**SECTION XXVII**

# METROPLUSHEALTH SCHEDULE OF BENEFITS
## GoldPrime Non-Standard

| **COST-SHARING** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | |
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| **Deductible**<br>• Individual<br>• Family | <br>$650<br>$1,300 | Non-Participating Provider services are not Covered except as required for emergency care . | |
| **Out-of-Pocket Limit**<br>• Individual<br>• Family | <br>$7,250<br>$14,500 | | |
| Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a calendar year ending on December 31 of each year. | | | |
| **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 (first 3 visits to PCP, Outpatient Mental Health Care or Outpatient Substance Use Services not subject to Deductible)<br><br>After 3 visits, $25 Copayment 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) | $35 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |

| **Referral required** | | | |
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| **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 | See Surgical Services Cost-Sharing | 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 | |

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| • Screening for Prostate Cancer | Covered in full | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Colon Cancer Screening | 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 after Deductible | $150 Copayment after Deductible | See benefit for description |
| Non-Emergency Ambulance Services | $150 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Emergency Department<br><br>Copayment waived if admitted to Hospital | $150 Copayment after Deductible<br><br>Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost Sharing | $150 Copayment after Deductible<br><br>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 after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| **PROFESSIONAL SERVICES and** | **Participating Provider Member** | **Non-Participating Provider** | **Limits** |

| OUTPATIENT CARE | Responsibility for Cost-Sharing | Member Responsibility for Cost-Sharing | |
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| Acupuncture | $35 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | 8 visits per Plan year |
| Advanced Imaging Services<br>• Performed in a Specialist Office<br>• Performed in a Freestanding Radiology Facility<br>• Performed as Outpatient Hospital Services<br>**Referral required** | <br>$35 Copayment after Deductible<br>$35 Copayment after Deductible<br>$35 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Allergy Testing and Treatment<br>• Performed in a PCP Office<br>• Performed in a Specialist Office<br>**Referral required** | <br>$25 Copayment after Deductible<br>$35 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Ambulatory Surgical Center Facility Fee<br>**Referral required** | $105 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Anesthesia Services<br>(all settings)<br>**Referral required** | Covered in full | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Cardiac and Pulmonary Rehabilitation<br>• Performed in a Specialist Office | <br>$25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |

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| • Performed as Outpatient Hospital Services<br>• Performed as Inpatient Hospital Services<br>**Referral required** | $25 Copayment after Deductible<br>Included as part of inpatient Hospital service Cost-Sharing | | |
| Chemotherapy and Immunotherapy<br>• Performed in a PCP Office<br>• Performed in a Specialist Office<br>• Performed as Outpatient Hospital Services<br>**Referral required** | $25 Copayment after Deductible<br>$25 Copayment after Deductible<br>$25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Chiropractic Services<br>**Referral required** | $35 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Clinical Trials<br>**Referral required** | Use Cost-Sharing for appropriate service | Use Cost-Sharing for appropriate service | See benefit for description |
| Diagnostic Testing<br>• Performed in a PCP Office<br>• Performed in a Specialist Office<br>• Performed as Outpatient Hospital Services | $25 Copayment after Deductible<br>$35 Copayment after Deductible<br>$35 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost<br>Non-Participating Provider services are not Covered and You pay the full cost<br>Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |

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| **Referral required** | | | |
| Dialysis<br>• Performed in a PCP Office | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description<br><br>Dialysis performed by Non-Participating Providers is limited to 10 visits per calendar year. Cost-Sharing for the visits is the same as for a Participating Provider. See benefit description for more information. |
| • Performed in a Specialist Office | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed in a Freestanding Center | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed as Outpatient Hospital Services | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed at Home<br><br>**Referral required** | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| Habilitation Services<br>(Physical Therapy, Occupational Therapy or Speech Therapy)<br><br>**Referral required after the first 20 visits** | $30 Copayment after Deductible | 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<br><br>**Referral required** | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | 40 visits per Plan Year |
| Infertility Services<br><br>**Referral required** | 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 |
| Infusion Therapy | | | See benefit for |

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| • Performed in a PCP Office | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | description |
| • Performed in Specialist Office | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed as Outpatient Hospital Services | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Home Infusion Therapy<br><br>**Referral required** | $25 Copayment after Deductible | 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 | $0 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Interruption of Pregnancy<br>• Abortion Service | Covered in full | Non-Participating Provider services are not Covered and You pay the full cost | See Benefit for description |
| Laboratory Procedures<br>• Performed in a PCP Office | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| • Performed in a Specialist Office | $35 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed in a Freestanding Laboratory Facility | $35 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Performed as Outpatient Hospital | $35 Copayment after Deductible | Non-Participating Provider | |

