

SECTION XXVII

**Affinity Health Plan SCHEDULE OF BENEFITS
Silver 87 CSR Level 150-200%FPL
[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>\$250 \$500</p> <p>\$2,000 \$4,000</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>\$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>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 Non-Participating</p>	<p>See benefit for description</p>

<ul style="list-style-type: none"> • Adult Annual Physical Examinations* 	Covered in full	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>\$15 Copayment after Deductible</p> <p>\$35 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>	
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)	\$75 Copayment after Deductible	\$75 Copayment after Deductible	See benefit for description
Non-Emergency Ambulance Services	\$75 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	\$75 Copayment after Deductible	\$75 Copayment after Deductible	See benefit for description
Urgent Care Center	\$50 Copayment after Deductible	\$50 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 Preauthorization required	\$35 Copayment after Deductible \$35 Copayment after Deductible Preauthorization required	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"> Performed in a PCP Office Performed in a Specialist Office Preauthorization required	\$15 Copayment after Deductible \$35 Copayment after Deductible Preauthorization required	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	\$75 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
Preauthorization required	Preauthorization required		
Autologous Blood Banking	10% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefits for description
Preauthorization required	Preauthorization required		
Cardiac and Pulmonary Rehabilitation			See benefits for description
<ul style="list-style-type: none"> Performed in a Specialist Office 	\$15 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 	\$15 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> Performed as Inpatient Hospital Services 	Included as part of inpatient Hospital service Cost-Sharing	Included as part of inpatient Hospital service Cost-Sharing	
Preauthorization required	Preauthorization required		

<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 required</p>	<p>\$15 Copayment after Deductible</p> <p>\$15 Copayment after Deductible</p> <p>\$15 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>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>Preauthorization required</p>	<p>\$35 Copayment after Deductible</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>Clinical Trials</p> <p>Preauthorization required</p>	<p>Use Cost-Sharing for appropriate service</p> <p>Preauthorization required</p>	<p>Use Cost-Sharing for appropriate service</p> <p>Preauthorization required</p>	<p>See benefit for description</p>
<p>Diagnostic Testing</p> <ul style="list-style-type: none"> Performed in a PCP Office 	<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>

<ul style="list-style-type: none"> Performed in a Specialist Office Performed as Outpatient Hospital Services 	<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>Dialysis</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Freestanding Center or Specialist Office Setting Performed as Outpatient Hospital Services <p>Preauthorization required with first encounter and after 12 visits</p>	<p>\$15 Copayment after Deductible</p> <p>\$15 Copayment after Deductible</p> <p>\$15 Copayment after Deductible</p> <p>Preauthorization required with first encounter and after 12 visits</p>	<p>\$15 Copayment after Deductible</p> <p>\$15 Copayment after Deductible</p> <p>\$15 Copayment after Deductible</p> <p>Preauthorization required with first encounter and after 12 visits</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>Preauthorization required after 12 visits</p>	<p>\$25 Copayment after Deductible</p> <p>Preauthorization required after 12 visits</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 Preauthorization required after 12 visits	\$15 Copayment after Deductible Preauthorization required after 12 visits	Non-Participating Provider services are not Covered and You pay the full cost	40 visits per Plan Year
Infertility Services Preauthorization required	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) Preauthorization required	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"> Performed in a PCP Office Performed in Specialist Office Performed as Outpatient Hospital Services Home Infusion Therapy Preauthorization required for first encounter and beyond 6 encounters	<ul style="list-style-type: none"> \$15 Copayment after Deductible \$15 Copayment after Deductible \$15 Copayment after Deductible \$15 Copayment after Deductible Preauthorization required for first encounter and beyond 6 encounters	<ul style="list-style-type: none"> 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 Non-Participating Provider services are not Covered and You pay the full cost 	<ul style="list-style-type: none"> See benefit for description Home infusion counts toward home health care visit limits

Inpatient Medical Visits	\$0 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preauthorization required	Preauthorization required		
Laboratory Procedures			See benefit for description
<ul style="list-style-type: none"> Performed in a PCP Office 	\$15 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 Laboratory Facility or Specialist Office 	\$35 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 	\$35 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"> Prenatal Care 	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> Inpatient Hospital Services and Birthing Center 	\$250 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"> Physician and Midwife Services for Delivery 	\$75 Copayment per admission after Deductible	Non-Participating Provider services are not Covered and 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	Covered for duration of breast feeding Limit of one (1) per pregnancy
<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	\$75 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		

<p>Diagnostic Radiology Services</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Freestanding Radiology Facility or Specialist Office Performed as Outpatient Hospital Services 	<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>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>\$15 Copayment after Deductible</p> <p>\$15 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>

Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) Preauthorization required on 13th visit and beyond	\$25 Copayment after Deductible Preauthorization required on 13th visit and beyond	Non-Participating Provider services are not Covered and You pay the full cost 	60 visits per condition, per lifetime; per Plan Year combined therapies Speech and physical therapy are only Covered following a Hospital stay or surgery
Second Opinions on the Diagnosis of Cancer, Surgery and Other Preauthorization required	\$35 Copayment After Deductible Preauthorization required	Non-Participating Provider services are not Covered and You pay the full cost Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist	See benefit for description
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy) <ul style="list-style-type: none"> • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center 	\$75 Copayment after Deductible \$75 Copayment after Deductible \$75 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 All transplants must be performed at designated Facilities Interruption of Pregnancy one (1) procedure for one (1) Member per Plan Year

<ul style="list-style-type: none"> Office Surgery 	<p>\$15 Copayment after Deductible for PCP, \$35 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>Preauthorization required</p>	<p>Preauthorization required</p>		
<p>ADDITIONAL SERVICES, EQUIPMENT and DEVICES</p>	<p>Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Non-Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Limits</p>
<p>ABA Treatment for Autism Spectrum Disorder</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>Preauthorization required</p>	<p>Preauthorization required</p>		
<p>Assistive Communication Devices for Autism Spectrum Disorder</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>Preauthorization required</p>	<p>Preauthorization required</p>		
<p>Diabetic Equipment, Supplies and Self-Management Education</p>			<p>See benefit for description</p>
<ul style="list-style-type: none"> Diabetic Equipment, Supplies and Insulin (30-day supply) 	<p>\$15 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	
<ul style="list-style-type: none"> Diabetic Education 	<p>\$15 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	
<p>Preauthorization required for insulin pump</p>	<p>Preauthorization required for insulin pump</p>		

Durable Medical Equipment and Braces Preauthorization required for DME items greater than cost of \$500 (NY Medicare rate/current fee schedule)	10% 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	10% 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	10% 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 Preauthorization required	\$250 Copayment per admission after Deductible \$15 Copayment after Deductible Preauthorization required	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
Medical Supplies Preauthorization required	10% Coinsurance after Deductible Preauthorization required	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

<p>Prosthetic Devices</p> <ul style="list-style-type: none"> External Internal <p>Preauthorization required</p>	<p>10% Coinsurance 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>One (1) prosthetic device, per limb, per lifetime</p> <p>Unlimited; See benefit for description</p>
<p>INPATIENT SERVICES and FACILITIES</p>	<p>Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Non-Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Limits</p>
<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>Preauthorization required. However, Preauthorization is not required for emergency admissions.</p>	<p>\$250 Copayment per admission after Deductible</p> <p>Preauthorization required. However, Preauthorization is not required for emergency admissions.</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>\$75 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>

Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)	\$250 Copayment per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	200 days per Plan Year
Preauthorization required	Preauthorization required		
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	\$250 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
Preauthorization required	Preauthorization required		
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)	\$250 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.		
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	\$15 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) Preauthorization required. However, Preauthorization is not required for emergency admissions.	\$250 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 Substance Use Services	\$15 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
PRESCRIPTION DRUGS	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy			
30-day supply			See benefit for description
Tier 1	\$9 Copayment not subject to Deductible		
Tier 2	\$20 Copayment not subject to Deductible		
Tier 3	\$40 Copayment not subject to Deductible		
Mail Order Pharmacy			
Up to a 90-day supply			See benefit for description
Tier 1	\$22.50 Copayment not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Tier 2	\$50 Copayment not subject to Deductible		

Tier 3	\$100 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	\$9 Copayment not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Tier 2	\$20 Copayment not subject to Deductible		
Tier 3	\$40 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 • Routine Dental Care • Major Dental (Endodontics, Periodontics and Prosthodontics) 	<p>\$15 Copayment after Deductible</p> <p>\$15 Copayment after Deductible</p> <p>\$15 Copayment after Deductible</p>	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"> • Orthodontics <p>Orthodontics and major dental require Preauthorization</p>	<p>\$15 Copayment after Deductible</p> <p>Orthodontics and major dental require Preauthorization</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) to 12-month intervals</p>
<p>Pediatric Vision Care</p> <ul style="list-style-type: none"> • Exams • Lenses and Frames • Contact Lenses <p>Contact lenses require Preauthorization</p>	<p>\$15 Copayment after Deductible</p> <p>10% Coinsurance after Deductible</p> <p>10% Coinsurance after Deductible</p> <p>Contact lenses require Preauthorization</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>

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.