Section XXIV

UNITEDHEALTHCARE COMMUNITY 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 3
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.	$200
Office Visits	
Primary Care Office Visits (or Home Visits)	$0
Specialist Office Visits (or Home Visits)	$0
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

Cost-Sharing	Essential Plan 3
Preventive Care *(continued)*	
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)	$0
Non-Emergency Ambulance Services ***Preauthorization required***	$0
Emergency Department Copay waived if admitted to Hospital	$0 Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing
Urgent Care Center	$0
Professional Services and Outpatient Care	
Advanced Imaging Services	
• Performed in a Freestanding Radiology Facility or Office Setting	$0
• Performed in a Specialist Office	$0
• Performed as Outpatient Hospital Services ***Preauthorization required***	$0

Cost-Sharing	Essential Plan 3
Professional Services and Outpatient Care *(continued)*	
Allergy Testing and Treatment	
• Performed in a PCP Office	$0
• Performed in a Specialist Office	$0
Ambulatory Surgical Center Facility Fee	$0
Anesthesia Services (all settings)	Covered in full
Autologous Blood Banking	Covered in full
Cardiac and Pulmonary Rehabilitation	
• Performed in a Specialist Office	$0
• Performed as Outpatient Hospital Services	$0
• Performed as Inpatient Hospital Services	Included as part of inpatient Hospital service cost-sharing
Chemotherapy	
• Performed in a PCP Office	$0
• Performed in a Specialist Office	$0
• Performed as Outpatient Hospital Services	$0
• Performed at home	$0
• Chemotherapy Medication	$0
Chiropractic Services	$0
Clinical Trials ***Preauthorization required***	Use Cost-Sharing for appropriate service

Cost-Sharing	Essential Plan 3
Professional Services and Outpatient Care *(continued)*	
Diagnostic Testing	
• Performed in a PCP Office	$0
• Performed in a Specialist Office	$0
• Performed as Outpatient Hospital Services	$0
Dialysis	
• Performed in a PCP Office	$0
• Performed in a Freestanding Center or Specialist Office Setting	$0
• Performed as Outpatient Hospital Services	$0
• Performed at Home	$0
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) 60 visits per condition, per Plan Year combined therapies	$0
Home Health Care 40 visits Per Plan Year ***Preauthorization required***	$0
Infertility Services ***Preauthorization required***	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)

Cost-Sharing	Essential Plan 3
Professional Services and Outpatient Care *(continued)*	
Infusion Therapy • Administration	
– Performed in a PCP Office	$0
– Performed in Specialist Office	$0
– Performed as Outpatient Hospital Services	$0
– Home Infusion Therapy (Home infusion counts toward home health care visit limits)	$0
– Infusion Therapy medication *Preauthorization required*	$0
Inpatient Medical Visits	$0 per admission
Interruption of Pregnancy	
• Medically Necessary Abortions Unlimited	Covered in Full
• Elective Abortions One (1) procedure per Plan Year	$0
Laboratory Procedures	
• Performed in a PCP Office	$0
• Performed in a Specialist Office	$0
• Performed in a Freestanding Laboratory Facility	$0
• Performed as Outpatient Hospital Services	$0

Cost-Sharing	Essential Plan 3
Professional Services and Outpatient Care *(continued)*	
Maternity and Newborn Care	
• Prenatal Care	$0
• Inpatient Hospital Services and Birthing Center One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early	$0
• Physician and Midwife Services for Delivery	$0
• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps Covered for duration of breast feeding	$0
• Postnatal Care ***Preauthorization required for Breast Pumps over $500***	Included in Physician and Midwife Services for Delivery Cost-Sharing
Outpatient Hospital Surgery Facility Charge	$0
Preadmission Testing	$0
Prescription Drugs Administered in Office or Outpatient Facilities	
• Administration	
– Performed in a PCP Office	$0
– Performed in Specialist Office	$0
– Performed in Outpatient Facilities	$0
– Prescription Drug Cost Sharing ***Preauthorization required on certain medications. Please see your Plan's Preferred Drug List.***	$0

