

**SECTION XXIX**

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

<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	
<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>Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a calendar year ending on December 31 of each year.</p>	<p>\$600 \$1,200</p> <p>\$4,000 \$8,000</p>	<p>Non-Participating Provider services are not Covered except as required for emergency care and Urgent Care.</p>	
<b>OFFICE VISITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Primary Care Office Visits (or Home Visits)	\$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Specialist Office Visits (or Home Visits)	\$40 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<b>PREVENTIVE CARE</b>	<b>Participating Provider Member</b>	<b>Non-Participating Provider Member</b>	<b>Limits</b>

	<b>Responsibility for Cost-Sharing</b>	<b>Responsibility for Cost-Sharing</b>	
<ul style="list-style-type: none"> <li>Well Child Visits and Immunizations*</li> </ul>	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<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>Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer</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	

<ul style="list-style-type: none"> <li>• Screening for Prostate Cancer <ul style="list-style-type: none"> <li>• Performed in PCP Office</li> <li>• Performed in Specialist Office</li> </ul> </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>\$25 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p> <p>Covered in full</p> <p>Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)</p>	<p>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>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	\$150 Copayment after Deductible	Non-Participating Provider services are not Covered	See benefit for description

		and You pay the full cost	
<b>Preauthorization required</b>	<b>Preauthorization required</b>		
Emergency Department  Copayment / Coinsurance waived if Hospital admission	\$150 Copayment after Deductible	\$150 Copayment after Deductible	See benefit for description
Urgent Care Center	\$60 Copayment after Deductible	\$60 Copayment after Deductible	See benefit for description
<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>	\$40 Copayment after Deductible  \$40 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost  Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<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> <li>Performed in a Specialist Office</li> </ul>	<p>\$25 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	
<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	20% 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>		
Cardiac and Pulmonary Rehabilitation			See benefit for description

<ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> <li>Performed as Inpatient Hospital Services</li> </ul> <p><b>Preauthorization required</b></p>	<p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p> <p>Included as part of inpatient Hospital service Cost-Sharing</p> <p><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>Included as part of inpatient Hospital service Cost-Sharing</p>	
<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>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p> <p>\$25 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>\$40 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered</p>	<p>See benefit for description</p>

		and You pay the full cost	
<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>	
Diagnostic Testing <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>\$25 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	See benefit for description
Dialysis <ul style="list-style-type: none"> <li>Performed in a</li> </ul>	\$25 Copayment	\$25 Copayment	See benefit for description Dialysis performed by Non-

<p>PCP Office</p> <ul style="list-style-type: none"> <li>Performed in a Freestanding Center or Specialist Office Setting</li> <li>Performed as Outpatient Hospital Services</li> </ul> <p><b>Preauthorization required</b></p>	<p>after Deductible</p> <p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p> <p><b>Preauthorization required</b></p>	<p>after Deductible</p> <p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p> <p><b>Preauthorization required</b></p>	<p>Participating Providers is limited to 10 visits per calendar year</p>
<p>Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p> <p><b>Preauthorization required after 6 visits</b></p>	<p>\$30 Copayment after Deductible</p> <p><b>Preauthorization required after 6 visits</b></p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>60 visits per condition, per Plan Year combined therapies</p>
<p>Home Health Care</p> <p><b>Preauthorization required</b></p>	<p>\$25 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>40 visits per Plan Year</p>
<p>Infertility Services</p> <p><b>Preauthorization required</b></p>	<p>Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory &amp; Diagnostic Procedures)</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>Infusion Therapy</p> <ul style="list-style-type: none"> <li>Performed in a</li> </ul>	<p>\$25 Copayment</p>	<p>Non-Participating</p>	<p>See benefit for description</p>



PCP Office	after Deductible	Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Performed in Specialist Office</li> </ul>	\$25 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>	\$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> <li>Home Infusion Therapy</li> </ul>	\$25 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
<b>Preauthorization required</b>	<b>Preauthorization required</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
Laboratory Procedures			See benefit for description

<ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul>	\$25 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>	\$40 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>	\$40 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Medications Administered in Office or Outpatient Facilities <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in Specialist Office</li> <li>Performed in Outpatient Facilities</li> </ul> <b>Preauthorization required</b>	\$25 Copayment after Deductible  \$40 Copayment after Deductible  \$25 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  Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Maternity and Newborn Care			See benefit for description

<ul style="list-style-type: none"> <li>• Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> </ul>	<p>Covered in full</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	
<ul style="list-style-type: none"> <li>• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> </ul>	<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>	
<ul style="list-style-type: none"> <li>• Inpatient Hospital Services and Birthing Center</li> </ul>	<p>\$1000 Copayment per admission after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>One (1) home care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early</p>
<ul style="list-style-type: none"> <li>• Physician and Midwife Services for Delivery</li> </ul>	<p>\$100 Copayment per admission after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	
<ul style="list-style-type: none"> <li>• Breast Pump</li> </ul>	<p>Covered in full</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>Covered for duration of breast feeding</p>
<ul style="list-style-type: none"> <li>• Postnatal Care</li> </ul>	<p>Included in Physician and Midwife Services for Delivery Cost-</p>	<p>Non-Participating Provider services are not Covered</p>	

<b>Preauthorization required for inpatient services and breast pump</b>	Sharing <b>Preauthorization required for inpatient services and breast pump</b>	and You pay the full cost	
Outpatient Hospital Surgery Facility Charge  <b>Preauthorization required</b>	\$100 Copayment after Deductible  <b>Preauthorization required</b>	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preadmission Testing  <b>Preauthorization required</b>	\$0 Copayment after Deductible  <b>Preauthorization required</b>	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Diagnostic Radiology Services  <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>\$25 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p> <p>\$40 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	See benefit for description
Therapeutic Radiology Services  <ul style="list-style-type: none"> <li>• Performed in a Freestanding</li> </ul>	\$25 Copayment after Deductible	Non-Participating Provider services	See benefit for description

<p>Radiology Facility or Specialist Office</p> <ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul> <p><b>Preauthorization required</b></p>	<p>\$25 Copayment after Deductible</p> <p><b>Preauthorization required</b></p>	<p>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>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p> <p><b>Preauthorization required after 6 visits</b></p>	<p>\$30 Copayment after Deductible</p> <p><b>Preauthorization required after 6 visits</b></p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>60 visits per condition, 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>\$40 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><b>Preauthorization required</b></p>	<p>See benefit for description</p>
<p>Surgical Services (including Oral Surgery; Reconstructive Breast Surgery;</p>			<p>See benefit for description</p>

<p>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> <li>Surgery Performed at an Ambulatory Surgical Center</li> <li>Office Surgery</li> </ul> <p><b>Preauthorization required</b></p>	<p>\$100 Copayment after Deductible</p> <p>\$100 Copayment after Deductible</p> <p>\$100 Copayment after Deductible</p> <p>\$25 Copayment after Deductible for PCP, \$40 Copayment after Deductible for Specialist based on type of physician performing the service</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>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p><b>All transplants must be performed at designated Facilities</b></p>
<p><b>ADDITIONAL SERVICES, EQUIPMENT and DEVICES</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>ABA Treatment for</p>	<p>\$25 Copayment</p>	<p>Non-Participating</p>	<p>See benefit for description</p>

Autism Spectrum Disorder	after Deductible	Provider services are not Covered and You pay the full cost	
<b>Preauthorization required</b>	<b>Preauthorization required</b>		
Assistive Communication Devices for Autism Spectrum Disorder	\$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
<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>	\$25 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>	\$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<b>Preauthorization required for insulin pump</b>	<b>Preauthorization required for insulin pump</b>		
Durable Medical Equipment and Braces	20% 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>		
External Hearing Aids	20% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Single purchase once every three (3) years

<b>Preauthorization required</b>	<b>Preauthorization required</b>		
Cochlear Implants	20% 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			See benefit for description
<ul style="list-style-type: none"> <li>Inpatient</li> </ul>	\$1000 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>	\$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Five (5) visits for family bereavement counseling
<b>Preauthorization required</b>	<b>Preauthorization required</b>		
Medical Supplies	20% 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			See benefit for description
<ul style="list-style-type: none"> <li>External</li> </ul>	20% Coinsurance after Deductible	Non-Participating Provider services are not Covered	One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements.



