

**SECTION XXVII**

**SCHEDULE OF BENEFITS  
Healthfirst Platinum Pro EPO  
Non-Standard**

<p><b>COST-SHARING</b></p> <p><b>Deductible</b></p> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul> <p><b>Out-of-Pocket Limit</b></p> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul> <p>Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a plan year basis.</p>	<p><b>Participating Provider Member Responsibility for Cost-Sharing</b></p> <p>None None</p> <p>\$2,000 \$4,000</p>	<p><b>Non-Participating Provider Member Responsibility for Cost-Sharing</b></p> <p>Non-Participating Provider services are not covered except as required for emergency care.</p>	
<p><b>OFFICE VISITS</b></p>	<p><b>Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Non-Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Limits</b></p>
<p>Primary Care Office Visits (or Home Visits)</p>	<p>\$20 Copayment</p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Specialist Office Visits (or Home Visits)</p>	<p>\$35 Copayment</p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>See benefit for description</p>

<b>PREVENTIVE CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<ul style="list-style-type: none"> <li>Well Child Visits and Immunizations*</li> </ul>	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
<ul style="list-style-type: none"> <li>Adult Annual Physical Examinations*</li> </ul>	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Adult Immunizations*</li> </ul>	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Routine Gynecological Services/Well Woman Exams*</li> </ul>	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer</li> </ul>	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Sterilization Procedures for Women*</li> </ul>	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Vasectomy</li> </ul>	\$35 Copayment	Non-Participating Provider services are not covered and You pay the full cost	

<ul style="list-style-type: none"> <li>• Bone Density Testing*</li> </ul>	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> <li>• Screening for Prostate Cancer</li> </ul>	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> <li>• All other preventive services required by USPSTF and HRSA.</li> </ul>	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> <li>• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.</li> </ul>	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	
<b>EMERGENCY CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Pre-Hospital Emergency Medical Services (Ambulance Services)	\$150 Copayment	\$150 Copayment	See benefit for description
Non-Emergency Ambulance Services	\$250 Copayment <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Emergency Department	\$250 Copayment	\$250 Copayment	See benefit for description
Copayment / Coinsurance waived if admitted to Hospital	Copayment / Coinsurance waived if admitted to Hospital  Health care forensic examinations performed under Public Health Law § 2805-i are not subject	Copayment / Coinsurance waived if admitted to Hospital  Health care forensic	

	to Cost-Sharing	examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	
Urgent Care Center	\$50 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
<b>PROFESSIONAL SERVICES and OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Acupuncture	\$35 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description 30 visits per Plan Year
Advanced Imaging Services <ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> <li>Performed in a Freestanding Radiology Facility</li> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$35 Copayment <b>Preauthorization Required</b></p> <p>\$35 Copayment <b>Preauthorization Required</b></p> <p>\$35 Copayment <b>Preauthorization Required</b></p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p>	See benefit for description
Allergy Testing and Treatment <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> </ul>	<p>\$20 Copayment</p> <p>\$35 Copayment</p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered</p>	See benefit for description

Ambulatory Surgical Center Facility Fee	\$200 Copayment <b>Preauthorization Required</b>	and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Anesthesia Services (all settings)	Covered in full <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Cardiac and Pulmonary Rehabilitation			See benefit for description
<ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> </ul>	\$35 Copayment <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul>	\$35 Copayment <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Performed as Inpatient Hospital Services</li> </ul>	Included as part of inpatient hospital service cost sharing <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	
Chemotherapy and Immunotherapy			See benefit for description
<ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul>	\$20 Copayment <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> </ul>	\$35 Copayment <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	

<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul>	\$35 Copayment <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	
Chiropractic Services	\$35 Copayment <b>Preauthorization Required</b>	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 (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures) <b>Preauthorization Required</b>	Use Cost-Sharing for appropriate service	See benefit for description
Diagnostic Testing <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul>	\$20 Copayment <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
	\$35 Copayment <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	
	\$35 Copayment <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	
Dialysis <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul>	\$20 Copayment <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description

<ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> <li>Performed in a Freestanding Center</li> <li>Performed as Outpatient Hospital Services</li> <li>Performed at Home</li> </ul>	<p>\$20 Copayment <b>Preauthorization Required</b></p> <p>\$20 Copayment <b>Preauthorization Required</b></p> <p>\$20 Copayment <b>Preauthorization Required</b></p> <p>\$20 Copayment <b>Preauthorization Required</b></p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>Dialysis performed by Non-Participating Providers is limited to 10 visits per Plan year</p> <p>Cost-Sharing for the visits is the same as for a Participating Provider. See benefit description for more information.</p>
<p>Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p>	<p>\$35 Copayment <b>Preauthorization Required</b></p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>60 visits per condition, per plan year combined therapies</p>
<p>Home Health Care</p>	<p>\$20 Copayment <b>Preauthorization Required</b></p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>40 visits per Plan Year</p>
<p>Infertility Services</p>	<p>Use Cost Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory &amp; Diagnostic Procedures)</p> <p><b>Preauthorization Required</b></p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>See benefit for description</p>

<p>Infusion Therapy</p> <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> <li>• Performed in Specialist Office</li> <li>• Performed as Outpatient Hospital Services</li> <li>• Home Infusion Therapy</li> </ul>	<p>\$20 Copayment <b>Preauthorization Required</b></p> <p>\$20 Copayment <b>Preauthorization Required</b></p> <p>\$20 Copayment <b>Preauthorization Required</b></p> <p>\$20 Copayment <b>Preauthorization Required</b></p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>See benefit for description</p> <p>Home infusion counts toward home health care visit limits</p>
<p>Inpatient Medical Visits</p>	<p>Covered in Full</p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Interruption of Pregnancy</p> <ul style="list-style-type: none"> <li>• Medically Necessary Abortions</li> <li>• Elective Abortions <ul style="list-style-type: none"> <li>• Inpatient Hospital Surgery</li> </ul> </li> </ul>	<p>Covered in full</p> <p>\$100 Copayment</p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>Unlimited</p> <p>One (1) procedure per Plan Year</p>



<ul style="list-style-type: none"> <li>• Outpatient Hospital Surgery</li> <li>• Surgery Performed at an Ambulatory Surgical Center</li> <li>• Office Surgery</li> </ul>	<p>\$100 Copayment</p> <p>\$100 Copayment</p> <p>\$20 Copayment after Deductible when performed by PCP \$35 Copayment after Deductible when performed by Specialist</p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p>	
<p>Laboratory Procedures</p> <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> <li>• Performed in a Specialist Office</li> <li>• Performed in a Freestanding Laboratory Facility</li> <li>• Performed as Outpatient Hospital Services</li> </ul>	<p>\$20 Copayment <b>Preauthorization Required</b></p> <p>\$35 Copayment <b>Preauthorization Required</b></p> <p>\$35 Copayment <b>Preauthorization Required</b></p> <p>\$35 Copayment <b>Preauthorization Required</b></p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>See benefit for description</p>

<p>Maternity and Newborn Care</p> <ul style="list-style-type: none"> <li>• Prenatal Care <ul style="list-style-type: none"> <li>• Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> <li>• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> </ul> </li> <li>• Inpatient Hospital Services and Birthing Center</li> <li>• Physician Midwife Services for Delivery</li> <li>• Breast Feeding Support, Counseling and Supplies, Including Breast Pumps</li> <li>• Postnatal Care</li> </ul>	<p>Covered in full</p> <p>Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)</p> <p>\$500 Copayment per admission <b>Preauthorization Required</b></p> <p>\$100 Copayment</p> <p>Covered in full <b>Preauthorization Required</b></p> <p>Covered in full</p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>See benefit for description</p> <p>One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early</p> <p>Covered for duration of breast feeding</p>
--	--	---	---