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| Services<br><br>**Referral required** | | services are not Covered and You pay the full cost | |
| Maternity and Newborn Care<br>• Prenatal Care<br>• 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) | Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) | |
| • Inpatient Hospital Services | $1,000 Copayment per admission after Deductible | 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 and Midwife Services for Delivery | $105 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Breastfeeding Support, Counseling and Supplies, Including Breast Pumps | Covered in full | Non-Participating Provider services are not Covered and You pay the full cost | Covered for duration of breast feeding |
| • Postnatal Care | Included in Physician and Midwife Services for Delivery Cost-Sharing | Non-Participating Provider services are not Covered and You pay the full cost | |
| Outpatient Hospital Surgery Facility Charge<br><br>**Referral required** | $105 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Preadmission Testing | $0 Copayment after Deductible | Non-Participating Provider | See benefit for |

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| **Referral required** | | services are not Covered and You pay the full cost | description |
| Prescription Drugs Administered in Office or Outpatient Facilities<br>• Performed in a PCP Office<br>• Performed in Specialist Office<br>• Performed in Outpatient Facilities<br>**Referral required** | Included as part of the PCP office visit Cost-Sharing<br>Included as part of the Specialist office visit Cost-Sharing<br>$25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost<br>Non-Participating Provider services are not Covered and You pay the full cost<br>Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Diagnostic Radiology Services<br>• Performed in a PCP Office<br>• Performed in a Specialist Office<br>• Performed in a Freestanding Radiology Facility<br>• Performed as Outpatient Hospital Services<br>**Referral required** | $25 Copayment after Deductible<br>$35 Copayment after Deductible<br>$35 Copayment after Deductible<br>$35 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost<br>Non-Participating Provider services are not Covered and You pay the full cost<br>Non-Participating Provider services are not Covered and You pay the full cost<br>Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Therapeutic Radiology Services | | | See benefit for |

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| • Performed in a Specialist Office<br><br>• Performed in a Freestanding Radiology Facility<br><br>• Performed as Outpatient Hospital Services<br><br>**Referral required** | $25 Copayment after Deductible<br><br>$25 Copayment after Deductible<br><br>$25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost<br><br>Non-Participating Provider services are not Covered and You pay the full cost<br><br>Non-Participating Provider services are not Covered and You pay the full cost | description |
| Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)<br><br>**Referral required after the first 20 visits** | $30 Copayment after Deductible | 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. |
| Second Opinions on the Diagnosis of Cancer, Surgery and Other | $35 Copayment after Deductible<br><br>**Referral required** | Non-Participating Provider services are not Covered and You pay the full cost<br><br>Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained.<br><br>**Preauthorization required** | See benefit for description |
| Surgical Services<br>(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants)<br>• Inpatient Hospital Surgery | $100 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |

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| • Outpatient Hospital Surgery | $105 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Surgery Performed at an Ambulatory Surgical Center | $100 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Office Surgery<br><br>**Referral required** | $25 Copayment in PCP office after Deductible<br>$35 Copayment in Specialist office after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| Telemedicine Program | $25 Copayment after Deductible | 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** |
| Diabetic Equipment, Supplies and Self-Management Education | | | See benefit for description |
| • Diabetic Equipment and Supplies | $25 Copayment after Deductible but no more than $100 (including before the Deductible) for a 30-day supply of insulin. | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Diabetic Insulin (30- day supply) | See the Prescription Drug Cost-Sharing, but not more than $100 for a 30-day supply of insulin. | Non-Participating Provider services are not Covered and You pay the full cost | |
| • Oral anti-diabetic agents and injectable anti-diabetic agents (30-day supply) | See the Prescription Drug Cost Sharing | | |

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| • Diabetic Education<br><br>**Referral required** | $25 Copayment after Deductible | | |
| Durable Medical Equipment and Braces<br><br>**Referral required** | 20% Coinsurance after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| External Hearing Aids<br>• Prescription Hearing Aids<br><br>• Over-the-Counter Hearing Aids<br><br>**Referral required** | 20% Coinsurance after Deductible<br><br>20% Coinsurance after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | Single purchase once every three (3) years |
| Cochlear Implants<br><br>**Referral required** | 20% Coinsurance after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | One (1) per ear per time Covered |
| Hospice Care<br>• Inpatient<br><br>• Outpatient<br><br>**Referral required** | $1,000 Copayment per admission after Deductible<br><br>$25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost<br><br>Non-Participating Provider services are not Covered and You pay the full cost | 210 days per Plan Year<br><br>Five (5) visits for family bereavement counseling |
| Medical Supplies<br><br>**Referral required** | 20% Coinsurance after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Prosthetic Devices<br>• External | 20% Coinsurance after Deductible | 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 |

