NY State of Health - Standard American Native/Alaskan Indian Plan
Schedule of Benefits

COST-SHARING	Member Cost-Sharing Responsibility for Services from Participating Providers*
Deductible	
• Individual	NONE
• Family	NONE
Out-of-Pocket Limit	
• Individual	NONE
• Family	NONE

OFFICE VISITS	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits**
Primary Care Office Visits (or Home Visits)	Covered in full	
Specialist Office Visits (or Home Visits)	Covered in full	

PREVENTIVE CARE	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
• Well Child Visits and Immunizations*	Covered in full	
• Adult Annual Physical Examinations*	Covered in full	
• Adult Immunizations*	Covered in full	
Routine Gynecological Services/Well Woman Exams*	Covered in full	
• Mammography Screenings*	Covered in full	
• Sterilization Procedures for Women*	Covered in full	
• Vasectomy	Covered in full	
• Bone Density Testing*	Covered in full	
• Screening for Prostate Cancer	Covered in full	
• All other preventive services required by USPSTF and HRSA.	Covered in full	
• *Preventive services that are provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA are covered in full. Preventive services that are provided outside of these guidelines may be subject to cost-sharing.	Covered in full	

EMERGENCY CARE	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	Covered in full (for services provided from both participating and non-participating providers)	
Non-Emergency Ambulance Services	Covered in full	
Emergency Department Coinsurance waived if Hospital admission	Covered in full (for services provided from both participating and non-participating providers)	
Urgent Care Center	Covered in full	

NY State of Health - Standard American Native/Alaskan Indian Plan
Schedule of Benefits

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting	Covered in full	
Advanced Imaging Services • Performed as Outpatient Hospital Services	Covered in full **Preauthorization Required**	
Allergy Testing & Treatment	Covered in full **Preauthorization Required**	
Ambulatory Surgical Center Facility Fee	Covered in full **Preauthorization Required**	
Anesthesia Services (all settings)	Covered in full **Preauthorization Required**	
Autologous Blood Banking	Covered in full **Preauthorization Required**	
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office	Covered in full	
Cardiac & Pulmonary Rehabilitation • Performed as Outpatient Hospital Services	Covered in full	
Cardiac & Pulmonary Rehabilitation • Performed as Inpatient Hospital Services	Covered in full **Preauthorization Required**	
Chemotherapy • Performed in a PCP Office	Covered in full	
Chemotherapy • Performed in a Specialist Office	Covered in full	
Chemotherapy • Performed as Outpatient Hospital Services	Covered in full **Preauthorization Required**	
Chiropractic Services	Covered in full **Preauthorization Required**	
Diagnostic Testing • Performed in a PCP Office	Covered in full	
Diagnostic Testing • Performed in a Specialist office	Covered in full	
Diagnostic Testing • Performed as Outpatient Hospital Services	Covered in full **Preauthorization Required**	
Dialysis • Performed in a PCP Office	Covered in full (for services provided from both participating and non-participating providers)	Dialysis Performed by Non-Participating Providers is Covered Only Outside the Service Area and is Limited to 10 Visits Per Calendar Year
Dialysis • Performed in a Freestanding Center or Specialist Office Setting	Covered in full (for services provided from both participating and non-participating providers)	
Dialysis • Performed as Outpatient Hospital Services	Covered in full (for services provided from both participating and non-participating providers)	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	Covered in full **Preauthorization Required**	60 visits per condition, per lifetime combined therapies
Home Health Care	Covered in full **Preauthorization Required**	40 Visits per Plan Year
Infertility Services	Covered in full	
Infusion Therapy • Performed in a PCP Office	Covered in full	Home Infusion counts towards Home Health Care Visit Limits
Infusion Therapy • Performed in Specialist Office	Covered in full	
Infusion Therapy • Performed as Outpatient Hospital Services	Covered in full **Preauthorization Required**	
Infusion Therapy • Home Infusion Therapy	Covered in full	
Inpatient Medical Visits	Covered in full	

NY State of Health - Standard American Native/Alaskan Indian Plan
Schedule of Benefits

