Section XXVIII

EmblemHealth Platinum POS 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	 $2,600 $5,200	
Prescription Drug Deductible • Individual • Family	 $0 $0	 Non-Participating Provider services are not Covered and You pay the full cost	
Out-of-Pocket Limit • Individual • Family	 $2,500 $5,000	 $5,000 $10,000	
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	30% Coinsurance after Deductible	See benefit for description
Specialist Office Visits (or Home Visits)	$35 Copayment	30% Coinsurance after Deductible	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	30% Coinsurance after Deductible	See benefit for description
• Adult Annual Physical Examinations*	Covered in full	30% Coinsurance after Deductible	
• Adult Immunizations*	Covered in full	30% Coinsurance after Deductible	
• Routine Gynecological Services/Well Woman Exams*	Covered in full	30% Coinsurance after Deductible	
• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full	30% Coinsurance after Deductible	
• **(1)[**Sterilization Procedures for Women***]**	**[**Covered in full**]**	30% Coinsurance after Deductible	
• **(2)[**Vasectomy**]**	**[**See Surgical Services Cost-Sharing**]**	**[**See Surgical Services Cost-Sharing**]**	
• Bone Density Testing*	Covered in full	30% Coinsurance after Deductible	
• Screening for Prostate Cancer	Covered in full	30% Coinsurance after Deductible	

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	30% Coinsurance after Deductible	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)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	
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)	20% Coinsurance	20% Coinsurance, not subject to Deductible	See benefit for description
Non-Emergency Ambulance Services **Preauthorization required**	$150 Copayment	30% Coinsurance after Deductible	See benefit for description
Emergency Department Coinsurance waived if admitted to Hospital	20% Coinsurance Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	20% Coinsurance, not subject to Deductible	See benefit for description
Urgent Care Center	$75 Copayment	30% Coinsurance after Deductible	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 • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services **Preauthorization required**	$35 Copayment $35 Copayment $35 Copayment	30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office	$15 Copayment $35 Copayment	30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
Ambulatory Surgical Center Facility Fee **Preauthorization required**	$150 Copayment	30% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings)	Covered in full	30% Coinsurance after Deductible	See benefit for description
Autologous Blood Banking	10% Coinsurance	30% Coinsurance after Deductible	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	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 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 **Preauthorization required**	 $15 Copayment $35 Copayment $35 Copayment	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
Chiropractic Services	$35 Copayment	30% Coinsurance after Deductible	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 • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services **Preauthorization required**	 $15 Copayment $35 Copayment $35 Copayment	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
Dialysis • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Center • Performed as Outpatient Hospital Services	 $15 Copayment $35 Copayment $35 Copayment $35 Copayment	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description Dialysis performed by Non-Participating Providers is limited to ten (10) visits per calendar year **Preauthorization required**

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**	 $15 Copayment $35 Copayment $35 Copayment	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	Sixty (60) visits per condition, per Plan Year combined therapies
Home Health Care **Preauthorization required**	$35 Copayment	30% Coinsurance after Deductible	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)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and Diagnostic Procedures)	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	30% Coinsurance after Deductible	
• Performed in a Specialist Office	$35 Copayment	30% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services **Preauthorization required**	$35 Copayment	30% Coinsurance after Deductible	
• Home Infusion Therapy **Preauthorization required**	$35 Copayment	30% Coinsurance after Deductible	Home infusion counts toward home health care visit limits
Inpatient Medical Visits	$0 Copayment	30% Coinsurance after Deductible	See benefit for description
(3)[Interruption of Pregnancy			
• Medically Necessary Abortions	Covered in full	Covered in full	Unlimited
• **(4)[**Elective Abortions**]** **Preauthorization required**	**[**$150 Copayment**]**	**[**30% Coinsurance after Deductible**]**	**[**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 • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Laboratory Facility • Performed as Outpatient Hospital Services **Preauthorization required**	 $15 Copayment $35 Copayment $35 Copayment $35 Copayment	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	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**
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	30% Coinsurance after Deductible	
• 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)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	
• Inpatient Hospital Services and Birthing Center	$500 Copayment per admission	30% Coinsurance per admission after Deductible	One (1) home care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
• Physician and Midwife Services for Delivery	$150 Copayment	30% Coinsurance after Deductible	
• Breastfeeding Support, Counseling and Supplies, including Breast Pumps	Covered in full	30% Coinsurance after Deductible	Covered for duration of breast feeding
• Postnatal Care	Covered in full	30% Coinsurance after Deductible	
Preauthorization required for inpatient services			