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| • Internal<br><br>**Referral required** | Included as part of inpatient Hospital Cost-Sharing | Non-Participating Provider services are not Covered and You pay the full cost | Unlimited;<br>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<br><br>**Referral required** | 20% Coinsurance after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care) | $1,000 Copayment per admission after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Observation Stay | $150 Copayment per admission 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) | $1,000 Copayment per admission after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | Unlimited |
| Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) | $1,000 Copayment per admission after Deductible | 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) | $1,000 Copayment per admission after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | 60 days per Plan Year combined therapies<br><br>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-** | **Non-Participating Provider Member Responsibility for** | **Limits** |

| | Sharing | Cost-Sharing | |
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| Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment)<br><br>**Referral required. However, Preauthorization is not required for emergency admissions or for admissions at Participating OMH-licensed Facilities for Members under 18.** | $1,000 Copayment per admission after Deductible | 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)<br><br>• Outpatient Services provided in a Facility licensed, certified, or otherwise authorized by OMH | $25 Copayment after Deductible<br><br>$25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| ABA Treatment for Autism Spectrum Disorder<br><br>**Referral required** | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Assistive Communication Devices for Autism Spectrum Disorder<br><br>**Referral required** | $25 Copayment after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)<br><br>**Referral required. However, Preauthorization is not required for emergency admissions or for** | $1,000 Copayment per admission after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |

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| **Participating OASAS-certified Facilities.** | | | |
| Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)<br><br>• Opioid Treatment Program | $25 Copayment after Deductible<br><br>Covered in full after 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**<br><br>*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<br><br>Tier 1<br><br>Tier 2<br><br>Tier 3<br><br>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. | <br><br>$10 Copayment not subject to Deductible<br><br>$40 Copayment not subject to Deductible<br><br>$80 Copayment not subject to Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| **Mail Order Pharmacy** | | | |

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| Up to a 30-day supply<br><br>Tier 1<br><br>Tier 2<br><br>Tier 3 | <br><br>$10 Copayment not subject to Deductible<br><br>$40 Copayment not subject to Deductible<br><br>$80 Copayment not subject to Deductible | Non-Participating Provider services are not Covered and You pay the full cost | |
| Up to a 90-day supply<br><br>Tier 1<br><br>Tier 2<br><br>Tier 3 | <br><br>$25 Copayment not subject to Deductible<br><br>$100 Copayment not subject to Deductible<br><br>$200 Copayment not subject to Deductible | Non-Participating Provider services are not Covered and You pay the full cost | See benefit for description |
| Enteral Formulas<br><br>Tier 1<br><br>Tier 2<br><br>Tier 3 | <br><br>$10 Copayment not subject to Deductible<br><br>$40 Copayment not subject to Deductible<br><br>$80 Copayment not subject to Deductible | 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 | Up to $200 per six (6) month period; up to an additional $100 | Up to $200 per six (6) month period; up to an |

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| | per six (6) month period for Spouse | per six (6) month period for Spouse | additional $100 per six (6) month period for Spouse |
| Meditation Benefit | Three (3) month membership to a meditation program through an online app | Three (3) month membership to a meditation program through an online app | Three (3) month membership to a meditation program through an online app |
| Healthy Living Rewards | Complete wellness activity to receive points which can be redeemed for items through an online portal.<br><br>See benefit for description. | Complete wellness activity to receive points which can be redeemed for items through an online portal.<br><br>See benefit for description. | Complete wellness activity to receive points which can be redeemed for items through an online portal.<br><br>See benefit for description. |
| **DENTAL and VISION CARE** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| **Pediatric Dental Care**<br>• Preventive Dental Care<br><br>• Routine Dental Care<br><br>• Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics)<br><br>• Orthodontics<br><br>**Orthodontics and major dental require Referral** | $25 Copayment after Deductible<br><br>$25 Copayment after Deductible<br><br>$25 Copayment after Deductible<br><br>$25 Copayment after 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<br><br>Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) month intervals |
| **Adult Dental Care**<br>• Preventive Dental Care | $25 Copayment after 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 |

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| • Routine Dental Care<br>• Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics)<br>• Orthodontics<br>**Orthodontics and major dental require Referral** | $25 Copayment after Deductible<br>$25 Copayment after Deductible<br>$25 Copayment after Deductible | | Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) month intervals |
| **Pediatric Vision Care**<br>• Exams<br>• Lenses and Frames<br>• Contact Lenses<br>**Contact Lenses require Referral** | $25 Copayment after Deductible<br>20% Coinsurance after Deductible<br>20% Coinsurance after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | One (1) exam per 12-month period<br>One (1) prescribed lenses and frames per 12-month period |
| **Adult Vision Care**<br>• Exams<br>• Lenses and Frames<br>• Contact Lenses<br>**Contact Lenses require Referral** | $25 Copayment after Deductible<br>20% Coinsurance after Deductible<br>20% Coinsurance after Deductible | Non-Participating Provider services are not Covered and You pay the full cost | One (1); exam per 12-month period<br>One (1) prescribed lenses and frames per 12-month period |

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.