

**SECTION XXVII**

**Affinity Health Plan SCHEDULE OF BENEFITS  
Silver 73 CSR Level  
[Non-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>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><b>Participating Provider Member Responsibility for Cost-Sharing</b></p> <p>\$1,650 \$3,300</p> <p>\$5,700 \$11,400</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</b></p>	<p><b>Non-Participating Provider Member</b></p>	<p><b>Limits</b></p>

	<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> <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>Covered in full</p> <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> <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</b>	<b>Non-Participating Provider Member Responsibility for</b>	<b>Limits</b>

	<b>Cost-Sharing</b>	<b>Cost-Sharing</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	\$250 Copayment after Deductible	\$250 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  • Performed in a Freestanding Radiology Facility or Office Setting  • Performed as Outpatient Hospital Services  <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  • Performed in a	\$30 Copayment	Non-Participating	See benefit for description

<p>PCP Office</p> <ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> </ul> <p><b>Preauthorization required</b></p>	<p>after Deductible</p> <p>\$50 Copayment after Deductible</p> <p><b>Preauthorization required</b></p>	<p>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>Ambulatory Surgical Center Facility Fee</p>	<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>Anesthesia Services (all settings)</p> <p><b>Preauthorization required</b></p>	<p>Covered in full</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>Autologous Blood Banking</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>See benefit for description</p>
<p>Cardiac and Pulmonary Rehabilitation</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> <li>Performed as Inpatient Hospital Services</li> </ul> <p><b>Preauthorization required</b></p>	<p>\$30 Copayment after Deductible</p> <p>\$30 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>\$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>\$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>

<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			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 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	
Dialysis			See benefit for description
<ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul>	\$30 Copayment after Deductible	\$30 Copayment after Deductible	Dialysis performed by Non-Participating Providers is limited to 10 visits per calendar year
<ul style="list-style-type: none"> <li>Performed in a</li> </ul>	\$30 Copayment	\$30 Copayment	

<p>Freestanding Center or Specialist Office Setting</p> <ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul> <p><b>Preauthorization required</b></p>	<p>after Deductible</p> <p>\$30 Copayment after Deductible</p> <p><b>Preauthorization required</b></p>	<p>after Deductible</p> <p>\$30 Copayment after Deductible</p> <p><b>Preauthorization required</b></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>\$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>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 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 Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> <li>Home Infusion Therapy</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>Home infusion counts toward home health care visit limits</p>
<p>Inpatient Medical Visits</p>	<p>\$0 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>Laboratory Procedures</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 Freestanding Laboratory Facility or 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>Medications Administered in Office or Outpatient Facilities</p> <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> <p><b>Preauthorization required</b></p>	<p>\$30 Copayment after Deductible</p> <p>\$50 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>Maternity and Newborn Care</p> <ul style="list-style-type: none"> <li>Prenatal Care provided in accordance with the comprehensive guidelines supported by</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>

<p>USPSTF and HRSA</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>\$1,500 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-Sharing</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	
<p><b>Preauthorization required for inpatient services and breast pump</b></p>	<p><b>Preauthorization required for inpatient services and breast pump</b></p>		

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>	\$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 Radiology 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	

<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 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>\$50 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</p>			<p>See benefit for description</p>

<p>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> <li>• Surgery Performed at an Ambulatory Surgical Center</li> <li>• Office Surgery</li> </ul> <p><b>Preauthorization</b></p>	<p>\$100 Copayment after Deductible</p> <p>\$100 Copayment after Deductible</p> <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><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>
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<b>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  <b>Preauthorization required</b>	\$30 Copayment after Deductible  <b>Preauthorization required</b>	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder  <b>Preauthorization required</b>	\$30 Copayment after Deductible  <b>Preauthorization required</b>	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education  <ul style="list-style-type: none"> <li>• Diabetic Equipment, Supplies and Insulin (30-day supply)</li> <li>• Diabetic Education</li> </ul> <b>Preauthorization required for insulin pump</b>	\$30 Copayment after Deductible  \$30 Copayment after Deductible  <b>Preauthorization required for insulin pump</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
Durable Medical Equipment and Braces  <b>Preauthorization required</b>	25% Coinsurance after Deductible  <b>Preauthorization required</b>	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
External Hearing Aids	25% 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	25% 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>	\$1,500 Copayment per admission after Deductible	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
<ul style="list-style-type: none"> <li>Outpatient</li> </ul>	\$30 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<b>Preauthorization required</b>	<b>Preauthorization required</b>		
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			See benefit for description
<ul style="list-style-type: none"> <li>External</li> </ul>	25% Coinsurance	Non-Participating	One (1) prosthetic device, per



<ul style="list-style-type: none"> <li>Internal</li> </ul> <p><b>Preauthorization required</b></p>	<p>after Deductible</p> <p>Included as part of inpatient Hospital service Cost-Sharing</p> <p><b>Preauthorization required</b></p>	<p>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>limb, per lifetime with coverage for repairs and replacements.</p> <p>Unlimited; See benefit for description</p>
<p><b>INPATIENT SERVICES and FACILITIES</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>Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and</p>	<p>\$1,500 Copayment per admission after Deductible</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>

End of Life Care)  <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	\$250 Copayment after Deductible.	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)  <b>Preauthorization required</b>	\$1,500 Copayment per admission after Deductible  <b>Preauthorization required</b>	Non-Participating Provider services are not Covered and You pay the full cost	200 days per Plan Year
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy)  <b>Preauthorization required</b>	\$1,500 Copayment per admission after Deductible  <b>Preauthorization required</b>	Non-Participating Provider services are not Covered and You pay the full cost	60 days per Plan Year combined therapies
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)  <b>Preauthorization required</b>	\$1,500 Copayment per admission after Deductible  <b>Preauthorization required</b>	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>MENTAL HEALTH and SUBSTANCE</b>	<b>Participating Provider Member</b>	<b>Non-Participating Provider Member</b>	<b>Limits</b>

<b>USE DISORDER SERVICES</b>	<b>Responsibility for Cost-Sharing</b>	<b>Responsibility for Cost-Sharing</b>	
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)  <b>Preauthorization required. However, Preauthorization is not required for emergency admissions.</b>	\$1,500 Copayment per admission after Deductible  <b>Preauthorization required. However, Preauthorization is not required for emergency admissions.</b>	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
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)  <b>Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.</b>	\$1,500 Copayment per admission after Deductible  <b>Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.</b>	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
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>  *Certain Prescription Drugs are not subject to Cost-Sharing when	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>

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>Retail Pharmacy</b>			
30-day supply			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>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		
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>			See benefit for description
<ul style="list-style-type: none"> <li>Preventive Dental Care</li> </ul>	\$30 Copayment after Deductible	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"> <li>Routine Dental Care</li> </ul>	\$30 Copayment after Deductible		Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) month intervals

<ul style="list-style-type: none"> <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>\$30 Copayment after Deductible</p> <p>\$30 Copayment after Deductible</p> <p><b>Orthodontics and major dental require Preauthorization</b></p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</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>\$30 Copayment after Deductible</p> <p>25% Coinsurance after Deductible</p> <p>25% 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>	\$0 Copayment not subject to Deductible  \$0 Copayment not subject to Deductible  \$0 Copayment not subject to 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 intervals  Two (2) bitewing x-rays at six (6)-month period intervals  See benefit for description
<b>Adult Vision Care</b> <ul style="list-style-type: none"> <li>• Routine Exam</li> </ul>	\$0 Copayment not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description  One (1) exam per Plan Year

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.