

SECTION XXVII

**SCHEDULE OF BENEFITS
Healthfirst Bronze 6850 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>\$6,850 \$13,700</p> <p>\$6,850 \$13,700</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>0% Coinsurance after Deductible</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>0% Coinsurance after Deductible</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"> Well Child Visits and Immunizations* 	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"> Adult Annual Physical Examinations* 	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> Adult Immunizations* 	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> Routine Gynecological Services/Well Woman Exams* 	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer 	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> Sterilization Procedures for Women* 	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> Vasectomy 	0% Coinsurance after Deductible	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)	0% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Non-Emergency Ambulance Services	0% Coinsurance after Deductible Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Emergency Department	0% Coinsurance after Deductible Copayment / Coinsurance waived if admitted to Hospital Health care forensic examinations performed	0% Coinsurance after Deductible Copayment / Coinsurance waived if admitted to Hospital	See benefit for description

	under Public Health Law § 2805-i are not subject to Cost-Sharing	Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	
Urgent Care Center	0% Coinsurance after Deductible	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	0% Coinsurance after Deductible	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"> Performed in a Specialist Office Performed in a Freestanding Radiology Facility Performed as Outpatient Hospital Services 	0% Coinsurance after Deductible Preauthorization Required 0% Coinsurance after Deductible Preauthorization Required 0% Coinsurance after Deductible 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
Allergy Testing and Treatment <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office 	0% Coinsurance after Deductible 0% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered	See benefit for description

		and You pay the full cost	
Ambulatory Surgical Center Facility Fee	0% Coinsurance after Deductible Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Anesthesia Services (all settings)	0% Coinsurance after Deductible Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Cardiac and Pulmonary Rehabilitation			See benefits for description
<ul style="list-style-type: none"> Performed in a Specialist Office 	0% Coinsurance after Deductible Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	0% Coinsurance after Deductible Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> Performed as Inpatient Hospital Services 	Included as part of inpatient Hospital Cost Sharing Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	
Chemotherapy			See benefit for description
<ul style="list-style-type: none"> Performed in a PCP Office 	0% Coinsurance after Deductible 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 	0% Coinsurance after Deductible Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	

<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	0% Coinsurance after Deductible Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	
Chiropractic Services	0% Coinsurance after Deductible Preauthorization Required	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) Preauthorization Required	Use Cost-Sharing for appropriate service	See benefit for description
Diagnostic Testing <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services 	0% Coinsurance after Deductible Preauthorization Required 0% Coinsurance after Deductible Preauthorization Required 0% Coinsurance after Deductible 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
Dialysis <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office 	0% Coinsurance after Deductible Preauthorization Required 0% Coinsurance after Deductible 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	See benefit for description Dialysis performed by Non-Participating Providers is limited to 10

<ul style="list-style-type: none"> Performed in a Freestanding Center Performed as Outpatient Hospital Services Performed at Home 	<p>0% Coinsurance after Deductible Preauthorization Required</p> <p>0% Coinsurance after Deductible Preauthorization Required</p> <p>0% Coinsurance after Deductible 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>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>0% Coinsurance after Deductible 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>0% Coinsurance after Deductible 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>
<p>Infertility Services</p>	<p>Use Cost Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) 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>Infusion Therapy</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in Specialist Office 	<p>0% Coinsurance after Deductible Preauthorization Required</p> <p>0% Coinsurance after Deductible 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>See benefit for description</p>

<ul style="list-style-type: none"> Performed as Outpatient Hospital Services Home Infusion Therapy 	<p>0% Coinsurance after Deductible Preauthorization Required</p> <p>0% Coinsurance after Deductible 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>Home infusion counts toward Home Health Care visit limits</p>
<p>Inpatient Medical Visits</p>	<p>0% Coinsurance after Deductible</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"> Medically Necessary Abortions Elective Abortions 	<p>Covered in full</p> <p>0% Coinsurance after Deductible</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>
<p>Laboratory Procedures</p> <ul style="list-style-type: none"> Performed in a PCP Office 	<p>0% Coinsurance after Deductible Preauthorization Required</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 in a Specialist Office Performed in a Freestanding Laboratory Facility Performed as Outpatient Hospital Services 	<p>0% Coinsurance after Deductible Preauthorization Required</p> <p>0% Coinsurance after Deductible Preauthorization Required</p> <p>0% Coinsurance after Deductible 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>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 Inpatient Hospital Services and Birthing Center 	<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>0% Coinsurance after Deductible per Admission 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>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 Breast Feeding Support, Counseling and Supplies, Including Breast Pumps Postnatal Care 	<p>0% Coinsurance after Deductible</p> <p>Covered in full Preauthorization Required</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>Covered for duration of breast feeding</p>
Outpatient Hospital Surgery Facility Charge	0% Coinsurance after Deductible Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Preadmission Testing	0% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
<p>Prescription Drugs Administered in Office</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office 	<p>Included as part of the PCP office visit Cost Sharing Preauthorization Required</p> <p>Included as part of the Specialist office visit Cost Sharing 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>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% Coinsurance after Deductible Preauthorization Required</p> <p>0% Coinsurance after Deductible Preauthorization Required</p> <p>0% Coinsurance after Deductible Preauthorization Required</p> <p>0% Coinsurance after Deductible 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>See benefit for description</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>0% Coinsurance after Deductible Preauthorization Required</p> <p>0% Coinsurance after Deductible Preauthorization Required</p> <p>0% Coinsurance after Deductible 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>0% Coinsurance after Deductible 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>

