Section XXX

EmblemHealth Platinum Premier Schedule of Benefits

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Medical Deductible • Individual • Family	 $0 $0	 None None	
Prescription Drug Deductible • Individual • Family	 $0 $0	 None None	
Out-of-Pocket Limit • Individual • Family	 $2,000 $4,000	 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 After 3 visits, $15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Specialist Office Visits (or Home Visits)	$35 Copayment	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	
• **(1)[**Sterilization Procedures for Women***]**	**[**Covered in full**]**	**[**Non-Participating Provider services are not Covered and You pay the full cost**]**	
• **(2)[**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	
• Screening for Prostate Cancer • Performed in a PCP Office	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• 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**
• 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	See benefit for description
• *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)	$100 Copayment	$100 Copayment	See benefit for description
Non-Emergency Ambulance Services **Preauthorization required**	$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Emergency Department Copayment waived if admitted to Hospital	$200 Copayment Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	$200 Copayment Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	See benefit for description
Urgent Care Center	$75 Copayment	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	Non-Participating Provider services are not Covered and You pay the full cost	Twelve (12) visits per Plan Year
Advanced Imaging Services • Performed in a Specialist Office	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
• Performed in a Freestanding Radiology Facility	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Allergy Testing and Treatment • Performed in a PCP Office	$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
• Performed in a Specialist Office	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Ambulatory Surgical Center Facility Fee **Preauthorization required**	$100 Copayment	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**	10% Coinsurance	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 • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services **Preauthorization required**	 $35 Copayment $35 Copayment Included as part of inpatient Hospital service Cost-Sharing	 Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Included as part of inpatient Hospital service Cost-Sharing	See benefit for description
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $15 Copayment $35 Copayment $35 Copayment	 Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Chiropractic Services	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Clinical Trials **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	$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Dialysis			See benefit for description Dialysis performed by Non-Participating Providers is limited to ten (10) visits per calendar year **Preauthorization required**
• Performed in a PCP Office	$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Center	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$35 Copayment	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) • Performed in a PCP Office • Performed in a Specialist Office • Performed in an Outpatient Facility **Preauthorization required**	 $35 Copayment $35 Copayment $35 Copayment	 Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	Sixty (60) visits per condition, per Plan Year combined therapies
Home Health Care **Preauthorization required**	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	Forty (40) visits per Plan Year
Infertility Services **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

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Infusion Therapy			See benefit for description
• Performed in a PCP Office	$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Home Infusion Therapy **Preauthorization required**	$35 Copayment	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	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Interruption of Pregnancy			
• Medically Necessary Abortions	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	Unlimited
• **(3)[**Elective Abortions**]** **Preauthorization required**	**[**$100 Copayment**]**	**[**Non-Participating Provider services are not Covered and You pay the full cost**]**	**[**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			See benefit for description
• Performed in a PCP Office	$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Laboratory Facility	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$35 Copayment	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			See benefit for description
• Prenatal Care • Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Prenatal Care that is 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	
• Inpatient Hospital Services and Birthing Center	$500 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	One (1) home care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
• Physician and Midwife Services for Delivery	$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Breastfeeding Support, Counseling and Supplies, including Breast Pumps	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	Covered for duration of breast feeding
• Postnatal Care **Preauthorization required for inpatient services; breast pump**	Covered in full	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**
Outpatient Hospital Surgery Facility Charge **Preauthorization required**	$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preadmission Testing **Preauthorization required**	$0 Copayment	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 a 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	$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office **Preauthorization required**	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Radiology Facility **Preauthorization required**	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization required**	$35 Copayment	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			See benefit for description
• Performed in a Specialist Office	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Radiology Facility	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)			Sixty (60) visits per condition, per Plan Year combined therapies. Speech and physical therapy are only Covered following a Hospital stay or surgery.
• Performed in a PCP Office	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in an Outpatient Facility **Preauthorization required**	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Second Opinions on the Diagnosis of Cancer, Surgery and Other	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained.	See benefit for description

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)			See benefit for description
• Inpatient Hospital Surgery	$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	**All transplants must be performed at designated Facilities**
• Outpatient Hospital Surgery	$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Surgery Performed at an Ambulatory Surgical Center	$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Office Surgery • Performed in a PCP Office	$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office **Preauthorization required**	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Telemedicine Program • Provided by a Telemedicine Physician	$0 Copayment	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 **Preauthorization required**	$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder **Preauthorization required**	$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-day supply) • Diabetic Education **Preauthorization required**	 $15 Copayment $15 Copayment	 Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Durable Medical Equipment and Braces **Preauthorization required**	10% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
External Hearing Aids **Preauthorization required**	10% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost	Single purchase once every three (3) years
Cochlear Implants **Preauthorization required**	10% Coinsurance	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 • Inpatient	$500 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	Two hundred ten (210) days per Plan Year
• Outpatient **Preauthorization required**	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	Five (5) visits for family bereavement counseling
Medical Supplies **Preauthorization required**	10% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Prosthetic Devices • External	10% Coinsurance	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
• Internal **Preauthorization required**	Included as part of inpatient Hospital Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	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.**	$500 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Observation Stay	$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) **Preauthorization required**	$500 Copayment	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**	$500 Copayment	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**	$500 Copayment	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
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment) **Preauthorization required. However, Preauthorization is not required for emergency admissions.**	$500 Copayment	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)			See benefit for description
• Office Visits	$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• All Other Outpatient Services	$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment) **Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.**	$500 Copayment	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)			Unlimited; Up to twenty (20) visits per Plan Year may be used for family counseling
• Office Visits	$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• All Other Outpatient Services	$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
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 Tier 1 Tier 2 Tier 3 If You have an Emergency Condition, Preauthorization is not required for a five (5) day emergency supply of a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.	 $15 Copayment $30 Copayment $70 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Mail Order Pharmacy			
Up to a 90-day supply Tier 1 Tier 2 Tier 3	 $37.50 Copayment $75 Copayment $175 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Enteral Formulas Tier 1 Tier 2 Tier 3	 $15 Copayment $30 Copayment $70 Copayment	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	Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for Spouse	Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for Spouse	Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for Spouse
VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Vision Care • Exams • Lenses and Frames • Contact Lenses	$0 Copayment 10% Coinsurance 10% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost	One (1) exam per twelve (12) month period; One (1) prescribed lenses and frames per twelve (12) month period
Adult Vision Care • Exams • Lenses and Frames • Contact Lenses	$0 Copayment 10% Coinsurance 10% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost	One (1) exam per twelve (12) month period; One (1) prescribed lenses and frames per twelve (12) month period

DENTAL CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care			
• Emergency Dental Care	$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Preventive Dental Care	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	One (1) dental exam and cleaning per six (6) month period
• Routine Dental Care	$15 Copayment	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
• Major Dental Care (Endodontics, Periodontics, Prosthodontics and Oral Surgery)	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Orthodontics	$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Major Dental Care and Orthodontics require Preauthorization			

DENTAL CARE – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Adult Dental Care			
• Emergency Dental Care	$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Preventive Dental Care	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	One (1) dental exam and cleaning per six (6) month period
• Routine Dental Care	$15 Copayment	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.