

SECTION XXIX

**Affinity Health Plan SCHEDULE OF BENEFITS
Gold Level
[Non-Standard] [Child Only]**

<p>COST-SHARING</p> <p>Deductible</p> <ul style="list-style-type: none"> • Individual • Family <p>Out-of-Pocket Limit</p> <ul style="list-style-type: none"> • Individual • Family 	<p>Participating Provider Member Responsibility for Cost-Sharing</p> <p>\$600 \$1,200</p> <p>\$4,000 \$8,000</p>	<p>Non-Participating Provider Member Responsibility for Cost-Sharing</p> <p>Non-Participating Provider services are not Covered except as required for emergency care and Urgent Care.</p>	
<p>OFFICE VISITS</p>	<p>Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Non-Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Limits</p>
<p>Primary Care Office Visits (or Home Visits)</p>	<p>\$25 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Specialist Office Visits (or Home Visits)</p>	<p>\$40 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>PREVENTIVE CARE</p>	<p>Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Non-Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Limits</p>
<ul style="list-style-type: none"> • Well Child Visits and Immunizations* 	<p>Covered in full</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>

<ul style="list-style-type: none"> • Adult Annual Physical Examinations* 	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> • Adult Immunizations* 	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> • Routine Gynecological Services/Well Woman Exams* 	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> • Mammography Screenings* 	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> • Sterilization Procedures for Women* 	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> • Vasectomy 	See Surgical Services Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> • Bone Density Testing* 	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	

<ul style="list-style-type: none"> Screening for Prostate Cancer <ul style="list-style-type: none"> Performed in PCP Office Performed in Specialist Office All other preventive services required by USPSTF and HRSA *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA 	<p>\$25 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p> <p>Covered in full</p> <p>Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	

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
Preauthorization required	Preauthorization required		
Emergency Department Copayment / Coinsurance waived if Hospital admission	\$150 Copayment after Deductible	\$150 Copayment after Deductible	See benefit for description
Urgent Care Center	\$60 Copayment after Deductible	\$60 Copayment after Deductible	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
Advanced Imaging Services <ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility or Office Setting Performed as Outpatient Hospital Services 	\$40 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preauthorization	Preauthorization		

required	required		
<p>Allergy Testing and Treatment</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office <p>Preauthorization required</p>	<p>\$25 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p> <p>Preauthorization required</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Ambulatory Surgical Center Facility Fee</p>	<p>\$100 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Anesthesia Services (all settings)</p> <p>Preauthorization required</p>	<p>Covered in full</p> <p>Preauthorization required</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Autologous Blood Banking</p> <p>Preauthorization</p>	<p>20% Coinsurance after Deductible</p> <p>Preauthorization</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefits for description</p>

required	required		
<p>Cardiac and Pulmonary Rehabilitation</p> <ul style="list-style-type: none"> Performed in a Specialist Office Performed as Outpatient Hospital Services Performed as Inpatient Hospital Services <p>Preauthorization required</p>	<p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p> <p>Included as part of inpatient Hospital service Cost-Sharing</p> <p>Preauthorization required</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Included as part of inpatient Hospital service Cost-Sharing</p>	<p>See benefits for description</p>
<p>Chemotherapy</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services <p>Preauthorization</p>	<p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p> <p>Preauthorization</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>

Preauthorization required	required		
Chiropractic Services	\$40 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preauthorization required	Preauthorization required		
Clinical Trials	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description
Preauthorization required	Preauthorization required	Preauthorization required	
Diagnostic Testing			See benefit for description
<ul style="list-style-type: none"> Performed in a PCP Office 	\$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> Performed in a Specialist Office 	\$40 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	\$40 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Dialysis			See benefit for description
<ul style="list-style-type: none"> Performed in a PCP Office 	\$25 Copayment after Deductible	\$25 Copayment after Deductible	Dialysis performed by Non-Participating Providers is limited to 12 visits per calendar year

