

**SECTION XXVII**

**Affinity Health Plan SCHEDULE OF BENEFITS  
Bronze Level  
[Standard] [Child Only]**

<p><b>COST-SHARING</b></p> <p><b>Deductible</b></p> <ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul> <p><b>Out-of-Pocket Limit</b></p> <ul style="list-style-type: none"> <li>Individual</li> <li>Family</li> </ul>	<p><b>Participating Provider Member Responsibility for Cost-Sharing</b></p> <p>\$3,500 \$7,000</p> <p>\$6,850 \$13,700</p>	<p><b>Non-Participating Provider Member Responsibility for Cost-Sharing</b></p> <p>Non-Participating Provider services are not Covered except as required for emergency care and Urgent Care.</p>	
<p><b>OFFICE VISITS</b></p>	<p><b>Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Non-Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Limits</b></p>
<p>Primary Care Office Visits (or Home Visits)</p>	<p>50% Coinsurance 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>50% Coinsurance 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><b>PREVENTIVE CARE</b></p>	<p><b>Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Non-Participating Provider Member Responsibility for Cost-Sharing</b></p>	<p><b>Limits</b></p>
<ul style="list-style-type: none"> <li>Well Child Visits and Immunizations*</li> </ul>	<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"> <li>• Adult Annual Physical Examinations*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>• Adult Immunizations*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>• Routine Gynecological Services/Well Woman Exams*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>• Mammography Screenings*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>• Sterilization Procedures for Women*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>• Vasectomy</li> </ul>	See Surgical Services Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>• Bone Density Testing*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	

<ul style="list-style-type: none"> <li>Screening for Prostate Cancer <ul style="list-style-type: none"> <li>Performed in PCP Office</li> </ul> </li>   <li>Performed in Specialist Office</li>   <li>All other preventive services required by USPSTF and HRSA</li>   <li>*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> </ul>	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance 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>	
<b>EMERGENCY CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
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	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<b>Preauthorization required</b>	<b>Preauthorization required</b>		
Emergency Department	50% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Copayment / Coinsurance waived if Hospital admission			
Urgent Care Center	50% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
<b>PROFESSIONAL SERVICES and OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Advanced Imaging Services			See benefit for description
<ul style="list-style-type: none"> <li>Performed in a Freestanding Radiology Facility or Office Setting</li> </ul>	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul>	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<b>Preauthorization required</b>	<b>Preauthorization required</b>		
Allergy Testing and Treatment			See benefit for description
<ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul>	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

<ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> </ul>	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<b>Preauthorization required</b>	<b>Preauthorization required</b>		
Ambulatory Surgical Center Facility Fee	50% Coinsurance after Deductible	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	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<b>Preauthorization required</b>	<b>Preauthorization required</b>		
Autologous Blood Banking	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefits for description
<b>Preauthorization required</b>	<b>Preauthorization required</b>		
Cardiac and Pulmonary Rehabilitation			See benefits for description
<ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> </ul>	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul>	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

<ul style="list-style-type: none"> <li>Performed as Inpatient Hospital Services</li> </ul>	Included as part of inpatient Hospital service Cost-Sharing	Included as part of inpatient Hospital service Cost-Sharing	
<b>Preauthorization required</b>	<b>Preauthorization required</b>		
Chemotherapy			See benefit for description
<ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul>	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> </ul>	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul>	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<b>Preauthorization required</b>	<b>Preauthorization required</b>		
Chiropractic Services	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<b>Preauthorization required</b>	<b>Preauthorization required</b>		
Clinical Trials	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description
<b>Preauthorization required</b>	<b>Preauthorization required</b>	<b>Preauthorization required</b>	

<p>Diagnostic Testing</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance 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>Dialysis</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Freestanding Center or Specialist Office Setting</li> <li>Performed as Outpatient Hospital Services</li> </ul> <p><b>Preauthorization required with first encounter and after 12 visits</b></p>	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p><b>Preauthorization required with first encounter and after 12 visits</b></p>	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p><b>Preauthorization required with first encounter and after 12 visits</b></p>	<p>See benefit for description</p> <p>Dialysis performed by Non-Participating Providers is limited to 12 visits per calendar year</p>

Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)  <b>Preauthorization required after 12 visits</b>	50% Coinsurance after Deductible  <b>Preauthorization required after 12 visits</b>	Non-Participating Provider services are not Covered and You pay the full cost	60 visits per condition, per lifetime combined therapies
Home Health Care  <b>Preauthorization required after 12 visits</b>	50% Coinsurance after Deductible  <b>Preauthorization required after 12 visits</b>	Non-Participating Provider services are not Covered and You pay the full cost	40 visits per Plan Year
Infertility Services  <b>Preauthorization required</b>	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)  <b>Preauthorization required</b>	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Infusion Therapy  <ul style="list-style-type: none"> <li>• Performed in a PCP Office</li> <li>• Performed in Specialist Office</li> <li>• Performed as Outpatient Hospital Services</li> </ul>	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance 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>	See benefit for description

