

SECTION XXVII

**SCHEDULE OF BENEFITS
Healthfirst Gold Pro Plus EPO
Non-Standard**

<p>COST-SHARING</p> <p>Deductible</p> <ul style="list-style-type: none"> • Individual • Family <p>Out-of-Pocket Limit</p> <ul style="list-style-type: none"> • Individual • Family <p>Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a plan year basis.</p>	<p>Participating Provider Member Responsibility for Cost-Sharing</p> <p>\$0 \$0</p> <p>\$5,275 \$10,550</p>	<p>Non-Participating Provider Member Responsibility for Cost-Sharing</p> <p>Non-Participating Provider services are not covered except as required for emergency care.</p>	
<p>OFFICE VISITS</p>	<p>Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Non-Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Limits</p>
<p>Primary Care Office Visits (or Home Visits)</p>	<p>\$25 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>\$40 Copayment</p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>See benefit for description</p>

PREVENTIVE CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<ul style="list-style-type: none"> <li data-bbox="193 367 604 427">• Well Child Visits and Immunizations* <li data-bbox="193 532 604 592">• Adult Annual Physical Examinations* <li data-bbox="193 698 604 727">• Adult Immunizations* <li data-bbox="193 873 604 971">• Routine Gynecological Services/Well Woman Exams* <li data-bbox="193 1076 604 1206">• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer <li data-bbox="193 1312 604 1372">• Sterilization Procedures for Women* 	<p data-bbox="625 367 1268 396">Covered in full</p> <p data-bbox="625 532 1268 561">Covered in full</p> <p data-bbox="625 711 1268 740">Covered in full</p> <p data-bbox="625 881 1268 911">Covered in full</p> <p data-bbox="625 1076 1268 1105">Covered in full</p> <p data-bbox="625 1312 1268 1341">Covered in full</p>	<p data-bbox="1278 367 1682 459">Non-Participating Provider services are not covered and You pay the full cost</p> <p data-bbox="1278 532 1682 625">Non-Participating Provider services are not covered and You pay the full cost</p> <p data-bbox="1278 698 1682 790">Non-Participating Provider services are not covered and You pay the full cost</p> <p data-bbox="1278 865 1682 958">Non-Participating Provider services are not covered and You pay the full cost</p> <p data-bbox="1278 1068 1682 1161">Non-Participating Provider services are not covered and You pay the full cost</p> <p data-bbox="1278 1304 1682 1396">Non-Participating Provider services are not covered and You pay the full cost</p>	<p data-bbox="1692 367 1917 427">See benefit for description</p>

<ul style="list-style-type: none"> • Vasectomy 	\$40 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> • Bone Density Testing* 	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> • Screening for Prostate Cancer 	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> • All other preventive services required by USPSTF and HRSA. 	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> • *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)	Non-Participating Provider services are not covered and You pay the full cost	
EMERGENCY CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	\$150 Copayment	\$150 Copayment	See benefit for description
Non-Emergency Ambulance Services	\$350 Copayment Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description

Emergency Department	\$350 Copayment Copayment / Coinsurance waived if admitted to Hospital Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	\$350 Copayment Copayment / Coinsurance waived if admitted to Hospital Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	See benefit for description
Urgent Care Center	\$60 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
PROFESSIONAL SERVICES and OUTPATIENT CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Acupuncture	\$40 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 • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services	\$40 Copayment Preauthorization Required \$40 Copayment Preauthorization Required \$40 Copayment Preauthorization Required	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 Non-Participating Provider services are not covered and You pay the full cost	See benefit for description

<p>Allergy Testing and Treatment</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office 	<p>\$25 Copayment</p> <p>\$40 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>See benefit for description</p>
<p>Ambulatory Surgical Center Facility Fee</p>	<p>\$300 Copayment</p> <p>Preauthorization Required</p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Anesthesia Services (all settings)</p>	<p>Covered in full</p> <p>Preauthorization Required</p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Cardiac and Pulmonary Rehabilitation</p> <ul style="list-style-type: none"> Performed in a Specialist Office Performed as Outpatient Hospital Services Performed as Inpatient Hospital Services 	<p>\$40 Copayment</p> <p>Preauthorization Required</p> <p>\$40 Copayment</p> <p>Preauthorization Required</p> <p>Included as part of inpatient hospital cost sharing</p> <p>Preauthorization Required</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>Chemotherapy and Immunotherapy</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services 	<p>\$25 Copayment Preauthorization Required</p> <p>\$40 Copayment Preauthorization Required</p> <p>\$40 Copayment Preauthorization Required</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>Chiropractic Services</p>	<p>\$40 Copayment Preauthorization Required</p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Clinical Trials</p>	<p>Use Cost Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory & Diagnostic Procedures) Preauthorization Required</p>	<p>Use Cost-Sharing for appropriate service</p>	<p>See benefit for description</p>
<p>Diagnostic Testing</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services 	<p>\$25 Copayment Preauthorization Required</p> <p>\$40 Copayment Preauthorization Required</p> <p>\$40 Copayment Preauthorization Required</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>Dialysis</p> <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Center • Performed as Outpatient Hospital Services • Performed at Home 	<p>\$25 Copayment Preauthorization Required</p> <p>\$25 Copayment Preauthorization Required</p> <p>\$25 Copayment Preauthorization Required</p> <p>\$25 Copayment Preauthorization Required</p> <p>\$25 Copayment Preauthorization Required</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>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>\$40 Copayment Preauthorization Required</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>\$25 Copayment Preauthorization Required</p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>40 visits per Plan Year</p>

