NY State of Health - Standard Gold Plan
Schedule of Benefits

COST-SHARING	Member Cost-Sharing Responsibility for Services from Participating Providers*
Deductible	
• Individual	$600
• Family	$1,200
Out-of-Pocket Limit	
• Individual	$4,000
• Family	$8,000

OFFICE VISITS	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits**
Primary Care Office Visits (or Home Visits)	$25 Copayment after Deductible	
Specialist Office Visits (or Home Visits)	$40 Copayment after Deductible	

PREVENTIVE CARE	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
• Well Child Visits and Immunizations*	Covered in full	
• Adult Annual Physical Examinations*	Covered in full	
• Adult Immunizations*	Covered in full	
Routine Gynecological Services/Well Woman Exams*	Covered in full	
• Mammography Screenings*	Covered in full	
• Sterilization Procedures for Women*	Covered in full	
• Vasectomy	$25 Copayment after Deductible (PCP) $40 Copayment after Deductible (Specialist)	
• 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	
• *Preventive services that are provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA are covered in full. Preventive services that are provided outside of these guidelines may be subject to cost-sharing.	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	

EMERGENCY CARE	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	$150 Copayment after Deductible (for services provided from both participating and non-participating providers)	
Non-Emergency Ambulance Services	$150 Copayment after Deductible **Preauthorization Required**	
Emergency Department Coinsurance waived if Hospital admission	$150 Copayment after Deductible (for services provided from both participating and non-participating providers)	
Urgent Care Center	$150 Copayment after Deductible **Preauthorization Required**	

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PROFESSIONAL SERVICES AND OUTPATIENT CARE	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting	$40 Copayment after Deductible	
Advanced Imaging Services • Performed as Outpatient Hospital Services	$40 Copayment after Deductible **Preauthorization Required**	
Allergy Testing & Treatment	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures) **Preauthorization Required**	
Ambulatory Surgical Center Facility Fee	$100 Copayment after Deductible **Preauthorization Required**	
Anesthesia Services (all settings)	Covered in Full **Preauthorization Required**	
Autologous Blood Banking	20% Coinsurance after Deductible **Preauthorization Required**	
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office	$25 Copayment after Deductible	
Cardiac & Pulmonary Rehabilitation • Performed as Outpatient Hospital Services	$25 Copayment after Deductible	
Cardiac & Pulmonary Rehabilitation • Performed as Inpatient Hospital Services	Included as part of Inpatient Hospital Service Cost Sharing **Preauthorization Required**	
Chemotherapy • Performed in a PCP Office	$25 Copayment after Deductible	
Chemotherapy • Performed in a Specialist Office	$25 Copayment after Deductible	
Chemotherapy • Performed as Outpatient Hospital Services	$25 Copayment after Deductible **Preauthorization Required**	
Chiropractic Services	$40 Copayment after Deductible **Preauthorization Required**	
Diagnostic Testing • Performed in a PCP Office	$25 Copayment after Deductible	
Diagnostic Testing • Performed in a Specialist office	$40 Copayment after Deductible	
Diagnostic Testing • Performed as Outpatient Hospital Services	$40 Copayment after Deductible **Preauthorization Required**	
Dialysis • Performed in a PCP Office	$25 Copayment after Deductible	Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Dialysis • Performed in a Freestanding Center or Specialist Office Setting	$25 Copayment after Deductible	
Dialysis • Performed as Outpatient Hospital Services	$25 Copayment after Deductible **Preauthorization Required**	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$30 Copayment after Deductible **Preauthorization Required**	60 visits per condition, per lifetime combined therapies
Home Health Care	$25 Copayment after Deductible **Preauthorization Required**	40 Visits per Plan Year
Infertility Services	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) **Preauthorization Required**	
Infusion Therapy • Performed in a PCP Office	$25 Copayment after Deductible	Home Infusion counts towards Home Health Care Visit Limits
Infusion Therapy • Performed in Specialist Office	$25 Copayment after Deductible	
Infusion Therapy • Performed as Outpatient Hospital Services	$25 Copayment after Deductible	
Infusion Therapy • Home Infusion Therapy	$25 Copayment after Deductible **Preauthorization Required**	
Inpatient Medical Visits	$0 Copayment after Deductible	

