SECTION XXVII

SCHEDULE OF BENEFITS
Healthfirst Gold 25/50/0 Pro Plus EPO
Non-Standard

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	 $0 $0	 Non-Participating Provider services are not covered except as required for emergency care.	
Out-of-Pocket Limit • Individual • Family Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a plan year basis.	 $7,000 $14,000		
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$25 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Specialist Office Visits (or Home Visits)	$50 Copayment	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description

PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
• 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
• Adult Annual Physical Examinations*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
• Adult Immunizations*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
• Routine Gynecological Services/Well Woman Exams*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
• 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	
• Sterilization Procedures for Women*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	

• Vasectomy	$50 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
• Bone Density Testing*	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
• Screening for Prostate Cancer	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
• 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	
• *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	See benefit for description

		You pay the full cost	
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	$50 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	 $50 Copayment **Preauthorization Required** $50 Copayment **Preauthorization Required** $50 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

Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office	 $25 Copayment $50 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
Ambulatory Surgical Center Facility Fee	$300 Copayment **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Anesthesia Services (all settings)	Covered in full **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Cardiac and Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	 $50 Copayment **Preauthorization Required** $50 Copayment **Preauthorization Required** Included as part of Inpatient Hospital Cost Sharing **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

Chemotherapy and Immunotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $25 Copayment **Preauthorization Required** $50 Copayment **Preauthorization Required** $50 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
Chiropractic Services	$50 Copayment **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 • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $25 Copayment **Preauthorization Required** $50 Copayment **Preauthorization Required** $50 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

Dialysis • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Center • Performed as Outpatient Hospital Services • Performed at Home	 $25 Copayment **Preauthorization Required** $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 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 visits per Plan year Cost-Sharing for the visits is the same as for a Participating Provider. See benefit description for more information.
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$50 Copayment **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	60 visits per condition, per Plan Year; combined therapies
Home Health Care	$25 Copayment **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	40 visits per Plan Year
Infertility Services	Use Cost Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description

	Preauthorization Required		
Infusion Therapy • 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 • Medically Necessary Abortions • Elective Abortions • Inpatient Hospital Surgery	 Covered in full $100 Copayment	 Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider	 Unlimited One (1) procedure per Plan Year]

		services are not covered and You pay the full cost	
• Outpatient Hospital Surgery	$100 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
• Surgery Performed at an Ambulatory Surgical Center	$100 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
• Office Surgery	$25 Copayment when performed by PCP $50 Copayment when performed by Specialist	Non-Participating Provider services are not covered and You pay the full cost	
Laboratory Procedures			See benefit for description
• Performed in a PCP Office	$25 Copayment **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed in a Specialist Office	$50 Copayment **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed in a Freestanding Laboratory Facility	$50 Copayment **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$50 Copayment **Preauthorization Required**	Non-Participating Provider services are not covered and	

		You pay the full cost	

Maternity and Newborn Care
 	
• Prenatal Care
 	
  • 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
 	
• Physician Midwife Services for Delivery
 	
• Breast Feeding Support, Counseling and Supplies, Including Breast Pumps
 	
• Postnatal Care
	Covered in full
	
	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)
	
	$500 Copayment per Admission
	Preauthorization Required
	
	$100 Copayment
	
	Covered in full
	Preauthorization Required
	
	Covered in full
		Non-Participating Provider services are not covered and You pay the full cost
		
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		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
			
			One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early
			
			Covered for duration of breast feeding

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			
• 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	
• 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
• Performed in a PCP Office	$25 Copayment **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed in a Specialist Office	$50 Copayment **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed in a Freestanding Radiology Facility	$40 Copayment **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$50 Copayment **Preauthorization Required**	Non-Participating Provider services are not covered and	

		You pay the full cost	
Therapeutic Radiology Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services	 $25 Copayment **Preauthorization Required** $50 Copayment **Preauthorization Required** $50 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
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$50 Copayment **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	60 visits per condition, per Plan Year combined therapies. Speech and physical therapy are only Covered following a Hospital stay or 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	$50 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
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants)			See benefit for description All transplants must be performed at designated Facilities
• Inpatient Hospital Surgery	$100 Copayment **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Outpatient Hospital Surgery	$100 Copayment **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Surgery Performed at an Ambulatory Surgical Center	$100 Copayment **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Office Surgery	$25 Copayment in PCP office $50 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			See benefit for description
• Diabetic Equipment, Supplies and Insulin (30-day; Up to a 90-day supply)	$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**	Non-Participating Provider services are not covered and You pay the full cost	See Prescription Drug benefit
• Diabetic Education	$25 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
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 • Inpatient • Outpatient	$500 Copayment per Admission **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	210 days per Plan Year Five (5) visits for family bereavement counseling
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 • External • Internal	15% Coinsurance **Preauthorization Required** 15% Coinsurance **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 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	$500 Copayment per Admission **Preauthorization Required**. **However,**	Non-Participating Provider services are not covered and	See benefit for description

(including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	**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**	You pay the full cost	
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	$500 Copayment per Admission **Preauthorization Required** **However, Preauthorization is Not Required**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description

Hospital) including Residential Treatment	**for Emergency Admission or for admissions at Participating OMH-licensed Facilities for Members under 18.**		
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 OASAS-certified Facilities**	$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
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.	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**

Retail Pharmacy 30-day supply Tier 1 Tier 2 Tier 3 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.	 $10 Copayment $50 Copayment $85 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 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
Up to a 90-day supply for Maintenance Drugs Tier 1 Tier 2 Tier 3	 $30 Copayment $150 Copayment $255 Copayment The Deductible does not apply to certain	 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

	Prescription Drugs. Visit Our website at Healthfirst.org to review Our formulary or call the number on Your ID card to learn more.		
Mail Order Pharmacy			
Up to a 90-day supply Tier 1 Tier 2 Tier 3	 $20 Copayment $100 Copayment $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 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
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			One (1) dental exam and cleaning per six (6) month period
• Preventive Dental Care	$25 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
• 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
• 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	
• Orthodontics	15% Coinsurance **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
Pediatric Vision Care			
• Exams	$10 Copayment	Non-Participating Provider services are not covered and You pay the full cost	One (1) exam 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 Allowance of up to $130 towards
• Frames	$25 Copayment	Non-Participating Provider services are not covered and You pay the full cost	

• Standard Contact Lenses	$25 Copayment	Non-Participating Provider services are not covered and You pay the full cost	glasses or contact lenses
DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Adult Dental Care			
• 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
• 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
• 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	
• Orthodontics	15% Coinsurance **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
Adult Vision Care			
• Exams	$10 Copayment	Non-Participating Provider services are not covered and You pay the full cost	One (1) exam 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.