

**SECTION XXVII**

**METROPLUSHEALTH SCHEDULE OF BENEFITS  
Gold Non-Standard**

<p><b>COST-SHARING</b></p> <p><b>Deductible</b></p> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul> <p><b>Out-of-Pocket Limit</b></p> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul> <p>Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a calendar year ending on December 31 of each year.</p>	<p><b>Participating Provider Member Responsibility for Cost-Sharing</b></p> <p>\$600 \$1,200</p> <p>\$4,000 \$8,000</p>	<p><b>Non-Participating Provider Member Responsibility for Cost-Sharing</b></p> <p>Non-Participating Provider services are not Covered except as required for emergency care .</p>	
<p><b>OFFICE VISITS</b></p>	<p><b>Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Non-Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Limits</b></p>
<p>Primary Care Office Visits (or Home Visits)</p>	<p>\$25 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Specialist Office Visits (or Home Visits)</p> <p><b>Referral required</b></p>	<p>\$35 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p><b>PREVENTIVE CARE</b></p>	<p><b>Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Non-Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Limits</b></p>

<ul style="list-style-type: none"> <li>Well Child Visits and Immunizations*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<ul style="list-style-type: none"> <li>Adult Annual Physical Examinations*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Adult Immunizations*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Routine Gynecological Services/Well Woman Exams*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Sterilization Procedures for Women*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Vasectomy</li> </ul>	See Surgical Services Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Bone Density Testing*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Screening for Prostate Cancer</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>All other preventive services required by USPSTF and HRSA</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	

<ul style="list-style-type: none"> <li>*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> </ul>	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	
<b>EMERGENCY CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Pre-Hospital Emergency Medical Services (Ambulance Services)	\$150 Copayment after Deductible	\$150 Copayment after Deductible	See benefit for description
Non-Emergency Ambulance Services	\$150 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Emergency Department  Copayment waived if admitted to Hospital	\$150 Copayment after Deductible  Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost Sharing	\$150 Copayment 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	\$60 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<b>PROFESSIONAL SERVICES and OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Acupuncture	\$35 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	8 visits per Plan year
Advanced Imaging Services <ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> </ul>	\$35 Copayment after Deductible	Non-Participating Provider services are not Covered and You	See benefit for description

<ul style="list-style-type: none"> <li>Performed in a Freestanding Radiology Facility</li> <li>Performed as Outpatient Hospital Services</li> </ul> <p><b>Referral required</b></p>	<p>\$35 Copayment after Deductible</p> <p>\$35 Copayment after Deductible</p>	<p>pay the full cost</p>	
<p>Allergy Testing and Treatment</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> </ul> <p><b>Referral required</b></p>	<p>\$25 Copayment after Deductible</p> <p>\$35 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Ambulatory Surgical Center Facility Fee</p> <p><b>Referral required</b></p>	<p>\$100 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Anesthesia Services (all settings)</p> <p><b>Referral required</b></p>	<p>Covered in full</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Cardiac and Pulmonary Rehabilitation</p> <ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> <li>Performed as Inpatient Hospital Services</li> </ul> <p><b>Referral required</b></p>	<p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p> <p>Included as part of inpatient Hospital service Cost-Sharing</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>

<p>Chemotherapy and Immunotherapy</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul> <p><b>Referral required</b></p>	<p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Chiropractic Services</p> <p><b>Referral required</b></p>	<p>\$35 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Clinical Trials</p> <p><b>Referral required</b></p>	<p>Use Cost-Sharing for appropriate service</p>	<p>Use Cost-Sharing for appropriate service</p>	<p>See benefit for description</p>
<p>Diagnostic Testing</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul> <p><b>Referral required</b></p>	<p>\$25 Copayment after Deductible</p> <p>\$35 Copayment after Deductible</p> <p>\$35 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Dialysis</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> </ul>	<p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider</p>	<p>See benefit for description</p> <p>Dialysis performed by Non-Participating Providers is limited to</p>

<ul style="list-style-type: none"> <li>Performed in a Freestanding Center</li> <li>Performed as Outpatient Hospital Services</li> <li>Performed at Home</li> </ul>	<p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p>	<p>services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>10 visits per calendar year. Cost-Sharing for the visits is the same as for a Participating Provider. See benefit description for more information.</p>
<b>Referral required</b>			
<p>Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p>	<p>\$30 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>60 visits per condition, per Plan Year combined therapies</p>
<b>Referral required after the first 20 visits</b>			
<p>Home Health Care</p>	<p>\$25 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>40 visits per Plan Year</p>
<b>Referral required</b>			
<p>Infertility Services</p>	<p>Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory &amp; Diagnostic Procedures)</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<b>Referral required</b>			
<p>Infusion Therapy</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in Specialist Office</li> </ul>	<p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You</p>	<p>See benefit for description</p>

