## **Section XXVIII**

## **EmblemHealth Platinum PPO-N Schedule of Benefits**

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
Medical Deductible			
Individual	\$0	\$3,000	
• Family	\$0	\$6,000	
Prescription Drug Deductible  • Individual  • Family	\$0 \$0	Non-Participating Provider services are not Covered and You pay the full cost	
Out-of-Pocket Limit	\$2,500 \$5,000	\$5,500 \$11,000	
		Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount of the Non-Participating Provider's charge that exceeds Our Allowed Amount.	
OFFICE VISITS	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Primary Care Office Visits	3 visits Covered in full	30% Coinsurance after	See benefit for
(or Home Visits)	(PCP, ABA, MH/SUD	Deductible	description
	or any combination thereof)  After 3 visits, \$15  Copayment		
Specialist Office Visits (or Home Visits)	\$35 Copayment	30% Coinsurance after Deductible	See benefit for description

PREVENTIVE CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Well Child Visits and Immunizations*	Covered in full	30% Coinsurance after Deductible	See benefit for description
Adult Annual Physical Examinations*	Covered in full	30% Coinsurance after Deductible	
Adult Immunizations*	Covered in full	30% Coinsurance after Deductible	
Routine Gynecological Services/Well Woman Exams*	Covered in full	30% Coinsurance after Deductible	
Mammograms,     Screening and     Diagnostic Imaging     for the Detection of     Breast Cancer	Covered in full	30% Coinsurance after Deductible	
• (1)[Sterilization Procedures for Women*]	[Covered in full]	30% Coinsurance after Deductible	
• (2)[Vasectomy]	[See Surgical Services Cost-Sharing]	[See Surgical Services Cost-Sharing]	
Bone Density Testing*	Covered in full	30% Coinsurance after Deductible	
Screening for Prostate Cancer	Covered in full	30% Coinsurance after Deductible	

PREVENTIVE CARE – Continued	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	Covered in full	30% Coinsurance after Deductible	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)	
EMERGENCY CARE	Participating Provider	Non-Participating Provider	Limits
	Member Responsibility for Cost-Sharing	Member Responsibility for Cost-Sharing	
Pre-Hospital Emergency Medical Services (Ambulance Services)	20% Coinsurance	20% Coinsurance, not subject to Deductible	See benefit for description
Non-Emergency Ambulance Services	\$200 Copayment	30% Coinsurance after Deductible	See benefit for description
Preauthorization required			
Emergency Department  Cost-Sharing waived if	20% Coinsurance	20% Coinsurance, not subject to Deductible	See benefit for description
admitted to Hospital	Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	
Urgent Care Center	\$100 Copayment	30% Coinsurance after Deductible	See benefit for description

PROFESSIONAL	Participating Provider	Non-Participating Provider	Limits
SERVICES and	<b>Member Responsibility</b>	Member Responsibility	
OUTPATIENT CARE	for Cost-Sharing	for Cost-Sharing	
Acupuncture	\$0 Copayment	Non-Participating Provider	Twelve (12)
		services are not Covered and	visits per Plan
		You pay the full cost	Year
Advanced Imaging Services			See benefit for
			description
<ul> <li>Performed in a</li> </ul>	\$35 Copayment	30% Coinsurance after	
Specialist Office		Deductible	
<ul> <li>Performed in a</li> </ul>	\$35 Copayment	30% Coinsurance after	
Freestanding		Deductible	
Radiology Facility			
<ul> <li>Performed as</li> </ul>	\$35 Copayment	30% Coinsurance after	
Outpatient Hospital		Deductible	
Services			
Preauthorization			
required			
Allergy Testing and			See benefit for
Treatment			description
<ul> <li>Performed in a PCP</li> </ul>	\$15 Copayment	30% Coinsurance after	
Office		Deductible	
	ф25 C	200/ G :	
Performed in a	\$35 Copayment	30% Coinsurance after	
Specialist Office	<b>4200</b> G	Deductible	G 1 2 2
Ambulatory Surgical Center	\$200 Copayment	30% Coinsurance after	See benefit for
Facility Fee		Deductible	description
Preauthorization			
required			
Anesthesia Services	Covered in full	30% Coinsurance after	See benefit for
(all settings)	Covered III IUII	Deductible	description
(an scungs)		Deductible	acscription