<ul style="list-style-type: none"> Performed in a Freestanding Center or Specialist Office Setting Performed as Outpatient Hospital Services 	\$25 Copayment after Deductible	\$25 Copayment after Deductible	
Preauthorization required with first encounter and after 12 visits	Preauthorization required with first encounter and after 12 visits	Preauthorization required with first encounter and after 12 visits	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	\$30 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	60 visits per condition, per lifetime combined therapies
Preauthorization required after 12 visits	Preauthorization required after 12 visits		
Home Health Care	\$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	40 visits per Plan Year
Preauthorization required after 12 visits	Preauthorization required after 12 visits		
Infertility Services	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

Preauthorization required	Preauthorization required		
<p>Infusion Therapy</p> <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy <p>Preauthorization required for first encounter and beyond 6 encounters</p>	<p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p> <p>Preauthorization required for first encounter and beyond 6 encounters</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p> <p>Home infusion counts toward home health care visit limits</p>
<p>Inpatient Medical Visits</p>	<p>\$0 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>

Preauthorization required	Preauthorization required		
Laboratory Procedures <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services 	\$25 Copayment after Deductible \$40 Copayment after Deductible \$40 Copayment 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 Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Maternity and Newborn Care <ul style="list-style-type: none"> • Prenatal Care • Inpatient Hospital Services and Birthing Center • Physician and Midwife Services 	Covered in full \$1000 Copayment per admission after Deductible \$100 Copayment per admission 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 Non-Participating Provider services are not Covered and	See benefit for description One (1) home care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast feeding Limit of one (1) per pregnancy

for Delivery		You pay the full cost	
<ul style="list-style-type: none"> Breast Pump 	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> 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	
Preauthorization required for inpatient services and breast pump	Preauthorization required for inpatient services and breast pump		
Outpatient Hospital Surgery Facility Charge	\$100 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preauthorization required	Preauthorization required		
Preadmission Testing	\$0 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preauthorization required	Preauthorization required		
Diagnostic Radiology Services			See benefit for description
<ul style="list-style-type: none"> Performed in a PCP Office 	\$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

<ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility or Specialist Office Performed as Outpatient Hospital Services 	<p>\$40 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	
<p>Therapeutic Radiology Services</p> <ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility or Specialist Office Performed as Outpatient Hospital Services <p>Preauthorization required</p>	<p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p> <p>Preauthorization required</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p>	<p>\$30 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>60 visits per condition, per lifetime; per Plan Year combined therapies Speech and physical therapy are only Covered following a Hospital stay or surgery</p>

Preauthorization required on 13 th visit and beyond	Preauthorization required on 13 th visit and beyond		
Second Opinions on the Diagnosis of Cancer, Surgery and Other	\$40 Copayment After Deductible	Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist	See benefit for description
Preauthorization required	Preauthorization required	Preauthorization required	
<p>Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)</p> <ul style="list-style-type: none"> • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center 	<p>\$100 Copayment after Deductible</p> <p>\$100 Copayment after Deductible</p> <p>\$100 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p> <p>All transplants must be performed at designated Facilities</p> <p>Interruption of Pregnancy one (1) procedure for one (1) Member per Plan Year</p>

<ul style="list-style-type: none"> Office Surgery 	<p>\$25 Copayment after Deductible for PCP, \$40 Copayment after Deductible for Specialist based on type of physician performing the service</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	
Preauthorization required	Preauthorization required		
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder	\$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preauthorization required	Preauthorization required		
Assistive Communication Devices for Autism Spectrum Disorder	\$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preauthorization required	Preauthorization required		
Diabetic Equipment, Supplies and Self-Management Education			See benefit for description
<ul style="list-style-type: none"> Diabetic Equipment, Supplies and Insulin (30-day supply) 	\$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> Diabetic Education 	\$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

Preauthorization required for insulin pump	Preauthorization required for insulin pump		
Durable Medical Equipment and Braces Preauthorization required for DME items greater than cost of \$500 (NY Medicare rate/current fee schedule)	20% Coinsurance after Deductible Preauthorization required for DME items greater than cost of \$500 (NY Medicare rate/current fee schedule)	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
External Hearing Aids Preauthorization required	20% 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 Preauthorization required	20% 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	\$1000 Copayment per admission after Deductible \$25 Copayment 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	210 days per Plan Year Five (5) visits for family bereavement counseling

Preauthorization required	Preauthorization required		
Medical Supplies	20% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preauthorization required	Preauthorization required		
Prosthetic Devices			
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> Internal 	Included as part of inpatient Hospital service Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	Unlimited; See benefit for description
Preauthorization required	Preauthorization required		
INPATIENT SERVICES and FACILITIES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	\$1000 Copayment per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preauthorization required. However, Preauthorization is not required for emergency admissions.	Preauthorization required. However, Preauthorization is not required for emergency admissions.		