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PROFESSIONAL SERVICES AND OUTPATIENT CARE *(cont'd)*	**Member Cost-Sharing Responsibility for Services from Participating Providers**	**Limits**
Laboratory Procedures • Performed in a PCP Office	$25 Copayment after Deductible	
Laboratory Procedures • Performed in a Freestanding Laboratory Facility or Specialist Office	$40 Copayment after Deductible	
Laboratory Procedures • Performed as Outpatient Hospital Services	$40 Copayment after Deductible	
Maternity & Newborn Care • Prenatal Care	Covered in Full	
Maternity & Newborn Care • Inpatient Hospital Services and Birthing Center	$1,000 per admission after Deductible	1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
Maternity & Newborn Care •Physician and Nurse Midwife Services for Delivery	$100 Copayment after Deductible	
Maternity & Newborn Care • Breast Pump	Covered in Full **Preauthorization Required**	Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge	$100 Copayment after Deductible **Preauthorization Required**	
Preadmission Testing	$0 Copayment after Deductible **Preauthorization Required**	
Diagnostic Radiology Services • Performed in a PCP Office	$25 Copayment after Deductible	
Diagnostic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office	$40 Copayment after Deductible	
Diagnostic Radiology Services • Performed as Outpatient Hospital Services	$40 Copayment after Deductible **Preauthorization Required**	
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office	$25 Copayment after Deductible	
Therapeutic Radiology Services • Performed as Outpatient Hospital Services	$25 Copayment after Deductible **Preauthorization Required**	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$30 Copayment after Deductible **Preauthorization Required**	60 visits per condition, per lifetime combined therapies Speech and Physical Therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	$40 Copayment after Deductible	
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery	$100 Copayment after Deductible	
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Outpatient Hospital Surgery	$100 Copayment after Deductible	
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Surgery Performed at an Ambulatory Surgical Center	$100 Copayment after Deductible	
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Office Surgery	$40 Copayment after Deductible (Specialist) $25 Copayment after Deductible (PCP) **Preauthorization Required**	

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ADDITIONAL SERVICES, EQUIPMENT & DEVICES	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
ABA Treatment for Autism Spectrum Disorder	$25 Copayment after Deductible **Preauthorization Required**	680 Hours Per Plan Year
[Acupuncture]	[$25 Copayment after Deductible]	
Assistive Communication Devices for Autism Spectrum Disorder	$25 Copayment after Deductible	
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply)	$25 Copayment after Deductible	
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Education	$25 Copayment after Deductible **Preauthorization Required**	
Durable Medical Equipment & Braces	20% Coinsurance after Deductible **Preauthorization Required for Items Above $100**	
External Hearing Aids	20% Coinsurance after Deductible **Preauthorization Required**	Single Purchase Once Every 3 Years
Cochlear Implants	20% Coinsurance after Deductible **Preauthorization Required**	One Per Ear Per Time Covered
Hospice Care • Inpatient	$1,000 per admission after Deductible	210 Days per Plan Year 5 Visits for Family Bereavement Counseling
Hospice Care • Outpatient	$25 Copayment after Deductible	
Medical Supplies	50% Coinsurance after Deductible **Preauthorization Required for Items Above $100**	
Prosthetic Devices • External	20% Coinsurance after Deductible	One prosthetic device, per limb, per lifetime
Prosthetic Devices • Internal	20% Coinsurance after Deductible **Preauthorization Required**	Unlimited

INPATIENT SERVICES & FACILITIES	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	$1,000 per admission after Deductible **Preauthorization Required**. **However, Preauthorization is Not Required for Emergency Admissions.**	
Observation Stay	$150 Copayment after Deductible **Preauthorization Required**	
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	$1,000 per admission after Deductible **Preauthorization Required**	200 Days Per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	$1,000 per admission after Deductible **Preauthorization Required**	60 Consecutive Days Per Condition, Per Lifetime

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	$1,000 Copayment after Deductible **Preauthorization Required**. **However, Preauthorization is Not Required for Emergency Admissions.**	
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	$25 Copayment after Deductible	
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	$1,000 Copayment after Deductible **Preauthorization Required**. **However, Preauthorization is Not Required for Emergency Admissions.**	
Outpatient Substance Use Services	$25 Copayment after Deductible	Unlimited; Up to 20 Visits a Plan Year May Be Used For Family Counseling

PRESCRIPTION DRUGS	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits

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Retail Pharmacy 30 Day Supply Tier 1 Tier 2 Tier 3	 $10 Copayment not subect to Deductible $35 Copayment not subject to Deductible $70 Copayment not subject to Deductible	

WELLNESS BENEFITS	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Gym Reimbursement	Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse, not subject to Deductible	Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse

PEDIATRIC DENTAL &VISION CARE***	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Pediatric Dental Care • Preventive/Routine Dental Care	$25 Copayment after Deductible	One Dental Exam & Cleaning Per 6 Month Period
Pediatric Dental Care • Major Dental (Endodontics & Prosthodontics)	$25 Copayment after Deductible **Orthodontia & Major Dental Require Preauthorization**	
Pediatric Dental Care • Orthodontia	$25 Copayment after Deductible **Orthodontia & Major Dental Require Preauthorization**	
Pediatric Vision Care • Exams	$25 Copayment after Deductible	One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12 Month Period
Pediatric Vision Care • Lenses & Frames	20% Coinsurance after Deductible	
Pediatric Vision Care • Contact Lenses	20% Coinsurance after Deductible **Contact Lenses Require Preauthorization**	
**NOTE: Unless otherwise noted, non-participating provider services are not covered and you pay the full cost*		
***NOTE: Additional limits may apply. Complete benefit descriptions are available from insurers upon effectuation of coverage.*		
****NOTE: Not all Standard Plans offer Pediatric Dental Benefits. A Stand-Alone Dental Plan may need to be purchased to receive these benefits. Please refer to the plan details on our website to see if this is included or discuss further with a navigator, broker, or customer service representative.*		