## Section XXVIII

# EmblemHealth Platinum Premier-P Schedule of Benefits

| **COST-SHARING** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | |
|---|---|---|---|
| **Medical Deductible**<br>• Individual<br>• Family | <br>$0<br>$0 | <br>None<br>None | |
| **Prescription Drug Deductible**<br>• Individual<br>• Family | <br>$0<br>$0 | <br>None<br>None | |
| **Out-of-Pocket Limit**<br>• Individual<br>• Family | <br>$2,500<br>$5,000 | <br>Non-Participating Provider services are not Covered except as required for emergency care. | |
| **OFFICE VISITS** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| Primary Care Office Visits (or Home Visits) | 3 visits Covered in full (PCP, ABA, MH/SUD or any combination thereof)<br><br>After 3 visits, $15 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Specialist Office Visits (or Home Visits) | $35 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | 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 | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| • Adult Annual Physical Examinations* | Covered in full | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Adult Immunizations* | Covered in full | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Routine Gynecological Services/Well Woman Exams* | Covered in full | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer | Covered in full | Non-Participating Provider services are not Covered and You pay the full cost | |
| • **(1)[**Sterilization Procedures for Women*] | [Covered in full] | [Non-Participating Provider services are not Covered and You pay the full cost] | |
| • **(2)[**Vasectomy] | [See Surgical Services Cost-Sharing] | [Non-Participating Provider services are not Covered and You pay the full cost] | |
| • Bone Density Testing* | Covered in full | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Screening for Prostate Cancer | Covered in full | Non-Participating Provider services are not Covered and You pay the full cost | |

| **PREVENTIVE CARE – Continued** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
|---|---|---|---|
| • All other preventive services required by USPSTF and HRSA | 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) | Non-Participating Provider services are not Covered and You pay the full cost | |
| **EMERGENCY CARE** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| Pre-Hospital Emergency Medical Services (Ambulance Services) | $250 Copayment | $250 Copayment | See benefit for description |
| Non-Emergency Ambulance Services<br><br>**Preauthorization required** | $250 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Emergency Department<br><br>Cost-Sharing waived if admitted to Hospital | $400 Copayment<br><br>Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing | $400 Copayment<br><br>Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing | See benefit for description |
| Urgent Care Center | $100 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |

| PROFESSIONAL SERVICES and OUTPATIENT CARE | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|---|
| Acupuncture | $0 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | Twelve (12) visits per Plan Year |
| Advanced Imaging Services<br>• Performed in a Specialist Office<br>• Performed in a Freestanding Radiology Facility<br>• Performed as Outpatient Hospital Services<br>**Preauthorization required** | $35 Copayment<br>$35 Copayment<br>$35 Copayment | Non-Participating Provider services are not Covered and You pay the full cost<br>Non-Participating Provider services are not Covered and You pay the full cost<br>Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Allergy Testing and Treatment<br>• Performed in a PCP Office<br>• Performed in a Specialist Office | $15 Copayment<br>$35 Copayment | Non-Participating Provider services are not Covered and You pay the full cost<br>Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Ambulatory Surgical Center Facility Fee<br>**Preauthorization required** | $250 Copayment | 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 |

| 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 | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed as Outpatient Hospital Services | $50 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed as Inpatient Hospital Services<br>**Preauthorization required** | Included as part of inpatient Hospital service Cost-Sharing | Non-Participating Provider services are not Covered and You pay the full cost | |
| Chemotherapy and Immunotherapy | | | See benefit for description |
| • Performed in a PCP Office | $15 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed in a Specialist Office | $35 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed as Outpatient Hospital Services | $35 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| Chiropractic Services | $35 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Clinical Trials<br>**Preauthorization required** | Use Cost-Sharing for appropriate service | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |

