SECTION XXVII

SCHEDULE OF BENEFITS
Healthfirst Silver 40/75/4700 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	 $4,700 $9,400	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.	 $7,900 $15,800		
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)	$40 Copayment not subject to Deductible	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Specialist Office Visits (or Home Visits)	$75 Copayment not subject to 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	$75 Copayment not subject to 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)	$300 Copayment after Deductible	$300 Copayment after Deductible	See benefit for description
Non-Emergency Ambulance Services	$600 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Emergency Department	$600 Copayment after Deductible Copayment / Coinsurance waived if admitted to Hospital Health care forensic examinations performed	$600 Copayment 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	$75 Copayment not subject to 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	$75 Copayment not subject to 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			See benefit for description
• Performed in a Specialist Office	$75 Copayment Not Subject to Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed in a Freestanding Radiology Facility	$75 Copayment Not Subject to Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$75 Copayment Not Subject to Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
Allergy Testing and Treatment			See benefit for description
• Performed in a PCP Office	$35 Copayment not subject to Deductible	Non-Participating Provider services are not covered and You pay the full cost	
• Performed in a Specialist	$75 Copayment not subject to Deductible	Non-Participating Provider	

Office		services are not covered and You pay the full cost	
Ambulatory Surgical Center Facility Fee	45% 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)	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			See benefits for description
• Performed in a Specialist Office	$75 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$75 Copayment 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 services 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	$40 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed in a Specialist Office	$75 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	

• Performed as Outpatient Hospital Services	$75 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
Chiropractic Services	$75 Copayment not subject to 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	$40 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed in a Specialist Office	$75 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$75 Copayment 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	$40 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	Dialysis

• Performed in a Specialist Office	$40 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	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.
• Performed in a Freestanding Center	$40 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$40 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed at Home	$40 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$75 Copayment not subject to 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	$40 Copayment 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	$40 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description

• Performed in Specialist Office	$40 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$40 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Home Infusion Therapy	$40 Copayment 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	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	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	Unlimited
• Elective Abortions			One (1) procedure per Plan Year
• Inpatient Hospital Surgery	$200 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
• Outpatient Hospital Surgery	$200 Copayment	Non-Participating Provider services are not covered and You pay the full cost	

• Surgery Performed at an Ambulatory Surgical Center	$200 Copayment	Non-Participating Provider services are not covered and You pay the full cost	
• Office Surgery	$40 Copayment after Deductible when performed by PCP $75 Copayment after Deductible 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	$40 Copayment not subject to Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed in a Specialist Office	$75 Copayment not subject to Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed in a Freestanding Laboratory Facility	$75 Copayment not subject to Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$75 Copayment not subject to Deductible **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	Covered in full	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
• 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	45% 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	$200 Copayment 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	45% Coinsurance after Deductible **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	$40 Copayment not subject to Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed in a Specialist Office	$75 Copayment not subject to Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed in a Freestanding Radiology Facility	$75 Copayment not subject to Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$75 Copayment not subject to Deductible **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	 $40 Copayment after Deductible **Preauthorization Required** $75 Copayment after Deductible **Preauthorization Required** $75 Copayment 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)	$75 Copayment not subject to 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	$40 Copayment not subject to Deductible	Non-Participating Provider services are not covered and You pay the full cost	

Second Opinions on the Diagnosis of Cancer, Surgery and Other	$75 Copayment after Deductible **Preauthorization Required**	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	$200 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Outpatient Hospital Surgery	$200 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Surgery Performed at an Ambulatory Surgical Center	$200 Copayment after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Office Surgery	$40 Copayment in PCP office after Deductible $75 Copayment in Specialist office after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	

Telemedicine Program	$0 Copayment not subject to 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	$40 Copayment not subject to 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	$40 Copayment not subject to 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)	$40 Copayment not subject to 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	$40 Copayment not subject to Deductible	Non-Participating Provider services are not covered and You pay the full cost	
Durable Medical Equipment and Braces	45% 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	45% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered	Single purchase once

		and You pay the full cost	every three (3) years
Cochlear Implants	45% 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	45% Coinsurance after Deductible per Admission **Preauthorization Required** $40 Copayment not subject to 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	45% 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	45% Coinsurance after Deductible **Preauthorization Required** 45% 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	45% 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)	45% 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 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	$500 Copayment 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)	45% 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)	45% 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
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	45% 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 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	45% Coinsurance after Deductible per Admission **Preauthorization Required** **However, Preauthorization is Not Required for Emergency Admissions or for admissions at Participating OMH-licensed Facilities for Members under 18.**	Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	$40 Copayment not subject to 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	45% coinsurance after deductible per Admission **Preauthorization Required** **However, Preauthorization is Not Required for Emergency Admissions 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) **Preauthorization Required** **However, Preauthorization is not required for Participating OASAS-certified Facilities**	$40 Copayment not subject to Deductible	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	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**

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.			
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.	 $20 Copayment not subject to Deductible $60 Copayment not subject to Deductible $110 Copayment not subject to 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
Up to a 90-day supply for Maintenance Drugs Tier 1 Tier 2 Tier 3	 $60 Copayment not subject to Deductible $180 Copayment not subject to Deductible $330 Copayment not subject to 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 Non-Participating Provider services are not covered	See benefit for description

	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.	and You pay the full cost	
Mail Order Pharmacy			
Up to a 90-day supply Tier 1 Tier 2 Tier 3	 $40 Copayment not subject to Deductible $120 Copayment not subject to Deductible $220 Copayment not subject to 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			
Enteral Formula	45% 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 • Preventive Dental Care	$40 Copayment not subject to Deductible	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	$40 Copayment after Deductible	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)	45% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
• Orthodontics	45% Coinsurance after Deductible **Preauthorization Required**	Non-Participating Provider services are not covered and You pay the full cost	
Pediatric Vision Care • Exams	$10 Copayment not subject to Deductible	Non-Participating Provider services are not covered and You pay the full cost	One (1) exam per 12-month period
• Lenses	$25 Copayment not subject to Deductible	Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider	One (1) prescribed lenses and frames per 12-month period

• Frames • Standard Contact Lenses	$25 Copayment not subject to Deductible $25 Copayment not subject to Deductible	services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	Allowance of up 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 • Preventive Dental Care • Routine Dental Care • Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics) • Orthodontics	 $40 Copayment not subject to Deductible $40 Copayment after Deductible 45% Coinsurance after Deductible **Preauthorization Required** 45% 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 Non-Participating Provider services are not covered and You pay the full cost	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) month intervals
Adult Vision Care • Exams • Lenses	 $10 Copayment not subject to Deductible $25 Copayment not subject to 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	 One (1) exam per 12-month period One (1) prescribed lenses and

			frames per 12-month period
• Frames	$25 Copayment not subject to Deductible	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 not subject to Deductible	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.