ESSENTIAL PLAN SECTION XXV

METROPLUS HEALTH PLAN SCHEDULE OF BENEFITS

See Benefit Description in Contract for More Details

Non-Participating Provider services are not Covered for any services other than those related to emergency care and You pay the full cost for services performed by a non-participating provider except in cases related to emergency care.

COST-SHARING	**ESSENTIAL PLAN 1 PLUS**
Deductible • Individual	$0
Out-of-Pocket Limit • Individual Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a Plan Year basis.	$2,000
OFFICE VISITS	
Primary Care Office Visits (or Home Visits)	$15
Specialist Office Visits (or Home Visits) **Referral required**	$25
PREVENTIVE CARE	
• Adult Annual Physical Examinations*	Covered in full

• Adult Immunizations*	Covered in full
• Routine Gynecological Services/Well Woman Exams*	Covered in full
• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full
• Sterilization Procedures for Women*	Covered in full
• Vasectomy	See Surgical Services Section Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge
• Bone Density Testing*	Covered in full
• Screening for Prostate Cancer	Covered in full
• All other preventive services required by USPSTF and HRSA	Covered in full
• *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)

EMERGENCY CARE	
Pre-Hospital Emergency Medical Services (Ambulance Services)	$75
Non-Emergency Ambulance Services **Referral required**	$75
Emergency Department Copay waived if admitted to Hospital	$75 Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing
Urgent Care Center	$25
PROFESSIONAL SERVICES and OUTPATIENT CARE	
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed in a Specialist Office • Performed as Outpatient Hospital Services **Referral required**	 $25 $25 $25
Allergy Testing and Treatment • Performed in a PCP Office	 $15

• Performed in a Specialist Office **Referral required**	$25
Ambulatory Surgical Center Facility Fee **Referral required**	$50
Anesthesia Services (all settings) **Referral required**	Covered in full
Autologous Blood Banking **Referral required**	5% coinsurance
Cardiac and Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services **Referral required**	 $25 $25 Included as part of inpatient Hospital service cost-sharing

Chemotherapy and Immunotherapy
• Administration
  • Performed in a PCP Office
 	
  • Performed in a Specialist Office
	
	$15
	
	$15

• Performed as Outpatient Hospital Services • Performed at Home • Chemotherapy and Immunotherapy Medications **Referral required**	$15 $15 $15
Chiropractic Services	$25
Clinical Trials	Use Cost-Sharing for appropriate service
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services **Referral required**	 $15 $25 $25
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office	 $15 $15

Setting • Performed as Outpatient Hospital Services **Referral required**	 $15
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) 60 visits per condition, per Plan Year combined therapies	$15
Home Health Care 40 visits Per Plan Year	$15
Infertility Services **Referral required**	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)

Infusion Therapy
• Administration
  • Performed in a PCP Office
  • Performed in a Specialist Office
  • Performed as Outpatient Hospital Services
  • Home Infusion Therapy
 	
• Infusion Therapy Medication
	
	$15
	
	$15
	
	$15
	
	$15
	
	$15

(Home infusion counts toward home health care visit limits) **Referral required**	
Inpatient Medical Visits **Referral required**	$0 per admission
Interruption of Pregnancy • Medically Necessary Abortions (Unlimited) • Elective Abortions (One (1) procedure per Plan Year)	Covered in Full See Surgical Services Cost-Sharing
Laboratory Procedures • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services **Referral required**	$15 $25 $25 $25
Maternity and Newborn Care • Prenatal Care	$0

• Inpatient Hospital Services One (1) home care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early • Physician and Midwife Services for Delivery • Breastfeeding Support, Counseling and Supplies, Including Breast Pumps Covered for duration of breast feeding • Postnatal Care	$150 per admission $50 $0 Included in Physician and Midwife Services for Delivery Cost-Sharing
Outpatient Hospital Surgery Facility Charge **Referral required**	$50
Preadmission Testing **Referral required**	$0

