SECTION XXVII

METROPLUSHEALTH SCHEDULE OF BENEFITS
GoldPrime Non-Standard

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	 $650 $1,300	Non-Participating Provider services are not Covered except as required for emergency care .	
Out-of-Pocket Limit • Individual • Family	 $6,000 $12,000		
Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a calendar year ending on December 31 of each year.			
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)	$25 Copayment (first 3 visits to PCP, Outpatient Mental Health Care or Outpatient Substance Use Services not subject to Deductible) After 3 visits, $25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Specialist Office Visits (or Home Visits) **Referral required**	$40 Copayment after Deductible	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	
• Sterilization Procedures for Women*	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• 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	

• 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	
• *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)	$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
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Acupuncture	$40 Copayment after Deductible	Non-Participating Provider services are not Covered and You	8 visits per Plan year

		pay the full cost	
Advanced Imaging Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services **Referral required**	 $40 Copayment after Deductible $40 Copayment after Deductible $40 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office **Referral required**	 $25 Copayment after Deductible $40 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Ambulatory Surgical Center Facility Fee **Referral required**	$100 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Anesthesia Services (all settings) **Referral required**	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Cardiac and Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $25 Copayment after Deductible $25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

• Performed as Inpatient Hospital Services **Referral required**	Included as part of inpatient Hospital service Cost-Sharing		
Chemotherapy and Immunotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services **Referral required**	 $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	See benefit for description
Chiropractic Services **Referral required**	$40 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Clinical Trials **Referral required**	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services **Referral required**	 $25 Copayment after Deductible $40 Copayment after Deductible $40 Copayment after Deductible	 Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Dialysis • Performed in a PCP Office	 $25 Copayment after Deductible	 Non-Participating Provider services are not Covered and You	See benefit for description

• Performed in a Specialist Office • Performed in a Freestanding Center • Performed as Outpatient Hospital Services • Performed at Home **Referral required**	$25 Copayment after Deductible $25 Copayment after Deductible $25 Copayment after Deductible $25 Copayment after Deductible	pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	Dialysis performed by Non-Participating Providers is limited to 10 visits per calendar year. Cost-Sharing for the visits is the same as for a Participating Provider. See benefit description for more information.
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **Referral required after the first 20 visits**	$30 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	60 visits per condition, per Plan Year combined therapies
Home Health Care **Referral required**	$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	40 visits per Plan Year
Infertility Services **Referral required**	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Infusion Therapy • Performed in a PCP Office	$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

• Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy **Referral required**	$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 Non-Participating Provider services are not Covered and You pay the full cost 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 after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Interruption of Pregnancy • Medically Necessary Abortions • Elective Abortions	Covered in full Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	Unlimited One (1) procedure per Plan Year
Laboratory Procedures • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Laboratory	$25 Copayment after Deductible $40 Copayment after Deductible $40 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider	See benefit for description

Facility • Performed as Outpatient Hospital Services **Referral required**	 $40 Copayment after Deductible	services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	

Maternity and Newborn Care
• Prenatal Care
  • Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA
 	
  • Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA
 	
• Inpatient Hospital Services
 	
• Physician and Midwife Services for Delivery
 	
• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps
 	
• Postnatal Care
	Covered in full
	
	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)
	
	$1,000 Copayment per admission after Deductible
	
	$100 Copayment after Deductible
	
	Covered in full
	
	Included in Physician and Midwife Services for Delivery Cost-Sharing
		Non-Participating Provider services are not Covered and You pay the full cost
		
		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
		
		Non-Participating Provider services are not Covered and You pay the full cost
		
		Non-Participating Provider services are not Covered and You pay the full cost
		
		Non-Participating Provider services are not Covered and You pay the full cost
			See benefit for description
			
			One (1) home care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
			
			Covered for duration of breast feeding

Outpatient Hospital Surgery Facility Charge **Referral required**	$100 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preadmission Testing **Referral required**	$0 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities			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 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	
• Performed in Outpatient Facilities **Referral required**	$25 Copayment after Deductible	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	$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office	$40 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Radiology Facility	$40 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$40 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

