

**Section XXX**

**EmblemHealth Gold Plus Schedule of Benefits**

<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Medical Deductible</b> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul>	\$550 \$1,100	None None	
<b>Prescription Drug Deductible</b> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul>	\$0 \$0	None None	
<b>Out-of-Pocket Limit</b> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul>	\$4,500 \$9,000	Non-Participating Provider services are not Covered except as required for emergency care.	
<b>OFFICE VISITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Primary Care Office Visits (or Home Visits)	3 visits Covered in full, not subject to Deductible  After 3 visits, \$40 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Specialist Office Visits (or Home Visits)  <b>Referral required</b>	\$60 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

<b>PREVENTIVE CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<ul style="list-style-type: none"> <li>Well Child Visits and Immunizations*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<ul style="list-style-type: none"> <li>Adult Annual Physical Examinations*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Adult Immunizations*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Routine Gynecological Services/Well Woman Exams*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li><b>(1)</b>[Sterilization Procedures for Women*]</li> </ul>	[Covered in full]	[Non-Participating Provider services are not Covered and You pay the full cost]	
<ul style="list-style-type: none"> <li><b>(2)</b>[Vasectomy]</li> </ul>	[See Surgical Services Cost-Sharing]	[Non-Participating Provider services are not Covered and You pay the full cost]	
<ul style="list-style-type: none"> <li>Bone Density Testing*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Screening for Prostate Cancer <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul> </li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li> <ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> </ul> </li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	

<b>PREVENTIVE CARE – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<ul style="list-style-type: none"> <li>All other preventive services required by USPSTF and HRSA</li> <li>*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> </ul>	<p>Covered in full</p> <p>Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	See benefit for description
<b>EMERGENCY CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Pre-Hospital Emergency Medical Services (Ambulance Services)	\$150 Copayment after Deductible	\$150 Copayment after Deductible	See benefit for description
Non-Emergency Ambulance Services  <b>Preauthorization required</b>	\$150 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Emergency Department  Copayment waived if admitted to Hospital	<p>\$300 Copayment after Deductible</p> <p>Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing</p>	<p>\$300 Copayment after Deductible</p> <p>Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing</p>	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

<b>PROFESSIONAL SERVICES and OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Acupuncture	\$0 Copayment, 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"> <li>Performed in a Specialist Office</li> <li>Performed in a Freestanding Radiology Facility</li> <li>Performed as Outpatient Hospital Services</li> </ul> <b>Referral required</b>	<p>\$60 Copayment after Deductible</p> <p>\$60 Copayment after Deductible</p> <p>\$60 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"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> </ul> <b>Referral required</b>	<p>\$40 Copayment after Deductible</p> <p>\$60 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><b>Preauthorization required</b></p>	\$150 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 <p><b>Preauthorization required</b></p>	20% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

<b>PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Cardiac and Pulmonary Rehabilitation <ul style="list-style-type: none"> <li>• Performed in a Specialist Office</li> <li>• Performed as Outpatient Hospital Services</li> <li>• Performed as Inpatient Hospital Services</li> </ul> <p style="text-align: center;"><b>Preauthorization required</b></p>	\$60 Copayment after Deductible  \$60 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  Included as part of inpatient Hospital service Cost-Sharing	See benefit for description
Chemotherapy <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> <li>• Performed in a Specialist Office</li> <li>• Performed as Outpatient Hospital Services</li> </ul> <p style="text-align: center;"><b>Referral required</b></p>	\$40 Copayment after Deductible  \$60 Copayment after Deductible  \$60 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	\$60 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 style="text-align: center;"><b>Preauthorization required</b></p>	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description

<b>PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Diagnostic Testing <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> <li>• Performed in a Specialist Office <b>Referral required</b></li> <li>• Performed as Outpatient Hospital Services <b>Referral required</b></li> </ul>	\$40 Copayment after Deductible  \$60 Copayment after Deductible  \$60 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"> <li>• Performed in a PCP Office</li> <li>• Performed in a Specialist Office <b>Referral required</b></li> <li>• Performed in a Freestanding Center <b>Referral required</b></li> <li>• Performed as Outpatient Hospital Services <b>Referral required</b></li> </ul>	\$40 Copayment after Deductible  \$60 Copayment after Deductible  \$60 Copayment after Deductible  \$60 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 <b>Preauthorization required</b>

<b>PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> <li>• Performed in a Specialist Office</li> <li>• Performed in an Outpatient Facility</li> </ul> <p><b>Preauthorization required</b></p>	\$60 Copayment after Deductible  \$60 Copayment after Deductible  \$60 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  <p><b>Preauthorization required</b></p>	\$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Forty (40) visits per Plan Year
Infertility Services  <p><b>Preauthorization required</b></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

