

Section XXX

EmblemHealth Gold Premier Schedule of Benefits

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
Medical Deductible <ul style="list-style-type: none"> • Individual • Family 	\$450 \$900	None None	
Prescription Drug Deductible <ul style="list-style-type: none"> • Individual • Family 	\$0 \$0	None None	
Out-of-Pocket Limit <ul style="list-style-type: none"> • Individual • Family 	\$4,000 \$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)	3 visits Covered in full, not subject to Deductible After 3 visits, \$30 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Specialist Office Visits (or Home Visits)	\$50 Copayment, not subject to 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
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> Adult Annual Physical Examinations* 	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> Adult Immunizations* 	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> Routine Gynecological Services/Well Woman Exams* 	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> 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	
<ul style="list-style-type: none"> (1)[Sterilization Procedures for Women*] 	[Covered in full]	[Non-Participating Provider services are not Covered and You pay the full cost]	
<ul style="list-style-type: none"> (2)[Vasectomy] 	[See Surgical Services Cost-Sharing]	[Non-Participating Provider services are not Covered and You pay the full cost]	
<ul style="list-style-type: none"> Bone Density Testing* 	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> Screening for Prostate Cancer <ul style="list-style-type: none"> Performed in a PCP Office 	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <ul style="list-style-type: none"> Performed in a Specialist Office 	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
<ul style="list-style-type: none"> All other preventive services required by USPSTF and HRSA *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA 	<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
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	\$150 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preauthorization required			
Emergency Department	\$300 Copayment after Deductible	\$300 Copayment after Deductible	See benefit for description
Copayment waived if admitted to Hospital	Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	
Urgent Care Center	\$75 Copayment, not subject to 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
Acupuncture	\$0 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"> Performed in a Specialist Office Performed in a Freestanding Radiology Facility Performed as Outpatient Hospital Services 	<p>\$50 Copayment after Deductible</p> <p>\$50 Copayment after Deductible</p> <p>\$50 Copayment 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>	See benefit for description
Allergy Testing and Treatment <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office 	<p>\$30 Copayment after Deductible</p> <p>\$50 Copayment 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>	See benefit for description
Ambulatory Surgical Center Facility Fee Preauthorization required	\$150 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 Preauthorization required	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 <ul style="list-style-type: none"> • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services <p style="text-align: center;">Preauthorization required</p>	\$50 Copayment after Deductible \$50 Copayment 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"> • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services 	\$30 Copayment after Deductible \$50 Copayment after Deductible \$50 Copayment 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	\$50 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Clinical Trials <p style="text-align: center;">Preauthorization required</p>	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
<p>Diagnostic Testing</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services 	<p>\$30 Copayment after Deductible</p> <p>\$50 Copayment after Deductible</p> <p>\$50 Copayment 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>See benefit for description</p>
<p>Dialysis</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed in a Freestanding Center Performed as Outpatient Hospital Services 	<p>\$30 Copayment after Deductible</p> <p>\$50 Copayment after Deductible</p> <p>\$50 Copayment after Deductible</p> <p>\$50 Copayment 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>See benefit for description</p> <p>Dialysis performed by Non-Participating Providers is limited to ten (10) visits per calendar year Preauthorization required</p>

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) <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office • Performed in an Outpatient Facility <p>Preauthorization required</p>	\$50 Copayment after Deductible \$50 Copayment after Deductible \$50 Copayment 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	Sixty (60) visits per condition, per Plan Year combined therapies
Home Health Care <p>Preauthorization required</p>	\$50 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Forty (40) visits per Plan Year
Infertility Services <p>Preauthorization required</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

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Infusion Therapy <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services Home Infusion Therapy Preauthorization required 	\$30 Copayment after Deductible \$50 Copayment after Deductible \$50 Copayment after Deductible \$50 Copayment 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 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Interruption of Pregnancy <ul style="list-style-type: none"> Medically Necessary Abortions (3)[Elective Abortions] Preauthorization required	Covered in full [\$150 Copayment 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]	Unlimited [One (1) procedure 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
Laboratory Procedures <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Laboratory Facility • Performed as Outpatient Hospital Services 	\$30 Copayment, not subject to Deductible \$50 Copayment, not subject to Deductible \$50 Copayment, not subject to Deductible \$50 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

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Maternity and Newborn Care</p> <ul style="list-style-type: none"> • Prenatal Care <ul style="list-style-type: none"> • Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA • Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA • Inpatient Hospital Services and Birthing Center • Physician and Midwife Services for Delivery • Breastfeeding Support, Counseling and Supplies, including Breast Pumps • Postnatal Care <p>Preauthorization required for inpatient services; breast pump</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>\$1,000 Copayment after Deductible</p> <p>\$150 Copayment 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>