<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> <li>Home Infusion Therapy</li> </ul> <p><b>Referral required</b></p>	<p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p>	<p>pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>Home infusion counts toward home health care visit limits</p>
<p>Inpatient Medical Visits</p>	<p>\$0 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Interruption of Pregnancy</p> <ul style="list-style-type: none"> <li>Medically Necessary Abortions</li> <li>Elective Abortions</li> </ul>	<p>Covered in full</p> <p>Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>Unlimited</p> <p>One (1) procedure per Plan Year</p>
<p>Laboratory Procedures</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed in a Freestanding Laboratory Facility</li> </ul>	<p>\$25 Copayment after Deductible</p> <p>\$35 Copayment after Deductible</p> <p>\$35 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>

<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul> <p><b>Referral required</b></p>	\$35 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<p>Maternity and Newborn Care</p> <ul style="list-style-type: none"> <li>Prenatal Care <ul style="list-style-type: none"> <li>Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> <li>Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> </ul> </li> <li>Inpatient Hospital Services</li> <li>Physician and Midwife Services for Delivery</li> <li>Breastfeeding Support, Counseling and Supplies, Including Breast Pumps</li> <li>Postnatal Care</li> </ul>	<p>Covered in full</p> <p>Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)</p> <p>\$1,000 Copayment per admission after Deductible</p> <p>\$100 Copayment after Deductible</p> <p>Covered in full</p> <p>Included in Physician and Midwife Services for Delivery Cost-Sharing</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p> <p>One (1) home care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early</p> <p>Covered for duration of breast feeding</p>
Outpatient Hospital Surgery Facility Charge	\$100 Copayment after Deductible	Non-Participating Provider services are not Covered and You	See benefit for description



<b>Referral required</b>		pay the full cost	
Preadmission Testing	\$0 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<b>Referral required</b>			
Prescription Drugs Administered in Office or Outpatient Facilities <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in Specialist Office</li> <li>Performed in Outpatient Facilities</li> </ul>	<p>Included as part of the PCP office visit Cost-Sharing</p> <p>Included as part of the Specialist office visit Cost-Sharing</p> <p>\$25 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	See benefit for description
<b>Referral required</b>			
Diagnostic Radiology Services <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed in a Freestanding Radiology Facility</li> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$25 Copayment after Deductible</p> <p>\$35 Copayment after Deductible</p> <p>\$35 Copayment after Deductible</p> <p>\$35 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	See benefit for description

<p><b>Referral required</b></p> <p>Therapeutic Radiology Services</p> <ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> <li>Performed in a Freestanding Radiology Facility</li> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p><b>Referral required</b></p> <p>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p> <p><b>Referral required after the first 20 visits</b></p>	<p>\$30 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>60 visits per condition, per Plan Year combined therapies. Speech and Physical Therapy are only Covered following a Hospital stay or surgery.</p>
<p>Second Opinions on the Diagnosis of Cancer, Surgery and Other</p>	<p>\$35 Copayment after Deductible</p> <p><b>Referral required</b></p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained.</p> <p><b>Preauthorization required</b></p>	<p>See benefit for description</p>
<p>Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants)</p> <ul style="list-style-type: none"> <li>Inpatient Hospital Surgery</li> </ul>	<p>\$100 Copayment after</p>	<p>Non-Participating Provider</p>	<p>See benefit for description</p>

<ul style="list-style-type: none"> <li>• Outpatient Hospital Surgery</li> <li>• Surgery Performed at an Ambulatory Surgical Center</li> <li>• Office Surgery</li> </ul> <p><b>Referral required</b></p>	<p>Deductible</p> <p>\$100 Copayment after Deductible</p> <p>\$100 Copayment after Deductible</p> <p>\$25 Copayment in PCP office after Deductible \$35 Copayment in Specialist office after Deductible</p>	<p>services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	
<p>Telemedicine Program</p>	<p>Covered in full.</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p><b>ADDITIONAL SERVICES, EQUIPMENT and DEVICES</b></p>	<p><b>Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Non-Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Limits</b></p>
<p>ABA Treatment for Autism Spectrum Disorder</p> <p><b>Referral required</b></p>	<p>\$25 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Assistive Communication Devices for Autism Spectrum Disorder</p> <p><b>Referral required</b></p>	<p>\$25 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Diabetic Equipment, Supplies and Self-Management Education</p> <ul style="list-style-type: none"> <li>• Diabetic Equipment, Supplies and Insulin (30-day supply)</li> </ul>	<p>\$25 Copayment after Deductible but no more than \$100 (including before the Deductible) for a 30-</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>

<ul style="list-style-type: none"> <li>Diabetic Education</li> </ul>	<p>day supply of insulin.</p> <p>\$25 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	
<p><b>Referral required</b></p>			
Durable Medical Equipment and Braces	20% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<p><b>Referral required</b></p>			
External Hearing Aids	20% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Single purchase once every three (3) years
<p><b>Referral required</b></p>			
Cochlear Implants	20% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	One (1) per ear per time Covered
<p><b>Referral required</b></p>			
Hospice Care			
<ul style="list-style-type: none"> <li>Inpatient</li> </ul>	\$1,000 Copayment per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	210 days per Plan Year
<ul style="list-style-type: none"> <li>Outpatient</li> </ul>	\$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Five (5) visits for family bereavement counseling
<p><b>Referral required</b></p>			
Medical Supplies	20% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<p><b>Referral required</b></p>			
Prosthetic Devices			
<ul style="list-style-type: none"> <li>External</li> </ul>	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

