

## Section XXVIII

### EmblemHealth Platinum Premier-P Schedule of Benefits

<b>COST-SHARING</b>  <b>Medical Deductible</b> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul> <b>Prescription Drug Deductible</b> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul> <b>Out-of-Pocket Limit</b> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>  \$0 \$0  \$0 \$0  \$2,000 \$4,000	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>  None None  None None  Non-Participating Provider services are not Covered except as required for emergency care.	
<b>OFFICE VISITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
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

<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</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)	\$250 Copayment	\$250 Copayment	See benefit for description
Non-Emergency Ambulance Services	\$250 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<b>Preauthorization required</b>			
Emergency Department	\$400 Copayment	\$400 Copayment	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		
Urgent Care Center	\$75 Copayment	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	\$0 Copayment	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> <p><b>Preauthorization required</b></p>	\$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	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>	\$15 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	See benefit for description
Ambulatory Surgical Center Facility Fee <p><b>Preauthorization required</b></p>	\$250 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	10% Coinsurance	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>	\$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  Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Chemotherapy and Immunotherapy <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>Preauthorization required</b></p>	\$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 <p><b>Preauthorization required</b></p>	Use Cost-Sharing for appropriate service	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>
Diagnostic Testing <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 style="text-align: center;"><b>Preauthorization required</b></p>	\$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
Dialysis <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 Center</li> <li>• Performed as Outpatient Hospital Services</li> </ul>	\$15 Copayment  \$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  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 <p style="text-align: center;"><b>Preauthorization required</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>
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> <li>• Performed in a Specialist Office</li> <li>• Performed in an Outpatient Facility</li> </ul> <b>Preauthorization required</b>	\$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	Sixty (60) visits per condition, per Plan Year combined therapies
Home Health Care  <b>Preauthorization required</b>	\$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	Forty (40) visits per Plan Year
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

<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>Infusion Therapy</p> <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 <b>Preauthorization required</b></li> <li>• Home Infusion Therapy <b>Preauthorization required</b></li> </ul>	<p>\$15 Copayment</p> <p>\$35 Copayment</p> <p>\$35 Copayment</p> <p>\$35 Copayment</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>Home infusion counts toward home health care visit limits</p>
<p>Inpatient Medical Visits</p>	<p>\$0 Copayment</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p><b>(3)</b>[Interruption of Pregnancy</p> <ul style="list-style-type: none"> <li>• Medically Necessary Abortions</li> <li>• <b>(4)</b>[Elective Abortions]</li> </ul> <p><b>Preauthorization required</b></p>	<p>Covered in full</p> <p>[\$250 Copayment]</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>Unlimited</p> <p>[One (1) procedure per Plan Year]]</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>
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> <p><b>Preauthorization required</b></p>	\$15 Copayment  \$35 Copayment  \$15 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  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</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>20% Coinsurance per admission</p> <p>\$250 Copayment</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>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>	\$250 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preadmission Testing  <b>Preauthorization required</b>	\$0 Copayment	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>	\$15 Copayment  \$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  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 style="text-align: center;"><b>Preauthorization required</b></p>	\$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	See benefit for description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> <li>• Performed in a Specialist Office</li> <li>• Performed in an Outpatient Facility</li> </ul> <p style="text-align: center;"><b>Preauthorization required</b></p>	\$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	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	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; and Transplants)</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>\$250 Copayment</p> <p>\$250 Copayment</p> <p>\$250 Copayment</p> <p>\$15 Copayment</p> <p>\$35 Copayment</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 Center of Excellence Facilities</b></p>
<p>Telemedicine Program</p> <ul style="list-style-type: none"> <li>• Provided by a Telemedicine Physician</li> </ul>	<p>\$0 Copayment</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>

<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>	\$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  <b>Preauthorization required</b>	\$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  <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>	\$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  <b>Preauthorization required</b>	10% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
External Hearing Aids  <b>Preauthorization required</b>	10% Coinsurance	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>	10% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost	One (1) per ear per time Covered

