SECTION XXIX

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

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	$6,850 $13,700	Non-Participating Provider services are not Covered except as required for emergency care and Urgent Care.	
Out-of-Pocket Limit • Individual • Family	$6,850 $13,700		
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	0% Coinsurance 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)	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
• 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

• Adult Annual Physical Examinations*	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Adult Immunizations*	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Routine Gynecological Services/Well Woman Exams*	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Mammography Screenings*	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Sterilization Procedures for Women*	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• Vasectomy	See Surgical Services Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	
• Bone Density Testing*	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	

• Screening for Prostate Cancer • Performed in PCP Office	0% Coinsurance after Deductible l	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in Specialist Office	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• All other preventive services required by USPSTF and HRSA	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	
• *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)	Non-Participating Provider services are not Covered and You pay the full cost	
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)	0% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Non-Emergency Ambulance Services **Preauthorization required**	0% Coinsurance after Deductible **Preauthorization required**	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	0% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Urgent Care Center	0% Coinsurance after Deductible	0% Coinsurance 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 • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services **Preauthorization required**	0% Coinsurance after Deductible 0% Coinsurance 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 • Performed in a PCP Office • Performed in a Specialist Office **Preauthorization required**	0% Coinsurance after Deductible 0% Coinsurance 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

Ambulatory Surgical Center Facility Fee	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Anesthesia Services (all settings) **Preauthorization required**	0% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Autologous Blood Banking **Preauthorization required**	0% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefits for description
Cardiac and Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services **Preauthorization required**	 0% Coinsurance after Deductible 0% Coinsurance after Deductible Included as part of inpatient Hospital service Cost-Sharing **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 Included as part of inpatient Hospital service Cost-Sharing	See benefits for description
Chemotherapy			See benefit for description

• Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services **Preauthorization required**	0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance 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 Non-Participating Provider services are not Covered and You pay the full cost	
Chiropractic Services **Preauthorization required**	0% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Clinical Trials **Preauthorization required**	Use Cost-Sharing for appropriate service **Preauthorization required**	Use Cost-Sharing for appropriate service **Preauthorization required**	See benefit for description
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as	 0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance	 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	See benefit for description

Outpatient Hospital Services	after Deductible	Provider services are not Covered and You pay the full cost	
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services **Preauthorization required with first encounter and after 12 visits**	 0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible **Preauthorization required with first encounter and after 12 visits**	 0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible **Preauthorization required with first encounter and after 12 visits**	See benefit for description Dialysis performed by Non-Participating Providers is limited to 12 visits per calendar year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **Preauthorization required after 12 visits**	0% Coinsurance after Deductible **Preauthorization required after 12 visits**	Non-Participating Provider services are not Covered and You pay the full cost	60 visits per condition, per lifetime combined therapies
Home Health Care **Preauthorization required after 12 visits**	0% Coinsurance after Deductible **Preauthorization required after 12 visits**	Non-Participating Provider services are not Covered and You pay the full cost	40 visits per Plan Year
Infertility Services	Use Cost-Sharing	Non-Participating	See benefit for description

Preauthorization required	for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) **Preauthorization required**	Provider services are not Covered and You pay the full cost	
Infusion Therapy • Performed in a PCP Office	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
• Performed in Specialist Office	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Home Infusion Therapy **Preauthorization required for first encounter and beyond 6 encounters**	0% Coinsurance after Deductible **Preauthorization required for first encounter and beyond 6 encounters**	Non-Participating Provider services are not Covered and You pay the full cost	Home infusion counts toward home health care visit limits
Inpatient Medical Visits **Preauthorization required**	0% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Laboratory			See benefit for description

Procedures • Performed in a PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance 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 Non-Participating Provider services are not Covered and You pay the full cost	
Maternity and Newborn Care • Prenatal Care • Inpatient Hospital Services and Birthing Center • Physician and Midwife Services for Delivery • Breast Pump • Postnatal Care	Covered in full 0% Coinsurance per admission after Deductible 0% Coinsurance per admission after Deductible Covered in full Included in	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 Non-Participating	See benefit for description One (1) home care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast feeding Limit of one (1) per pregnancy

Preauthorization required for inpatient services and breast pump	Physician and Midwife Services for Delivery Cost-Sharing **Preauthorization required for inpatient services and breast pump**	Provider services are not Covered and You pay the full cost	
Outpatient Hospital Surgery Facility Charge **Preauthorization required**	0% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preadmission Testing **Preauthorization required**	0% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance 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 Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Therapeutic			See benefit for description

Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services **Preauthorization required**	0% Coinsurance after Deductible 0% Coinsurance 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	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **Preauthorization required on 13th visit and beyond**	0% Coinsurance after Deductible **Preauthorization required on 13th visit and beyond**	Non-Participating Provider services are not Covered and You pay the full cost	60 visits per condition, per lifetime; per Plan Year combined therapies Speech and physical therapy are only Covered following a Hospital stay or surgery
Second Opinions on the Diagnosis of Cancer, Surgery and Other **Preauthorization required**	0% Coinsurance after Deductible **Preauthorization required**	Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist **Preauthorization required**	See benefit for description

Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)			See benefit for description **All transplants must be performed at designated Facilities** **Interruption of Pregnancy one (1) procedure for one (1) Member per Plan Year**
• Inpatient Hospital Surgery	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Outpatient Hospital Surgery	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Surgery Performed at an Ambulatory Surgical Center	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Office Surgery	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Preauthorization required	**Preauthorization required**		
ADDITIONAL	**Participating**	**Non-Participating**	

SERVICES, EQUIPMENT and DEVICES	Provider Member Responsibility for Cost-Sharing	Provider Member Responsibility for Cost-Sharing	
ABA Treatment for Autism Spectrum Disorder **Preauthorization required**	0% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder **Preauthorization required**	0% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-day supply) • Diabetic Education **Preauthorization required for insulin pump**	 0% Coinsurance after Deductible 0% Coinsurance after Deductible **Preauthorization required for insulin pump**	 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 **Preauthorization required for DME items greater than cost of $500 (NY Medicare rate/current fee schedule)**	0% Coinsurance after Deductible **Preauthorization required for DME items greater than cost of $500 (NY Medicare rate/current fee schedule)**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
External Hearing	0% Coinsurance	Non-Participating	Single purchase once every

Aids **Preauthorization required**	after Deductible **Preauthorization required**	Provider services are not Covered and You pay the full cost	three (3) years
Cochlear Implants **Preauthorization required**	0% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	One (1) per ear per time Covered
Hospice Care • Inpatient • Outpatient **Preauthorization required**	0% Coinsurance per admission after Deductible 0% Coinsurance 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	210 days per Plan Year Five (5) visits for family bereavement counseling
Medical Supplies **Preauthorization required**	0% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Prosthetic Devices			

• External • Internal **Preauthorization required**	0% Coinsurance after Deductible Included as part of inpatient Hospital service Cost-Sharing **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	One (1) prosthetic device, per limb, per lifetime Unlimited; See benefit for description
INPATIENT SERVICES and FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
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.**	0% Coinsurance 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
Observation Stay	0% Coinsurance after Deductible; Copay is waived if direct transfer from outpatient surgery setting to an observation care	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

	unit		
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) **Preauthorization required**	0% Coinsurance 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 Rehabilitation Services (Physical, Speech and Occupational Therapy) **Preauthorization required**	0% Coinsurance per admission after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	60 consecutive days per condition, per lifetime 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.**	0% Coinsurance 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)	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Inpatient Substance	0% Coinsurance	Non-Participating	See benefit for description

Use Services (for a continuous confinement when in a Hospital) **Preauthorization required. However, Preauthorization is not required for emergency admissions.**	per admission after Deductible **Preauthorization required. However, Preauthorization is not required for emergency admissions.**	Provider services are not Covered and You pay the full cost	
Outpatient Substance Use Services	0% Coinsurance 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	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy			
30-day supply Tier 1 Tier 2 Tier 3	 0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible		See benefit for description
Mail Order Pharmacy			
Up to a 90-day supply Tier 1 Tier 2	 0% Coinsurance after Deductible 0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

Tier 3	0% Coinsurance after Deductible		
Enteral Formulas Tier 1 Tier 2 Tier 3 **Preauthorization required**	 0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible **Preauthorization required**	 Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
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 • Preventive Dental Care • Routine Dental Care • Major Dental (Endodontics, Periodontics and Prosthodontics) • Orthodontics	 0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	 Non-Participating Provider services are not Covered and You pay the full cost	Pediatric dental option must be selected at time of enrollment. 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	**Orthodontics and major dental require Preauthorization**		
Pediatric Vision Care • Exams • Lenses and Frames • Contact Lenses **Contact lenses require Preauthorization**	0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible **Contact lenses require Preauthorization**	Non-Participating Provider services are not Covered and You pay the full cost	One (1) exam per 12-month period One (1) prescribed lenses and frames per 12-month period;
Adult Dental Care • Preventive & Diagnostic Dental Care • Comprehensive Dental Visit • Whitening Treatment	0% Coinsurance not subject to Deductible 0% Coinsurance not subject to Deductible 0% Coinsurance not subject to 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 intervals Bitewing x-rays at six (6)-month period intervals One (1) whitening treatment per Plan Year
Adult Vision Care • Routine Exam	0% Coinsurance not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	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.