SECTION XXVII

Affinity Health Plan SCHEDULE OF BENEFITS
Catastrophic Level
[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)	3 PCP office visits with \$0 Copayment not subject to Deductible; Subsequent PCP 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	0% Coinsurance	Non-Participating	

	after Deductible	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	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	
		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)		
EMERGENCY	**Participating**	**Non-Participating**	**Limits**

CARE	**Provider Member Responsibility for Cost-Sharing**	**Provider Member Responsibility for Cost-Sharing**	
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			See benefit for description

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	
Ambulatory Surgical Center Facility Fee **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
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	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefits for description

• Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services **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 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 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	See benefit for description
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	Use Cost-Sharing	Use Cost-Sharing	See benefit for description

Preauthorization required	for appropriate service **Preauthorization required**	for appropriate service **Preauthorization required**	
Diagnostic Testing • 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 a 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	
Dialysis • Performed in a PCP Office	0% Coinsurance after Deductible	0% Coinsurance 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	0% Coinsurance after Deductible	0% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services **Preauthorization required with first encounter and after 12 visits**	0% Coinsurance after Deductible **Preauthorization required with first encounter and after 12 visits**	0% Coinsurance after Deductible **Preauthorization required with first encounter and after 12 visits**	
Habilitation Services	0% Coinsurance	Non-Participating	60 visits per condition, per

(Physical Therapy, Occupational Therapy or Speech Therapy) **Preauthorization required after 12 visits**	after Deductible **Preauthorization required after 12 visits**	Provider services are not Covered and You pay the full cost	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 **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	0% Coinsurance after Deductible	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	
• Performed as Outpatient Hospital Services	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Home Infusion	0% Coinsurance	Non-Participating	

Therapy **Preauthorization required for first encounter and beyond 6 encounters**	after Deductible **Preauthorization required for first encounter and beyond 6 encounters**	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 Procedures • 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 a Freestanding Laboratory Facility or 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	
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 One (1) home care visit is

• Inpatient Hospital Services and Birthing Center	0% Coinsurance per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Covered at no Cost-Sharing if mother is discharged from Hospital early
• Physician and Midwife Services for Delivery	0% Coinsurance 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	Included in Physician and Midwife Services for Delivery Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	
Preauthorization required for inpatient services and breast pump	**Preauthorization required for inpatient services and breast pump**		
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	0% Coinsurance	Non-Participating	See benefit for description

Testing **Preauthorization required**	after Deductible **Preauthorization required**	Provider services are not Covered and You pay the full cost	
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 Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as	0% Coinsurance after Deductible 0% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating	See benefit for description

Outpatient Hospital Services **Preauthorization required**	after Deductible **Preauthorization required**	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**	Non-Participating Provider services are not Covered and You pay the full cost Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist	See benefit for description
Surgical Services			See benefit for description

(including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy) • Inpatient Hospital Surgery	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	**All transplants must be performed at designated Facilities** **Interruption of Pregnancy one (1) procedure for one (1) Member per Plan Year**
• 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**		

SERVICES, EQUIPMENT and DEVICES	Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
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			See benefit for description
• Diabetic Equipment, Supplies and Insulin (30-day supply)	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Diabetic Education **Preauthorization required for insulin pump**	0% Coinsurance after Deductible **Preauthorization required for insulin pump**	Non-Participating Provider services are not Covered and You pay the full cost	
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 Aids	0% Coinsurance after Deductible	Non-Participating Provider services	Single purchase once every three (3) years

Preauthorization required	**Preauthorization required**	are not Covered and You pay the full cost	
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	**Participating Provider Member**	**Non-Participating Provider Member**	**Limits**

FACILITIES	**Responsibility for Cost-Sharing**	**Responsibility for Cost-Sharing**	
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 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**	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	**Participating Provider Member**	**Non-Participating Provider Member**	**Limits**

USE DISORDER SERVICES	Responsibility for Cost-Sharing	Responsibility for Cost-Sharing	
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 Use Services (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 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 Tier 3	 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	See benefit for description
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			Pediatric dental option must be selected at time of enrollment.
• Preventive Dental Care	0% Coinsurance after 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
• Routine Dental Care	0% Coinsurance after Deductible		Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) to 12-month intervals
• Major Dental (Endodontics, Periodontics and Prosthodontics)	0% Coinsurance after Deductible		
• Orthodontics	0% Coinsurance after Deductible		
Orthodontics and major dental require Preauthorization	**Orthodontics and major dental require Preauthorization**		
Pediatric Vision Care			
• Exams	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	One (1) exam per 12-month period
• Lenses and Frames	0% Coinsurance after Deductible		One (1) prescribed lenses and frames per 12-month period;

• Contact Lenses **Contact lenses require Preauthorization**	0% Coinsurance after Deductible **Contact lenses require Preauthorization**	Non-Participating Provider services are not Covered and You pay the full cost	

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.