

Section XXVIII

EmblemHealth Platinum Value-S Schedule of Benefits

| | | | |
|---|---|--|------------------------------------|
| <p>COST-SHARING</p> <p>Deductible</p> <ul style="list-style-type: none"> • Individual • Family <p>Out-of-Pocket Limit</p> <ul style="list-style-type: none"> • Individual • Family | <p>Participating Provider Member Responsibility for Cost-Sharing</p> <p>\$250 \$500</p> <p>\$2,500 \$5,000</p> | <p>Non-Participating Provider Member Responsibility for Cost-Sharing</p> <p>None None</p> <p>Non-Participating Provider services are not Covered except as required for emergency care.</p> | |
| <p>OFFICE VISITS</p> | <p>Participating Provider Member Responsibility for Cost-Sharing</p> | <p>Non-Participating Provider Member Responsibility for Cost-Sharing</p> | <p>Limits</p> |
| <p>Primary Care Office Visits (or Home Visits)</p> | <p>3 visits Covered in full, not subject to Deductible</p> <p>After 3 visits, \$15 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> |
| <p>Specialist Office Visits (or Home Visits)</p> | <p>\$35 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> |

| 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 | 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) | \$250 Copayment after Deductible | \$250 Copayment after Deductible | See benefit for description |
| Non-Emergency Ambulance Services | \$250 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Preauthorization required | | | |
| Emergency Department Copayment waived if admitted to Hospital | \$400 Copayment after Deductible Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing | \$400 Copayment after Deductible | See benefit for description |
| 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>Preauthorization required</p> | <p>\$35 Copayment after Deductible</p> <p>\$35 Copayment after Deductible</p> <p>\$35 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>\$15 Copayment after Deductible</p> <p>\$35 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 <p>Preauthorization required</p> | \$250 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 | 10% 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>Preauthorization required</p> | \$35 Copayment after Deductible \$35 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 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"> • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services <p>Preauthorization required</p> | \$15 Copayment after Deductible \$35 Copayment after Deductible \$35 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 | \$35 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>Preauthorization required</p> | Use Cost-Sharing for appropriate service | 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 |
|---|--|--|---|
| Diagnostic Testing <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services <p style="text-align: center;">Preauthorization required</p> | \$15 Copayment after Deductible \$35 Copayment after Deductible \$35 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 |
| Dialysis <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 | \$15 Copayment after Deductible \$35 Copayment after Deductible \$35 Copayment after Deductible \$35 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 Dialysis performed by Non-Participating Providers is limited to ten (10) visits per calendar year <p style="text-align: center;">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 Preauthorization required | \$15 Copayment after Deductible \$35 Copayment after Deductible \$35 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 Preauthorization required | \$35 Copayment after Deductible | 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 |
|---|---|---|---|
| <p>Infusion Therapy</p> <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services Preauthorization required • Home Infusion Therapy Preauthorization required | <p>\$15 Copayment after Deductible</p> <p>\$35 Copayment after Deductible</p> <p>\$35 Copayment after Deductible</p> <p>\$35 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>Home infusion counts toward home health care visit limits</p> |
| <p>Inpatient Medical Visits</p> | <p>\$0 Copayment after Deductible</p> | <p>Non-Participating Provider services are not Covered and You pay the full cost</p> | <p>See benefit for description</p> |
| <p>(3)[Interruption of Pregnancy</p> <ul style="list-style-type: none"> • Medically Necessary Abortions • (4)[Elective Abortions] <p>Preauthorization required</p> | <p>Covered in full</p> <p>[\$250 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>Unlimited</p> <p>[One (1) procedure per Plan Year]]</p> |

| PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | Limits |
|--|---|---|------------------------------------|
| <p>Laboratory Procedures</p> <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 <p>Preauthorization required</p> | <p>\$15 Copayment, not subject to Deductible</p> <p>\$35 Copayment, not subject to Deductible</p> <p>\$15 Copayment, not subject to Deductible</p> <p>\$35 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>See benefit for description</p> |