Observation Stay	\$150 Copayment after Deductible; Copay is waived if direct transfer from outpatient surgery setting to an observation care unit	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) Preauthorization required	\$1000 Copayment per admission after Deductible Preauthorization required	Non-Participating Provider services are not Covered and You pay the full cost	200 days per Plan Year
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) Preauthorization required	\$1000 Copayment per admission after Deductible Preauthorization required	Non-Participating Provider services are not Covered and You pay the full cost	60 consecutive days per condition, per lifetime 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 (for a continuous confinement when in a Hospital) Preauthorization required. However, Preauthorization is not required for emergency admissions.	\$1000 Copayment per admission after Deductible Preauthorization required. However, Preauthorization is not required for emergency admissions.	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)	\$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	\$1000 Copayment per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

a Hospital) Preauthorization required. However, Preauthorization is not required for emergency admissions.	Preauthorization required. However, Preauthorization is not required for emergency admissions.		
Outpatient Substance Use Services	\$25 Copayment 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	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy			
30-day supply			
Tier 1	\$10 Copayment not subject to Deductible		
Tier 2	\$35 Copayment not subject to Deductible		
Tier 3	\$70 Copayment not subject to Deductible		
Mail Order Pharmacy			
Up to a 90-day supply			See benefit for description
Tier 1	\$25 Copayment not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Tier 2	\$87.50 Copayment not subject to Deductible		
Tier 3	\$175 Copayment not subject to Deductible		
Enteral Formulas			See benefit for description

Tier 1	\$10 Copayment not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Tier 2	\$35 Copayment not subject to Deductible		
Tier 3	\$70 Copayment not subject to Deductible		
Preauthorization required	Preauthorization required		
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			Pediatric dental option must be selected at time of enrollment.
<ul style="list-style-type: none"> 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
<ul style="list-style-type: none"> Routine Dental Care 	\$25 Copayment after Deductible		Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) to 12-month intervals
<ul style="list-style-type: none"> Major Dental (Endodontics, Periodontics and Prosthodontics) 	\$25 Copayment after Deductible		
<ul style="list-style-type: none"> Orthodontics 	\$25 Copayment		

	after Deductible		
Orthodontics and major dental require Preauthorization	Orthodontics and major dental require Preauthorization		
Pediatric Vision Care			
<ul style="list-style-type: none"> Exams Lenses and Frames Contact Lenses 	<p>\$25 Copayment after Deductible</p> <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>One (1) exam per 12-month period</p> <p>One (1) prescribed lenses and frames per 12-month period;</p>
Contact lenses require Preauthorization	Contact lenses require Preauthorization		
Adult Dental Care			
<ul style="list-style-type: none"> Preventive & Diagnostic Dental Care Comprehensive Dental Visit Whitening Treatment 	<p>\$0 Copayment not subject to Deductible</p> <p>\$0 Copayment not subject to Deductible</p> <p>\$0 Copayment not subject to Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>One (1) dental exam and cleaning per six (6)-month period intervals</p> <p>Bitewing x-rays at six (6)-month period intervals</p> <p>One (1) whitening treatment per Plan Year</p>
Adult Vision Care			
<ul style="list-style-type: none"> Routine Exam 	<p>\$0 Copayment not subject to Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>One (1) exam per Plan Year</p>

Eligible American Indians, as determined by the NYSOH, are exempt from Cost-Sharing requirements when Covered Services are rendered by an Indian Health Service, Indian Tribe, Tribal Organization or Urban Indian Organization, or through Referral under contract health services.

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.