Outpatient Hospital Surgery Facility Charge	\$200 Copayment <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Preadmission Testing	Covered in Full	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Prescription Drugs Administered in Office			See benefit for description
<ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> </ul>	<p>Included as part of the PCP office visit Cost Sharing <b>Preauthorization Required</b></p> <p>Included as part of the Specialist office visit Cost Sharing <b>Preauthorization Required</b></p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p>	
Diagnostic Radiology Services			See benefit for description
<ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed in a Freestanding Radiology Facility</li> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$20 Copayment <b>Preauthorization Required</b></p> <p>\$35 Copayment <b>Preauthorization Required</b></p> <p>\$35 Copayment <b>Preauthorization Required</b></p> <p>\$35 Copayment <b>Preauthorization Required</b></p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p>	

<p>Therapeutic Radiology Services</p> <ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> <li>Performed in a Freestanding Radiology Facility</li> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$20 Copayment <b>Preauthorization Required</b></p> <p>\$35 Copayment <b>Preauthorization Required</b></p> <p>\$35 Copayment <b>Preauthorization Required</b></p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p>	<p>\$35 Copayment <b>Preauthorization Required</b></p>	<p>Non-Participating Provider services are not covered and You pay the full cost</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>Retail Health Clinic Care</p>	<p>\$20 Copayment</p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Second Opinions on the Diagnosis of Cancer, Surgery and Other</p>	<p>\$35 Copayment</p>	<p>Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist.</p>	<p>See benefit for description</p>

<p>Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants)</p> <ul style="list-style-type: none"> <li>• Inpatient Hospital Surgery</li> <li>• Outpatient Hospital Surgery</li> <li>• Surgery Performed at an Ambulatory Surgical Center</li> <li>• Office Surgery</li> </ul>	<p>\$100 Copayment <b>Preauthorization Required</b></p> <p>\$100 Copayment <b>Preauthorization Required</b></p> <p>\$100 Copayment <b>Preauthorization Required</b></p> <p>\$20 Copayment in PCP office; \$35 Copayment in Specialist office <b>Preauthorization Required</b></p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>See benefit for description</p> <p>All transplants must be performed at designated Facilities</p>
<p>Telemedicine Program</p>	<p>\$0 Copayment</p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>No Limit</p>
<p><b>ADDITIONAL SERVICES, EQUIPMENT and DEVICES</b></p>	<p><b>Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Non-Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Limits</b></p>
<p>ABA Treatment for Autism Spectrum Disorder</p>	<p>\$20 Copayment <b>Preauthorization Required</b></p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>See benefit for description</p>

Assistive Communication Devices for Autism Spectrum Disorder	\$20 Copayment <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education			See benefit for description
<ul style="list-style-type: none"> <li>Diabetic Equipment, Supplies and Insulin (30-day; Up to a 90-day supply)</li> </ul>	\$20 Copayment. Diabetic insulin cost-sharing is no more than \$100 (including before deductible based on the plan) for a 30-day supply. <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	See Prescription Drug benefit
<ul style="list-style-type: none"> <li>Diabetic Education</li> </ul>	\$20 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
Durable Medical Equipment and Braces	10% Coinsurance <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
External Hearing Aids	10% Coinsurance <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	Single purchase once every three (3) years
Cochlear Implants	10% Coinsurance <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	One (1) per Ear per time Covered
Hospice Care			
<ul style="list-style-type: none"> <li>Inpatient</li> </ul>	\$500 Copayment per admission <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	210 days per Plan Year Five (5) visits for family bereavement counseling

<ul style="list-style-type: none"> <li>Outpatient</li> </ul>	\$20 Copayment <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	
Medical Supplies	10% Coinsurance <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Prosthetic Devices  <ul style="list-style-type: none"> <li>External</li> <li>Internal</li> </ul>	10% Coinsurance <b>Preauthorization Required</b>  10% Coinsurance <b>Preauthorization Required</b>	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
<b>INPATIENT SERVICES and FACILITIES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Autologous Blood Banking Services	10% Coinsurance	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and	\$500 Copayment per admission <b>Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions or services provided</b>	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description