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Outpatient Hospital Surgery Facility Charge Preauthorization required	\$150 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preadmission Testing Preauthorization required	\$0 Copayment, 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"> • Performed in a PCP Office • Performed in a Specialist Office 	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"> • Performed in a PCP Office • Performed in a Specialist Office Preauthorization required • Performed in a Freestanding Radiology Facility Preauthorization required • Performed as Outpatient Hospital Services Preauthorization required 	\$30 Copayment after Deductible \$50 Copayment after Deductible \$50 Copayment after Deductible \$50 Copayment 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

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 <ul style="list-style-type: none"> • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services 	\$50 Copayment after Deductible \$50 Copayment after Deductible \$50 Copayment 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) <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office • Performed in an Outpatient Facility <p>Preauthorization required</p>	\$50 Copayment after Deductible \$50 Copayment after Deductible \$50 Copayment 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	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	\$50 Copayment 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

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants)</p> <ul style="list-style-type: none"> • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office <p>Preauthorization required</p>	<p>\$150 Copayment after Deductible</p> <p>\$150 Copayment after Deductible</p> <p>\$150 Copayment after Deductible</p> <p>\$30 Copayment after Deductible</p> <p>\$50 Copayment 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>All transplants must be performed at designated Facilities</p>
<p>Telemedicine Program</p> <ul style="list-style-type: none"> • Provided by a Telemedicine Physician 	<p>\$0 Copayment, not subject to Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>

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 Preauthorization required	\$30 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 Preauthorization required	\$30 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 <ul style="list-style-type: none"> • Diabetic Equipment, Supplies and Insulin (30-day supply) • Diabetic Education Preauthorization required	\$30 Copayment after Deductible \$30 Copayment 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 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 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 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

ADDITIONAL SERVICES, EQUIPMENT and DEVICES – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Hospice Care <ul style="list-style-type: none"> • Inpatient • Outpatient <p style="text-align: center;">Preauthorization required</p>	\$1,000 Copayment after Deductible \$50 Copayment 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 <p style="text-align: center;">Preauthorization required</p>	20% 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"> • External • Internal <p style="text-align: center;">Preauthorization required</p>	20% 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) 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 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) Preauthorization required	\$1,000 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	(4) [Two hundred (200); Three hundred sixty-five (365)] days per Plan Year
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) Preauthorization required	\$1,000 Copayment 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) Preauthorization required	\$1,000 Copayment 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

MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment)</p> <p>Preauthorization required. However, Preauthorization is not required for emergency admissions.</p>	\$1,000 Copayment after Deductible	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"> • Office Visits • All Other Outpatient Services 	<p>\$30 Copayment, not subject to Deductible</p> <p>\$30 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>	See benefit for description
<p>Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)</p> <p>Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.</p>	\$1,000 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) <ul style="list-style-type: none"> • Office Visits • All Other Outpatient Services 	\$30 Copayment, not subject to Deductible \$30 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	Unlimited; Up to twenty (20) visits per Plan Year may be used for family counseling
PRESCRIPTION DRUGS *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

PRESCRIPTION DRUGS – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy			
30-day supply		Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 1	\$10 Copayment		
Tier 2	\$30 Copayment		
Tier 3	\$70 Copayment		
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.			
Mail Order Pharmacy			
Up to a 90-day supply		Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 1	\$25 Copayment		
Tier 2	\$75 Copayment		
Tier 3	\$175 Copayment		
Enteral Formulas		Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 1	\$10 Copayment		
Tier 2	\$30 Copayment		
Tier 3	\$70 Copayment		

WELLNESS BENEFITS	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
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
VISION CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Vision Care		Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> • Exams • Lenses and Frames • Contact Lenses 	<p>\$0 Copayment, not subject to Deductible</p> <p>20% Coinsurance, not subject to Deductible</p> <p>20% Coinsurance, not subject to Deductible</p>		<p>One (1) exam per twelve (12) month period;</p> <p>One (1) prescribed lenses and frames per twelve (12) month period</p>
Adult Vision Care		Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> • Exams • Lenses and Frames • Contact Lenses 	<p>\$0 Copayment, not subject to Deductible</p> <p>20% Coinsurance, not subject to Deductible</p> <p>20% Coinsurance, not subject to Deductible</p>		<p>One (1) exam per twelve (12) month period;</p> <p>One (1) prescribed lenses and frames per twelve (12) month period</p>

DENTAL CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Pediatric Dental Care</p> <ul style="list-style-type: none"> • Emergency Dental Care • Preventive Dental Care • Routine Dental Care • Major Dental Care (Endodontics, Periodontics, Prosthodontics and Oral Surgery) • Orthodontics <p>Major Dental Care and Orthodontics require Preauthorization</p>	<p>\$30 Copayment, not subject to Deductible</p> <p>\$0 Copayment, not subject to Deductible</p> <p>\$30 Copayment, not subject to Deductible</p> <p>\$50 Copayment, not subject to Deductible</p> <p>\$50 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>

DENTAL CARE – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Adult Dental Care			
<ul style="list-style-type: none"> • Emergency Dental Care 	\$30 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> • Preventive Dental Care 	\$0 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	One (1) dental exam and cleaning per six (6) month period
<ul style="list-style-type: none"> • Routine Dental Care 	\$30 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	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.