Section XXV

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 1 Plus Dental and Vision
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.	$2,000
Office Visits	
Primary Care Office Visits (or Home Visits)	$15
Specialist Office Visits (or Home Visits)	$25
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 1 Plus Dental and Vision
Preventive Care *(continued)*	
Bone Density Testing*	Covered in full
Screening for Prostate Cancer	
• Performed in PCP Office	$15
• Performed in Specialist Office	$25
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
Emergency Care	
Pre-Hospital Emergency Medical Services (Ambulance Services)	$75
Non-Emergency Ambulance Services *Preauthorization required*	$75
Emergency Department Copayment/Coinsurance waived if Hospital admission	$75
Urgent Care Center	$25
Professional Services and Outpatient Care	
Advanced Imaging Services	
• Performed in a Freestanding Radiology Facility or Office Setting	$25
• Performed as Outpatient Hospital Services *Preauthorization required*	$25

Cost-Sharing	Essential Plan 1 Plus Dental and Vision
Professional Services and Outpatient Care *(continued)*	
Allergy Testing and Treatment	
• Performed in a PCP Office	$15
• Performed in a Specialist Office	$25
Ambulatory Surgical Center Facility Fee	$50
Anesthesia Services (all settings)	Covered in full
Autologous Blood Banking	5% coinsurance
Cardiac and Pulmonary Rehabilitation	
• Performed in a Specialist Office	$25
• Performed as Outpatient Hospital Services	$25
• Performed as Inpatient Hospital Services	Included as part of inpatient Hospital service cost-sharing
Chemotherapy	
• Performed in a PCP Office	$15
• Performed in a Specialist Office	$15
• Performed as Outpatient Hospital Services	$15
Chiropractic Services	$25
Clinical Trials *Preauthorization required*	Use Cost-Sharing for appropriate service
Diagnostic Testing	
• Performed in a PCP Office	$15
• Performed in a Specialist Office	$25
• Performed as Outpatient Hospital Services	$25

Cost-Sharing	Essential Plan 1 Plus Dental and Vision
Professional Services and Outpatient Care *(continued)*	
Dialysis	
• Performed in a PCP Office	$15
• Performed in a Freestanding Center or Specialist Office Setting	$15
• Performed as Outpatient Hospital Services	$15
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) 60 visits per condition, per lifetime combined therapies	$15
Home Health Care 40 visits Per Plan Year ***Preauthorization required***	$15
Infertility Services ***Preauthorization required***	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)
Infusion Therapy	
• Performed in a PCP Office	$15
• Performed in Specialist Office	$15
• Performed as Outpatient Hospital Services	$15
• Home Infusion Therapy (Home infusion counts toward home health care visit limits) ***Preauthorization required***	$15

Cost-Sharing	Essential Plan 1 Plus Dental and Vision
Professional Services and Outpatient Care *(continued)*	
Inpatient Medical Visits	$0 per admission
Laboratory Procedures	
• Performed in a PCP Office	$15
• Performed in a Freestanding Laboratory Facility or Specialist Office	$25
• Performed as Outpatient Hospital Services	$25
Maternity and Newborn Care	
• Prenatal Care	$0
• Inpatient Hospital Services and Birthing Center	$150 per admission
• Physician and Midwife Services for Delivery	$50
• Breast Pump	$0
• Postnatal Care	Included in Physician and Midwife Services for Delivery Cost-Sharing
Outpatient Hospital Surgery Facility Charge	$50
Preadmission Testing	$0
Diagnostic Radiology Services	
• Performed in a PCP Office	$15
• Performed in a Freestanding Radiology Facility or Specialist Office	$25
• Performed as Outpatient Hospital Services	$25

Cost-Sharing	Essential Plan 1 Plus Dental and Vision
Professional Services and Outpatient Care *(continued)*	
Therapeutic Radiology Services	
• Performed in a Freestanding Radiology Facility or Specialist Office	$15
• Performed as Outpatient Hospital Services	$15
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) (60 visits per condition, per lifetime; per Plan Year combined therapies)	$15
Second Opinions on the Diagnosis of Cancer, Surgery and Other	$25
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy) **All transplants must be performed at designated Facilities**	
• Inpatient Hospital Surgery	$50
• Outpatient Hospital Surgery	$50
• Surgery Performed at an Ambulatory Surgical Center	$50
• Office Surgery *Preauthorization required*	$15 (when performed at PCP office) $25 (when performed at specialist office

Cost-Sharing	Essential Plan 1 Plus Dental and Vision
Additional Services, Equipment and Devices	
ABA Treatment for Autism Spectrum Disorder *Preauthorization required*	$15
Assistive Communication Devices for Autism Spectrum Disorder *Preauthorization required*	$15
Diabetic Equipment, Supplies and Self-Management Education	
• Diabetic Equipment, Supplies and Insulin (30-day supply)	$15
• Diabetic Education	$15
Durable Medical Equipment and Braces *Preauthorization required*	5% cost-sharing
External Hearing Aids **(Single purchase — one every three (3) years)**	5% cost-sharing
Cochlear Implants **(One (1) per ear per time Covered)** *Preauthorization required*	5% cost-sharing
Hospice Care	
• Inpatient	$150
• Outpatient	$15
210 days per Plan Year	
Medical Supplies *Preauthorization required*	5% coinsurance

Cost-Sharing	Essential Plan 1 Plus Dental and Vision
Additional Services, Equipment and Devices *(continued)*	
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***	 5% coinsurance 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) ***Preauthorization required. However, Preauthorization is not required for emergency admissions.***	$150
Observation Stay Copay waived if direct transfer from outpatient surgery setting to observation	$75
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***	$150

Cost-Sharing	Essential Plan 1 Plus Dental and Vision
Inpatient Services and Facilities *(continued)*	
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) 60 consecutive days per condition, per lifetime ***Preauthorization required***	$150
Mental Health and Substance Use Disorder Services	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) ***Preauthorization required. However, Preauthorization is not required for emergency admissions.***	$150
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) ***Preauthorization required***	$15
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.***	$150
Outpatient Substance Use Services ***Preauthorization required***	$15

Cost-Sharing	Essential Plan 1 Plus Dental and Vision
Prescription Drugs	
Retail Pharmacy 30-day supply	
Tier 1	$6
Tier 2	$15
Tier 3	$30
Mail Order Pharmacy Up to a 90-day supply	
Tier 1	$15
Tier 2	$37.50
Tier 3	$75
Enteral Formulas	
Tier 1	$6
Tier 2	$15
Tier 3	$30
Wellness Benefits	
Gym Reimbursement	Up to $200 per plan year, $100 per 6-month period after attending 48 visits in a 6-month period.

Cost-Sharing	Essential Plan 1 Plus Dental and Vision
Dental and Vision Care	
Dental Care • Preventive Dental Care • Routine Dental Care • Major Dental (Endodontics, Periodontics, 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. ***Major dental, Restorative Services/Crowns and Orthodontic Services require Preauthorization***	 $15 $15 $15
Vision Care • Exams • Lenses and Frames • Contact Lenses One (1) exam per Plan Year One (1) prescribed lenses and frames per Plan Year ***Contact lenses require Preauthorization***	 $15 10% coinsurance 10% coinsurance

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.