Cost-Sharing	Essential Plan 3
Professional Services and Outpatient Care *(continued)*	
Diagnostic Radiology Services	
• Performed in a PCP Office	$0
• Performed in a Specialist Office	$0
• Performed in a Freestanding Radiology Facility	$0
• Performed as Outpatient Hospital Services	$0
Therapeutic Radiology Services	
• Performed in a Specialist Office	$0
• Performed in a Freestanding Radiology Facility	$0
• Performed as Outpatient Hospital Services	$0
Preauthorization required	
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	$0
Second Opinions on the Diagnosis of Cancer, Surgery and Other	$0

Cost-Sharing	Essential Plan 3
Professional Services and Outpatient Care *(continued)*	
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	$0
• Outpatient Hospital Surgery	$0
• Surgery Performed at an Ambulatory Surgical Center	$0
• Office Surgery	$0
Preauthorization required	
Additional Services, Equipment and Devices	
ABA Treatment for Autism Spectrum Disorder *Preauthorization required*	$0
Assistive Communication Devices for Autism Spectrum Disorder *Preauthorization required*	$0
Diabetic Equipment, Supplies and Self-Management Education	
• Diabetic Equipment, Supplies and Insulin (30-day supply); Up to a 90-day supply	$0
• Diabetic Education	$0

Cost-Sharing	Essential Plan 3
Additional Services, Equipment and Devices *(continued)*	
Durable Medical Equipment and Braces *Preauthorization required*	$0
External Hearing Aids **(Single purchase — one every three (3) years)**	$0
Cochlear Implants **(One (1) per ear per time Covered)** *Preauthorization required*	$0
Hospice Care • Inpatient • Outpatient 210 days per Plan Year Five (5) visits for family bereavement counseling	 $0 $0
Medical Supplies *Preauthorization required*	$0
Prosthetic Devices • External One (1) prosthetic device, per limb, per lifetime, and the cost of repair and replacement of the prosthetic devices and its parts • Internal *Preauthorization required*	 $0 Included as part of Inpatient Hospital Cost-sharing

Cost-Sharing	Essential Plan 3
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) ***Preauthorization required. However, Preauthorization is not required for emergency admissions.***	$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 ***Preauthorization required***	$0
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) 60 days per Plan Year combined therapies ***Preauthorization required***	$0
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) 60 per Plan Year combined therapies ***Preauthorization required***	$0

Cost-Sharing	Essential Plan 3
Mental Health and Substance Use Disorder Services	
Inpatient Mental Health Care including Residential Treatment (for a continuous confinement when in a Hospital) ***Preauthorization required. However, Preauthorization is not required for emergency admissions.***	$0
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) • Office Visits • All other outpatient services ***Preauthorization required***	$0 $0 $0
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) ***Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.***	$0
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) Up to 20 visits per Plan Year may be used for family counseling ***Preauthorization required***	$0

Cost-Sharing	Essential Plan 3
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	$1
Tier 2	$3
Tier 3	$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.	
Mail-Order Pharmacy Up to a 90-day supply	
Tier 1	$2.50
Tier 2	$7.50
Tier 3	$7.50
Non-Prescription Drugs	$.50
Enteral Formulas	
Tier 1	$1
Tier 2	$3
Tier 3	$3
Wellness Benefits	
Gym Reimbursement	Up to $400 per plan year, $200 per 6-month period after attending 50 visits in a 6-month period

Cost-Sharing	Essential Plan 3
Dental and Vision Care	
Dental Care • Preventive Dental Care • Routine Dental Care • Major Dental (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 Preauthorization***	 $0 $0 $0
Vision Care • Exams • Lenses and Frames • Contact Lenses One (1) exam per 24 months One (1) prescribed lenses and frames per Plan Year ***Contact lenses require Preauthorization***	 $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.