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			See benefit for description
Performed in a     Specialist Office	\$50 Copayment	30% Coinsurance after Deductible	
<ul> <li>Performed as         Outpatient Hospital         Services     </li> </ul>	\$50 Copayment	30% Coinsurance after Deductible	
<ul> <li>Performed as Inpatient Hospital Services</li> </ul>	Included as part of inpatient Hospital service Cost-Sharing	Included as part of inpatient Hospital service Cost-Sharing	
Preauthorization required			
Chemotherapy and Immunotherapy			See benefit for description
Performed in a PCP     Office	\$15 Copayment	30% Coinsurance after Deductible	
Performed in a     Specialist Office	\$35 Copayment	30% Coinsurance after Deductible	
<ul> <li>Performed as         Outpatient Hospital         Services     </li> </ul>	\$35 Copayment	30% Coinsurance after Deductible	
Chiropractic Services	\$35 Copayment	30% Coinsurance after Deductible	See benefit for description
Clinical Trials	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description
Preauthorization required	Tr F	Tr Promote State S	

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Diagnostic Testing			See benefit for
Performed in a PCP     Office	\$15 Copayment	30% Coinsurance after Deductible	description
Performed in a     Specialist Office	\$35 Copayment	30% Coinsurance after Deductible	
<ul> <li>Performed as         Outpatient Hospital         Services     </li> </ul>	\$35 Copayment	30% Coinsurance after Deductible	
Preauthorization required			
Dialysis			See benefit for description
Performed in a PCP Office	\$15 Copayment	30% Coinsurance after Deductible	description
Performed in a     Specialist Office	\$35 Copayment	30% Coinsurance after Deductible	
<ul> <li>Performed in a         Freestanding Center     </li> <li>Preauthorization</li> <li>required</li> </ul>	\$35 Copayment	30% Coinsurance after Deductible	
<ul> <li>Performed as         Outpatient Hospital         Services     </li> <li>Preauthorization</li> <li>required</li> </ul>	\$35 Copayment	30% Coinsurance after Deductible	

