SECTION XXVII

SCHEDULE OF BENEFITS
Healthfirst Bronze 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	$5,950 $11,900	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.	$6,900 $13,800		
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)	50% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Specialist Office Visits (or Home Visits)	50% Coinsurance after Deductible	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% Coinsurance after Deductible	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)	50% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Non-Emergency Ambulance Services	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Emergency Department	50% Coinsurance after Deductible Copayment / Coinsurance waived if admitted to Hospital Health care forensic examinations performed under Public Health Law § 2805-i are not subject	50% Coinsurance after Deductible Copayment / Coinsurance waived if admitted to Hospital	See benefit for description

	to Cost-Sharing	Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	
Urgent Care Center	50% 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	50% 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 • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services	50% Coinsurance after Deductible **Preauthorization Required** 50% Coinsurance after Deductible **Preauthorization Required** 50% 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 • Performed in a PCP Office • Performed in a Specialist Office	50% Coinsurance after Deductible 50% Coinsurance after Deductible	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	50% 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)	50% 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
• Performed in a Specialist Office	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed as Outpatient Hospital Services	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• 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 and Immunotherapy			See benefit for description
• Performed in a PCP Office	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed in a Specialist Office	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed as Outpatient Hospital Services	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	

Chiropractic Services	50% 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			See benefit for description
• Performed in a PCP Office	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed in a Specialist Office	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed as Outpatient Hospital Services	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
Dialysis			See benefit for description
• Performed in a PCP Office	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed in a Specialist Office	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	Dialysis performed by Non-Participating Providers is limited to 10 visits per Plan year

• Performed in a Freestanding Center • Performed as Outpatient Hospital Services • Performed at Home	50% Coinsurance after Deductible **Preauthorization Required** 50% Coinsurance after Deductible **Preauthorization Required** 50% 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	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% Coinsurance after Deductible **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	50% Coinsurance after Deductible **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) **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office	 50% Coinsurance after Deductible **Preauthorization Required** 50% 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

• Performed as Outpatient Hospital Services	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Home Infusion Therapy	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	Home infusion counts toward Home Health Care visit limits
Inpatient Medical Visits	50% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Interruption of Pregnancy			
• Medically Necessary Abortions	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	Unlimited
• Elective Abortions	50% coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	One (1) procedure per Plan Year
Laboratory Procedures			See benefit for description
• Performed in a PCP Office	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed in a Specialist Office	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed in a Freestanding Laboratory Facility	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	

• Performed as Outpatient Hospital Services	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
Maternity and Newborn Care • Prenatal Care			See benefit for description
• Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
• Prenatal Care that is 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	
• Inpatient Hospital Services and Birthing Center	50% Coinsurance after Deductible per admission **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	One (1) home care visit is covered at no Cost-Sharing if mother is discharged from Hospital early
• Physician Midwife Services for Delivery	50% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	
• Breast Feeding Support, Counseling and Supplies, Including Breast Pumps	Covered in full **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	Covered for duration of breast feeding

• Postnatal Care	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	
Outpatient Hospital Surgery Facility Charge	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Preadmission Testing	50% Coinsurance after Deductible	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	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed in a Specialist Office	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	

• Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services	50% Coinsurance after Deductible **Preauthorization Required** 50% 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	
Therapeutic Radiology Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services	 50% Coinsurance after Deductible **Preauthorization Required** 50% Coinsurance after Deductible **Preauthorization Required** 50% 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
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	50% Coinsurance after Deductible **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	50% Coinsurance after Deductible		
Second Opinions on the Diagnosis of Cancer, Surgery and Other	50% 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
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	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Outpatient Hospital Surgery	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Surgery Performed at an Ambulatory Surgical Center	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Office Surgery	50% 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	50% 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	50% 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
• Diabetic Equipment, Supplies and Insulin (30-day; Up to a 90-day supply)	50% 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
• Diabetic Education	50% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	
Durable Medical Equipment and Braces	50% 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	50% 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	50% Coinsurance 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 • Inpatient • Outpatient	50% Coinsurance after Deductible **Preauthorization Required** 50% 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	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Prosthetic Devices • External • Internal	50% Coinsurance after Deductible **Preauthorization Required** 50% 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	50% 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	50% Coinsurance after Deductible per admission **Preauthorization Required**. **However, Preauthorization is Not Required for Emergency Admissions or services provided in a neonatal intensive care unit of a Hospital**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description

End of Life Care)	**certified pursuant to Article 28 of the Public Health Law.**		
Observation Stay	50% 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)	50% 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)	50% 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)	50% 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	50% Coinsurance after Deductible per Admission **Preauthorization Required However, Preauthorization is Not Required for**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description

Hospital) including Residential Treatment	**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)	50% 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	50% 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)	50% Coinsurance after Deductible **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	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			See benefit for description

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.	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% 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 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	
Up to a 90-day supply for Maintenance Drugs Tier 1 Tier 2 Tier 3	 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% 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 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

Mail Order Pharmacy			
Up to a 90-day supply Tier 1 Tier 2 Tier 3	 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% 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 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	50% 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			One (1) dental exam and cleaning per six (6) month period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at six (6) intervals
• Preventive Dental Care	50% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	
• Routine Dental Care	50% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	
• Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics)	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Orthodontics	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
Pediatric Vision Care			
• Exams	$10 Copayment after Deductible	Non-Participating Provider services are not covered and You pay the full cost	One (1) exam per 12-month period
• Lenses	$25 Copayment 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 Allowance of up
• Frames	$25 Copayment after Deductible	Non-Participating Provider services are not covered and You pay the full cost	

• Standard Contact Lenses	$25 Copayment after Deductible	Non-Participating Provider services are not covered and You pay the full cost	to $130 towards 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			One (1) dental exam and cleaning per six (6) month period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at six (6) intervals
• Preventive Dental Care	50% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	
• Routine Dental Care	50% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost	
• Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics)	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Orthodontics	50% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
Adult Vision Care			
• Exams	$10 Copayment after Deductible	Non-Participating Provider services are not covered and You pay the full cost	One (1) exam per 12-month period
• Lenses	$25 Copayment after Deductible	Non-Participating Provider services are not covered and You pay the full cost	One (1) prescribed lenses and

• Frames	$25 Copayment after Deductible	Non-Participating Provider services are not covered and You pay the full cost	frames per 12-month period Allowance of up to $130 towards
• Standard Contact Lenses	$25 Copayment after Deductible	Non-Participating Provider services are not covered and You pay the full cost	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.