<ul style="list-style-type: none"> <li>Internal</li> </ul>	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
<b>Referral required</b>			
<b>INPATIENT SERVICES and FACILITIES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Autologous Blood Banking Services	20% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<b>Referral required</b>			
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	\$1,000 Copayment per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Observation Stay	\$150 Copayment per admission 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)	\$1,000 Copayment per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Unlimited
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)	\$1,000 Copayment per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	60 days per Plan Year combined therapies
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	\$1,000 Copayment per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	60 days per Plan Year combined therapies  Speech and physical therapy are only Covered following a Hospital stay or surgery
<b>MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>

Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment)  <b>Referral required. However, Preauthorization is not required for emergency admissions or for admissions at Participating OMH-licensed Facilities for Members under 18.</b>	\$1,000 Copayment 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)	\$25 Copayment after Deductible	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)  <b>Referral required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.</b>	\$1,000 Copayment 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)	\$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Unlimited; Up to 20 visits per Plan Year may be used for family counseling
<b>PRESCRIPTION DRUGS</b>  *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.	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<b>Retail Pharmacy</b>			
30-day supply		Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 1	\$10 Copayment not subject to		

Tier 2	Deductible \$35 Copayment not subject to Deductible		
Tier 3	\$70 Copayment not subject to 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.			
<b>Mail Order Pharmacy</b>			
Up to a 30-day supply			
Tier 1	\$10 Copayment not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Tier 2	\$35 Copayment not subject to Deductible		
Tier 3	\$70 Copayment not subject to Deductible		
Up to a 90-day supply			
Tier 1	\$25 Copayment not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	\$87.50 Copayment not subject to Deductible		
Tier 3	\$175 Copayment not subject to		

	Deductible		
Enteral Formulas		Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 1	\$10 Copayment not subject to Deductible		
Tier 2	\$35 Copayment not subject to Deductible		
Tier 3	\$70 Copayment not subject to Deductible		
<b>WELLNESS BENEFITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	
Gym Reimbursement	Up to \$200 per six (6) month period; up to an additional \$100 per six (6) month period for Spouse	Up to \$200 per six (6) month period; up to an additional \$100 per six (6) month period for Spouse	Up to \$200 per six (6) month period; up to an additional \$100 per six (6) month period for Spouse
Meditation Benefit	Three (3) month membership to a meditation program through an online app	Three (3) month membership to a meditation program through an online app	Three (3) month membership to a meditation program through an online app
Healthy Living Rewards	Complete wellness activity to receive points which can be redeemed for items through an online portal.  See benefit for description.	Complete wellness activity to receive points which can be redeemed for items through an online portal.  See benefit for description.	Complete wellness activity to receive points which can be redeemed for items through an online portal.  See benefit for description.



<b>DENTAL and VISION CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<b>Pediatric Dental Care</b> <ul style="list-style-type: none"> <li>• Preventive Dental Care</li> <li>• Routine Dental Care</li> <li>• Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics)</li> <li>• Orthodontics</li> </ul> <p><b>Orthodontics and major dental require Referral</b></p>	\$25 Copayment after Deductible  \$25 Copayment after Deductible  \$25 Copayment after Deductible  \$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	One (1) dental exam and cleaning per six (6) month period  Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) month intervals
<b>Adult Dental Care</b> <ul style="list-style-type: none"> <li>• Preventive Dental Care</li> <li>• Routine Dental Care</li> <li>• Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics)</li> <li>• Orthodontics</li> </ul> <p><b>Orthodontics and major dental require Referral</b></p>	\$25 Copayment after Deductible  \$25 Copayment after Deductible  \$25 Copayment after Deductible  \$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	One (1) dental exam and cleaning per six (6) month period  Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) month intervals
<b>Pediatric Vision Care</b> <ul style="list-style-type: none"> <li>• Exams</li> </ul>	\$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	One (1) exam per 12-month period

<ul style="list-style-type: none"> <li>Lenses and Frames</li> <li>Contact Lenses</li> </ul> <p><b>Contact lenses require Referral</b></p>	<p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p>		<p>One (1) prescribed lenses and frames per 12-month period</p>
<p><b>Adult Vision Care</b></p> <ul style="list-style-type: none"> <li>Exams</li> <li>Lenses and Frames</li> <li>Contact Lenses</li> </ul> <p><b>Contact lenses require Referral</b></p>	<p>\$25 Copayment after Deductible</p> <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>One (1); exam per 12-month period</p> <p>One (1) prescribed lenses and frames per 12-month period</p>

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not Covered under the Contract, You will be responsible for the full cost of the services.