| **PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
|---|---|---|---|
| Diagnostic Testing<br>• Performed in a PCP Office<br>• Performed in a Specialist Office<br>• Performed as Outpatient Hospital Services<br>**Preauthorization required** | <br>$15 Copayment<br>$35 Copayment<br>$35 Copayment | <br>Non-Participating Provider services are not Covered and You pay the full cost<br>Non-Participating Provider services are not Covered and You pay the full cost<br>Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Dialysis<br>• Performed in a PCP Office<br>• Performed in a Specialist Office<br>• Performed in a Freestanding Center<br>**Preauthorization required**<br>• Performed as Outpatient Hospital Services<br>**Preauthorization required** | <br>$15 Copayment<br>$35 Copayment<br>$35 Copayment<br>$35 Copayment | <br>Non-Participating Provider services are not Covered and You pay the full cost<br>Non-Participating Provider services are not Covered and You pay the full cost<br>Non-Participating Provider services are not Covered and You pay the full cost<br>Non-Participating Provider services are not Covered and You pay the full cost | Dialysis performed by Non-Participating Providers is limited to ten (10) visits per calendar year. Cost-Sharing for the visits is the same as for a Participating Provider. See benefit description for more information. **Preauthorization required** |

| **PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
|---|---|---|---|
| Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) | | | Sixty (60) visits per condition, per Plan Year combined therapies |
| • Performed in a PCP Office | $15 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed in a Specialist Office | $35 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed in an Outpatient Facility<br>**Preauthorization required** | $35 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| Home Health Care<br>**Preauthorization required** | $35 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | Forty (40) visits per Plan Year |
| Infertility Services<br>**Preauthorization required** | Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory and Diagnostic Procedures) | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |

| **PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
|---|---|---|---|
| Infusion Therapy | | | See benefit for description |
| • Performed in a PCP Office | $15 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed in a Specialist Office | $35 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed as Outpatient Hospital Services **Preauthorization required** | $35 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Home Infusion Therapy **Preauthorization required** | $35 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | Home infusion counts toward home health care visit limits |
| Inpatient Medical Visits | $0 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| **(3)[**Interruption of Pregnancy | | | |
| • Medically Necessary Abortions | Covered in full | Non-Participating Provider services are not Covered and You pay the full cost | Unlimited |
| • **(4)[**Elective Abortions**]** **Preauthorization required** | **[**$250 Copayment**]** | **[**Non-Participating Provider services are not Covered and You pay the full cost**]** | **[**One (1) procedure per Plan Year**]]** |

| 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 | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed in a Specialist Office | $35 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed in a Freestanding Laboratory Facility | $15 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed as Outpatient Hospital Services **Preauthorization required** | $35 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |

| 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 description |
| • Prenatal Care<br>  • Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA | 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 | 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 | 20% Coinsurance per admission | 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 |
| • Physician and Midwife Services for Delivery | $250 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Breastfeeding Support, Counseling and Supplies, including Breast Pumps | Covered in full | Non-Participating Provider services are not Covered and You pay the full cost | Covered for duration of breast feeding |
| • Postnatal Care<br><br>**Preauthorization required for inpatient services** | Covered in full | Non-Participating Provider services are not Covered and You pay the full cost | |

| P**ROFESSIONAL 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<br><br>**Preauthorization required** | $250 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Preadmission Testing<br><br>**Preauthorization required** | $0 Copayment | 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 | 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 | Included as part of the Specialist office visit Cost-Sharing | Non-Participating Provider services are not Covered and You pay the full cost | |
| Diagnostic Radiology Services | | | See benefit for description |
| • Performed in a PCP Office | $15 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed in a Specialist Office<br>**Preauthorization required** | $35 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed in a Freestanding Radiology Facility<br>**Preauthorization required** | $35 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed as Outpatient Hospital Services<br>**Preauthorization required** | $35 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |

| 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<br>• Performed in a Specialist Office<br>• Performed in a Freestanding Radiology Facility<br>• Performed as Outpatient Hospital Services<br>**Preauthorization required** | $35 Copayment<br>$35 Copayment<br>$35 Copayment | Non-Participating Provider services are not Covered and You pay the full cost<br>Non-Participating Provider services are not Covered and You pay the full cost<br>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)<br>• Performed in a PCP Office<br>• Performed in a Specialist Office<br>• Performed in an Outpatient Facility<br>**Preauthorization required** | $15 Copayment<br>$35 Copayment<br>$35 Copayment | Non-Participating Provider services are not Covered and You pay the full cost<br>Non-Participating Provider services are not Covered and You pay the full cost<br>Non-Participating Provider services are not Covered and You pay the full cost | Sixty (60) visits per condition, per Plan Year combined therapies |
| Second Opinions on the Diagnosis of Cancer, Surgery and Other | $35 Copayment | Non-Participating Provider services are not Covered and You pay the full cost<br><br>Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained. | See benefit for description |

| PROFESSIONAL SERVICES and OUTPATIENT CARE – Continued | Participating Provider Member Responsibility for Cost-Sharing | Non-Participating Provider Member Responsibility for Cost-Sharing | Limits |
|---|---|---|---|
| Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants) | | | See benefit for description |
| • Inpatient Hospital Surgery | $250 Copayment | 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 | $250 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Surgery Performed at an Ambulatory Surgical Center | $250 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Office Surgery<br>  • Performed in a PCP Office | $15 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed in a Specialist Office<br>**Preauthorization required** | $35 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| Telemedicine Program | | | See benefit for description |
| • Provided by a Telemedicine Physician | $0 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |

| 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 | | | See benefit for description |
| • Retail Diabetic Equipment, Supplies and Insulin (30-day supply) **Preauthorization required** | $15 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Mail Order Diabetic Equipment, Supplies and Insulin (90-day supply) **Preauthorization required** | $37.50 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Diabetic Education | $15 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| 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 |
| • Outpatient **Preauthorization required** | $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 | Non-Participating Provider services are not Covered and You pay the full cost | 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<br>• External<br>**Preauthorization required** | 10% Coinsurance | 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 | 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** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| Autologous Blood Banking Services | 10% Coinsurance | 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)<br>**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 | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Observation Stay | $250 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |

| **INPATIENT SERVICES and FACILITIES – Continued** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
|---|---|---|---|
| Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)<br><br>**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 Habilitation Services<br>(Physical, Speech and Occupational Therapy)<br><br>**Preauthorization required** | 20% Coinsurance per admission | Non-Participating Provider services are not Covered and You pay the full cost | Sixty (60) days per Plan Year combined therapies |
| Inpatient Rehabilitation Services<br>(Physical, Speech and Occupational Therapy)<br><br>**Preauthorization required** | 20% Coinsurance per admission | Non-Participating Provider services are not Covered and You pay the full cost | Sixty (60) days per Plan Year combined therapies |
| **MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment)<br><br>**Preauthorization required. However, Preauthorization is not required for emergency admissions or for admissions at Participating OMH-licensed Facilities for Members under eighteen (18).** | 20% Coinsurance per admission | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |

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

| **MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES – Continued** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
|---|---|---|---|
| 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)<br><br>After 3 visits, $15 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| • All Other Outpatient Services | $15 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | |
| **PRESCRIPTION DRUGS**<br><br>*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. | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |

| **PRESCRIPTION DRUGS – Continued** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
|---|---|---|---|
| **Retail Pharmacy** | | | |
| 30-day supply<br>Tier 1<br><br>Tier 2<br><br>Tier 3<br><br>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. | <br>$0 Copayment<br><br>$30 Copayment<br><br>$65 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| **Mail Order Pharmacy** | | | |
| Up to a 90-day supply<br>Tier 1<br><br>Tier 2<br><br>Tier 3 | <br>$0 Copayment<br><br>$75 Copayment<br><br>$162.50 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Enteral Formulas<br>Tier 1<br><br>Tier 2<br><br>Tier 3 | <br>$0 Copayment<br><br>$30 Copayment<br><br>$65 Copayment | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |

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

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