SECTION XXIV

MetroPlus Health Plan SCHEDULE OF BENEFITS
MetroPlus Gold

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	 $0 $0	Non-Participating Provider services are not Covered except as required for emergency care.	
Out-of-Pocket Limit • Individual • Family	 $7,150 $14,300		
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)	$0 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**	$0 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
  • Performed in PCP Office
  • Performed in Specialist Office
	$0 Copayment
	$0 Copayment
		Non-Participating Provider services are not Covered and You pay the full cost	

• 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)	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	
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)	$0 Copayment	$0 Copayment	See benefit for description
Non-Emergency Ambulance Services	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Emergency Department	$150 Copayment	$150 Copayment	Copayment waived if Hospital admission.
Urgent Care Center	$0 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**
Advanced Imaging Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility	 $0 Copayment $0 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	See benefit for description

• Performed as Outpatient Hospital Services **Referral required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office **Referral required**	 $0 Copayment $0 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	See benefit for description
Ambulatory Surgical Center Facility Fee **Referral required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Anesthesia Services (all settings) **Referral required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Autologous Blood Banking **Referral required**	$0 Copayment	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	 $0 Copayment $0 Copayment Included as part of inpatient Hospital service 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 Included as part of inpatient Hospital service Cost-Sharing	See benefit for description

Referral required		**Preauthorization required**	
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services **Referral required**	 $0 Copayment $0 Copayment $0 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
Chiropractic Services	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Clinical Trials	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service **Preauthorization required**	See benefit for description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services **Referral required**	 $0 Copayment $0 Copayment $0 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	 $0 Copayment	 $0 Copayment	See benefit for description

• Performed in a Specialist Office • Performed in a Freestanding Center • Performed as Outpatient Hospital Services **Referral required**	$0 Copayment $0 Copayment $0 Copayment	$0 Copayment $0 Copayment $0 Copayment	Dialysis performed by Non-Participating Providers is limited to 10 visits per calendar year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **Referral required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	20 visits per Plan Year combined therapies
Home Health Care	$0 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 • Performed as Outpatient Hospital Services • Home Infusion Therapy	 $0 Copayment $0 Copayment $0 Copayment $0 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	See benefit for description Home infusion counts toward home health

Referral required		and You pay the full cost	care visit limits
Inpatient Medical Visits **Referral required**	$0 Copayment	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 $0 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	 Unlimited One (1) procedure per Plan Year
Laboratory Procedures • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Laboratory Facility • Performed as Outpatient Hospital Services **Referral required**	 $0 Copayment $0 Copayment $0 Copayment $0 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
Maternity and Newborn Care • Prenatal Care • Prenatal Care provided in accordance with the comprehensive guidelines	 Covered in full	 Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

supported by USPSTF and HRSA • 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	$0 Copayment	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	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps	$0 Copayment	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 **Preauthorization required**	
Outpatient Hospital Surgery Facility Charge **Referral required**	$0 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	Included as part of the PCP office visit Cost-Sharing	Non-Participating Provider services are not Covered	See benefit for description

		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	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Referral required			
Diagnostic Radiology Services			See benefit for description
• Performed in a PCP Office	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Specialist Office	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Radiology Facility	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Referral required			
Therapeutic Radiology Services			See benefit for description
• Performed in a Specialist Office	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Radiology Facility	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	

• Performed as Outpatient Hospital Services **Referral required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **Referral required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	20 visits per Plan Year combined therapies
Second Opinions on the Diagnosis of Cancer, Surgery and Other **Referral required**	$0 Copayment	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)			See benefit for description
• Inpatient Hospital Surgery	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	**All transplants must be performed at designated Facilities**
• Outpatient Hospital Surgery	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Surgery Performed at an Ambulatory Surgical Center	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Office Surgery	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	

Referral required			
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**	$0 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	$0 Copayment	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 (30-day supply) • Diabetic Education **Referral required**	 $0 Copayment if procured through DME. $5 Copayment if procured through pharmacy $0 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	See benefit for description
Durable Medical Equipment and Braces	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
External Hearing Aids	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	Single purchase once every three (3) years
Cochlear Implants	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	One (1) per ear per time Covered
Hospice Care • Inpatient	 $0 Copayment	 Non-Participating Provider services are not Covered and You pay the full cost	 210 days per Plan Year Five (5) visits for family

• Outpatient	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	bereavement counseling
Medical Supplies **Referral required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Prosthetic Devices • External • Internal	$0 Copayment 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 Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Observation Stay **Referral required**	$0 Copayment	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)	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	200 days per Plan Year
Inpatient Habilitation Services (Physical, Speech and Occupational	$0 Copayment	Non-Participating Provider services are not Covered	20 visits per Plan Year combined therapies

Therapy) **Referral required**		and You pay the full cost	
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) **Referral required**	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	20 visits per Plan Year combined therapies
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 including Residential Treatment (for a continuous confinement when in a Hospital)	$0 Copayment	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)	$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Inpatient Substance Use Services including Residential Treatment (for a continuous confinement when in a Hospital)	$0 Copayment	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)	$0 Copayment	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 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.	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**

Retail Pharmacy			
30-day supply Tier 1 Tier 2 Tier 3 If You have an Emergency Condition, Preauthorization is not required for a five (5) day emergency supply of 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 $35 Copayment $70 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 $35 Copayment $70 Copayment	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	 $10 Copayment $70 Copayment $140 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Enteral Formulas Tier 1	 $5 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

Tier 2 Tier 3	$35 Copayment $70 Copayment		

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.