Infertility Services	Use Cost Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Infusion Therapy <ul style="list-style-type: none"> Performed in a PCP Office Performed in Specialist Office Performed as Outpatient Hospital Services Home Infusion Therapy 	\$25 Copayment Preauthorization Required \$25 Copayment Preauthorization Required \$25 Copayment Preauthorization Required \$25 Copayment Preauthorization Required	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 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	See benefit for description Home infusion counts toward home health care visit limits
Inpatient Medical Visits	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Interruption of Pregnancy <ul style="list-style-type: none"> Medically Necessary Abortions Elective Abortions 	Covered in full 	Non-Participating Provider services are not covered and You pay the full cost	Unlimited One (1)

<ul style="list-style-type: none"> • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery 	<p>\$100 Copayment</p> <p>\$100 Copayment</p> <p>\$100 Copayment</p> <p>\$25 Copayment after Deductible when performed by PCP \$40 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>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>procedure per Plan Year</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 	<p>\$25 Copayment Preauthorization Required</p> <p>\$40 Copayment Preauthorization Required</p> <p>\$40 Copayment Preauthorization Required</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>

<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	<p>\$40 Copayment Preauthorization Required</p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p>	
<p>Maternity and Newborn Care</p>			
<ul style="list-style-type: none"> Prenatal Care <ul style="list-style-type: none"> Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA 	<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>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>
<ul style="list-style-type: none"> Inpatient Hospital Services and Birthing Center 	<p>\$500 Copayment per admission Preauthorization Required</p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early</p>
<ul style="list-style-type: none"> Physician Midwife Services for Delivery 	<p>\$100 Copayment</p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p>	
<ul style="list-style-type: none"> Breast Feeding Support, Counseling and Supplies, Including Breast Pumps 	<p>Covered in full Preauthorization Required</p>	<p>Non-Participating Provider services are not covered and You pay the full cost</p>	<p>Covered for duration of breast feeding</p>

<ul style="list-style-type: none"> • Postnatal Care 	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
Outpatient Hospital Surgery Facility Charge	\$300 Copayment Preauthorization Required	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			
<ul style="list-style-type: none"> • Performed in a PCP Office 	Included as part of the PCP office visit Cost Sharing Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> • Performed in a Specialist Office 	Included as part of the Specialist office visit Cost Sharing Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	
Diagnostic Radiology Services			See benefit for description
<ul style="list-style-type: none"> • Performed in a PCP Office 	\$25 Copayment Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> • Performed in a Specialist Office 	\$40 Copayment Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> • Performed in a Freestanding Radiology 	\$40 Copayment Preauthorization Required	Non-Participating Provider services are not covered and	

<p>Facility</p> <ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	<p>\$40 Copayment Preauthorization Required</p>	<p>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"> Performed in a Specialist Office Performed in a Freestanding Radiology Facility Performed as Outpatient Hospital Services 	<p>\$25 Copayment Preauthorization Required</p> <p>\$25 Copayment Preauthorization Required</p> <p>\$25 Copayment Preauthorization Required</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>\$40 Copayment Preauthorization Required</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</p>

			surgery
Retail Health Clinic Care	\$25 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
Second Opinions on the Diagnosis of Cancer, Surgery and Other	\$40 Copayment	Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained.	See benefit for description
<p>Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants)</p> <ul style="list-style-type: none"> • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center 	<p>\$100 Copayment Preauthorization Required</p> <p>\$100 Copayment Preauthorization Required</p> <p>\$100 Copayment Preauthorization Required</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>

<ul style="list-style-type: none"> Office Surgery 	\$25 Copayment in PCP office \$40 Copayment in Specialist office Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	
Telemedicine Program	\$0 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder	\$25 Copayment Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	\$25 Copayment Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education <ul style="list-style-type: none"> Diabetic Equipment, Supplies and Insulin (30-day; Up to a 90-day supply) Diabetic Education 	\$25 Copayment. Diabetic insulin cost-sharing is no more than \$100 (including before deductible based on the plan) for a 30-day supply. Preauthorization Required \$25 Copayment	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	See benefit for description See Prescription Drug benefit

