Affinity Health Plan

Essential Plan 2016 Schedule of Benefits

	ESSENTIAL PLAN 1	ESSENTIAL PLAN 2	ESSENTIAL PLAN 3	ESSENTIAL PLAN 4
COST-SHARING				
Deductible				
• Individual	$0	$0	$0	$0
Out-of-Pocket Limit				
• Individual	$2,000	$200	$200	$0
OFFICE VISITS				
Primary Care Office Visits (or Home Visits)	$15	$0	$0	$0
Specialist Office Visits (or Home Visits)	$25	$0	$0	$0
PREVENTIVE CARE				
• Adult Annual Physical Examinations*	Covered in full	Covered in full	Covered in full	Covered in full
• Adult Immunizations*	Covered in full	Covered in full	Covered in full	Covered in full
• Routine Gynecological Services/Well Woman Exams*	Covered in full	Covered in full	Covered in full	Covered in full
• Mammography Screenings*	Covered in full	Covered in full	Covered in full	Covered in full
• Sterilization Procedures for Women*	Covered in full	Covered in full	Covered in full	Covered in full
• Vasectomy	Covered in full	Covered in full	Covered in full	Covered in full
• Bone Density Testing*	Covered in full	Covered in full	Covered in full	Covered in full
• Screening for Prostate Cancer Performed in PCP Office				
Performed in PCP Office	$15	$0	$0	$0
Performed in Specialist Office	$25	$0	$0	$0
• All other preventive services required by USPSTF and HRSA	Covered in full	Covered in full	Covered in full	Covered in full
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)
EMERGENCY CARE				
Pre-Hospital Emergency Medical Services (Ambulance Services)	$75	$0	$0	$0
Non-Emergency Ambulance Services **Preauthorization Required**	$75	$0	$0	$0
Emergency Department [Copayment / Coinsurance waived if Hospital admission]	$75	$0	$0	$0
Urgent Care Center	$25	$0	$0	$0

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PROFESSIONAL SERVICES and OUTPATIENT CARE				
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services **Preauthorization Required**	 $25 $25	 $0 $0	 $0 $0	 $0 $0
Allergy Testing and Treatment • Performed in a PCP Office • Performed in a Specialist Office	 $15 $25	 $0 $0	 $0 $0	 $0 $0
Ambulatory Surgical Center Facility Fee Anesthesia Services (all settings) **Preauthorization Required**	$50 Covered in full	$0 Covered in full	$0 Covered in full	$0 Covered in full
Autologous Blood Banking **Preauthorization Required**	5% coinsurance	Covered in full	Covered in full	Covered in full
Cardiac and Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services **Preauthorization Required**	 $25 $25 Included as part of inpatient Hospital service cost-sharing	 $0 $0 Included as part of inpatient Hospital service cost-sharing	 $0 $0 Included as part of inpatient Hospital service cost-sharing	 $0 $0 Included as part of inpatient Hospital service cost-sharing
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services **Preauthorization Requiredm (preauthorizaion not required for injectables and infusions)**	 $15 $15 $15 $15	 $0 $0 $0 $0	 $0 $0 $0 $0	 $0 $0 $0 $0
Chiropractic Services **Preauthorization Required**	$25	$0	$0	$0
Clinical Trials **Preauthorization Required**	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service

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Diagnostic Testing				
• Performed in a PCP Office	$15	$0	$0	$0
• Performed in a Specialist Office	$25	$0	$0	$0
• Performed as Outpatient Hospital Services	$25	$0	$0	$0
Dialysis				
• Performed in a PCP Office	$15	$0	$0	$0
• Performed in a Freestanding Center or Specialist Office Setting	$15	$0	$0	$0
• Performed as Outpatient Hospital Services	`	$0	$0	$0
Preauthorization required with first encounter and after 12 visits				
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) 60 visits per condition, per lifetime combined therapies **No preauthorization during 2016 calendar year. Starting 1/1/2017 preauth required after 6 visits.**	$15	$0	$0	$0
Home Health Care 40 visits Per Plan Year **Preauthorization required**	$15	$0	$0	$0
Infertility Services **Preauthorization Required**	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)
Infusion Therapy				
• Performed in a PCP Office	$15	$0	$0	$0
• Performed in Specialist Office	$15	$0	$0	$0
• Performed as Outpatient Hospital Services	$15	$0	$0	$0
• Home Infusion Therapy	$15	$0	$0	$0
(Home infusion counts toward home health care visit limits) **Preauthorization required for first encounter and beyond 6 encounters**				
Inpatient Medical Visits **Preauthorization Required**	$0 per admission	$0 per admission	$0 per admission	$0 per admission
Laboratory Procedures				
• Performed in a PCP Office	$15	$0	$0	$0
• Performed in a Freestanding Laboratory Facility or Specialist Office	$25	$0	$0	$0
• Performed as Outpatient Hospital Services	$50	$0	$0	$0

