

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 4
Deductible • Individual Out-of-Pocket Limit • Individual Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a Plan Year basis.	\$0 \$0
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

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Cost-Sharing	Essential Plan 4
Preventive Care (continued)	
Bone Density Testing* Screening for Prostate Cancer All other preventive services required by USPSTF and HRSA <i>*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</i>	Covered in full Covered in full 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 <i>Preauthorization required</i>	\$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 <ul style="list-style-type: none"> • Performed in a Freestanding Radiology Facility or Office Setting • Performed in a Specialist Office • Performed as Outpatient Hospital Services <i>Preauthorization required</i>	\$0 \$0 \$0



Cost-Sharing	Essential Plan 4
Professional Services and Outpatient Care (continued)	
Allergy Testing and Treatment <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office 	\$0 \$0
Ambulatory Surgical Center Facility Fee	\$0
Anesthesia Services (all settings)	Covered in full
Autologous Blood Banking	Covered in full
Cardiac and Pulmonary Rehabilitation <ul style="list-style-type: none"> • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services 	\$0 \$0 Included as part of inpatient Hospital service cost-sharing
Chemotherapy <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed at home • Chemotherapy Medication 	\$0 \$0 \$0 \$0 \$0
Chiropractic Services	\$0
Clinical Trials <i>Preauthorization required</i>	Use Cost-Sharing for appropriate service

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Cost-Sharing	Essential Plan 4
Professional Services and Outpatient Care (continued)	
Diagnostic Testing <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services 	\$0 \$0 \$0
Dialysis <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services • Performed at Home 	\$0 \$0 \$0 \$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 <i>Preauthorization required</i>	\$0
Infertility Services <i>Preauthorization required</i>	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)



Cost-Sharing	Essential Plan 4
Professional Services and Outpatient Care (continued)	
<p>Infusion Therapy</p> <ul style="list-style-type: none"> • Administration <ul style="list-style-type: none"> – Performed in a PCP Office – Performed in Specialist Office – Performed as Outpatient Hospital Services – Home Infusion Therapy (Home infusion counts toward home health care visit limits) – Infusion Therapy medication <p><i>Preauthorization required</i></p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p>
<p>Inpatient Medical Visits</p>	<p>\$0 per admission</p>
<p>Interruption of Pregnancy</p> <ul style="list-style-type: none"> • Medically Necessary Abortions Unlimited • Elective Abortions One (1) procedure per Plan Year 	<p>Covered in Full</p> <p>\$0</p>
<p>Laboratory Procedures</p> <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Laboratory Facility • Performed as Outpatient Hospital Services 	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p>

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Cost-Sharing	Essential Plan 4
Professional Services and Outpatient Care (continued)	
<p>Maternity and Newborn Care</p> <ul style="list-style-type: none"> • Prenatal Care • Inpatient Hospital Services and Birthing Center 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 <p><i>Preauthorization required for Breast Pumps over \$500</i></p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p> <p>Included in Physician and Midwife Services for Delivery Cost-Sharing</p>
<p>Outpatient Hospital Surgery Facility Charge</p>	<p>\$0</p>
<p>Preadmission Testing</p>	<p>\$0</p>
<p>Prescription Drugs Administered in Office or Outpatient Facilities</p> <ul style="list-style-type: none"> • Administration <ul style="list-style-type: none"> – Performed in a PCP Office – Performed in Specialist Office – Performed in Outpatient Facilities – Prescription Drug Cost Sharing <p><i>Preauthorization required on certain medications. Please see your Plan's Preferred Drug List.</i></p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p>



Cost-Sharing	Essential Plan 4
Professional Services and Outpatient Care (continued)	
<p>Diagnostic Radiology Services</p> <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services 	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p>
<p>Therapeutic Radiology Services</p> <ul style="list-style-type: none"> • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services <p><i>Preauthorization required</i></p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>
<p>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p> <p>(60 visits per condition; per Plan Year combined therapies)</p> <p>Speech and physical therapy are only covered following a hospital stay or surgery</p>	<p>\$0</p>
<p>Second Opinions on the Diagnosis of Cancer, Surgery and Other</p>	<p>\$0</p>

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Cost-Sharing	Essential Plan 4
Professional Services and Outpatient Care (continued)	
<p>Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants)</p> <p>All transplants must be performed at designated Facilities</p> <ul style="list-style-type: none"> • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery <p><i>Preauthorization required</i></p>	<p>\$0</p> <p>\$0</p> <p>\$0</p> <p>\$0</p>
Additional Services, Equipment and Devices	
<p>ABA Treatment for Autism Spectrum Disorder</p> <p><i>Preauthorization required</i></p>	<p>\$0</p>
<p>Assistive Communication Devices for Autism Spectrum Disorder</p> <p><i>Preauthorization required</i></p>	<p>\$0</p>
<p>Diabetic Equipment, Supplies and Self-Management Education</p> <ul style="list-style-type: none"> • Diabetic Equipment, Supplies and Insulin (30-day supply); Up to a 90-day supply • Diabetic Education 	<p>\$0</p> <p>\$0</p>



