Section (1)[XXVIII]

EmblemHealth (2)[Gold Virtual EPO-N Plan] Schedule of Benefits

COST-SHARING	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Medical Deductible • Individual • Family	 $0 $0	 $750 $1,500	Non-Participating Provider services are not Covered except as required for emergency care.	
Out-of-Pocket Limit • Individual • Family	 $8,000 $16,000	 $8,000 $16,000		Cost sharing amounts that accumulate toward the Out-of-Pocket Limit, apply to both Preferred and Participating Providers
OFFICE VISITIS	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$0 Copayment	$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)	Not Covered	$60 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

PREVENTIVE CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
• Well Child Visits and Immunizations*	Not Covered	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
• Adult Annual Physical Examinations*	Not Covered	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Adult Immunizations*	Not Covered	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Routine Gynecological Services/Well Woman Exams*	Not Covered	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	

PREVENTIVE CARE (Continued)	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Not Covered	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost]	See benefit for description
• **(3)[**Sterilization Procedures for Women*	Not Covered	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost]	
• **(4)[**Vasectomy	Not Covered	See Surgical Services Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost]	
• Bone Density Testing*	Not Covered	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Screening for Prostate Cancer	Not Covered	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	

PREVENTIVE CARE (Continued)	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
• All other preventive services required by USPSTF and HRSA	Not Covered	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Non-Participating Provider services are not Covered and You pay the full cost	
EMERGENCY CARE	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	Not Covered	$350 Copayment after Deductible	$350 Copayment after Deductible	See benefit for description

EMERGENCY CARE (Continued)	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Non-Emergency Ambulance Services **Preauthorization required**	Not Covered	$350 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Emergency Department Cost sharing waived if admitted to Hospital	Not Covered	40% Coinsurance after Deductible Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing.	40% 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	Not Covered	$100 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Acupuncture	Not Covered	$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

PROFESSIONAL SERVICES and OUTPATIENT CARE (Continued)	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Advanced Imaging Services				See benefit for description
• Performed in a Specialist Office	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Radiology Facility	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization required**	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Allergy Testing and Treatment				See benefit for description
• Performed in a PCP Office	Not Covered	$40 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE (Continued)	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Ambulatory Surgical Center Facility Fee **Preauthorization required**	Not Covered	$350 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Anesthesia Services (all settings)	Not Covered	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Cardiac and Pulmonary Rehabilitation				See benefit for description
• Performed in a Specialist Office	Not Covered	$75 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services	Not Covered	$75 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Inpatient Hospital Services **Preauthorization required**	Not Covered	Included as part of inpatient Hospital service Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE (Continued)	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Chemotherapy and Immunotherapy				See benefit for description
• Performed in a PCP Office	Not Covered	$40 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Chiropractic Services	Not Covered	$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 **Preauthorization required**	Not Covered	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)	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Diagnostic Testing				See benefit for description
• Performed in a PCP Office	Not Covered	$40 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization required**	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE (Continued)	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Dialysis • Performed in a PCP Office	Not Covered	$40 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Dialysis performed by Non-Participating Providers is limited to 10 visits per calendar year calendar year.
• Performed in a Specialist Office	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	**Preauthorization required** Cost-Sharing for the visits is the same as for a Participating Provider. See benefit description for more information
• Performed in a Freestanding Center **Preauthorization required**	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization required**	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE (Continued)	Preferred Provider Member Responsibility for Cost-Sharing	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)				Sixty (60) visits per condition, per Plan Year combined therapies
• Performed in a PCP Office	Not Covered	$40 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in an Outpatient Facility **Preauthorization required**	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE (Continued)	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Home Health Care **Preauthorization required**	Not Covered	$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 **Preauthorization required**	Not Covered	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)	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Infusion Therapy • Performed in a PCP Office	Not Covered	$40 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
• Performed in a Specialist Office	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization required**	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Home Infusion Therapy **Preauthorization required**	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Inpatient Medical Visits	Not Covered	$0 Copayment 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)	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
(5)[Interruption of Pregnancy				
• Medically Necessary Abortions	Not Covered	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	Unlimited
• **(6)[**Elective Abortions **Preauthorization required**	Not Covered	$350 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	**(7)[**One (1) procedure per Member per Plan Year**]]]**
Laboratory Procedures				See benefit for description
• Performed in a PCP Office	$0 Copayment	$0 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office	Not Covered	$60 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Laboratory Facility	$0 Copayment	$0 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization required**	Not Covered	$60 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE (Continued)	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Maternity and Newborn Care				See benefit for description
• Prenatal Care • Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Not Covered	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Not Covered	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Non-Participating Provider services are not Covered and You pay the full cost	
• Inpatient Hospital Services and Birthing Center	Not Covered	30% Coinsurance per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE (Continued)	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Maternity and Newborn Care (continued)				
• Physician and Midwife Services for Delivery	Not Covered	$350 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	One (1) home care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
• Breastfeeding Support, Counseling and Supplies, including Breast Pumps	Not Covered	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	Covered for duration of breast feeding
• Postnatal Care **Preauthorization required for inpatient services**	Not Covered	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE (Continued)	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Outpatient Hospital Surgery Facility Charge **Preauthorization required**	Not Covered	$350 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preadmission Testing **Preauthorization required**	Not Covered	$0 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Prescription Drugs Administered in Office				See benefit for description
• Performed in a PCP Office	Not Covered	Included as part of the PCP office visit Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office	Not Covered	Included as part of the Specialist office visit Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE (Continued)	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Diagnostic Radiology Services				
• Performed in a PCP Office	Not Covered	$40 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office **Preauthorization required**	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Radiology Facility **Preauthorization required**	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization required**	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE (Continued)	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Therapeutic Radiology Services				See benefit for description
• Performed in a Specialist Office	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Radiology Facility	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization required**	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Rehabilitation Services (Physical Therapy, Occupational Therapy, Speech Therapy or Pulmonary Rehabilitation)				Sixty (60) visits per condition, per Plan Year combined therapies.
• Performed in a PCP Office	Not Covered	$40 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in an Outpatient Facility **Preauthorization required**	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE (Continued)	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Second Opinions on the Diagnosis of Cancer, Surgery and Other	Not Covered	$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.	See benefit for description