Pulmonary Rehabilitation, and End of Life Care)	<b>in a neonatal intensive care unit of a Hospital certified pursuant to Article 28 of the Public Health Law.</b>		
Observation Stay	\$250 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)	\$500 Copayment per admission <b>Preauthorization Required</b>	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 Therapy)	\$500 Copayment per admission <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	60 days per Plan Year
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	\$500 Copayment per admission <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	60 days per Plan Year combined therapies.  Speech and physical therapy are only Covered following a Hospital stay or surgery.
<b>MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment)	\$500 Copayment per admission <b>Preauthorization Required</b> <b>However, Preauthorization is Not Required for Emergency Admissions or for admissions at</b>	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description



	<b>Participating OMH-licensed Facilities for Members under 18.</b>		
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	\$20 Copayment <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)	\$500 Copayment per admission <b>Preauthorization Required</b> <b>However, Preauthorization is Not Required for Emergency Admissions or for Participating OASAS-certified Facilities.</b>	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)	\$20 Copayment <b>Preauthorization Required</b> <b>However, Preauthorization is not required for Participating OASAS-certified Facilities</b>	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
<b>PRESCRIPTION DRUGS</b> *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.	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<b>Retail Pharmacy</b>			
30-day supply			See benefit for description
Tier 1	\$10 Copayment	Non-Participating Provider services are not covered	

Tier 2	\$30 Copayment	and You pay the full cost  Non-Participating Provider services are not covered and You pay the full cost	
Tier 3	\$60 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
<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>The Deductible does not apply to certain Prescription Drugs. Visit Our website at <a href="http://Healthfirst.org">Healthfirst.org</a> to review Our formulary or call the number on Your ID card to learn more.</p>	
Up to a 90-day supply for Maintenance Drugs			See benefit for description
Tier 1	\$30 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
Tier 2	\$90 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
Tier 3	\$180 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
		<p>The Deductible does not apply to certain Prescription Drugs. Visit Our website at <a href="http://Healthfirst.org">Healthfirst.org</a> to review Our formulary or call the number on Your ID card to learn more.</p>	

<b>Mail Order Pharmacy</b>			
Up to a 90-day supply			See benefit for description
Tier 1	\$20 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
Tier 2	\$60 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
Tier 3	\$120 Copayment  The Deductible does not apply to certain Prescription Drugs. Visit Our website at Healthfirst.org to review Our formulary or call the number on Your ID card to learn more.	Non-Participating Provider services are not covered and You pay the full cost	
Enteral Formulas	10% Coinsurance <b>Preauthorization Required</b>	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
<b>WELLNESS BENEFITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	
Gym Reimbursement	Up to \$200 per six (6) month period; up to an additional \$100 per six (6) month period for Spouse	Non-Participating Provider services are not covered and You pay the full cost	Up to \$200 per six (6) month period; up to an additional \$100 per six (6) month period for Spouse
<b>PEDIATRIC DENTAL and VISION CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>

<p><b>Pediatric Dental Care</b></p> <ul style="list-style-type: none"> <li>• Preventive Dental Care</li> <li>• Routine Dental Care</li> <li>• Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics)</li> <li>• Orthodontics</li> </ul>	<p>\$20 Copayment</p> <p>\$20 Copayment</p> <p>10% Coinsurance <b>Preauthorization Required</b></p> <p>10% Coinsurance <b>Preauthorization Required</b></p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>One (1) dental exam and cleaning per six (6) month period</p> <p>Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 month intervals</p>
<p><b>Pediatric Vision Care</b></p> <ul style="list-style-type: none"> <li>• Exams</li> <li>• Lenses</li> <li>• Frames</li> <li>• Standard Contact Lenses</li> </ul>	<p>\$10 Copayment</p> <p>\$25 Copayment</p> <p>\$25 Copayment</p> <p>\$25 Copayment</p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p> <p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>One (1) exam per 12-month period</p> <p>One (1) prescribed lenses and frames per 12-month period</p> <p>Allowance of up to \$130 towards glasses or contact lenses</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.*