<b>PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Infusion Therapy <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> <li>• Performed in a Specialist Office <b>Referral required</b></li> <li>• Performed as Outpatient Hospital Services <b>Referral required</b></li> <li>• Home Infusion Therapy <b>Preauthorization required</b></li> </ul>	\$40 Copayment after Deductible  \$60 Copayment after Deductible  \$60 Copayment after Deductible  \$60 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    Home infusion counts toward home health care visit limits
Inpatient Medical Visits	\$0 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Interruption of Pregnancy <ul style="list-style-type: none"> <li>• Medically Necessary Abortions</li> <li>• <b>(3)</b>[Elective Abortions] <b>Preauthorization required</b></li> </ul>	Covered in full  [\$150 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]	Unlimited  [One (1) procedure per Plan Year]



<b>PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Laboratory Procedures <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> <li>• Performed in a Specialist Office</li> <li>• Performed in a Freestanding Laboratory Facility</li> <li>• Performed as Outpatient Hospital Services</li> </ul>	\$40 Copayment, not subject to Deductible  \$60 Copayment, not subject to Deductible  \$60 Copayment, not subject to Deductible  \$60 Copayment, 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  Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

<b>PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<p>Maternity and Newborn Care</p> <ul style="list-style-type: none"> <li>• Prenatal Care <ul style="list-style-type: none"> <li>• Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> <li>• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> </ul> </li> <li>• Inpatient Hospital Services and Birthing Center</li> <li>• Physician and Midwife Services for Delivery</li> <li>• Breastfeeding Support, Counseling and Supplies, including Breast Pumps</li> <li>• Postnatal Care</li> </ul> <p><b>Preauthorization required for inpatient services; breast pump</b></p>	<p>Covered in full</p> <p>Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)</p> <p>\$1,500 Copayment after Deductible</p> <p>\$150 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>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p> <p>One (1) home care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early</p> <p>Covered for duration of breast feeding</p>

<b>PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Outpatient Hospital Surgery Facility Charge  <b>Preauthorization required</b>	\$150 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preadmission Testing  <b>Preauthorization required</b>	\$0 Copayment, 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"> <li>• Performed in a PCP Office</li> <li>• Performed in a Specialist Office</li> </ul>	Included as part of the PCP office visit Cost-Sharing  Included as part of the Specialist office visit Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Diagnostic Radiology Services <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> <li>• Performed in a Specialist Office <b>Preauthorization required</b></li> <li>• Performed in a Freestanding Radiology Facility <b>Preauthorization required</b></li> <li>• Performed as Outpatient Hospital Services <b>Preauthorization required</b></li> </ul>	\$40 Copayment after Deductible  \$60 Copayment after Deductible  \$60 Copayment after Deductible  \$60 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

<b>PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Therapeutic Radiology Services <ul style="list-style-type: none"> <li>• Performed in a Specialist Office</li> <li>• Performed in a Freestanding Radiology Facility</li> <li>• Performed as Outpatient Hospital Services</li> </ul> <p style="text-align: center;"><b>Referral required</b></p>	\$60 Copayment after Deductible  \$60 Copayment after Deductible  \$60 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"> <li>• Performed in a PCP Office</li> <li>• Performed in a Specialist Office</li> <li>• Performed in an Outpatient Facility</li> </ul> <p style="text-align: center;"><b>Preauthorization required</b></p>	\$60 Copayment after Deductible  \$60 Copayment after Deductible  \$60 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 <p style="text-align: center;"><b>Referral required</b></p>	\$60 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

<b>PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<p>Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants)</p> <ul style="list-style-type: none"> <li>• Inpatient Hospital Surgery</li> <li>• Outpatient Hospital Surgery</li> <li>• Surgery Performed at an Ambulatory Surgical Center</li> <li>• Office Surgery <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> <li>• Performed in a Specialist Office</li> </ul> </li> </ul> <p><b>Preauthorization required</b></p>	<p>\$150 Copayment after Deductible</p> <p>\$150 Copayment after Deductible</p> <p>\$150 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p> <p>\$60 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><b>All transplants must be performed at designated Facilities</b></p>
<p>Telemedicine Program</p> <ul style="list-style-type: none"> <li>• Provided by a Telemedicine Physician</li> </ul>	<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>

<b>ADDITIONAL SERVICES, EQUIPMENT and DEVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<p>ABA Treatment for Autism Spectrum Disorder</p> <p style="text-align: center;"><b>Preauthorization required</b></p>	\$40 Copayment 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 style="text-align: center;"><b>Preauthorization required</b></p>	\$40 Copayment 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"> <li>• Diabetic Equipment, Supplies and Insulin (30-day supply)</li> <li>• Diabetic Education</li> </ul> <p style="text-align: center;"><b>Preauthorization required</b></p>	<p>\$40 Copayment after Deductible</p> <p>\$40 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
<p>Durable Medical Equipment and Braces</p> <p style="text-align: center;"><b>Preauthorization required</b></p>	20% 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 style="text-align: center;"><b>Preauthorization required</b></p>	20% 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 style="text-align: center;"><b>Preauthorization required</b></p>	20% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	One (1) per ear per time Covered

