

**SECTION XXVII**  
**Affinity Health Plan SCHEDULE OF BENEFITS**  
**Platinum 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>\$0 \$0</p> <p>\$2,000 \$4,000</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>\$15 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>\$35 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><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> </ul>	\$15 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Performed in Specialist Office</li> </ul>	\$35 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>All other preventive services required by USPSTF and HRSA</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>*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> </ul>	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	
<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)	\$100 Copayment after Deductible	\$100 Copayment after Deductible	See benefit for description

Non-Emergency Ambulance Services	\$100 Copayment 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	\$100 Copayment after Deductible	\$100 Copayment after Deductible	See benefit for description
Copayment / Coinsurance waived if Hospital admission			
Urgent Care Center	\$55 Copayment after Deductible	\$55 Copayment 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>	\$35 Copayment 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>	\$35 Copayment 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>	\$15 Copayment 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>	\$35 Copayment 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	\$100 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Anesthesia Services (all settings)	Covered in full	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	10% 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>	\$15 Copayment 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>	\$15 Copayment 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>	\$15 Copayment 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>	\$15 Copayment 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>	\$15 Copayment 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	\$35 Copayment 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>\$15 Copayment after Deductible</p> <p>\$35 Copayment after Deductible</p> <p>\$35 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>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>\$15 Copayment after Deductible</p> <p>\$15 Copayment after Deductible</p> <p>\$15 Copayment after Deductible</p> <p><b>Preauthorization required with first encounter and after 12 visits</b></p>	<p>\$15 Copayment after Deductible</p> <p>\$15 Copayment after Deductible</p> <p>\$15 Copayment 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)	\$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	60 visits per condition, per lifetime combined therapies
<b>Preauthorization required after 12 visits</b>	<b>Preauthorization required after 12 visits</b>		
Home Health Care	\$15 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	40 visits per Plan Year
<b>Preauthorization required after 12 visits</b>	<b>Preauthorization required after 12 visits</b>		
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
<b>Preauthorization required</b>	<b>Preauthorization required</b>		
Infusion Therapy			See benefit for description
<ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul>	\$15 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Performed in Specialist Office</li> </ul>	\$15 Copayment 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>	\$15 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



<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>	<p>\$15 Copayment after Deductible</p> <p><b>Preauthorization required for first encounter and beyond 6 encounters</b></p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	
<p>Inpatient Medical Visits</p> <p><b>Preauthorization required</b></p>	<p>\$0 Copayment 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>Laboratory Procedures</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Freestanding Laboratory Facility or Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$15 Copayment after Deductible</p> <p>\$35 Copayment after Deductible</p> <p>\$35 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>Maternity and Newborn Care</p> <ul style="list-style-type: none"> <li>Prenatal Care</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>Inpatient Hospital Services and Birthing Center</li> </ul>	\$500 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
<ul style="list-style-type: none"> <li>Physician and Midwife Services for Delivery</li> </ul>	\$100 Copayment 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	\$100 Copayment 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	\$0 Copayment 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>	\$15 Copayment 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>	\$35 Copayment 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>	\$35 Copayment 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>	\$15 Copayment 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> <p><b>Preauthorization required</b></p>	<p>\$15 Copayment 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>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>\$25 Copayment 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>\$35 Copayment After Deductible</p> <p><b>Preauthorization required</b></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>\$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><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>	\$100 Copayment 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>	\$100 Copayment 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>	\$15 Copayment after Deductible for PCP, \$35 Copayment after Deductible for Specialist based on type of physician performing the service	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	\$15 Copayment 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	\$15 Copayment 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>\$15 Copayment after Deductible</p> <p>\$15 Copayment 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>10% 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>10% 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>

Cochlear Implants	10% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	One (1) per ear per time Covered
<b>Preauthorization required</b>	<b>Preauthorization required</b>		
Hospice Care			
<ul style="list-style-type: none"> <li>Inpatient</li> </ul>	\$500 Copayment per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	210 days per Plan Year
<ul style="list-style-type: none"> <li>Outpatient</li> </ul>	\$15 Copayment after Deductible		Five (5) visits for family bereavement counseling
<b>Preauthorization required</b>	<b>Preauthorization required</b>	Non-Participating Provider services are not Covered and You pay the full cost	
Medical Supplies	10% 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>		
Prosthetic Devices			
<ul style="list-style-type: none"> <li>External</li> </ul>	10% 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"> <li>Internal</li> </ul>	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
<b>Preauthorization required</b>	<b>Preauthorization required</b>		

<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>\$500 Copayment 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>\$100 Copayment 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>\$500 Copayment 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>\$500 Copayment 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>\$500 Copayment 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>\$15 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>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>\$500 Copayment 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>\$15 Copayment 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 not subject to Deductible		
Tier 2	\$30 Copayment not subject to Deductible		
Tier 3	\$60 Copayment not subject to Deductible		
<b>Mail Order Pharmacy</b>			
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	\$75 Copayment not subject to Deductible		
Tier 3	\$150 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	\$30 Copayment not subject to Deductible		
Tier 3	\$60 Copayment not subject to Deductible		
<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 data-bbox="147 730 431 793">• Preventive Dental Care</li> <li data-bbox="147 932 396 995">• Routine Dental Care</li> <li data-bbox="147 1134 418 1268">• Major Dental (Endodontics, Periodontics and Prosthodontics)</li> <li data-bbox="147 1302 367 1339">• Orthodontics</li> </ul> <p data-bbox="147 1407 396 1533"><b>Orthodontics and major dental require Preauthorization</b></p>	<p data-bbox="453 730 672 793">\$15 Copayment after Deductible</p> <p data-bbox="453 932 672 995">\$15 Copayment after Deductible</p> <p data-bbox="453 1134 672 1197">\$15 Copayment after Deductible</p> <p data-bbox="453 1302 672 1365">\$15 Copayment after Deductible</p> <p data-bbox="453 1398 704 1533"><b>Orthodontics and major dental require Preauthorization</b></p>	<p data-bbox="740 730 1013 865">Non-Participating Provider services are not Covered and You pay the full cost</p>	<p data-bbox="1036 630 1446 693">Pediatric dental option must be selected at time of Enrollment.</p> <p data-bbox="1036 730 1471 793">One (1) dental exam and cleaning per six (6)-month period</p> <p data-bbox="1036 831 1463 961">Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) to 12-month intervals</p>
<b>Pediatric Vision Care</b> <ul style="list-style-type: none"> <li data-bbox="147 1646 289 1675">• Exams</li> <li data-bbox="147 1814 354 1877">• Lenses and Frames</li> </ul>	<p data-bbox="453 1646 672 1709">\$15 Copayment after Deductible</p> <p data-bbox="453 1814 691 1877">10% Coinsurance after Deductible</p>	<p data-bbox="740 1646 1013 1780">Non-Participating Provider services are not Covered and You pay the full cost</p>	<p data-bbox="1036 1612 1403 1675">One (1) exam per 12-month period</p> <p data-bbox="1036 1814 1438 1877">One (1) prescribed lenses and frames per 12-month period;</p>

<ul style="list-style-type: none"> <li>Contact Lenses</li> </ul> <p><b>Contact lenses require Preauthorization</b></p>	<p>10% Coinsurance 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.