<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>
Hospice Care <ul style="list-style-type: none"> <li>• Inpatient</li> <li>• Outpatient</li> </ul> <p style="text-align: center;"><b>Preauthorization required</b></p>	20% Coinsurance per admission  \$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	Two hundred ten (210) days per Plan Year  Five (5) visits for family bereavement counseling
Medical Supplies <p style="text-align: center;"><b>Preauthorization required</b></p>	10% Coinsurance	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> <p style="text-align: center;"><b>Preauthorization required</b></p>	10% Coinsurance  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

<b>INPATIENT SERVICES and FACILITIES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
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 or services provided in a neonatal intensive care unit of a Hospital certified pursuant to Article 28 of the Public Health Law.</b>	20% Coinsurance per admission	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Observation Stay	\$250 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)  <b>Preauthorization required</b>	20% Coinsurance per admission	Non-Participating Provider services are not Covered and You pay the full cost	<b>(5)</b> [Two hundred (200); Three hundred sixty-five (365)] days per Plan Year
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)  <b>Preauthorization required</b>	20% Coinsurance per admission	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>	20% Coinsurance per admission	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>
<p>Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment)</p> <p><b>Preauthorization required. However, Preauthorization is not required for emergency admissions or for admissions at Participating OMH-licensed Facilities for Members under eighteen (18).</b></p>	20% Coinsurance per admission	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"> <li>• Office Visits</li> <li>• All Other Outpatient Services</li> </ul>	<p>3 visits Covered in full</p> <p>After 3 visits, \$15 Copayment</p> <p>\$15 Copayment</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><b>Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.</b></p>	20% Coinsurance per admission	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

<b>MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES – 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>Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)</p> <ul style="list-style-type: none"> <li>• Office Visits</li> <li>• All Other Outpatient Services</li> </ul>	<p>3 visits Covered in full</p> <p>After 3 visits, \$15 Copayment</p> <p>\$15 Copayment</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>Unlimited; Up to twenty (20) visits per Plan Year may be used for family counseling</p>
<p><b>PRESCRIPTION DRUGS</b></p> <p>*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.</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>

<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	\$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	\$30 Copayment		
Tier 3	\$65 Copayment		
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.			
<b>Mail Order Pharmacy</b>			
Up to a 90-day supply Tier 1	\$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	\$75 Copayment		
Tier 3	\$162.50 Copayment		
Enteral Formulas Tier 1	\$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	\$30 Copayment		
Tier 3	\$65 Copayment		

<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	\$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
<b>PEDIATRIC VISION and 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>
<b>Pediatric Vision Care</b> <ul style="list-style-type: none"> <li>• Exams</li> <li>• Lenses and Frames</li> <li>• Contact Lenses</li> </ul>	\$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

<b>PEDIATRIC VISION and 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>Pediatric Dental Care</b> <ul style="list-style-type: none"> <li data-bbox="165 448 443 515">• Preventive Dental Care</li> <li data-bbox="165 593 475 622">• Routine Dental Care</li> <li data-bbox="165 739 456 913">• Major Dental Care (Endodontics, Periodontics, Prosthodontics and Oral Surgery)</li> <li data-bbox="165 952 379 981">• Orthodontics</li> </ul> <p data-bbox="213 1064 475 1191"><b>Major Dental Care and Orthodontics require Preauthorization</b></p>	<p data-bbox="520 448 708 477">\$0 Copayment</p> <p data-bbox="520 593 724 622">\$15 Copayment</p> <p data-bbox="520 739 724 768">\$35 Copayment</p> <p data-bbox="520 952 724 981">\$35 Copayment</p>	<p data-bbox="861 448 1235 551">Non-Participating Provider services are not Covered and You pay the full cost</p> <p data-bbox="861 593 1235 696">Non-Participating Provider services are not Covered and You pay the full cost</p> <p data-bbox="861 739 1235 842">Non-Participating Provider services are not Covered and You pay the full cost</p> <p data-bbox="861 952 1235 1055">Non-Participating Provider services are not Covered and You pay the full cost</p>	<p data-bbox="1267 448 1458 622">One (1) dental exam and cleaning per six (6) month period</p> <p data-bbox="1267 665 1458 1010">Full mouth x-rays or panoramic x-rays at thirty-six (36) month intervals and bitewing x-rays at six (6) month intervals</p>

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.