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	30% Coinsurance after Deductible	See benefit for description
Preadmission Testing **Preauthorization required**	$0 Copayment	30% Coinsurance after Deductible	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	Included as part of the PCP office visit Cost-Sharing	
• Performed in a Specialist Office	Included as part of the Specialist office visit Cost-Sharing	Included as part of the Specialist office visit Cost-Sharing	
Diagnostic Radiology Services			See benefit for description
• Performed in a PCP Office	$15 Copayment	30% Coinsurance after Deductible	
• Performed in a Specialist Office **Preauthorization required**	$35 Copayment	30% Coinsurance after Deductible	
• Performed in a Freestanding Radiology Facility **Preauthorization required**	$35 Copayment	30% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services **Preauthorization required**	$35 Copayment	30% Coinsurance after Deductible	

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 • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services **Preauthorization required**	 $35 Copayment $35 Copayment $35 Copayment	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
Rehabilitation 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**	 $15 Copayment $35 Copayment $35 Copayment	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	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	$35 Copayment	30% Coinsurance after Deductible	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	$150 Copayment	30% Coinsurance after Deductible	**All transplants must be performed at designated Facilities**
• Outpatient Hospital Surgery	$150 Copayment	30% Coinsurance after Deductible	
• Surgery Performed at an Ambulatory Surgical Center	$150 Copayment	30% Coinsurance after Deductible	
• Office Surgery • Performed in a PCP Office	$15 Copayment	30% Coinsurance after Deductible	
• Performed in a Specialist Office	$35 Copayment	30% Coinsurance after Deductible	
Preauthorization required			
Telemedicine Program			See benefit for description
• Provided by a Telemedicine Physician	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	

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	30% Coinsurance after Deductible	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder **Preauthorization required**	$15 Copayment	30% Coinsurance after Deductible	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	 $50 Copayment, not subject to Deductible $50 Copayment, not subject to Deductible	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 per admission	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	30% Coinsurance after Deductible	See benefit for description
Prosthetic Devices • External	10% Coinsurance	30% Coinsurance after Deductible	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	Included as part of inpatient Hospital Cost-Sharing	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 per admission	30% Coinsurance per admission after Deductible	See benefit for description
Observation Stay	$150 Copayment	30% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) **Preauthorization required**	$500 Copayment per admission	Non-Participating Provider services are not Covered and You pay the full cost	**(5)[**Two hundred (200); Three hundred sixty-five (365)**]** days per Plan Year
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) **Preauthorization required**	$500 Copayment per admission	30% Coinsurance per admission after Deductible	Sixty (60) days per Plan Year combined therapies
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) **Preauthorization required**	$500 Copayment per admission	30% Coinsurance per admission after Deductible	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 or for admissions at Participating OHM-licensed Facilities for Members under eighteen (18).**	$500 Copayment per admission	30% Coinsurance per admission after Deductible	See benefit for description
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) • Office Visits • All Other Outpatient Services	 $15 Copayment $15 Copayment	 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
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 per admission	30% Coinsurance per admission after Deductible	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	30% Coinsurance after Deductible	
• All Other Outpatient Services	$15 Copayment	30% Coinsurance after Deductible	
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 Preauthorization is not required for a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.	 $0 Copayment $30 Copayment $60 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	 $0 Copayment $75 Copayment $150 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	 $0 Copayment $30 Copayment $60 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	$200 per six (6) month calendar year period; an additional $100 per six (6) month calendar year period for covered Dependents	$200 per six (6) month calendar year period; an additional $100 per six (6) month calendar year period for covered Dependents	$200 per six (6) month calendar year period; an additional $100 per six (6) month calendar year period for covered Dependents
PEDIATRIC VISION and DENTAL 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

PEDIATRIC VISION and DENTAL CARE – Continued	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			

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.

If You fail to seek Our Preauthorization for Out-of-Network benefits, We will pay an amount $500 less than We would otherwise have paid for the care, or We will pay only 50% of the amount We would otherwise have paid for the care, whichever results in a greater benefit for You. You must pay the remaining charges. We will pay the amount specified above only if We determine the care was Medically Necessary even though You did not seek Our Preauthorization. If We determine that the services were not Medically Necessary, You will be responsible for paying the entire charge for the service.