

**SECTION XXVII**

**Affinity Health Plan SCHEDULE OF BENEFITS  
Silver CSR 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>\$1,500 \$3,000</p> <p>\$5,450 \$10,900</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>\$30 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>\$50 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> <li>• Adult Annual</li> </ul>	<p>Covered in full</p> <p>Covered in full</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services</p>	<p>See benefit for description</p>

Physical Examinations*		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	
• Mammography Screenings*	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	

<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>\$30 Copayment after Deductible</p> <p>\$50 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>	
<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)	\$150 Copayment after Deductible	\$150 Copayment after Deductible	See benefit for description
Non-Emergency Ambulance Services  <b>Preauthorization required</b>	\$150 Copayment after Deductible  <b>Preauthorization required</b>	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

Emergency Department  Copayment / Coinsurance waived if Hospital admission	\$150 Copayment after Deductible	\$150 Copayment after Deductible	See benefit for description
Urgent Care Center	\$70 Copayment after Deductible	\$70 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  <ul style="list-style-type: none"> <li>Performed in a Freestanding Radiology Facility or Office Setting</li> <li>Performed as Outpatient Hospital Services</li> </ul> <b>Preauthorization required</b>	\$50 Copayment after Deductible  \$50 Copayment after Deductible  <b>Preauthorization required</b>	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
Allergy Testing and Treatment  <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> </ul> <b>Preauthorization required</b>	\$30 Copayment after Deductible  \$50 Copayment after Deductible  <b>Preauthorization required</b>	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

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	25% 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>	\$30 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>	\$30 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>		

<p>Chemotherapy</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><b>Preauthorization required</b></p>	<p>\$30 Copayment after Deductible</p> <p>\$30 Copayment after Deductible</p> <p>\$30 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>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>Chiropractic Services</p> <p><b>Preauthorization required</b></p>	<p>\$50 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>Clinical Trials</p> <p><b>Preauthorization required</b></p>	<p>Use Cost-Sharing for appropriate service</p> <p><b>Preauthorization required</b></p>	<p>Use Cost-Sharing for appropriate service</p> <p><b>Preauthorization required</b></p>	<p>See benefit for description</p>
<p>Diagnostic Testing</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul>	<p>\$30 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>

<ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$50 Copayment after Deductible</p> <p>\$50 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>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>\$30 Copayment after Deductible</p> <p>\$30 Copayment after Deductible</p> <p>\$30 Copayment after Deductible</p> <p><b>Preauthorization required with first encounter and after 12 visits</b></p>	<p>\$30 Copayment after Deductible</p> <p>\$30 Copayment after Deductible</p> <p>\$30 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>
<p>Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p> <p><b>Preauthorization required after 12 visits</b></p>	<p>\$30 Copayment after Deductible</p> <p><b>Preauthorization required after 12 visits</b></p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>60 visits per condition, per lifetime combined therapies</p>

Home Health Care	\$30 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> <li>• Performed in Specialist Office</li> <li>• Performed as Outpatient Hospital Services</li> <li>• Home Infusion Therapy</li> </ul>	<p>\$30 Copayment after Deductible</p> <p>\$30 Copayment after Deductible</p> <p>\$30 Copayment after Deductible</p> <p>\$30 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>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>
<b>Preauthorization required for first encounter and beyond 6 encounters</b>	<b>Preauthorization required for first encounter and beyond 6 encounters</b>		



Inpatient Medical Visits	\$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>		
Laboratory Procedures			See benefit for description
<ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul>	\$30 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 Laboratory Facility or Specialist Office</li> </ul>	\$50 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>	\$50 Copayment 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>	\$1,500 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>		

<p>Diagnostic Radiology Services</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Freestanding Radiology Facility or Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$30 Copayment after Deductible</p> <p>\$50 Copayment after Deductible</p> <p>\$50 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>Therapeutic Radiology Services</p> <ul style="list-style-type: none"> <li>Performed in a Freestanding Radiology Facility or Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul> <p><b>Preauthorization required</b></p>	<p>\$30 Copayment after Deductible</p> <p>\$30 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>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><b>Preauthorization required on 13<sup>th</sup> visit and beyond</b></p>	<p>\$30 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</p>
<p>Second Opinions on the Diagnosis of Cancer, Surgery and Other</p> <p><b>Preauthorization required</b></p>	<p>\$50 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>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> <li>• Outpatient Hospital Surgery</li> </ul>	<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>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>Surgery Performed at an Ambulatory Surgical Center</li> <li>Office Surgery</li> </ul>	<p>\$100 Copayment after Deductible</p> <p>\$30 Copayment after Deductible for PCP, \$50 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> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	
<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	\$30 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	\$30 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>		
Diabetic Equipment, Supplies and Self-Management Education			See benefit for description
<ul style="list-style-type: none"> <li>Diabetic Equipment, Supplies and Insulin (30-day supply)</li> </ul>	\$30 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

<ul style="list-style-type: none"> <li>Diabetic Education</li> </ul> <p><b>Preauthorization required for insulin pump</b></p>	<p>\$30 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>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>25% 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>25% 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>25% 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>\$1,500 Copayment per admission after Deductible</p> <p>\$30 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>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>

Medical Supplies	25% 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>	25% 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>
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)	\$1,500 Copayment per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<b>Preauthorization required. However, Preauthorization is not required for emergency admissions.</b>	<b>Preauthorization required. However, Preauthorization is not required for emergency admissions.</b>		

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)	\$1,500 Copayment per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	200 days per Plan Year
<b>Preauthorization required</b>	<b>Preauthorization required</b>		
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	\$1,500 Copayment per admission after Deductible	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
<b>Preauthorization required</b>	<b>Preauthorization required</b>		
<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>
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	\$1,500 Copayment per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<b>Preauthorization required. However, Preauthorization is not required for emergency admissions.</b>	<b>Preauthorization required. However, Preauthorization is not required for emergency admissions.</b>		



Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	\$30 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)	\$1,500 Copayment per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<b>Preauthorization required. However, Preauthorization is not required for emergency admissions.</b>	<b>Preauthorization required. However, Preauthorization is not required for emergency admissions.</b>		
Outpatient Substance Use Services	\$30 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Up to 20 visits per Plan Year may be used for family counseling
<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	\$35 Copayment not subject to Deductible		
Tier 3	\$70 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	\$87.50 Copayment not subject to Deductible		
Tier 3	\$175 Copayment not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
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		
<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>	\$30 Copayment after Deductible  \$30 Copayment after Deductible  \$30 Copayment after Deductible  \$30 Copayment after Deductible  <b>Orthodontics and major dental require Preauthorization</b>	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	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> <li>Contact Lenses</li> </ul> <b>Contact lenses require Preauthorization</b>	\$30 Copayment after Deductible  25% Coinsurance after Deductible  25% Coinsurance after Deductible  <b>Contact lenses require Preauthorization</b>	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;

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.