurance after Deductible</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> <li>• Provided by a Dietitian/Nutritionist</li> </ul>	\$0 Copayment, not subject to Deductible  \$0 Copayment, not subject to Deductible	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</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>	0% Coinsurance 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  <b>Preauthorization required</b>	0% Coinsurance 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 <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>	0% Coinsurance after Deductible  0% Coinsurance after Deductible	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
Durable Medical Equipment and Braces  <b>Preauthorization required</b>	0% Coinsurance after Deductible	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>
External Hearing Aids  <b>Preauthorization required</b>	0% 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  <b>Preauthorization required</b>	0% 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  <ul style="list-style-type: none"> <li>• Inpatient</li> <li>• Outpatient</li> </ul> <b>Preauthorization required</b>	0% Coinsurance after Deductible  0% Coinsurance after Deductible	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>	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Prosthetic Devices  <ul style="list-style-type: none"> <li>• External</li> <li>• Internal</li> </ul> <b>Preauthorization required</b>	0% Coinsurance after Deductible  Included as part of inpatient Hospital 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

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)  <b>Preauthorization required. However, Preauthorization is not required for emergency admissions.</b>	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Observation Stay	0% Coinsurance 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)  <b>Preauthorization required</b>	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Two hundred (200) days per Plan Year
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)  <b>Preauthorization required</b>	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Sixty (60) days per Plan Year combined therapies
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)  <b>Preauthorization required</b>	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Sixty (60) days per Plan Year combined therapies  Speech and physical therapy are only Covered following a Hospital stay or surgery

<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>
Inpatient Mental Health Care including Residential Treatment (for a continuous confinement when in a Hospital) <b>Preauthorization required. However, Preauthorization is not required for emergency admissions.</b>	0% Coinsurance 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)	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Inpatient Substance Use Services including Residential Treatment (for a continuous confinement when in a Hospital) <b>Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.</b>	0% Coinsurance 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)	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Unlimited; Up to twenty (20) visits per Plan 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>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>Retail Pharmacy</b>			
30-day supply Tier 1	\$30 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	0% Coinsurance after Deductible		
Tier 3	0% Coinsurance after Deductible		
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.			
<b>Mail Order Pharmacy</b>			
Up to a 90-day supply Tier 1	\$75 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	0% Coinsurance after Deductible		
Tier 3	0% Coinsurance after Deductible		
Enteral Formulas Tier 1	\$30 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	0% Coinsurance after Deductible		
Tier 3	0% Coinsurance after Deductible		



<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; not subject to Deductible	Up to \$200 per six (6) month period; up to an additional \$100 per six (6) month period for Spouse; not subject to Deductible	Up to \$200 per six (6) month period; up to an additional \$100 per six (6) month period for Spouse
<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>Pediatric Vision Care</b>			
<ul style="list-style-type: none"> <li>Exams</li> <li>Lenses and Frames</li> <li>Contact Lenses</li> </ul>	<p>0% Coinsurance, not subject to Deductible</p> <p>0% Coinsurance, not subject to Deductible</p> <p>0% Coinsurance, not subject to Deductible</p>	Non-Participating Provider services are not Covered and You pay the full cost	<p>One (1) exam per twelve (12) month period;</p> <p>One (1) prescribed lenses and frames per twelve (12) month period</p>
<b>Adult Vision Care</b>			
<ul style="list-style-type: none"> <li>Exams</li> <li>Lenses and Frames</li> <li>Contact Lenses</li> </ul>	<p>0% Coinsurance, not subject to Deductible</p> <p>0% Coinsurance, not subject to Deductible</p> <p>0% Coinsurance, not subject to Deductible</p>	Non-Participating Provider services are not Covered and You pay the full cost	<p>One (1) exam per twelve (12) month period;</p> <p>One (1) prescribed lenses and frames per twelve (12) month period</p>

<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>
<p><b>Pediatric Dental Care</b></p> <ul style="list-style-type: none"> <li>• Emergency Dental Care</li> <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>\$55 Copayment, not subject to Deductible</p> <p>\$0 Copayment, not subject to Deductible</p> <p>\$55 Copayment, not subject to Deductible</p> <p>\$75 Copayment, not subject to Deductible</p> <p>\$75 Copayment, not subject to Deductible</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>One (1) dental exam and 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>DENTAL 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>
<b>Adult Dental Care</b> <ul style="list-style-type: none"> <li data-bbox="154 363 446 430">• Emergency Dental Care</li> <li data-bbox="154 510 446 577">• Preventive Dental Care</li> <li data-bbox="154 804 446 871">• Routine Dental Care</li> </ul>	\$55 Copayment, not subject to Deductible  \$0 Copayment, not subject to Deductible  \$55 Copayment, not subject to Deductible	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) month intervals

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.