Durable Medical Equipment and Braces	15% Coinsurance Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
External Hearing Aids	15% Coinsurance Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	Single purchase once every three (3) years
Cochlear Implants	15% Coinsurance Preauthorization Required	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"> • Inpatient • Outpatient 	<p>\$500 Copayment per admission Preauthorization Required</p> <p>\$25 Copayment Preauthorization Required</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>210 days per Plan Year</p> <p>Five (5) visits for family bereavement counseling</p>
Medical Supplies	15% Coinsurance Preauthorization Required	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"> • External • Internal 	<p>15% Coinsurance Preauthorization Required</p> <p>15% Coinsurance Preauthorization Required</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) prosthetic device, per limb, per lifetime with coverage for repairs and replacements.</p>

			Unlimited; See benefit for description
INPATIENT SERVICES and FACILITIES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Autologous Blood Banking Services	15% 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 Pulmonary Rehabilitation, and End of Life Care)	\$500 Copayment per admission Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions or services provided in a neonatal intensive care unit of a Hospital certified pursuant to Article 28 of the Public Health Law.	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Observation Stay	\$300 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 Preauthorization Required	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 Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	60 days per Plan Year combined therapies
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	\$500 Copayment per admission Preauthorization Required	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.
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Mental Health Care including Residential Treatment (for a continuous confinement when in a Hospital) including Residential Treatment	\$500 Copayment per admission Preauthorization Required However, Preauthorization is Not Required for Emergency Admission or for admissions at Participating OMH-licensed Facilities for Members under 18.	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	\$25 Copayment Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Inpatient Substance Use Services including Residential Treatment (for a continuous confinement when in a Hospital) including Residential Treatment	\$500 Copayment per admission Preauthorization Required However, Preauthorization is Not Required for Emergency Admission or for Participating OASAS-certified Facilities.	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) However, Preauthorization is not required for Participating	\$25 Copayment	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

OASAS-certified Facilities			
<p>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.</p>	<p>Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Non-Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Limits</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>\$10 Copayment</p> <p>\$50 Copayment</p> <p>\$85 Copayment</p> <p>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.</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>Up to a 90-day supply for Maintenance Drugs</p> <p>Tier 1</p>	<p>\$30 Copayment</p>	<p>Non-Participating Provider</p>	<p>See benefit for description</p>

Tier 2	\$150 Copayment	services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	
Tier 3	\$255 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	
Mail Order Pharmacy			
Up to a 90-day supply			
Tier 1	\$20 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Tier 2	\$100 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
Tier 3	\$170 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	15% Coinsurance Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description

WELLNESS BENEFITS	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
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
PEDIATRIC DENTAL and VISION CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care <ul style="list-style-type: none"> • Preventive Dental Care • Routine Dental Care • Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics) • Orthodontics 	<p>\$25 Copayment</p> <p>\$25 Copayment</p> <p>15% Coinsurance Preauthorization Required</p> <p>15% Coinsurance Preauthorization Required</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 six (6) month intervals</p>
Pediatric Vision Care <ul style="list-style-type: none"> • Exams 	\$10 Copayment	Non-Participating Provider services are not covered and You pay the full cost	One (1) exam per 12-month period

<ul style="list-style-type: none"> Lenses 	\$25 Copayment	Non-Participating Provider services are not covered and You pay the full cost	One (1) prescribed lenses and frames per 12-month period
<ul style="list-style-type: none"> Frames 	\$25 Copayment	Non-Participating Provider services are not covered and You pay the full cost	Allowance of up to \$130 towards glasses or contact lenses
<ul style="list-style-type: none"> Standard Contact Lenses 	\$25 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
DENTAL and VISION CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Adult Dental Care			
<ul style="list-style-type: none"> Preventive Dental Care 	\$25 Copayment	Non-Participating Provider services are not covered and You pay the full cost	One (1) dental exam and cleaning per six (6) month period
<ul style="list-style-type: none"> Routine Dental Care 	\$25 Copayment	Non-Participating Provider services are not covered and You pay the full cost	Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at six (6) month intervals
<ul style="list-style-type: none"> Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics) 	15% Coinsurance Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> Orthodontics 	15% Coinsurance Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	
Adult Vision Care			
<ul style="list-style-type: none"> Exams 	\$10 Copayment	Non-Participating Provider	One (1) exam

		services are not covered and You pay the full cost	per 12-month period
• Lenses	\$25 Copayment	Non-Participating Provider services are not covered and You pay the full cost	One (1) prescribed lenses and frames per 12- month period
• Frames	\$25 Copayment	Non-Participating Provider services are not covered and You pay the full cost	Allowance of up to \$130 towards glasses or contact lenses
• Standard Contact Lenses	\$25 Copayment	Non-Participating Provider services are not covered and You pay the full cost	

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.