SECTION XXVII

METROPLUSHEALTH SCHEDULE OF BENEFITS
Platinum Non-Standard

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	None None	Non-Participating Provider services are not Covered except as required for emergency care .	
Out-of-Pocket Limit • Individual • Family Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a calendar year ending on December 31 of each year.	$2,000 $4,000		
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)	$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) **Referral required**	$25 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	
• 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	
• Colon Cancer Screening	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)	$100 Copayment	$100 Copayment	See benefit for description
Non-Emergency Ambulance Services	$100 Copayment	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	$100 Copayment Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Copayment	$100 Copayment Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Copayment	See benefit for description
Urgent Care Center	$55 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	$25 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	8 visits per Plan year
Advanced Imaging Services • Performed in a Specialist Office	$25 Copayment	Non-Participating Provider services are not Covered and You	See benefit for description

• Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services **Referral required**	$25 Copayment $25 Copayment	pay the full cost	
Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office **Referral required**	$15 Copayment $25 Copayment	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	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 • Performed as Inpatient Hospital Services **Referral required**	$15 Copayment $15 Copayment Included as part of inpatient Hospital service Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

Chemotherapy and Immunotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services **Referral required**	$15 Copayment $15 Copayment $15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Chiropractic Services **Referral required**	$25 Copayment	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**	$15 Copayment $25 Copayment $25 Copayment	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 • Performed in a Specialist Office	$15 Copayment $15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider	See benefit for description Dialysis performed by Non-Participating Providers is limited to

• Performed in a Freestanding Center • Performed as Outpatient Hospital Services • Performed at Home **Referral required**	\$15 Copayment \$15 Copayment \$15 Copayment	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	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**	\$25 Copayment	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**	\$15 Copayment	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 • Performed in Specialist Office	 \$15 Copayment \$15 Copayment	 Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You	See benefit for description

		pay the full cost	
• Performed as Outpatient Hospital Services	$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Home Infusion Therapy **Referral required**	$15 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
Interruption of Pregnancy • Abortion Service	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Laboratory Procedures • Performed in a PCP Office	$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
• Performed in a Specialist Office	$25 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Laboratory Facility	$25 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Referral required**	$25 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Maternity and Newborn Care			See benefit for

• Prenatal Care • 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	description
• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	
• Inpatient Hospital Services	$500 Copayment 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	$100 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	Included in Physician and Midwife Services for Delivery Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	
Outpatient Hospital Surgery Facility Charge **Referral required**	$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preadmission Testing **Referral 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 or Outpatient Facilities • Performed in a PCP Office • Performed in Specialist Office • Performed in Outpatient Facilities **Referral required**	Included as part of the PCP office visit Cost-Sharing Included as part of the Specialist office visit Cost-Sharing $15 Copayment	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
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 Copayment $25 Copayment $25 Copayment $25 Copayment	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
Therapeutic Radiology Services • Performed in a Specialist Office	$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

• Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services **Referral required**	$15 Copayment $15 Copayment	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	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **Referral required after the first 20 visits**	$25 Copayment	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	$25 Copayment **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 Corrective Surgery; and Transplants) • Inpatient Hospital Surgery • Outpatient Hospital Surgery	 $100 Copayment $100 Copayment	 Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You	See benefit for description

		pay the full cost	
• Surgery Performed at an Ambulatory Surgical Center	$100 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Office Surgery **Referral required**	$15 Copayment in PCP office $25 Copayment in Specialist office	Non-Participating Provider services are not Covered and You pay the full cost	
Telemedicine Program	$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Diabetic Equipment, Supplies and Self-Management Education			See benefit for description
• Diabetic Equipment and Supplies	$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Diabetic Insulin (30- day supply)	See the Prescription Drug Cost-Sharing, but not more than $100 for a 30-day supply of insulin.	Non-Participating Provider services are not Covered and You pay the full cost	
• Oral anti-diabetic agents and injectable anti-diabetic agents (30-day supply)	See the Prescription Drug Cost Sharing		
• Diabetic Education **Referral required**	$15 Copayment		
Durable Medical Equipment and Braces	10% Coinsurance	Non-Participating Provider services are not Covered and You	See benefit for description

Referral required		pay the full cost	
External Hearing Aids • Prescription Hearing Aids • Over-the-Counter Hearing Aids **Referral required**	10% Coinsurance 10% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost	Single purchase once every three (3) years
Cochlear Implants **Referral 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 • Outpatient **Referral required**	$500 Copayment per admission $15 Copayment	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**	10% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Prosthetic Devices • External • Internal **Referral required**	10% Coinsurance Included as part of inpatient Hospital Cost-Sharing	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	One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements Unlimited; See benefit for description
INPATIENT SERVICES and FACILITIES	**Participating Provider Member**	**Non-Participating Provider**	**Limits**

	Responsibility for Cost-Sharing	**Member Responsibility for Cost-Sharing**	
Autologous Blood Banking Services **Referral required**	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)	$500 Copayment per admission	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Observation Stay	$100 Copayment per admission	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)	$500 Copayment per admission	Non-Participating Provider services are not Covered and You pay the full cost	Unlimited
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)	$500 Copayment per admission	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)	$500 Copayment per admission	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-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) **Referral required. However,**	$500 Copayment per admission	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

Preauthorization is not required for emergency admissions or for admissions at Participating OMH-licensed Facilities for Members under 18.			
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) • Outpatient Services provided in a Facility licensed, certified, or otherwise authorized by OMH	$15 Copayment $15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
ABA Treatment for Autism Spectrum Disorder **Referral required**	$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 **Referral 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) **Referral required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.**	$500 Copayment per admission	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) • Opioid Treatment Program	$15 Copayment Covered in full	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.	 $5 Copayment $25 Copayment $50 Copayment	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	 $5 Copayment $25 Copayment $50 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Up to a 90-day supply		Non-Participating Provider	See benefit for

Tier 1 Tier 2 Tier 3	$12.50 Copayment $62.60 Copayment $125 Copayment	services are not Covered and You pay the full cost	description
Enteral Formulas Tier 1 Tier 2 Tier 3	 $5 Copayment $25 Copayment $50 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**	
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.
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**	 $15 Copayment $15 Copayment $15 Copayment $15 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 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 Referral**	 $15 Copayment $15 Copayment $15 Copayment $15 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 Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) month intervals
Pediatric Vision Care		Non-Participating Provider	

• Exams • Lenses and Frames • Contact Lenses **Contact Lenses require Referral**	$15 Copayment 10% Coinsurance 10% Coinsurance	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**	$15 Copayment 10% Coinsurance 10% Coinsurance	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.