**ATTENTION:** Language assistance services, free of charge, are available to you. Call **1-877-411-3625** (TTY/TDD: **711**).

**Español (Spanish)**

ATENCIÓN: Usted tiene a su disposición, gratis, servicios de ayuda para idiomas. Llame al **1-877-411-3625** (TTY/TDD: **711**).

**中文 (Traditional Chinese)**

注意：我們免費提供相關的語言協助服務。請致電 **1-877-411-3625** (TTY/TDD: **711**)。

**Русский (Russian)**

ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика. Звоните по тел. **1-877-411-3625** (служба текстового телефона TTY/TDD: **711**).

**Kreyòl Ayisyen (Haitian Creole)**

ATANSYON: Gen sèvis èd nan lang gratis ki disponib pou ou. Rele nimewo **1-877-411-3625** (TTY/TDD: **711**).

**한국어 (Korean)**

주의: 귀하에게 언어 지원 서비스가 무료로 제공됩니다. **1-877-411-3625**(TTY/TDD: **711**)번으로 전화하십시오.

**Italiano (Italian)**

ATTENZIONE: sono disponibili servizi gratuiti di assistenza linguistica. Chiami il numero **1-877-411-3625** (TTY/TDD: **711**).

**אידיש (Yiddish)**

אכטונג: שפראך הילף סערוויסעס, אהן קיין פרייז, זיינען דא צו באקומען פאר אייך. רופט **1-877-411-3625** (TTY/TDD: **711**).

**বাংলা (Bengali)**

মনোযোগ দিন: ভাষা সহায়তা পরিষেবাগুলি আপনার জন্য বিনামূল্যে উপলব্ধ আছে। **1-877-411-3625** (TTY/TDD: **711**) নম্বরে ফোন করুন।

**Polski (Polish)**

UWAGA: dostępna jest bezpłatna pomoc językowa. Prosimy zadzwonić pod numer **1-877-411-3625** (TTY/TDD: **711**).

**العربية (Arabic)**

يرجى الانتباه: تتوفر لك خدمات المساعدة اللغوية مجاناً، اتصل على الرقم **1-877-411-3625** أو (TTY/TDD: **711**).

**Français (French)**

ATTENTION : une assistance d'interprétation gratuite est à votre disposition. Veuillez composer le **1-877-411-3625** (TTY/TDD : **711**).

وجہ دیں: آپ کے لیے زبان سے متعلق اعانت کی خدمات، مفت دستیاب ہیں۔ 1-877-411-3625 (TTY/TDD: 711) پر کال کریں۔

**Tagalog (Tagalog)**

NANANAWAGAN NG PANSIN: Mayroon kang magagamit na mga serbisyo para sa tulong sa wika nang walang bayad. Tawagan ang **1-877-411-3625** (TTY/TDD: **711**).

**Ελληνικά (Greek)**

ΠΡΟΣΟΧΗ: Διατίθενται για σας υπηρεσίες γλωσσικής βοήθειας, δωρεάν. Καλέστε το **1-877-411-3625** (για άτομα με προβλήματα ακοής (TTY/TDD): **711**).

**Shqip (Albanian)**

VINI RE: Shërbime ndihmore për gjuhën, falas, janë në dispozicionin tuaj. Telefononi në **1-877-411-3625** (TTY/TDD: **711**).

**NOTICE OF NONDISCRIMINATION POLICY**

EmblemHealth complies with Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. EmblemHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

**EmblemHealth:**

- Provides free aids and services to people with disabilities to help
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call member services at **1-877-411-3625** (TTY/TDD: **711**).

If you believe that EmblemHealth has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with EmblemHealth Grievance and Appeals Department, PO Box 2844, New York, NY 10116, or call member services at **1-877-411-3625**. (Dial **711** for TTY/TDD services.) You can file a grievance in person, by mail or by phone. If you need help filing a grievance, EmblemHealth's Grievance and Appeals Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office of Civil Rights electronically through the Office of Civil Rights Complaint Portal, available at [ocrportal.hhs.gov/ocr/portal/lobby.jsf](https://ocrportal.hhs.gov/ocr/portal/lobby.jsf) or by mail or phone at **U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201; 1-800-368-1019**, (dial **1-800-537-7697** for TTY services).

Complaint forms are available at [hhs.gov/ocr/office/file/index.html](https://hhs.gov/ocr/office/file/index.html).