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 AL**
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.	$0
OFFICE VISITS	
Primary Care Office Visits (or Home Visits)	$0 in Office by Telehealth
Specialist Office Visits (or Home Visits) **Referral required**	$0 in Office by Telehealth
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
• Screening for Colon Cancer	Covered in full

• All other preventive services required by USPSTF and HRSA • *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full 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)	$0
Non-Emergency Ambulance Services **Referral required**	$0 **See Contract on how to use this service**
Emergency Department Copayment waived if admitted to Hospital	$0
Urgent Care Center	$0 in Office by Telehealth
PROFESSIONAL SERVICES and OUTPATIENT CARE	
Advanced Imaging Services	$0

• Performed in a Freestanding Radiology Facility or Office Setting • Performed in a Specialist Office • Performed as Outpatient Hospital Services **Referral required**	 $0 $0
Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office **Referral required**	$0 $0
Ambulatory Surgical Center Facility Fee **Referral required**	$0
Anesthesia Services (all settings) **Referral required**	Covered in full
Cardiac and Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services **Referral required**	 $0 $0 Included as part of inpatient Hospital service cost-sharing

Chemotherapy and Immunotherapy
• Administration
  • Performed in a PCP Office
  • Performed in a Specialist Office
  • Performed as Outpatient Hospital Services
  • Performed at Home
• Chemotherapy and Immunotherapy Medications
 	
Referral required
	
	$0
	$0
	$0
	$0
	$0

Chiropractic Services	$0
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	 $0 $0 $0

Referral required	
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services Dialysis performed by Non-Participating Providers is limited to 10 visits per calendar year. See benefit description for more information. **Referral required**	$0 $0 $0
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **Referral required**	$0
Home Health Care 40 visits Per Plan Year **Referral required**	$0
Infertility Services	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)

Referral required	

Infusion Therapy
• Administration
  • Performed in a PCP Office
  • Performed in a Specialist Office
  • Performed as Outpatient Hospital Services
  • Home Infusion Therapy
• Infusion Therapy Medication
 	
(Home infusion counts toward home health care visit limits)
 	
Referral required
	$0
	$0
	$0
	$0
	$0

Inpatient Medical Visits **Referral required**	$0 per admission
Interruption of Pregnancy • Abortion Services	Covered in Full
Laboratory Procedures • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Laboratory Facility or Specialist Office	$0 $0 $0

• Performed as Outpatient Hospital Services **Referral required**	$0
Maternity and Newborn Care • Prenatal Care • 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	 $0 $0 $0 $0 Included in Physician and Midwife Services for Delivery Cost-Sharing
Outpatient Hospital Surgery Facility Charge **Referral required**	$0
Preadmission Testing **Referral required**	$0
Prescription Drugs Administered in Office or Outpatient Facilities • Administration • Performed in a PCP Office	 $0

• Performed in Specialist Office • Performed in Outpatient Facilities • Prescription Drug Cost-Sharing **Referral required**	$0 $0 $0
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**	 $0 $0 $0 $0
Therapeutic Radiology Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services **Referral required**	 $0 $0 $0
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	

• Performed in a PCP Office • Performed in a Specialist Office • Performed in an Outpatient Facility **Referral required**	$0 $0 $0
Retail Health Clinic Care **Referral required**	$0
Second Opinions on the Diagnosis of Cancer, Surgery and Other **Referral required**	$0
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants **All transplants must be performed at designated Center of Excellence Facilities** • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery	$0 $0 $0 $0

Referral required	
Telemedicine Program	$0
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	
Diabetic Equipment, Supplies and Self-Management Education • Retail Diabetic Equipment and Supplies and Insulin (30-day; Up to a 90 supply) • Diabetic Education **Referral required**	 $0 $0
Durable Medical Equipment and Braces	$0
External Hearing Aids • Prescription Hearing Aids **(Single purchase one every three (3) years** • Over the Counter Hearing Aids	$0 $0
Cochlear Implants **(One (1) per ear per time Covered)**	$0
Hospice Care • Inpatient	

• Outpatient 210 days per Plan Year Five (5) visits for family bereavement counseling **Referral required**	$0 $0
Medical Supplies **Referral required**	$0
Prosthetic Devices • External One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements • Internal	$0 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)	$0
Autologous Blood Banking Services	$0

Observation Stay Copay waived if direct transfer from outpatient surgery setting to observation	$0
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	$0
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)	$0
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) 60 per Plan Year combined therapies	$0
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment)	$0
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) • Office Visits	 $0 in Office by Telehealth

• Outpatient Services provided in a Facility licensed, certified, or otherwise authorized by OMH • All Other Outpatient Services	$0 in Office by Telehealth $0 in Office by Telehealth
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)	$0
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) • Office Visits • Opioid Treatment Programs However, Preauthorization is not required for Participating OASAS-certified Facilities	 $0 in Office by Telehealth Covered in full
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.	 $0 $0 $0
Up to a 90-day supply for Maintenance Drugs Tier 1 Tier 2 Tier 3	 $0 $0 $0
Mail Order Pharmacy	
Up to a 30-day supply Tier 1 Tier 2 Tier 3	 $0 $0 $0

Up to a 90-day supply Tier 1 Tier 2 Tier 3	 $0 $0 $0
Enteral Formulas Tier 1 Tier 2 Tier 3	 $0 $0 $0
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)	 $0 $0 $0

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**	**Orthodontics and major dental require**
Vision Care • Exams • Lenses and Frames • Contact Lenses One (1) exam per Plan Year, unless otherwise medically necessary One (1) prescribed lenses and frames per Plan Year, unless otherwise medically necessary	 $0 $0 $0

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.