Cost-Sharing	Essential Plan 4
Additional Services, Equipment and Devices (continued)	
Durable Medical Equipment and Braces <i>Preauthorization required</i>	\$0
External Hearing Aids (Single purchase – one every three (3) years)	\$0
Cochlear Implants (One (1) per ear per time Covered) <i>Preauthorization required</i>	\$0
Hospice Care <ul style="list-style-type: none"> • Inpatient • Outpatient 210 days per Plan Year Five (5) visits for family bereavement counseling	\$0 \$0
Medical Supplies <i>Preauthorization required</i>	\$0
Prosthetic Devices <ul style="list-style-type: none"> • External One (1) prosthetic device, per limb, per lifetime, and the cost of repair and replacement of the prosthetic devices and its parts • Internal <i>Preauthorization required</i>	\$0 Included as part of Inpatient Hospital Cost-sharing

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Cost-Sharing	Essential Plan 4
Inpatient Services and Facilities	
<p>Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)</p> <p><i>Preauthorization required. However, Preauthorization is not required for emergency admissions.</i></p>	\$0
<p>Observation Stay</p> <p>Copay waived if direct transfer from outpatient surgery setting to observation</p>	\$0
<p>Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)</p> <p>200 days per Plan Year</p> <p>Copay waived for each admission if directly transferred from hospital inpatient setting to skilled nursing facility</p> <p><i>Preauthorization required</i></p>	\$0
<p>Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)</p> <p>60 days per Plan Year combined therapies</p> <p><i>Preauthorization required</i></p>	\$0
<p>Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)</p> <p>60 per Plan Year combined therapies</p> <p><i>Preauthorization required</i></p>	\$0



Cost-Sharing	Essential Plan 4
Mental Health and Substance Use Disorder Services	
<p>Inpatient Mental Health Care including Residential Treatment (for a continuous confinement when in a Hospital)</p> <p><i>Preauthorization required.</i> <i>However, Preauthorization is not required for emergency admissions.</i></p>	\$0
<p>Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)</p> <ul style="list-style-type: none"> • Office Visits • All other outpatient services <p><i>Preauthorization required</i></p>	\$0 \$0 \$0
<p>Inpatient Substance Use Services (for a continuous confinement when in a Hospital)</p> <p><i>Preauthorization required.</i> <i>However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.</i></p>	\$0
<p>Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)</p> <p>Up to 20 visits per Plan Year may be used for family counseling</p> <p><i>Preauthorization required</i></p>	\$0

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Cost-Sharing	Essential Plan 4
<p style="text-align: center;">Prescription Drugs</p> <p style="text-align: center;">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.</p>	
<p>Retail Pharmacy 30-day supply</p> <p>Tier 1</p> <p>Tier 2</p> <p>Tier 3</p> <p>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.</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>
<p>Mail-Order Pharmacy Up to a 90-day supply</p> <p>Tier 1</p> <p>Tier 2</p> <p>Tier 3</p>	<p>See benefit for description</p> <p>See benefit for description</p> <p>See benefit for description</p>
<p>Non-Prescription Drugs</p>	<p>\$0</p>
<p>Enteral Formulas</p> <p>Tier 1</p> <p>Tier 2</p> <p>Tier 3</p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>
<p style="text-align: center;">Wellness Benefits</p>	
<p>Gym Reimbursement</p>	<p>Up to \$400 per plan year, \$200 per 6-month period after attending 50 visits in a 6-month period</p>



Cost-Sharing	Essential Plan 4
Dental and Vision Care	
<p>Dental Care</p> <ul style="list-style-type: none"> • Preventive Dental Care • Routine Dental Care • Major Dental (Endodontics, Periodontics, and Prosthodontics) <ul style="list-style-type: none"> – 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 <p><i>Orthodontics and major dental require Preauthorization</i></p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>
<p>Vision Care</p> <ul style="list-style-type: none"> • Exams • Lenses and Frames • Contact Lenses <p>One (1) exam per 24 months</p> <p>One (1) prescribed lenses and frames per Plan Year</p> <p><i>Contact lenses require Preauthorization</i></p>	<p>\$0</p> <p>\$0</p> <p>\$0</p>

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.