| 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</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 after Deductible</p> <p>\$250 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>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 |
|---|---|---|-----------------------------|
| <p>Outpatient Hospital Surgery Facility Charge</p> <p>Preauthorization required</p> | \$250 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| <p>Preadmission Testing</p> <p>Preauthorization required</p> | \$0 Copayment, not subject to Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| <p>Prescription Drugs Administered in Office</p> <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office | <p>Included as part of the PCP office visit Cost-Sharing</p> <p>Included as part of the Specialist office visit Cost-Sharing</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>Diagnostic Radiology Services</p> <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services <p>Preauthorization required</p> | <p>\$15 Copayment after Deductible</p> <p>\$35 Copayment after Deductible</p> <p>\$35 Copayment after Deductible</p> <p>\$35 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> | 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 <p style="text-align: center;">Preauthorization required</p> | \$35 Copayment after Deductible \$35 Copayment after Deductible \$35 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 style="text-align: center;">Preauthorization required</p> | \$15 Copayment after Deductible \$35 Copayment after Deductible \$35 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 | \$35 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>\$250 Copayment after Deductible</p> <p>\$250 Copayment after Deductible</p> <p>\$250 Copayment after Deductible</p> <p>\$15 Copayment after Deductible</p> <p>\$35 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 Center of Excellence 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 |
|--|---|---|--|
| <p>ABA Treatment for Autism Spectrum Disorder</p> <p>Preauthorization required</p> | \$15 Copayment, not subject to Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| <p>Assistive Communication Devices for Autism Spectrum Disorder</p> <p>Preauthorization required</p> | \$15 Copayment, not subject to Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| <p>Diabetic Equipment, Supplies and Self-Management Education</p> <ul style="list-style-type: none"> • Diabetic Equipment, Supplies and Insulin (30-day supply) • Diabetic Education <p>Preauthorization required</p> | <p>\$15 Copayment, not subject to Deductible</p> <p>\$15 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>Durable Medical Equipment and Braces</p> <p>Preauthorization required</p> | 10% Coinsurance after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| <p>External Hearing Aids</p> <p>Preauthorization required</p> | 10% Coinsurance after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | Single purchase once every three (3) years |
| <p>Cochlear Implants</p> <p>Preauthorization required</p> | 10% 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> | 20% Coinsurance per admission after Deductible \$35 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> | 10% 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> | 10% 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. | 20% Coinsurance per admission after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Observation Stay | \$250 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 | 20% Coinsurance per admission after Deductible | 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 | 20% Coinsurance per admission 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 | 20% Coinsurance per admission 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 or for admissions at Participating OMH-licensed Facilities for Members under eighteen (18).</p> | <p>20% Coinsurance per admission after Deductible</p> | <p>Non-Participating Provider services are not Covered and You pay the full cost</p> | <p>See benefit for description</p> |
| <p>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>3 visits Covered in full, not subject to Deductible</p> <p>After 3 visits, \$15 Copayment, not subject to Deductible</p> <p>\$15 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>See benefit for description</p> |
| <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> | <p>20% Coinsurance per admission after Deductible</p> | <p>Non-Participating Provider services are not Covered and You pay the full cost</p> | <p>See benefit for description</p> |

| MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES – Continued | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | Limits |
|--|--|---|--|
| <p>Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)</p> <ul style="list-style-type: none"> • Office Visits • All Other Outpatient Services | <p>3 visits Covered in full, not subject to Deductible</p> <p>After 3 visits, \$15 Copayment, not subject to Deductible</p> <p>\$15 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>Unlimited; Up to twenty (20) visits per Plan Year may be used for family counseling</p> |
| <p>PRESCRIPTION DRUGS</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>Participating Provider Member Responsibility for Cost-Sharing</p> | <p>Non-Participating Provider Member Responsibility for Cost-Sharing</p> | <p>Limits</p> |

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

| 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 <ul style="list-style-type: none"> • Exams • Lenses and Frames • Contact Lenses | <p>\$0 Copayment, not subject to Deductible</p> <p>10% Coinsurance, not subject to Deductible</p> <p>10% Coinsurance, not subject to Deductible</p> | Non-Participating Provider services are not Covered and You pay the full cost | <p>One (1) exam per twelve (12) month period</p> <p>One (1) prescribed lenses and frames per twelve (12) month period</p> |

| 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 <ul style="list-style-type: none"> • 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>\$0 Copayment, not subject to Deductible</p> <p>\$15 Copayment, not subject to Deductible</p> <p>\$35 Copayment, not subject to Deductible</p> <p>\$35 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>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> |

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.