SERVICES and OUTPATIENT CARE – Continued  Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)  • Performed in a PCP Office  • Performed in a Specialist Office  • Performed in an Outpatient Facility  Preauthorization required  Home Health Care  Preauthorization required  Infertility Services  Wember Responsibility for Cost-Sharing  Member Responsibility for Cost-Sharing  Member Responsibility for Cost-Sharing  Sixty (60) visits per condition, per Plan Year combined therapies  Sixty (60) visits per condition, per Plan Year combined therapies  Sixty (60) visits per condition, per Plan Year combined therapies  30% Coinsurance after Deductible  30% Coinsurance after Deductible  S35 Copayment  30% Coinsurance after Deductible  Forty (40) visits per Plan Year  See benefit for description  (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and	PROFESSIONAL	Participating Provider	Non-Participating Provider	Limits
Continued  Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)  Performed in a PCP Office  Performed in a Specialist Office  Performed in an Outpatient Facility  Preauthorization required  Home Health Care Preauthorization required  Infertility Services  Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and  Use Cost-Sharing for appropriate services; Surgery; Laboratory and  Sixty (60) visits per condition, per Plan Year  Sixty (60) visits per condition, per Plan Year  Combined therapies  30% Coinsurance after Deductible  Sixty (60) visits per condition, per Plan Year  Solve Coinsurance after Deductible  Forty (40) visits per Plan Year  Forty (40) visits per Plan Year  Forty (40) visits per Plan Year  See benefit for description  (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and Surgery; Laboratory and	SERVICES and	<b>Member Responsibility</b>	Member Responsibility	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)  Performed in a PCP Office Performed in a Specialist Office Performed in an Outpatient Facility Preauthorization required  Infertility Services Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and  Sixty (60) visits per condition, per Plan Year combined therapies  30% Coinsurance after Deductible  Sixty (60) visits per condition, per Plan Year combined therapies  Sixty (60) visits per condition, per Plan Year combined therapies  Some Coinsurance after Deductible  Forty (40) visits per Plan Year  See benefit for description description	OUTPATIENT CARE –	for Cost-Sharing	for Cost-Sharing	
(Physical Therapy, Occupational Therapy or Speech Therapy)  • Performed in a PCP Office  • Performed in a Specialist Office  • Performed in an Outpatient Facility  Preauthorization required  Home Health Care Preauthorization required  Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and  per condition, per Plan Year combined therapies  Poductible  30% Coinsurance after Deductible  Forty (40) visits per Plan Year  Forty (40) visits per Plan Year  See benefit for description	Continued			
Occupational Therapy or Speech Therapy)  • Performed in a PCP Office  • Performed in a Specialist Office  • Performed in an Outpatient Facility  Preauthorization required  Home Health Care  Preauthorization required  Infertility Services  Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and Summer Su	Habilitation Services			Sixty (60) visits
<ul> <li>Speech Therapy)         <ul> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> </ul>          \$15 Copayment         30% Coinsurance after Deductible               Performed in a Specialist Office             \$35 Copayment             30% Coinsurance after Deductible               Performed in an Outpatient Facility             \$35 Copayment             30% Coinsurance after Deductible               Preauthorization required             \$35 Copayment             30% Coinsurance after Deductible               Home Health Care             \$35 Copayment             30% Coinsurance after Deductible             Forty (40) visits per Plan Year               Infertility Services             Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and             Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and             Surgery; Laboratory and      </li></ul>				
<ul> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed in an Outpatient Facility</li> <li>Preauthorization required</li> <li>Infertility Services</li> <li>Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and</li> <li>Sassing Coinsurance after Deductible</li> <li>30% Coinsurance after Deductible</li> <li>30% Coinsurance after Deductible</li> <li>Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and</li> </ul>				
<ul> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed in an Specialist Office</li> <li>Performed in an Outpatient Facility</li> <li>Preauthorization required</li> <li>Infertility Services</li> <li>Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and</li> <li>Sass Copayment</li> <li>30% Coinsurance after Deductible</li> <li>30% Coinsurance after Deductible</li> <li>Forty (40) visits per Plan Year</li> <li>See benefit for description</li> <li>Goffice Visit; Diagnostic Radiology Services; Surgery; Laboratory and</li> </ul>	Speech Therapy)			
Office  Performed in a Specialist Office  Performed in an Outpatient Facility  Preauthorization required  Home Health Care  Preauthorization required  Infertility Services  Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and  Deductible  30% Coinsurance after Deductible  Forty (40) visits per Plan Year  Forty (40) visits per Plan Year  Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and				therapies
<ul> <li>Performed in a Specialist Office</li> <li>Performed in an Outpatient Facility</li> <li>Preauthorization required</li> <li>Home Health Care</li> <li>Preauthorization required</li> <li>Infertility Services</li> <li>Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and</li> <li>Sass Copayment</li> <li>30% Coinsurance after Deductible</li> <li>Forty (40) visits per Plan Year</li> <li>Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and</li> <li>Surgery; Laboratory and</li> </ul>		\$15 Copayment		
Specialist Office  Performed in an Outpatient Facility  Preauthorization required  Home Health Care  Preauthorization prequired  Infertility Services  Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and  System Deductible  Poductible  Some Coinsurance after Deductible  Forty (40) visits per Plan Year  Forty (40) visits per Plan Year  See benefit for description	Office		Deductible	
Specialist Office  Performed in an Outpatient Facility  Preauthorization required  Home Health Care  Preauthorization prequired  Infertility Services  Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and  System Deductible  Poductible  Some Coinsurance after Deductible  Forty (40) visits per Plan Year  Forty (40) visits per Plan Year  See benefit for description		4.5.5.5		
• Performed in an Outpatient Facility  Preauthorization required  Home Health Care  Preauthorization required  Infertility Services  Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and  \$35 Copayment  30% Coinsurance after Deductible  Forty (40) visits per Plan Year  Forty (40) visits per Plan Year  Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and		\$35 Copayment		
Outpatient Facility  Preauthorization required  Home Health Care  \$35 Copayment  \$30% Coinsurance after Deductible  Preauthorization required  Infertility Services  Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and  Seductible  Forty (40) visits per Plan Year  Forty (40) visits per Plan Year  Vise Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and	Specialist Office		Deductible	
Outpatient Facility  Preauthorization required  Home Health Care  \$35 Copayment  \$30% Coinsurance after Deductible  Preauthorization required  Infertility Services  Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and  Seductible  Forty (40) visits per Plan Year  Forty (40) visits per Plan Year  Vise Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and		\$25 Carrament	200/ Gaine manage Gan	
Preauthorization required  Home Health Care  \$35 Copayment  \$30\% Coinsurance after Deductible  Preauthorization required  Infertility Services  Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and  Some Coinsurance after Deductible  Forty (40) visits per Plan Year  Forty (40) visits per Plan Year  Vise Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and		\$35 Copayment		
Home Health Care \$35 Copayment 30% Coinsurance after Deductible per Plan Year  Preauthorization required  Infertility Services Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and Surgery; Laboratory and Some per Plan Year  See benefit for description  Coffice Visit; Diagnostic Radiology Services; Surgery; Laboratory and	Outpatient Facility		Deductible	
Home Health Care \$35 Copayment 30% Coinsurance after Deductible per Plan Year  Preauthorization required  Infertility Services Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and Surgery; Laboratory and Some per Plan Year  See benefit for description  Coffice Visit; Diagnostic Radiology Services; Surgery; Laboratory and	December 11 and 12 and 12 and			
Home Health Care    \$35 Copayment   30% Coinsurance after Deductible   Forty (40) visits per Plan Year				
Preauthorization required  Infertility Services  Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and  Deductible per Plan Year  Vse Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and Surgery; Laboratory and		\$25 Consument	200/ Coingurance ofter	Forty (40) visits
Preauthorization required  Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and See benefit for description  Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and Surgery; Laboratory and	Home Health Care	\$33 Copayment		• , ,
requiredUse Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory andUse Cost-Sharing for appropriate service (appropriate service description)Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and Surgery; Laboratory andSee benefit for description	Pregutherization		Deductible	per i iaii i eai
Infertility Services  Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and  Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and Surgery; Laboratory and				
appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and	-	Use Cost-Sharing for	Use Cost-Sharing for	See benefit for
(Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and			· ·	
Radiology Services; Surgery; Laboratory and Surgery; Laboratory and			1 * * *	
Surgery; Laboratory and Surgery; Laboratory and			, ,	
			,	
<b>Preauthorization</b>   Diagnostic Procedures)   Diagnostic Procedures)	Preauthorization	Diagnostic Procedures)	Diagnostic Procedures)	
required	required			