<ul style="list-style-type: none"> <li>Home Infusion Therapy</li> </ul> <p><b>Preauthorization required for first encounter and beyond 6 encounters</b></p>	50% Coinsurance 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	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Laboratory Procedures			See benefit for description
<ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul>	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Performed in a Freestanding Laboratory Facility or Specialist Office</li> </ul>	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul>	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Maternity and Newborn Care			See benefit for description
<ul style="list-style-type: none"> <li>Prenatal Care</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	

<ul style="list-style-type: none"> <li>Inpatient Hospital Services and Birthing Center</li> </ul>	50% Coinsurance 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
<ul style="list-style-type: none"> <li>Physician and Midwife Services for Delivery</li> </ul>	50% Coinsurance per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Breast Pump</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	Covered for duration of breast feeding  Limit of one (1) per pregnancy
<ul style="list-style-type: none"> <li>Postnatal Care</li> </ul>	Included in Physician and Midwife Services for Delivery Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	
<b>Preauthorization required for inpatient services and breast pump</b>	<b>Preauthorization required for inpatient services and breast pump</b>		
Outpatient Hospital Surgery Facility Charge	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<b>Preauthorization required</b>	<b>Preauthorization required</b>		

Preadmission Testing	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<b>Preauthorization required</b>	<b>Preauthorization required</b>		
Diagnostic Radiology Services			See benefit for description
<ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul>	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Performed in a Freestanding Radiology Facility or Specialist Office</li> </ul>	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul>	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Therapeutic Radiology Services			See benefit for description
<ul style="list-style-type: none"> <li>Performed in a Freestanding Radiology Facility or Specialist Office</li> </ul>	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul>	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<b>Preauthorization required</b>	<b>Preauthorization required</b>		

<p>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p> <p><b>Preauthorization required on 13<sup>th</sup> visit and beyond</b></p>	<p>50% Coinsurance after Deductible</p> <p><b>Preauthorization required on 13<sup>th</sup> visit and beyond</b></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>
<p>Second Opinions on the Diagnosis of Cancer, Surgery and Other</p> <p><b>Preauthorization required</b></p>	<p>50% Coinsurance after Deductible</p> <p><b>Preauthorization required</b></p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist</p>	<p>See benefit for description</p>
<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"> <li>Inpatient Hospital Surgery</li> </ul>	<p>50% Coinsurance 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><b>All transplants must be performed at designated Facilities</b></p> <p><b>Interruption of Pregnancy one (1) procedure for one (1) Member per Plan Year</b></p>

<ul style="list-style-type: none"> <li>• Outpatient Hospital Surgery</li> </ul>	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>• Surgery Performed at an Ambulatory Surgical Center</li> </ul>	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>• Office Surgery</li> </ul>	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<b>Preauthorization required</b>	<b>Preauthorization required</b>		
<b>ADDITIONAL SERVICES, EQUIPMENT and DEVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
ABA Treatment for Autism Spectrum Disorder	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<b>Preauthorization required</b>	<b>Preauthorization required</b>		
Assistive Communication Devices for Autism Spectrum Disorder	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<b>Preauthorization required</b>	<b>Preauthorization required</b>		

<p>Diabetic Equipment, Supplies and Self-Management Education</p> <ul style="list-style-type: none"> <li>• Diabetic Equipment, Supplies and Insulin (30-day supply)</li> <li>• Diabetic Education</li> </ul> <p><b>Preauthorization required for insulin pump</b></p>	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p><b>Preauthorization required for insulin pump</b></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>Durable Medical Equipment and Braces</p> <p><b>Preauthorization required for DME items greater than cost of \$500 (NY Medicare rate/current fee schedule)</b></p>	<p>50% Coinsurance after Deductible</p> <p><b>Preauthorization required for DME items greater than cost of \$500 (NY Medicare rate/current fee schedule)</b></p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>External Hearing Aids</p> <p><b>Preauthorization required</b></p>	<p>50% Coinsurance after Deductible</p> <p><b>Preauthorization required</b></p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>Single purchase once every three (3) years</p>
<p>Cochlear Implants</p> <p><b>Preauthorization required</b></p>	<p>50% Coinsurance after Deductible</p> <p><b>Preauthorization required</b></p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>One (1) per ear per time Covered</p>