Prescription Drugs Administered in Office or Outpatient Facilities
• Administration
  • Performed in a PCP Office
  • Performed in Specialist Office
  • Performed in Outpatient Facilities
• Prescription Drug Cost-Sharing
	
	$15
	$25
	$25
	$15

Referral required	
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services **Referral required**	 $15 $25 $25 $25
Therapeutic Radiology Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services **Referral required**	 $15 $15 $15
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) 60 visits per condition, per Plan Year combined therapies Speech and physical therapy are only Covered following a Hospital stay or surgery • Performed in a PCP Office • Performed in a Specialist Office	 $15 $15

• Performed in an Outpatient Facility **Referral required**	$15
Second Opinions on the Diagnosis of Cancer, Surgery and Other **Referral required**	$25
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants **All transplants must be performed at designated Facilities** • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery **Referral required**	 $50 $50 $50 $15 (when performed at PCP office) $25 (when performed at specialist office)
Telemedicine Program	$15 PCP visit $25 specialist visit
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	
ABA Treatment for Autism Spectrum Disorder **Referral required**	$15

Assistive Communication Devices for Autism Spectrum Disorder	$15
Diabetic Equipment, Supplies and Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-day; Up to a 90 supply) • Diabetic Education **Referral required**	 $15 $15
Durable Medical Equipment and Braces	5% cost-sharing
External Hearing Aids **(Single purchase one every three (3) years)**	5% cost-sharing
Cochlear Implants **(One (1) per ear per time Covered)**	5% cost-sharing
Hospice Care • Inpatient • Outpatient 210 days per Plan Year Five (5) visits for family bereavement counseling	 $150 $15

Medical Supplies **Referral required**	5% coinsurance
Prosthetic Devices • External One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements • Internal	 5% coinsurance Included as part of Inpatient Hospital Cost-sharing
INPATIENT SERVICES and FACILITIES	
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	$150
Observation Stay Copay waived if direct transfer from outpatient surgery setting to observation	$75
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) 200 days per Plan Year Copay waived for each admission if directly transferred from hospital inpatient setting to skilled nursing facility	$150
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)	$150

60 days per Plan Year combined therapies	
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) 60 per Plan Year combined therapies	$150
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment)	$150
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) • Office Visits • All Other Outpatient Services	 $15 $15
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)	$150
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)	$15
PRESCRIPTION DRUGS *Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an “A” or “B” rating from the USPSTF and obtained at a participating pharmacy.	

Retail Pharmacy	
30-day supply Tier 1 Tier 2 Tier 3 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.	 $6 $15 $30
Up to a 90-day supply for Maintenance Drugs Tier 1 Tier 2 Tier 3	 $18 $45 $90
Mail Order Pharmacy	
Up to a 30-day supply Tier 1	 $6

Tier 2 Tier 3	$15 $30
Up to a 90-day supply Tier 1 Tier 2 Tier 3	 $15 $37.50 $75
Enteral Formulas Tier 1 Tier 2 Tier 3	 $6 $15 $30
WELLNESS BENEFITS	
Gym Reimbursement	Up to $200 per six (6)-month period

DENTAL and VISION CARE	
Dental Care • Preventive Dental Care • Routine Dental Care • Major Dental (Oral Surgery, Endodontics, Periodontics and Prosthodontics) 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) to 12-month intervals **Orthodontics and major dental require Referral**	 $15 $15 $15
Vision Care • Exams • Lenses and Frames • Contact Lenses One (1) exam per Plan Year One (1) prescribed lenses and frames per Plan Year	 $15 10% coinsurance 10% coinsurance

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.

Eligible American Indians/Alaska Natives, as determined by NYSOH, are exempt from Cost Sharing requirements, including when Covered Services are rendered by an Indian Health Service, Indian Tribe, Tribal Organization or Urban Indian Organization, or through a Referral

under the Purchased/Referred Care (PRC) program, formerly known as the Contract Health Services (CHS).