

SECTION XXVII

**Affinity Health Plan SCHEDULE OF BENEFITS
Silver Level
[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>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>Participating Provider Member Responsibility for Cost-Sharing</p> <p>\$2,000 \$4,000</p> <p>\$6,750 \$13,500</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>\$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>PREVENTIVE CARE</p>	<p>Participating</p>	<p>Non-Participating</p>	<p>Limits</p>

	Provider Member Responsibility for Cost-Sharing	Provider Member Responsibility for Cost-Sharing	
<ul style="list-style-type: none"> Well Child Visits and Immunizations* 	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"> Adult Annual Physical Examinations* 	Covered in full	Non-Participating 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"> Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer 	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 	Covered in full	Non-Participating Provider services	

<p>Testing*</p> <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>\$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>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>	
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)	\$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 and	See benefit for description

Preauthorization required	Preauthorization required	You pay the full cost	
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
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	\$50 Copayment after Deductible \$50 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			See benefit for description

<ul style="list-style-type: none"> Performed in a PCP Office 	\$30 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 Specialist Office 	\$50 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Preauthorization required	Preauthorization required		
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
Preauthorization required.	Preauthorization required.		
Autologous Blood Banking	30% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preauthorization required	Preauthorization required		
Cardiac and Pulmonary Rehabilitation			See benefit for description
<ul style="list-style-type: none"> Performed in a Specialist Office 	\$30 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 	\$30 Copayment after Deductible	Non-Participating Provider services are not Covered and	

<p>Hospital Services</p> <ul style="list-style-type: none"> Performed as Inpatient Hospital Services <p>Preauthorization required</p>	<p>Included as part of inpatient Hospital service Cost-Sharing</p> <p>Preauthorization required</p>	<p>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"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services <p>Preauthorization required</p>	<p>\$30 Copayment after Deductible</p> <p>\$30 Copayment after Deductible</p> <p>\$30 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>\$50 Copayment after Deductible</p>	<p>Non-Participating Provider services are not Covered and</p>	<p>See benefit for description</p>

		You pay the full cost	
Preauthorization required	Preauthorization required		
Clinical Trials	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description
Preauthorization required	Preauthorization required	Preauthorization required	
Diagnostic Testing			See benefit for description
<ul style="list-style-type: none"> Performed in a PCP Office 	\$30 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 Specialist Office 	\$50 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 	\$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"> Performed in a PCP Office 	\$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"> Performed in a Freestanding Center or Specialist Office Setting Performed as Outpatient Hospital Services 	\$30 Copayment after Deductible	\$30 Copayment after Deductible	
Preauthorization required	Preauthorization required	Preauthorization required	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	\$30 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	60 visits per condition, per Plan Year combined therapies
Preauthorization required after 6 visits	Preauthorization required after 6 visits		
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
Preauthorization required	Preauthorization required		
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
Preauthorization required	Preauthorization required		
Infusion Therapy <ul style="list-style-type: none"> Performed in a PCP Office 	\$30 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

<ul style="list-style-type: none"> Performed in Specialist Office 	\$30 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 	\$30 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
<ul style="list-style-type: none"> Home Infusion Therapy 	\$30 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
Preauthorization required	Preauthorization required		
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"> Performed in a PCP Office 	\$30 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 	\$50 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 	\$50 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

<p>Medications Administered in Office or Outpatient Facilities</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in Specialist Office Performed in Outpatient Facilities <p>Preauthorization required</p>	<p>Included as part of the PCP office visit Cost-Sharing</p> <p>Included as part of the Specialist office visit Cost-Sharing</p> <p>\$30 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>	See benefit for description
Maternity and Newborn Care			See benefit for description

<ul style="list-style-type: none"> • Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA 	<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"> • Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA 	<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"> • Inpatient Hospital Services and Birthing Center 	<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"> • Physician and Midwife Services for Delivery 	<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"> • Breast Pump 	<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"> • Postnatal Care 	<p>Included in Physician and Midwife Services</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	

	for Delivery Cost-Sharing		
Preauthorization required for inpatient services and breast pump	Preauthorization required for inpatient services and breast pump		
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
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		
Diagnostic Radiology Services			See benefit for description
<ul style="list-style-type: none"> Performed in a PCP Office 	\$30 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 Radiology Facility or Specialist Office 	\$50 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full	
<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	\$50 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Therapeutic Radiology Services			See benefit for description

<ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility or Specialist Office Performed as Outpatient Hospital Services <p>Preauthorization required</p>	<p>\$30 Copayment after Deductible</p> <p>\$30 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>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p> <p>Preauthorization required after 6 visits</p>	<p>\$30 Copayment after Deductible</p> <p>Preauthorization required after 6 visits</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>Preauthorization required</p>	<p>\$50 Copayment After Deductible</p> <p>Preauthorization required</p>	<p>Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist</p> <p>Preauthorization required</p>	<p>See benefit for description</p>
<p>Surgical Services (including Oral Surgery; Reconstructive</p>			<p>See benefit for description</p> <p>All transplants must be</p>

<p>Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)</p> <ul style="list-style-type: none"> • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery <p>Preauthorization required</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>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>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>performed at designated Facilities</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</p>	<p>\$30 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	
Preauthorization required	Preauthorization required		
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
Preauthorization required	Preauthorization required		
Diabetic Equipment, Supplies and Self-Management Education			See benefit for description
<ul style="list-style-type: none"> • Diabetic Equipment, Supplies and Insulin (30-day supply) • Diabetic Education 	<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>	
Preauthorization required for insulin pump	Preauthorization required for insulin pump		
Durable Medical Equipment and Braces	30% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preauthorization required	Preauthorization required		
External Hearing Aids	30% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Single purchase once every three (3) years
Preauthorization	Preauthorization		

required	required		
Cochlear Implants	30% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	One (1) per ear per time Covered
Preauthorization required	Preauthorization required		
Hospice Care			See benefit for description
<ul style="list-style-type: none"> Inpatient 	\$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
<ul style="list-style-type: none"> Outpatient 	\$30 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Five (5) visits for family bereavement counseling
Preauthorization required	Preauthorization required		
Medical Supplies	30% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preauthorization required	Preauthorization required		
Prosthetic Devices			See benefit for description
<ul style="list-style-type: none"> External 	30% Coinsurance after Deductible	Non-Participating Provider services are not Covered and	One (1) prosthetic device, per limb, per lifetime with coverage for repairs and

<ul style="list-style-type: none"> Internal <p>Preauthorization required</p>	<p>Included as part of inpatient Hospital service Cost-Sharing</p> <p>Preauthorization required</p>	<p>You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>replacements.</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>\$1,500 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>

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) Preauthorization required	\$1,500 Copayment per admission after Deductible Preauthorization required	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) Preauthorization required	\$1,500 Copayment per admission after Deductible Preauthorization required	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) Preauthorization required	\$1,500 Copayment per admission after Deductible Preauthorization required	Non-Participating Provider services are not Covered and You pay the full cost	60 days per Plan Year combined therapies. Speech and physical therapy are only Covered following a Hospital stay or surgery
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) Preauthorization required. However, Preauthorization is not required for emergency admissions.	\$1,500 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 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) Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.	\$1,500 Copayment per admission after Deductible Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.	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	Unlimited; Up to 20 visits per Plan Year may be used for family counseling
PRESCRIPTION DRUGS *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.	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits

Retail Pharmacy			
30-day supply			
Tier 1	\$10 Copayment not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	\$35 Copayment not subject to Deductible		
Tier 3	\$70 Copayment not subject to Deductible		
Mail Order Pharmacy			
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		
Enteral Formulas			
Tier 1	\$10 Copayment not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Tier 2	\$35 Copayment not subject to Deductible		
Tier 3	\$70 Copayment not subject to Deductible		

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 <ul style="list-style-type: none"> • Preventive Dental Care • Routine Dental Care • Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics) • Orthodontics <p>Orthodontics and major dental require Preauthorization</p>	<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>Orthodontics and major dental require Preauthorization</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</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>Pediatric Vision Care</p> <ul style="list-style-type: none"> • Exams • Lenses and Frames • Contact Lenses <p>Contact lenses require Preauthorization</p>	<p>\$30 Copayment after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% 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>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> <p>.</p>
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Eligible American Indians, as determined by the NYSOH, are exempt from Cost-Sharing requirements when Covered Services are rendered by an Indian Health Service, Indian Tribe, Tribal Organization or Urban Indian Organization, or through Referral under contract health services.

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