			Speech and physical therapy are only Covered following a Hospital stay or surgery
Retail Health Clinic Care	0% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	
Second Opinions on the Diagnosis of Cancer, Surgery and Other	0% Coinsurance after Deductible	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>0% Coinsurance after Deductible Preauthorization Required</p> <p>0% Coinsurance after Deductible Preauthorization Required</p> <p>0% Coinsurance after Deductible 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 	0% Coinsurance after Deductible Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	
Telemedicine Program	\$0 Copayment after Deductible	Non-Participating Provider services are not covered and You pay the full cost	No Limit
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	0% Coinsurance after Deductible 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	0% Coinsurance after Deductible 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			See benefit for description
<ul style="list-style-type: none"> Diabetic Equipment, Supplies and Insulin (30-day; Up to a 90-day supply) 	0% Coinsurance after Deductible. Diabetic insulin cost-sharing is no more than \$100 (including before deductible based on the plan) for a 30-day supply. Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	See Prescription Drug benefit
<ul style="list-style-type: none"> Diabetic Education 	0% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	
Durable Medical Equipment and Braces	0% Coinsurance after Deductible Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description

External Hearing Aids	0% Coinsurance after Deductible Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	Single purchase once every three (3) years
Cochlear Implants	0% Coin surance after Deductible 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 	0% Coinsurance after Deductible Preauthorization Required 0% Coinsurance after Deductible 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	210 days per Plan Year Five (5) visits for family bereavement counseling
Medical Supplies	0% Coinsurance after Deductible 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 	0% Coinsurance after Deductible Preauthorization Required 0% Coinsurance after Deductible 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	One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements. 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	0% Coinsurance after Deductible Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	See benefits for description
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	0% Coinsurance after Deductible per admission Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions 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	0% Coinsurance after Deductible	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)	0% Coinsurance after Deductible 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)	0% Coinsurance after Deductible 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)	0% Coinsurance after Deductible per admission Preauthorization Required	Non-Participating Provider services are not covered and You pay the full cost	60 days per plan 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	0% Coinsurance after Deductible per Admission Preauthorization Required However, Preauthorization is Not Required for Emergency Admission or for admissions at Participating OHM-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)	0% Coinsurance after Deductible 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	0% Coinsurance after Deductible 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)	0% Coinsurance after Deductible Preauthorization Required However, Preauthorization is not required for Participating OASAS-certified Facilities	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
PRESCRIPTION DRUGS *Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits

or if the item or service has an “A” or “B” rating from the USPSTF and obtained at a participating pharmacy.			
Retail Pharmacy			
30-day supply			See benefit for description
Tier 1	0% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	
Tier 2	0% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	
Tier 3	0% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	
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.	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.		
Up to a 90-day supply for Maintenance Drugs			See benefit for description
Tier 1	0% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	
Tier 2	0% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	

Tier 3	0% Coinsurance after Deductible 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			See benefit for description
Tier 1	0% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	
Tier 2	0% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	
Tier 3	0% Coinsurance after Deductible 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	0% Coinsurance after Deductible 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"> <li data-bbox="193 699 548 727">• Preventive Dental Care <li data-bbox="193 870 506 898">• Routine Dental Care <li data-bbox="193 1040 554 1170">• Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics) <li data-bbox="193 1243 407 1271">• Orthodontics 	<p data-bbox="625 699 1058 727">0% Coinsurance after Deductible</p> <p data-bbox="625 870 1058 898">0% Coinsurance after Deductible</p> <p data-bbox="625 1040 1058 1101">0% Coinsurance after Deductible Preauthorization Required</p> <p data-bbox="625 1243 1058 1304">0% Coinsurance after Deductible Preauthorization Required</p>	<p data-bbox="1295 699 1640 797">Non-Participating Provider services are not covered and You pay the full cost</p> <p data-bbox="1295 870 1640 967">Non-Participating Provider services are not covered and You pay the full cost</p> <p data-bbox="1295 1040 1640 1138">Non-Participating Provider services are not covered and You pay the full cost</p> <p data-bbox="1295 1243 1640 1341">Non-Participating Provider services are not covered and You pay the full cost</p>	<p data-bbox="1692 634 1902 797">One (1) dental exam and cleaning per six (6) month period</p> <p data-bbox="1692 837 1902 1097">Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at six (6) intervals</p>

<p>Pediatric Vision Care</p> <ul style="list-style-type: none"> • Exams • Lenses • Frames • Standard Contact Lenses 	<p>0% Coinsurance after Deductible</p> <p>0% Coinsurance after Deductible</p> <p>0% Coinsurance after Deductible</p> <p>0% Coinsurance after Deductible</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>
<p>DENTAL and VISION CARE</p>	<p>Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Non-Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Limits</p>
<p>Adult Dental Care</p> <ul style="list-style-type: none"> • Preventive Dental Care • Routine Dental Care • Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics) 	<p>0% Coinsurance after Deductible</p> <p>0% Coinsurance after Deductible</p> <p>0% Coinsurance after Deductible 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>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) intervals</p>

<ul style="list-style-type: none"> • Orthodontics 	0% Coinsurance after Deductible 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 	0% Coinsurance after Deductible	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 	0% Coinsurance after Deductible	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 	0% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	
<ul style="list-style-type: none"> • Standard Contact Lenses 	0% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	Allowance of up to \$130 towards glasses or contact lenses

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.