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Infusion Therapy			See benefit for
Performed in a PCP     Office	\$15 Copayment	30% Coinsurance after Deductible	description
Performed in a     Specialist Office	\$35 Copayment	30% Coinsurance after Deductible	
<ul> <li>Performed as         Outpatient Hospital         Services     </li> <li>Preauthorization</li> <li>required</li> </ul>	\$35 Copayment	30% Coinsurance after Deductible	
<ul> <li>Home Infusion         Therapy         Preauthorization         required     </li> </ul>	\$35 Copayment	30% Coinsurance after Deductible	Home infusion counts toward home health care visit limits
Inpatient Medical Visits	\$0 Copayment	30% Coinsurance after Deductible	See benefit for description
(3)[Interruption of Pregnancy			
Medically Necessary     Abortions	Covered in full	Covered in full	Unlimited
• (4)[Elective Abortions]	[\$200 Copayment]	[30% Coinsurance after Deductible]	[One (1) procedure per Plan 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
Laboratory Procedures			See benefit for description
Performed in a PCP     Office	\$15 Copayment	30% Coinsurance after Deductible	1
Performed in a     Specialist Office	\$35 Copayment	30% Coinsurance after Deductible	
Performed in a     Freestanding     Laboratory Facility	\$15 Copayment	30% Coinsurance after Deductible	
<ul> <li>Performed as         Outpatient Hospital         Services     </li> <li>Preauthorization</li> </ul>	\$35 Copayment	30% Coinsurance after Deductible	
required			