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Maternity and Newborn Care				
• Prenatal Care	$0	$0	$0	$0
• Inpatient Hospital Services	$150 Per Admission	$0	$0	$0
• Physician and Midwife Services for Delivery	$50	$0	$0	$0
• Breast Pump	$0	$0	$0	$0
• Postnatal Care	Included in Physician and Midwife Services for Delivery Cost-Sharing	Included in Physician and Midwife Services for Delivery Cost-Sharing	Included in Physician and Midwife Services for Delivery Cost-Sharing	Included in Physician and Midwife Services for Delivery Cost-Sharing
Preauthorization required at initial visit then at 36 weeks				
Outpatient Hospital Surgery Facility Charge **Preauthorization Required for hospital (not for freestanding)**	$50	$0	$0	$0
Preadmission Testing	$0	$0	$0	$0
Diagnostic Radiology Services				
• Performed in a PCP Office	$15	$0	$0	$0
• Performed in a Freestanding Radiology Facility or Specialist Office	$25	$0	$0	$0
• Performed as Outpatient Hospital Services	$25	$0	$0	$0
Therapeutic Radiology Services				
• Performed in a Freestanding Radiology Facility or Specialist Office	$15	$0	$0	$0
• Performed as Outpatient Hospital Services	$15	$0	$0	$0
Preauthorization Required				
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) *see also "Habilitation" (60 visits per condition, per lifetime; per Plan Year combined therapies) **No preauthorization during 2016 calendar year. Starting 1/1/2017 preauth required after 6 visits.**	$15	$0	$0	$0
Second Opinions on the Diagnosis of Cancer, Surgery and Other **Preauthorization Required**	$25	$0	$0	$0

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Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy) **All transplants must be performed at designated Facilities** • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery **Preauthorization Required**	 $50 $50 $50 $15 (when performed at PCP office) $25 (when performed at specialist office	 $0 $0 $0 $0	 $0 $0 $0 $0	 $0 $0 $0 $0
ADDITIONAL SERVICES, EQUIPMENT and DEVICES				
ABA Treatment for Autism Spectrum Disorder **Preauthorization Required**	$15	$0	$0	$0
Assistive Communication Devices for Autism Spectrum Disorder **Preauthorization Required**	$15	$0	$0	$0
Diabetic Equipment, Supplies and Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-day supply) • Diabetic Education **Preauthorization required for insulin pump**	 $15 $15	 $0 $0	 $0 $0	 $0 $0
Durable Medical Equipment and Braces **Preauthorization required for DME items greater than cost of $500 (NY Medicare rate/current fee schedule)**	5% cost-sharing	$0	$0	$0
External Hearing Aids (Single purchase one every three (3) years)s **Preauthorization required**	5% cost-sharing	$0	$0	$0
Cochlear Implants (One (1) per ear per time Covered) **Preauthorization required**	5% cost-sharing	$0	$0	$0

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Hospice Care • Inpatient • Outpatient 210 days per Plan Year **Preauthorization required**	 $150 $15	 $0 $0	 $0 $0	 $0 $0
Medical Supplies **Preauthorization required for greater than cost of $500**	5% coinsurance	$0	$0	$0
Prosthetic Devices • External One (1) prosthetic device, per limb, per lifetime, and the cost of repair and replacement of the prosthetic devices and its parts • Internal **Preauthorization required for greater than cost of $500**	5% coinsurance Included as part of Inpatient Hospital Cost-sharing	$0 Included as part of Inpatient Hospital Cost-sharing	$0 Included as part of Inpatient Hospital Cost-sharing	$0 Included as part of Inpatient Hospital Cost-sharing
INPATIENT SERVICES and FACILITIES				
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care) **Preauthorization required. However, Preauthorization is not required for emergency admissions.**	$150	$0	$0	$0
Observation Stay **Preathorization Required.** Copay waived if direct transfer from outpatient surgery setting to observation	$75	$0	$0	$0
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) 200 days per Plan Year Copay waived for each admission if directly transferred from hospital inpatient setting to skilled nursing facility **Preauthorization required**	$150	$0	$0	$0
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) 60 consecutive days per condition, per lifetime **Preauthorization required**	$150	$0	$0	$0

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MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES				
Inpatient Mental Health Care (for a continuous confinement when in a Hospital) **Preauthorization required. However, Preauthorization is not required for emergency admissions.**	$150	$0	$0	$0
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services) **Preauthorization required**	$15	$0	$0	$0
Inpatient Substance Use Services (for a continuous confinement when in a Hospital) **Preauthorization required. However, Preauthorization is not required for emergency admissions.**	$150	$0	$0	$0
Outpatient Substance Use Services	$15	$0	$0	$0
PRESCRIPTION DRUGS				
Retail Pharmacy				
30-day supply Tier 1	$6	$1	$1	$0
Tier 2	$15	$3	$3	$0
Tier 3	$30	$3	$3	$0

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Mail Order Pharmacy				
Up to a 90-day supply for Maintenance Drugs (2.5x copay) Tier 1	$15	$2.50	$2.50	$0
Tier 2	$37.50	$7.50	$7.50	$0
Tier 3	$75	$7.50	$7.50	$0
WELLNESS BENEFITS				
Gym Reimbursement	Up to $200 per six (6)-month period	Up to $200 per six (6)-month period	Up to $200 per six (6)-month period	Up to $200 per six (6)-month period
NON-PRESCRIPTION DRUGS				
(only include for Essential Plans 3 & 4)	N/A	N/A	$0.50	$0
DENTAL and VISION CARE				
Dental Care • Preventive Dental Care • Routine Dental Care • Major Dental (Endodontics, Periodontics and Prosthodontics One (1) dental exam and cleaning per six (6)-month period. Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) to 12-month intervals **Orthodontics and major dental require Preauthorization**	 N/A N/A N/A	 N/A N/A N/A	 $0 $0 $0	 $0 $0 $0
Vision Care • Exams • Lenses and Frames • Contact Lenses One (1) exam per [12-month period; Plan Year] One (1) prescribed lenses and frames per Plan Year **Contact lenses require Preauthorization**	 N/A N/A N/A	 N/A N/A N/A	 $0 $0 $0	 $0 $0 $0