<p>Hospice Care</p> <ul style="list-style-type: none"> <li>Inpatient</li> <li>Outpatient</li> </ul> <p><b>Preauthorization required</b></p>	<p>50% Coinsurance per admission after Deductible</p> <p>50% Coinsurance after Deductible</p> <p><b>Preauthorization required</b></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>210 days per Plan Year</p> <p>Five (5) visits for family bereavement counseling</p>
<p>Medical Supplies</p> <p><b>Preauthorization required</b></p>	<p>50% Coinsurance after Deductible</p> <p><b>Preauthorization required</b></p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Prosthetic Devices</p> <ul style="list-style-type: none"> <li>External</li> <li>Internal</li> </ul> <p><b>Preauthorization required</b></p>	<p>50% Coinsurance after Deductible</p> <p>Included as part of inpatient Hospital service Cost-Sharing</p> <p><b>Preauthorization required</b></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>One (1) prosthetic device, per limb, per lifetime</p> <p>Unlimited; See benefit for description</p>

<b>INPATIENT SERVICES and FACILITIES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<p>Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)</p> <p><b>Preauthorization required. However, Preauthorization is not required for emergency admissions.</b></p>	<p>50% Coinsurance per admission after Deductible</p> <p><b>Preauthorization required. However, Preauthorization is not required for emergency admissions.</b></p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Observation Stay</p>	<p>50% Coinsurance after Deductible; Copay is waived if direct transfer from outpatient surgery setting to an observation care unit</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)</p> <p><b>Preauthorization required</b></p>	<p>50% Coinsurance per admission after Deductible</p> <p><b>Preauthorization required</b></p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>200 days per Plan Year</p>
<p>Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)</p> <p><b>Preauthorization required</b></p>	<p>50% Coinsurance per admission after Deductible</p> <p><b>Preauthorization required</b></p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>60 consecutive days per condition, per lifetime Speech and physical therapy are only Covered following a Hospital stay or surgery</p>

<b>MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<p>Inpatient Mental Health Care (for a continuous confinement when in a Hospital)</p> <p><b>Preauthorization required. However, Preauthorization is not required for emergency admissions.</b></p>	<p>50% Coinsurance per admission after Deductible</p> <p><b>Preauthorization required. However, Preauthorization is not required for emergency admissions.</b></p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)</p>	<p>50% Coinsurance 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>Inpatient Substance Use Services (for a continuous confinement when in a Hospital)</p> <p><b>Preauthorization required. However, Preauthorization is not required for emergency admissions.</b></p>	<p>50% Coinsurance per admission after Deductible</p> <p><b>Preauthorization required. However, Preauthorization is not required for emergency admissions.</b></p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Outpatient Substance Use Services</p>	<p>50% Coinsurance after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>Unlimited; Up to 20 visits per Plan Year may be used for family counseling</p>

<b>PRESCRIPTION DRUGS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<b>Retail Pharmacy</b>			
30-day supply			See benefit for description
Tier 1	\$10 Copayment after Deductible		
Tier 2	\$35 Copayment after Deductible		
Tier 3	\$70 Copayment after Deductible		
<b>Mail Order Pharmacy</b>			
Up to a 90-day supply			See benefit for description
Tier 1	\$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Tier 2	\$87.50 Copayment after Deductible		
Tier 3	\$175 Copayment after Deductible		
Enteral Formulas			See benefit for description
Tier 1	\$10 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Tier 2	\$35 Copayment after Deductible		
Tier 3	\$70 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<b>Preauthorization required</b>	<b>Preauthorization required</b>		

<b>WELLNESS BENEFITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	
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
<b>PEDIATRIC DENTAL and VISION CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<b>Pediatric Dental Care</b> <ul style="list-style-type: none"> <li>• Preventive Dental Care</li> <li>• Routine Dental Care</li> <li>• Major Dental (Endodontics, Periodontics and Prosthodontics)</li> <li>• Orthodontics</li> </ul> <b>Orthodontics and major dental require Preauthorization</b>	50% Coinsurance after Deductible  50% Coinsurance after Deductible  50% Coinsurance after Deductible  50% Coinsurance after Deductible  <b>Orthodontics and major dental require Preauthorization</b>	Non-Participating Provider services are not Covered and You pay the full cost	Pediatric dental option must be selected at time of Enrollment.  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) to 12-month intervals
<b>Pediatric Vision Care</b> <ul style="list-style-type: none"> <li>• Exams</li> <li>• Lenses and Frames</li> </ul>	50% Coinsurance after Deductible  50% Coinsurance after Deductible  50% Coinsurance	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;

<ul style="list-style-type: none"> <li>Contact Lenses</li> </ul> <p><b>Contact lenses require Preauthorization</b></p>	<p>after Deductible</p> <p><b>Contact lenses require Preauthorization</b></p>		
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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.