

Section XXVIII

EmblemHealth Bronze Premier-M 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>\$5,500 \$11,000</p> <p>\$8,700 \$17,400</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 (PCP, ABA, MH/SUD or any combination thereof)</p> <p>After 3 visits, 50% Coinsurance 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>Specialist Office Visits (or Home Visits)</p> <p>Referral required</p>	<p>50% Coinsurance after 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)	50% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Non-Emergency Ambulance Services	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preauthorization required			
Emergency Department	50% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Cost-Sharing waived if admitted to Hospital	Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	
Urgent Care Center	\$75 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Advanced Imaging Services</p> <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>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance 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
<p>Allergy Testing and Treatment</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office <p>Referral required</p>	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance 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
<p>Ambulatory Surgical Center Facility Fee</p> <p>Preauthorization required</p>	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<p>Anesthesia Services (all settings)</p>	Covered in full	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>Cardiac and Pulmonary Rehabilitation</p> <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>	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>Included as part of inpatient Hospital service 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> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	See benefit for description
<p>Chemotherapy and Immunotherapy</p> <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>	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance 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
Chiropractic Services	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<p>Clinical Trials</p> <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
<p>Diagnostic Testing</p> <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office Referral required • Performed as Outpatient Hospital Services Preauthorization required 	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Dialysis</p> <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office Referral required • Performed in a Freestanding Center Referral required • Performed as Outpatient Hospital Services Referral required 	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance 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>Dialysis performed by Non-Participating Providers is limited to ten (10) visits per calendar year. Cost-Sharing for the visits is the same as for a Participating Provider. See benefit description for more information. 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	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance 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	50% Coinsurance 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 Referral required • Performed as Outpatient Hospital Services Preauthorization required • Home Infusion Therapy Preauthorization required 	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance 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>[50% Coinsurance 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
Laboratory Procedures <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Laboratory Facility • Performed as Outpatient Hospital Services Preauthorization required	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<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>50% Coinsurance per admission after Deductible</p> <p>50% Coinsurance 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
Outpatient Hospital Surgery Facility Charge Preauthorization required	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preadmission Testing Preauthorization required	\$0 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Prescription Drugs Administered in Office <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office 	Included as part of the PCP office visit Cost-Sharing Included as part of the Specialist office visit Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Diagnostic Radiology Services <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office Preauthorization required • Performed in a Freestanding Radiology Facility Preauthorization required • Performed as Outpatient Hospital Services Preauthorization required 	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Therapeutic Radiology Services <ul style="list-style-type: none"> • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services <p style="text-align: center;">Preauthorization required</p>	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance 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>	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance 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.
Second Opinions on the Diagnosis of Cancer, Surgery and Other <p style="text-align: center;">Referral required</p>	50% Coinsurance 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>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance 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
ABA Treatment for Autism Spectrum Disorder Preauthorization required	3 visits Covered in full, not subject to Deductible (PCP, ABA, MH/SUD or any combination thereof) After 3 visits, 50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder Preauthorization required	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education <ul style="list-style-type: none"> • Diabetic Equipment, Supplies and Insulin (30-day supply) • Diabetic Education Preauthorization required	50% Coinsurance, not subject to Deductible but not more than \$100 for a 30-day supply of insulin 50% Coinsurance, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Durable Medical Equipment and Braces Preauthorization required	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
External Hearing Aids Preauthorization required	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Single purchase once every three (3) years
Cochlear Implants Preauthorization required	50% 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>	50% Coinsurance per admission after Deductible 50% Coinsurance 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>	50% 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>	50% 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
Autologous Blood Banking Services	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
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.	50% Coinsurance per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Observation Stay	50% Coinsurance 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	50% 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	50% 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	50% 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

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>	50% Coinsurance per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<p>Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)</p> <ul style="list-style-type: none"> • Office Visits • All Other Outpatient Services 	<p>3 visits Covered in full, not subject to Deductible (PCP, ABA, MH/SUD or any combination thereof)</p> <p>After 3 visits, 50% Coinsurance after Deductible</p> <p>50% Coinsurance 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
<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>	50% Coinsurance per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<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 (PCP, ABA, MH/SUD or any combination thereof)</p> <p>After 3 visits, 50% Coinsurance after Deductible</p> <p>50% Coinsurance 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; 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	\$50 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	50% Coinsurance 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.	50% Coinsurance after Deductible		
Mail Order Pharmacy			
Up to a 90-day supply Tier 1	\$125 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	50% Coinsurance after Deductible		
Tier 3	50% Coinsurance after Deductible		
Enteral Formulas Tier 1	\$50 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	50% Coinsurance after Deductible		
Tier 3	50% Coinsurance 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>50% Coinsurance, not subject to Deductible</p> <p>50% 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"> <li data-bbox="165 450 443 517">• Preventive Dental Care <li data-bbox="165 595 475 622">• Routine Dental Care <li data-bbox="165 741 456 913">• Major Dental Care (Endodontics, Periodontics, Prosthodontics and Oral Surgery) <li data-bbox="165 954 379 981">• Orthodontics <p data-bbox="213 1066 475 1191">Major Dental Care and Orthodontics require Preauthorization</p>	<p data-bbox="520 450 794 517">\$0 Copayment, not subject to Deductible</p> <p data-bbox="520 595 794 663">\$40 Copayment, not subject to Deductible</p> <p data-bbox="520 741 794 808">\$70 Copayment after Deductible</p> <p data-bbox="520 954 794 1021">\$70 Copayment after Deductible</p>	<p data-bbox="861 450 1235 551">Non-Participating Provider services are not Covered and You pay the full cost</p> <p data-bbox="861 595 1235 696">Non-Participating Provider services are not Covered and You pay the full cost</p> <p data-bbox="861 741 1235 842">Non-Participating Provider services are not Covered and You pay the full cost</p> <p data-bbox="861 954 1235 1055">Non-Participating Provider services are not Covered and You pay the full cost</p>	<p data-bbox="1267 450 1458 618">One (1) dental exam and cleaning per six (6) month period</p> <p data-bbox="1267 663 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.