Referral required			
Therapeutic Radiology Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services **Referral required**	$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 Non-Participating Provider services are not Covered and You pay the full cost 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) **Referral required after the first 20 visits**	$30 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	60 visits per condition, per Plan Year combined therapies. Speech and Physical Therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery and Other	$40 Copayment after Deductible **Referral required**	Non-Participating Provider services are not Covered and You pay the full cost Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained. **Preauthorization required**	See benefit for description
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and			See benefit for description

Corrective Surgery; and Transplants) • Inpatient Hospital Surgery	$100 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Outpatient Hospital Surgery	$100 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Surgery Performed at an Ambulatory Surgical Center	$100 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Office Surgery **Referral required**	$25 Copayment in PCP office after Deductible $40 Copayment in Specialist office after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Telemedicine Program	Covered in full.	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**
ABA Treatment for Autism Spectrum Disorder **Referral required**	$25 Copayment (first 3 visits to PCP, Outpatient Mental Health Care or Outpatient Substance Use Services not subject to Deductible)	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder **Referral required**	$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education • Diabetic Equipment, Supplies and Insulin	$25 Copayment after Deductible	Non-Participating Provider	See benefit for description

(30-day supply) • Diabetic Education **Referral required**	but no more than $100 (including before the Deductible) for a 30-day supply of insulin. $25 Copayment after Deductible	services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	
Durable Medical Equipment and Braces **Referral required**	20% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
External Hearing Aids **Referral required**	20% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Single purchase once every three (3) years
Cochlear Implants **Referral required**	20% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	One (1) per ear per time Covered
Hospice Care • Inpatient • Outpatient **Referral required**	$1,000 Copayment per admission after Deductible $25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	210 days per Plan Year Five (5) visits for family bereavement counseling
Medical Supplies **Referral required**	20% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Prosthetic Devices • External	20% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements

• Internal **Referral required**	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 **Referral required**	20% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	$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
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-**	**Non-Participating Provider Member Responsibility for**	**Limits**

	Sharing	**Cost-Sharing**	
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment) **Referral required. However, Preauthorization is not required for emergency admissions or for admissions at Participating OMH-licensed Facilities for Members under 18.**	$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 (first 3 visits to PCP, Outpatient Mental Health Care or Outpatient Substance Use Services not subject to Deductible) After 3 visits, $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) **Referral required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.**	$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 (first 3 visits to PCP, Outpatient Mental Health Care or Outpatient Substance Use Services not subject to Deductible) After 3 visits, $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
PRESCRIPTION DRUGS *Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**

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.	 $10 Copayment not subject to Deductible $40 Copayment not subject to Deductible $80 Copayment not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Mail Order Pharmacy			
Up to a 30-day supply Tier 1 Tier 2 Tier 3	 $10 Copayment not subject to Deductible $40 Copayment not subject to Deductible $80 Copayment not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

Up to a 90-day supply Tier 1 Tier 2 Tier 3	 $25 Copayment not subject to Deductible $100 Copayment not subject to Deductible $200 Copayment not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Enteral Formulas Tier 1 Tier 2 Tier 3	 $10 Copayment not subject to Deductible $40 Copayment not subject to Deductible $80 Copayment not subject to Deductible	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**	
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.	Complete wellness activity to receive points which can be redeemed for items through an online portal.	Complete wellness activity to receive points which can be redeemed for items

	See benefit for description.	See benefit for description.	through an online portal. See benefit for description.
DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care • Preventive Dental Care • Routine Dental Care • Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics) • Orthodontics **Orthodontics and major dental require Referral**	 $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
Adult Dental Care • Preventive Dental Care • Routine Dental Care • Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics) • Orthodontics **Orthodontics and major dental require**	 $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

Referral			
Pediatric Vision Care • Exams • Lenses and Frames • Contact Lenses **Contact Lenses require Referral**	 $25 Copayment after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	 One (1) exam per 12-month period One (1) prescribed lenses and frames per 12-month period
Adult Vision Care • Exams • Lenses and Frames • Contact Lenses **Contact Lenses require Referral**	 $25 Copayment after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	 One (1); exam per 12-month period One (1) prescribed lenses and frames per 12-month period

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.