PROFESSIONAL SERVICES and OUTPATIENT CARE (Continued)	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants)				See benefit for description
• Inpatient Hospital Surgery	Not Covered	$350 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	**All transplants must be performed at designated Center of Excellence Facilities**
• Outpatient Hospital Surgery	Not Covered	$350 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Surgery Performed at an Ambulatory Surgical Center	Not Covered	$350 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Office Surgery • Performed in a PCP Office	Not Covered	$40 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office **Preauthorization required**	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

PROFESSIONAL SERVICES and OUTPATIENT CARE (Continued)	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Telemedicine Program	$0 Copayment	$0 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Diabetic Equipment, Supplies and Self-Management Education				See benefit for description
• Retail Diabetic Equipment, Supplies and Insulin (30-day) **Preauthorization required**	Not Covered	$40 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Mail Order Diabetic Equipment, Supplies and Insulin (90-day) **Preauthorization required**	Not Covered	$100 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Diabetic Education	Not Covered	$40 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Durable Medical Equipment and Braces	Not Covered	20% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

ADDITIONAL SERVICES, EQUIPMENT and DEVICES (Continued)	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
External Hearing Aids **Preauthorization required**	Not Covered	20% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Single purchase per ear, once every three (3) years.
Cochlear Implants **Preauthorization required**	Not Covered	20% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	One (1) per ear per time Covered.
Hospice Care • Inpatient	Not Covered	30% Coinsurance per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Two hundred ten (210) days per Plan Year
• Outpatient **Preauthorization required**	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Five (5) visits for family bereavement counseling
Medical Supplies **Preauthorization required**	Not Covered	20% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Prosthetic Devices • External **Preauthorization required**	Not Covered	20% Coinsurance after Deductible	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.
• Internal	Not Covered	Included as part of inpatient Hospital Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	Unlimited; See benefit for description

INPATIENT SERVICES and FACILITIES	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Autologous Blood Banking	Not Covered	20% 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.**	Not Covered	30% Coinsurance per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

INPATIENT SERVICES and FACILITIES(Continued)	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Observation Stay	Not Covered	$350 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) **Preauthorization required**	Not Covered	30% Coinsurance per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	**(8)[**Two hundred (200); Three hundred sixty-five**]** days per Plan Year
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) **Preauthorization required**	Not Covered	30% 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**	Not Covered	30% 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	Preferred Provider Member Responsibility for Cost-Sharing	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 or for admissions at Participating OHM-licensed Facilities for Members under eighteen (18).**	Not Covered	30% Coinsurance per admission 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)				See benefit for description
• Office Visits	Not Covered	$40 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• All Other Outpatient Services	Not Covered	$40 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES (Continued)	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder **Preauthorization required**	Not Covered	$40 Copayment, not subject to 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**	Not Covered	$40 Copayment. not subject to 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)	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
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.**	Not Covered	30% Coinsurance per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)				Unlimited
• Office Visits	Not Covered	$40 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• All Other Outpatient Services	Not Covered	$40 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

PRESCRIPTION DRUGS *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.	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy				
30-day supply Tier 1	$0 Copayment	$0 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	$40 Copayment	$40 Copayment after Deductible		
Tier 3	$80 Copayment	$80 Copayment after Deductible		
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.				

PRESCRIPTION DRUGS (Continued)	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Mail Order Pharmacy				
Up to a 90-day supply Tier 1	$0 Copayment	$0 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	$100 Copayment	$100 Copayment after Deductible	.	
Tier 3	$200 Copayment	$200 Copayment after Deductible		
Enteral Formulas Tier 1	$0 Copayment	$0 Copayment. not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	$40 Copayment	$40 Copayment after Deductible		
Tier 3	$80 Copayment	$80 Copayment after Deductible		

WELLNESS BENEFITS	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Gym Reimbursement	Not Covered	$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	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Vision Care				
• Exams	Not Covered	$0 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	One (1) exam per Calendar Year
• Lenses and Frames	Not Covered	20% Coinsurance, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	One (1) prescribed lenses and frames per twelve (12); month period
• Contact Lenses	Not Covered	20% Coinsurance, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

PEDIATRIC VISION and DENTAL CARE – Continued	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care				One (1) dental exam and cleaning per six (6) month period
• Preventive Dental Care	Not Covered	$0 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Routine Dental Care	Not Covered	$40 Copayment, not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Full mouth x-rays or panoramic x-rays at thirty-six (36)-month intervals and bitewing x-rays at six (6) month intervals
• Major Dental Care (Endodontics, Periodontics, Prosthodontics and Oral Surgery)	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Orthodontics	Not Covered	$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Major Dental Care and Orthodontics require Preauthorization				

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.