<b>ADDITIONAL SERVICES, EQUIPMENT and DEVICES – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Hospice Care <ul style="list-style-type: none"> <li>• Inpatient</li> <li>• Outpatient</li> </ul> <p style="text-align: center;"><b>Preauthorization required</b></p>	\$1,500 Copayment after Deductible  \$60 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;"><b>Preauthorization required</b></p>	20% 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"> <li>• External</li> <li>• Internal</li> </ul> <p style="text-align: center;"><b>Preauthorization required</b></p>	20% 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

<b>INPATIENT SERVICES and FACILITIES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care) <b>Preauthorization required. However, Preauthorization is not required for emergency admissions or services provided in a neonatal intensive care unit of a Hospital certified pursuant to Article 28 of the Public Health Law.</b>	\$1,500 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Observation Stay	\$150 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)  <b>Preauthorization required</b>	\$1,500 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	<b>(4)</b> [Two hundred (200); Three hundred sixty-five (365)] days per Plan Year
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)  <b>Preauthorization required</b>	\$1,500 Copayment 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)  <b>Preauthorization required</b>	\$1,500 Copayment 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



<b>MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<p>Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment)</p> <p><b>Preauthorization required. However, Preauthorization is not required for emergency admissions.</b></p>	\$1,500 Copayment 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"> <li>• Office Visits</li> <li>• All Other Outpatient Services</li> </ul>	<p>\$40 Copayment, not subject to Deductible</p> <p>\$40 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>Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)</p> <p><b>Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.</b></p>	\$1,500 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

<b>MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<p>Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)</p> <ul style="list-style-type: none"> <li>• Office Visits</li> <li>• All Other Outpatient Services</li> </ul>	<p>\$40 Copayment, not subject to Deductible</p> <p>\$40 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><b>PRESCRIPTION DRUGS</b></p> <p>*Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an “A” or “B” rating from the USPSTF and obtained at a participating pharmacy.</p>	<p><b>Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Non-Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Limits</b></p>

<b>PRESCRIPTION DRUGS – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<b>Retail Pharmacy</b>			
30-day supply		Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 1	\$15 Copayment		
Tier 2	\$30 Copayment		
Tier 3	\$70 Copayment		
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.			
<b>Mail Order Pharmacy</b>			
Up to a 90-day supply		Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 1	\$37.50 Copayment		
Tier 2	\$75 Copayment		
Tier 3	\$175 Copayment		
Enteral Formulas		Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 1	\$15 Copayment		
Tier 2	\$30 Copayment		
Tier 3	\$70 Copayment		

<b>WELLNESS BENEFITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Gym Reimbursement	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
<b>VISION CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<b>Pediatric Vision Care</b>		Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>• Exams</li> <li>• Lenses and Frames</li> <li>• Contact Lenses</li> </ul>	<p>\$0 Copayment, not subject to Deductible</p> <p>20% Coinsurance, not subject to Deductible</p> <p>20% Coinsurance, not subject to Deductible</p>		<p>One (1) exam per twelve (12) month period;</p> <p>One (1) prescribed lenses and frames per twelve (12) month period</p>
<b>Adult Vision Care</b>		Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>• Exams</li> <li>• Lenses and Frames</li> <li>• Contact Lenses</li> </ul>	<p>\$0 Copayment, not subject to Deductible</p> <p>20% Coinsurance, not subject to Deductible</p> <p>20% Coinsurance, not subject to Deductible</p>		<p>One (1) exam per twelve (12) month period;</p> <p>One (1) prescribed lenses and frames per twelve (12) month period</p>

<b>DENTAL CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<p><b>Pediatric Dental Care</b></p> <ul style="list-style-type: none"> <li>• Emergency Dental Care</li> <li>• Preventive Dental Care</li> <li>• Routine Dental Care</li> <li>• Major Dental Care (Endodontics, Periodontics, Prosthodontics and Oral Surgery)</li> <li>• Orthodontics</li> </ul> <p><b>Major Dental Care and Orthodontics require Preauthorization</b></p>	<p>\$40 Copayment, not subject to Deductible</p> <p>\$0 Copayment, not subject to Deductible</p> <p>\$40 Copayment, not subject to Deductible</p> <p>\$60 Copayment, not subject to Deductible</p> <p>\$60 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>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>

<b>DENTAL CARE – Continued</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Adult Dental Care <ul style="list-style-type: none"> <li>• Emergency Dental Care</li> <li>• Preventive Dental Care</li> <li>• Routine Dental Care</li> </ul>	\$40 Copayment, not subject to Deductible  \$0 Copayment, not subject to Deductible  \$40 Copayment, 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  Non-Participating Provider services are not Covered and You pay the full cost	One (1) dental exam and cleaning per six (6) month period  Full mouth x-rays or panoramic x-rays at thirty-six (36) month intervals and bitewing x-rays at six (6) month intervals

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.