

Section XXVIII

EmblemHealth Bronze Plus HSA 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>\$6,550 \$13,100</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>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* • Adult Annual Physical Examinations* • Adult Immunizations* • Routine Gynecological Services/Well Woman Exams* • Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer • (1)[Sterilization Procedures for Women*] • (2)[Vasectomy] • Bone Density Testing* • Screening for Prostate Cancer <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office 	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p> <p>[Covered in full]</p> <p>[See Surgical Services Cost-Sharing]</p> <p>Covered in full</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>[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>

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 Preauthorization required	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Emergency Department Coinsurance waived if admitted to Hospital	50% Coinsurance after Deductible Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	50% Coinsurance after Deductible Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	See benefit for description
Urgent Care Center	50% 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	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>Referral 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>	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<p>Autologous Blood Banking</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

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>	50% Coinsurance after Deductible 50% Coinsurance 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 Included as part of inpatient Hospital service Cost-Sharing	See benefit for description
Chemotherapy <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services <p>Referral 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
Chiropractic Services	50% Coinsurance after 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	Use Cost-Sharing for appropriate service	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Diagnostic Testing <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office Referral required • Performed as Outpatient Hospital Services Referral 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	See benefit for description
Dialysis <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 	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 Dialysis performed by Non-Participating Providers is limited to ten (10) visits per calendar year Preauthorization required

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office • Performed in an Outpatient Facility <p>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
Home Health Care <p>Preauthorization required</p>	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 <p>Preauthorization required</p>	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 Referral 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>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>Interruption of Pregnancy</p> <ul style="list-style-type: none"> • Medically Necessary Abortions • (3)[Elective Abortions] Preauthorization required 	<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
<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>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>

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; breast pump</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 after Deductible</p> <p>50% Coinsurance after Deductible</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>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	50% Coinsurance after 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>Referral 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>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. Speech and physical therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery and Other <p>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 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>	50% Coinsurance after 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>	50% Coinsurance after 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>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>Durable Medical Equipment and Braces</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>External Hearing Aids</p> <p>Preauthorization required</p>	50% 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>	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 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
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 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 after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	(4) [Two hundred (200); Three hundred sixty-five (365)] days per Plan Year
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) Preauthorization required	50% Coinsurance 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 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
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment) Preauthorization required. However, Preauthorization is not required for emergency admissions.	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) <ul style="list-style-type: none"> • Office Visits • All Other Outpatient Services 	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	See benefit for description
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment) Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.	50% Coinsurance 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>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	\$10 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	\$35 Copayment after Deductible		
Tier 3	\$75 Copayment after Deductible		
If You have an Emergency Condition, Preauthorization is not required for a five (5) day emergency supply of a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.			
Mail Order Pharmacy			
Up to a 90-day supply Tier 1	\$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	\$87.50 Copayment after Deductible		
Tier 3	\$187.50 Copayment after Deductible		
Enteral Formulas Tier 1	\$10 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	\$35 Copayment after Deductible		
Tier 3	\$75 Copayment after Deductible		

WELLNESS BENEFITS	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Gym Reimbursement	Up to \$200 per six (6) month period; up to an additional \$100 per six (6) month period for Spouse; not subject to Deductible	Up to \$200 per six (6) month period; up to an additional \$100 per six (6) month period for Spouse; not subject to Deductible	Up to \$200 per six (6) month period; up to an additional \$100 per six (6) month period for Spouse
VISION CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Vision Care <ul style="list-style-type: none"> • Exams • Lenses and Frames • Contact Lenses 	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	One (1) exam per twelve (12) month period; One (1) prescribed lenses and frames per twelve (12) month period

DENTAL CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Pediatric Dental Care</p> <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>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>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.