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Maternity and Newborn Care			See benefit for
<ul> <li>Prenatal Care</li> <li>Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> </ul>	Covered in full	30% Coinsurance after Deductible	description
Prenatal Care that is 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)	
• Inpatient Hospital Services and Birthing Center	20% Coinsurance per admission	30% Coinsurance per admission after Deductible	One (1) home care visit is Covered at no Cost-Sharing
Physician and     Midwife Services for     Delivery	\$200 Copayment	30% Coinsurance after Deductible	if mother is discharged from Hospital early
Breastfeeding     Support, Counseling     and Supplies,     including Breast     Pumps	Covered in full	30% Coinsurance after Deductible	Covered for duration of breast feeding
Postnatal Care	Covered in full	30% Coinsurance after Deductible	
Preauthorization required for inpatient services			

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	\$200 Copayment	30% Coinsurance after Deductible	See benefit for description
Preauthorization required			
Preadmission Testing  Preauthorization	\$0 Copayment	30% Coinsurance after Deductible	See benefit for description
required			
Prescription Drugs Administered in Office			See benefit for description
Performed in a PCP     Office	Included as part of the PCP office visit Cost-Sharing	Included as part of the PCP office visit Cost-Sharing	
Performed in a     Specialist Office	Included as part of the Specialist office visit Cost-Sharing	Included as part of the Specialist office visit Cost-Sharing	
Diagnostic Radiology Services			See benefit for description
Performed in a PCP     Office	\$15 Copayment	30% Coinsurance after Deductible	
<ul> <li>Performed in a         Specialist Office     </li> <li>Preauthorization</li> <li>required</li> </ul>	\$35 Copayment	30% Coinsurance after Deductible	
<ul> <li>Performed in a         Freestanding         Radiology Facility         Preauthorization         required</li> </ul>	\$35 Copayment	30% Coinsurance after Deductible	
<ul> <li>Performed as         Outpatient Hospital         Services     </li> <li>Preauthorization</li> <li>required</li> </ul>	\$35 Copayment	30% Coinsurance after Deductible	

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			See benefit for description
<ul> <li>Performed in a Specialist Office</li> </ul>	\$35 Copayment	30% Coinsurance after Deductible	
Performed in a     Freestanding     Radiology Facility	\$35 Copayment	30% Coinsurance after Deductible	
<ul> <li>Performed as         Outpatient Hospital         Services     </li> </ul>	\$35 Copayment	30% Coinsurance after Deductible	
Preauthorization required			
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)			Sixty (60) visits per condition, per Plan Year combined
Performed in a PCP     Office	\$15 Copayment	30% Coinsurance after Deductible	therapies.
Performed in a     Specialist Office	\$35 Copayment	30% Coinsurance after Deductible	
Performed in an     Outpatient Facility	\$35 Copayment	30% Coinsurance after Deductible	
Preauthorization required			
Second Opinions on the Diagnosis of Cancer, Surgery and Other	\$35 Copayment	30% Coinsurance after Deductible	See benefit for description
		Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained.	

PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued	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	\$200 Copayment	30% Coinsurance after Deductible	All transplants must be
Outpatient Hospital     Surgery	\$200 Copayment	30% Coinsurance after Deductible	performed at designated Center of
Surgery Performed at an Ambulatory Surgical Center	\$200 Copayment	30% Coinsurance after Deductible	Excellence Facilities
<ul><li>Office Surgery</li><li>Performed in a PCP Office</li></ul>	\$15 Copayment	30% Coinsurance after Deductible	
Performed in a     Specialist Office	\$35 Copayment	30% Coinsurance after Deductible	
Preauthorization required			
Provided by a     Telemedicine     Physician	\$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

ADDITIONAL SERVICES, EQUIPMENT and DEVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Diabetic Equipment, Supplies and Self- Management Education  • Retail Diabetic Equipment, Supplies and Insulin (30-day supply) Preauthorization required	\$15 Copayment	\$50 Copayment, not subject to Deductible	See benefit for description
<ul> <li>Mail Order Diabetic Equipment, Supplies and Insulin (90-day supply)</li> <li>Preauthorization required</li> </ul>	\$37.50 Copayment	\$150 Copayment, not subject to Deductible	
Diabetic Education	\$15 Copayment	\$50 Copayment, not subject to Deductible	
Durable Medical Equipment and Braces	10% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
External Hearing Aids  Preauthorization required	10% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost	Single purchase once every three (3) years
Cochlear Implants  Preauthorization required	10% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost	One (1) per ear per time Covered
Hospice Care  • Inpatient	20% Coinsurance per admission	Non-Participating Provider services are not Covered and You pay the full cost	Two hundred ten (210) days per Plan Year
<ul><li>Outpatient</li><li>Preauthorization required</li></ul>	\$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	Five (5) visits for family bereavement counseling
Medical Supplies  Preauthorization required	10% Coinsurance	30% Coinsurance after Deductible	See benefit for description

ADDITIONAL SERVICES, EQUIPMENT and DEVICES – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Prosthetic Devices  • External  Preauthorization  required	10% Coinsurance	30% Coinsurance after Deductible	One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements
• Internal	Included as part of inpatient Hospital Cost-Sharing	Included as part of inpatient Hospital Cost-Sharing	Unlimited; See benefit for description
INPATIENT SERVICES	Participating Provider	Non-Participating Provider	Limits
and FACILITIES	Member Responsibility for Cost-Sharing	Member Responsibility for Cost-Sharing	
Autologous Blood Banking	10% Coinsurance	30% Coinsurance after	See benefit for
Services		Deductible	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.	20% Coinsurance per admission	30% Coinsurance per admission after Deductible	See benefit for description
Observation Stay	\$200 Copayment	30% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)  Preauthorization required	20% Coinsurance per admission	Non-Participating Provider services are not Covered and You pay the full cost	(5)[Two hundred (200); Three hundred sixty-five (365)] days per Plan Year

INPATIENT SERVICES and FACILITIES –	Participating Provider Member Responsibility	Non-Participating Provider Member Responsibility	Limits
Continued	for Cost-Sharing	for Cost-Sharing	
Inpatient Habilitation	20% Coinsurance per	30% Coinsurance per	Sixty (60)
Services	admission	admission after Deductible	days per Plan
(Physical, Speech and			Year
Occupational Therapy)			combined
			therapies
Preauthorization			
required			
Inpatient Rehabilitation	20% Coinsurance per	30% Coinsurance per	Sixty (60)
Services	admission	admission after Deductible	days per Plan
(Physical, Speech and			Year
Occupational Therapy)			combined
			therapies
Preauthorization			_
required			
MENTAL HEALTH and	Participating Provider	Non-Participating Provider	Limits
SUBSTANCE USE	Member Responsibility	Member Responsibility	
DISORDER SERVICES	for Cost-Sharing	for Cost-Sharing	
Inpatient Mental Health Care	20% Coinsurance per	200/ 0-1	~ 4 ~ ~
T	20% Comsulance per	30% Coinsurance per	See benefit for
for a continuous confinement	admission	admission after Deductible	See benefit for description
	_		
for a continuous confinement	_		
for a continuous confinement when in a Hospital (including	_		
for a continuous confinement when in a Hospital (including	_		
for a continuous confinement when in a Hospital (including Residential Treatment)	_		
for a continuous confinement when in a Hospital (including Residential Treatment)  Preauthorization required.	_		
for a continuous confinement when in a Hospital (including Residential Treatment)  Preauthorization required. However, Preauthorization	_		
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	_		
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 OMH-	_		
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 OMH-licensed Facilities for	_		
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 OMH-	_		

MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES – Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)			See benefit for description
Office Visits	3 visits Covered in full (PCP, ABA, MH/SUD or any combination thereof)  After 3 visits, \$15  Copayment	30% Coinsurance after Deductible	
All Other Outpatient     Services	\$15 Copayment	30% Coinsurance after Deductible	
ABA Treatment for Autism Spectrum Disorder	3 visits Covered in full (PCP, ABA, MH/SUD or any combination	30% Coinsurance after Deductible	See benefit for description
Preauthorization required	thereof) After 3 visits, \$15		
Assistive Communication Devices for Autism Spectrum Disorder	\$15 Copayment	30% Coinsurance after Deductible	See benefit for description
Preauthorization required			
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)	20% Coinsurance per admission	30% Coinsurance per admission after Deductible	See benefit for description
Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS- certified Facilities.			

MENTAL HEALTH and SUBSTANCE USE	Participating Provider Member Responsibility	Non-Participating Provider Member Responsibility	Limits
DISORDER SERVICES –	for Cost-Sharing	for Cost-Sharing	
Continued	8	D	
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)			Unlimited; Up to twenty (20) visits per Plan Year may be used for family counseling
Office Visits	3 visits Covered in full (PCP, ABA, MH/SUD or any combination thereof)  After 3 visits, \$15 Copayment	30% Coinsurance after Deductible	
All Other Outpatient Services	\$15 Copayment	30% Coinsurance after Deductible	
PRESCRIPTION DRUGS	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
*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.			

PRESCRIPTION DRUGS - Continued	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy			
30-day supply Tier 1	\$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	\$30 Copayment		
Tier 3	\$80 Copayment		
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.			
Mail Order Pharmacy			
Up to a 90-day supply Tier 1	\$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	\$75 Copayment		
Tier 3	\$200 Copayment		
Enteral Formulas		Non-Participating Provider	See benefit for
Tier 1	\$0 Copayment	services are not Covered and You pay the full cost	description
Tier 2	\$30 Copayment		
Tier 3	\$80 Copayment		

WELLNESS BENEFITS	<b>Participating Provider</b>	Non-Participating Provider	Limits
	<b>Member Responsibility</b>	Member Responsibility	
	for Cost-Sharing	for Cost-Sharing	
Gym Reimbursement	\$200 per six (6) month	\$200 per six (6) month	\$200 per six
	calendar year period; an	calendar year period; an	(6) month
	additional \$100 per six	additional \$100 per six	calendar year
	(6) month calendar year	(6) month calendar year	period; an
	period for covered	period for covered	additional
	Dependents	Dependents	\$100 per six
			(6) month
			calendar year
			period for
			covered
			Dependents
PEDIATRIC VISION and	<b>Participating Provider</b>	Non-Participating Provider	Limits
DENTAL CARE	Member Responsibility	Member Responsibility	
	for Cost-Sharing	for Cost-Sharing	
Pediatric Vision Care		Non-Participating Provider	
		services are not Covered and	
• Exams	\$0 Copayment	You pay the full cost	One (1) exam
			per twelve
<ul> <li>Lenses and Frames</li> </ul>	10% Coinsurance		(12) month
			period
Contact Lenses	10% Coinsurance		
			One (1)
			prescribed
			lenses and
			frames per
			twelve (12)
			month period

PEDIATRIC VISION and	Participating Provider	Non-Participating Provider	Limits
DENTAL CARE –	Member Responsibility	Member Responsibility	
Continued	for Cost-Sharing	for Cost-Sharing	
Pediatric Dental Care			
Preventive Dental Care	\$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	One (1) dental exam and cleaning per six (6) month
Routine Dental Care	\$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	period Full mouth x-rays or
<ul> <li>Major Dental Care (Endodontics, Periodontics, Prosthodontics and Oral Surgery)</li> </ul>	\$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	panoramic x- rays at thirty- six (36) month intervals and bitewing x- rays at six (6)
• Orthodontics	\$35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	month intervals
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.