<ul style="list-style-type: none"> <li>Internal</li> </ul> <p><b>Preauthorization required</b></p>	<p>Included as part of inpatient Hospital service Cost-Sharing</p> <p><b>Preauthorization required</b></p>	<p>and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</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>\$1000 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>\$150 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>Skilled Nursing Facility (including Cardiac and Pulmonary</p>	<p>\$1000 Copayment per admission after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full</p>	<p>200 days per Plan Year</p>

Rehabilitation)		cost	
<b>Preauthorization required</b>	<b>Preauthorization required</b>		
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)	\$1000 Copayment per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	60 days per Plan Year combined therapies
<b>Preauthorization required</b>	<b>Preauthorization required</b>		
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)	\$1000 Copayment per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	60 days per Plan Year combined therapies. Speech and physical therapy 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)	\$1000 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)	\$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Inpatient Substance Use Services (for a continuous	\$1000 Copayment per admission after Deductible	Non-Participating Provider services are not Covered	See benefit for description

confinement when in a Hospital)  <b>Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.</b>	<b>Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.</b>	and You pay the full cost	
Outpatient Substance Use Services	\$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Unlimited; Up to 20 visits per Plan Year may be used for family counseling
<b>PRESCRIPTION DRUGS</b>  *Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF.	<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  Tier 1          Tier 2	\$10 Copayment not subject to Deductible          \$35 Copayment not subject to	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

Tier 3	Deductible  \$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	Non-Participating Provider services are not Covered and You pay the full cost	
Tier 3	\$175 Copayment not subject to Deductible		
Enteral Formulas			See benefit for description
Tier 1	\$10 Copayment not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Tier 2	\$35 Copayment not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

Tier 3	\$70 Copayment not subject to Deductible		
<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>  • Preventive Dental Care	\$25 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description One (1) dental exam and cleaning per six (6)-month period

<ul style="list-style-type: none"> <li>• Routine Dental Care</li> <li>• Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics)</li> <li>• Orthodontics</li> </ul> <p><b>Orthodontics and major dental require Preauthorization</b></p>	<p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p> <p>\$25 Copayment after Deductible</p> <p><b>Orthodontics and major dental require Preauthorization</b></p>		<p>Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) month intervals</p>
<p><b>Pediatric Vision Care</b></p> <ul style="list-style-type: none"> <li>• Exams</li> <li>• Lenses and Frames</li> <li>• Contact Lenses</li> </ul>	<p>\$25 Copayment after Deductible</p> <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p> <p>One (1) exam per 12-month period</p> <p>One (1) prescribed lenses and frames per 12-month period;</p>

<b>Contact lenses require Preauthorization</b>	<b>Contact lenses require Preauthorization</b>		
<b>Adult Dental Care</b>			
<ul style="list-style-type: none"> <li>Preventive &amp; Diagnostic Dental Care</li> <li>Routine Dental Care</li> <li>Whitening Treatment</li> </ul>	<p>\$0 Copayment not subject to Deductible</p> <p>\$0 Copayment not subject to Deductible</p> <p>\$0 Copayment not subject to Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p> <p>One (1) dental exam and cleaning per six (6)-month period intervals</p> <p>Two (2) bitewing x-rays at six (6)-month period intervals</p> <p>See benefit for description</p>
<b>Adult Vision Care</b>			
<ul style="list-style-type: none"> <li>Routine Exam</li> </ul>	<p>\$0 Copayment not subject to Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p> <p>One (1) exam per Plan Year</p>

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

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not Covered under the Contract, You will be responsible for the full cost of the services.