SECTION XXIX
Affinity Health Plan SCHEDULE OF BENEFITS
Platinum 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	$0 $0	Non-Participating Provider services are not Covered except as required for emergency care and Urgent Care.	
Out-of-Pocket Limit • Individual • Family Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a calendar year ending on December 31 of each year.	$2,000 $4,000		
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)	$15 Copayment 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)	$35 Copayment 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	$15 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in Specialist Office	$35 Copayment 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)	$100 Copayment after Deductible	$100 Copayment after Deductible	See benefit for description

Non-Emergency Ambulance Services **Preauthorization required**	$100 Copayment 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	$100 Copayment after Deductible	$100 Copayment after Deductible	See benefit for description
Urgent Care Center	$55 Copayment after Deductible	$55 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 • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services **Preauthorization required**	 $35 Copayment after Deductible $35 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 • Performed in a PCP Office	 $15 Copayment after Deductible	 Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

• Performed in a Specialist Office **Preauthorization required**	$35 Copayment after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	
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) **Preauthorization required**	Covered in full **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Autologous Blood Banking **Preauthorization required**	10% 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	 $15 Copayment after Deductible $15 Copayment 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	See benefits for description

• Performed as Inpatient Hospital Services **Preauthorization required**	Included as part of inpatient Hospital service Cost-Sharing **Preauthorization required**	Included as part of inpatient Hospital service Cost-Sharing	
Chemotherapy • Performed in a PCP Office	$15 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
• Performed in a Specialist Office	$15 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization required**	$15 Copayment after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	
Chiropractic Services **Preauthorization required**	$35 Copayment 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	$15 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
• Performed in a Specialist Office	$35 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$35 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Dialysis • Performed in a PCP Office	$15 Copayment after Deductible	$15 Copayment after Deductible	See benefit for description Dialysis performed by Non-Participating Providers is limited to 12 visits per calendar year
• Performed in a Freestanding Center or Specialist Office Setting	$15 Copayment after Deductible	$15 Copayment after Deductible	
• Performed as Outpatient Hospital Services	$15 Copayment after Deductible	$15 Copayment after Deductible	
Preauthorization required with first encounter and after 12 visits	**Preauthorization required with first encounter and after 12 visits**	**Preauthorization required with first encounter and after 12 visits**	

Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **Preauthorization required after 12 visits**	$25 Copayment 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**	$15 Copayment 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 **Preauthorization required**	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Infusion Therapy			See benefit for description
• Performed in a PCP Office	$15 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in Specialist Office	$15 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$15 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

• Home Infusion Therapy **Preauthorization required for first encounter and beyond 6 encounters**	$15 Copayment after Deductible **Preauthorization required for first encounter and beyond 6 encounters**	Non-Participating Provider services are not Covered and You pay the full cost	
Inpatient Medical Visits **Preauthorization required**	$0 Copayment after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Laboratory Procedures • Performed in a PCP Office	$15 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
• Performed in a Freestanding Laboratory Facility or Specialist Office	$35 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$35 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Maternity and Newborn Care • Prenatal Care	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

• Inpatient Hospital Services and Birthing Center	$500 Copayment per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	One (1) home care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
• Physician and Midwife Services for Delivery	$100 Copayment per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Breast Pump	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	Covered for duration of breast feeding Limit of one (1) per pregnancy
• Postnatal Care **Preauthorization required for inpatient services and breast pump**	Included in Physician and Midwife Services for Delivery Cost-Sharing **Preauthorization required for inpatient services and breast pump**	Non-Participating Provider services are not Covered and You pay the full cost	
Outpatient Hospital Surgery Facility Charge **Preauthorization required**	$100 Copayment 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 Copayment 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	$15 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
• Performed in a Freestanding Radiology Facility or Specialist Office	$35 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$35 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office	$15 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

• Performed as Outpatient Hospital Services **Preauthorization required**	$15 Copayment after Deductible **Preauthorization required**	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**	$25 Copayment 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**	$35 Copayment 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) • Inpatient Hospital Surgery	 $100 Copayment after Deductible	 Non-Participating Provider services are not Covered and You pay the full cost	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**

• Outpatient Hospital Surgery	$100 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Surgery Performed at an Ambulatory Surgical Center	$100 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Office Surgery **Preauthorization required**	$15 Copayment after Deductible for PCP, $35 Copayment after Deductible for Specialist based on type of physician performing the service **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	
ADDITIONAL SERVICES, EQUIPMENT and DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
ABA Treatment for Autism Spectrum Disorder **Preauthorization required**	$15 Copayment 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**	$15 Copayment 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**	$15 Copayment after Deductible $15 Copayment 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)**	10% 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 Aids **Preauthorization required**	10% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	Single purchase once every three (3) years

Cochlear Implants **Preauthorization required**	10% 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	$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
• Outpatient **Preauthorization required**	$15 Copayment after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	
Medical Supplies **Preauthorization required**	10% 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	10% Coinsurance after Deductible	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
• Internal **Preauthorization required**	Included as part of inpatient Hospital service Cost-Sharing **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	

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.**	$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
Observation Stay	$100 Copayment after Deductible; Copay is waived if direct transfer from outpatient surgery setting to an observation care unit	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**	$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 Rehabilitation Services (Physical, Speech and Occupational Therapy) **Preauthorization required**	$500 Copayment 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.**	$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)	$15 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.**	$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 Substance Use Services	$15 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	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	 $10 Copayment not subject to Deductible $30 Copayment not subject to Deductible $60 Copayment not subject to Deductible		See benefit for description
Mail Order Pharmacy			
Up to a 90-day supply Tier 1 Tier 2 Tier 3	 $25 Copayment not subject to Deductible $75 Copayment not subject to Deductible $150 Copayment not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Enteral Formulas Tier 1 Tier 2	 $10 Copayment not subject to Deductible $30 Copayment not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

Tier 3 **Preauthorization required**	$60 Copayment not subject to Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	
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 **Orthodontics and major dental require Preauthorization**	 $15 Copayment after Deductible $15 Copayment after Deductible $15 Copayment after Deductible $15 Copayment after Deductible **Orthodontics and major dental require Preauthorization**	 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

Pediatric Vision Care • Exams • Lenses and Frames • Contact Lenses **Contact lenses require Preauthorization**	$15 Copayment after Deductible 10% Coinsurance after Deductible 10% 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 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	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 Copayment not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	One (1) exam per Plan Year

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.