PROFESSIONAL SERVICES AND OUTPATIENT CARE *(cont'd)*	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Laboratory Procedures • Performed in a PCP Office	Covered in full	
Laboratory Procedures • Performed in a Freestanding Laboratory Facility or Specialist Office	Covered in full	
Laboratory Procedures • Performed as Outpatient Hospital Services	Covered in full	
Maternity & Newborn Care • Prenatal Care	Covered in Full	
Maternity & Newborn Care • Inpatient Hospital Services and Birthing Center	Covered in full	1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
Maternity & Newborn Care •Physician and Nurse Midwife Services for Delivery	Covered in full	
Maternity & Newborn Care • Breast Pump	Covered in Full **Preauthorization Required**	Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge	Covered in Full **Preauthorization Required**	
Preadmission Testing	Covered in Full **Preauthorization Required**	
Diagnostic Radiology Services • Performed in a PCP Office	Covered in full	
Diagnostic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office	Covered in full	
Diagnostic Radiology Services • Performed as Outpatient Hospital Services	Covered in Full **Preauthorization Required**	
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office	Covered in full	
Therapeutic Radiology Services • Performed as Outpatient Hospital Services	Covered in Full **Preauthorization Required**	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	Covered in Full **Preauthorization Required**	60 visits per condition, per lifetime combined therapies Speech and Physical Therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	Covered in full	
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Inpatient Hospital Surgery	Covered in full	
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Outpatient Hospital Surgery	Covered in full	
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Surgery Performed at an Ambulatory Surgical Center	Covered in full	
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants; & Interruption of Pregnancy) • Office Surgery	Covered in Full **Preauthorization Required**	

NY State of Health - Standard American Native/Alaskan Indian Plan
Schedule of Benefits

ADDITIONAL SERVICES, EQUIPMENT & DEVICES	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
ABA Treatment for Autism Spectrum Disorder	Covered in Full **Preauthorization Required**	680 Hours Per Plan Year
Assistive Communication Devices for Autism Spectrum Disorder	Covered in Full **Preauthorization Required**	
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-Day Supply)	Covered in full	
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Education	Covered in Full **Preauthorization Required**	
Durable Medical Equipment & Braces	Covered in Full **Preauthorization Required for Items Above $100**	
External Hearing Aids	Covered in Full **Preauthorization Required**	Single Purchase Once Every 3 Years
Cochlear Implants	Covered in Full **Preauthorization Required**	One Per Ear Per Time Covered
Hospice Care • Inpatient	Covered in full	210 Days per Plan Year 5 Visits for Family Bereavement Counseling
Hospice Care • Outpatient	Covered in Full **Preauthorization Required**	
Medical Supplies	Covered in Full **Preauthorization Required**	
Prosthetic Devices • External	Covered in Full **Preauthorization Required**	One prosthetic device, per limb, per lifetime
Prosthetic Devices • Internal	Covered in full	Unlimited

INPATIENT SERVICES & FACILITIES	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	Covered in full **Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.**	
Observation Stay	Covered in Full **Preauthorization Required**	
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	Covered in Full **Preauthorization Required**	200 Days Per Plan Year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	Covered in Full **Preauthorization Required**	60 Consecutive Days Per Condition, Per Lifetime

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)	Covered in full **Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.**	
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	Covered in full	
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)	Covered in full **Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.**	
Outpatient Substance Use Services	Covered in full	Unlimited; Up to 20 Visits a Plan Year May Be Used For Family Counseling

PRESCRIPTION DRUGS	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Retail Pharmacy 30 Day Supply Tier 1 Tier 2 Tier 3	 Covered in full Covered in full Covered in full	

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WELLNESS BENEFITS	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Gym Reimbursement	Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse, not subject to Deductible	Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse

PEDIATRIC DENTAL &VISION CARE***	Member Cost-Sharing Responsibility for Services from Participating Providers	Limits
Pediatric Dental Care • Preventive/Routine Dental Care	Covered in full	One Dental Exam & Cleaning Per 6 Month Period
Pediatric Dental Care • Major Dental (Endodontics & Prosthodontics)	Covered in full **Orthodontia & Major Dental Require Preauthorization**	
Pediatric Dental Care • Orthodontia	Covered in full **Orthodontia & Major Dental Require Preauthorization**	
Pediatric Vision Care • Exams	Covered in full	One Exam Per 12-Month Period; One Prescribed Lenses & Frames in a 12 Month Period
Pediatric Vision Care • Lenses & Frames	Covered in full	
Pediatric Vision Care • Contact Lenses	Covered in full **Contact Lenses Require Preauthorization**	

**NOTE: Unless otherwise noted, non-participating provider services are not covered and you pay the full cost*

***NOTE: Additional restrictions may apply. Complete benefit descriptions are available from insurers upon effectuation of coverage.*

****NOTE: Not all Standard Plans offer Pediatric Dental Benefits. A Stand-Alone Dental Plan may need to be purchased to receive these benefits. Please refer to the plan details on our website to see if this is included or discuss further with a navigator, broker, or customer service representative.*