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	$7,150 $14,300	Non-Participating Provider services are not Covered except as required for emergency care and Urgent Care.	
Out-of-Pocket Limit • Individual • Family	$7,150 $14,300		
Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a calendar year ending on December 31 of each year.			
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**	**Non-Participating Provider Member**	**Limits**

	Responsibility for Cost-Sharing	Responsibility for Cost-Sharing	
• 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	
• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	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	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**	**Non-Participating Provider Member Responsibility for**	**Limits**

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

• 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	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 benefit for description
Cardiac and Pulmonary Rehabilitation			See benefit for description

• 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	
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	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered	See benefit for description

Preauthorization required	**Preauthorization required**	and You pay the full cost	
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			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 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			See benefit for description
• Performed in a	0% Coinsurance	0% Coinsurance	Dialysis performed by Non-

PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services **Preauthorization required**	after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible **Preauthorization required**	after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible **Preauthorization required**	Participating Providers is limited to 10 visits per calendar year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **Preauthorization required after 6 visits**	0% Coinsurance after Deductible **Preauthorization required after 6 visits**	Non-Participating Provider services are not Covered and You pay the full cost	60 visits per condition, per Plan Year combined therapies
Home Health Care **Preauthorization required**	0% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	40 visits per Plan Year
Infertility Services	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic	Non-Participating Provider services are not Covered and You pay the full	See benefit for description

Preauthorization required	Radiology Services; Surgery; Laboratory & Diagnostic Procedures) **Preauthorization required**	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**	0% Coinsurance after Deductible **Preauthorization required**	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	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Laboratory Procedures • Performed in a	 0% Coinsurance	 Non-Participating	See benefit for description

PCP Office	after Deductible	Provider services are not Covered and You pay the full cost	
• 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	
Medications Administered in Office or Outpatient Facilities • Performed in a PCP Office • Performed in Specialist Office • Performed in Outpatient Facilities **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
Maternity and Newborn Care • Prenatal Care	 Covered in full	 Non-Participating	See benefit for description

provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA		Provider services are not Covered and You pay the full cost	
• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	0% Coinsurance 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
• 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	
• 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
• 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	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full	See benefit for description

Preauthorization required	**Preauthorization required**	cost	
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 Radiology Services • Performed in a Freestanding	 0% Coinsurance after Deductible	 Non-Participating Provider services	See benefit for description

Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services **Preauthorization required**	0% Coinsurance after Deductible **Preauthorization required**	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 after 6 visits**	0% Coinsurance after Deductible **Preauthorization required after 6 visits**	Non-Participating Provider services are not Covered and You pay the full cost	60 visits per condition, 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;			See benefit for description

Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)			**All transplants must be performed at designated Facilities**
• 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 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**	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	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full	See benefit for description

Preauthorization required	**Preauthorization required**	cost	
External Hearing Aids **Preauthorization required**	0% 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**	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	See benefit for description 210 days per Plan Year Five (5) visits for family bereavement counseling
Medical Supplies	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered	See benefit for description

Preauthorization required	**Preauthorization required**	and You pay the full cost	
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	See benefit for description One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements. 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.	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 Habilitation 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 days per Plan Year combined therapies.
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 days per Plan Year combined therapies. Speech and physical therapy 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 Use Services (for a continuous confinement when in a Hospital) **Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.**	0% Coinsurance per admission after Deductible **Preauthorization required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.**	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 *Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an “A” or “B” rating from the USPSTF.	**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	Non-Participating Provider services are not Covered and You pay the full cost	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	 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
WELLNESS	**Participating**	**Non-Participating**	

BENEFITS	Provider Member Responsibility for Cost-Sharing	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 Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics) • Orthodontics **Orthodontics and major dental require Preauthorization**	0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible **Orthodontics and major dental require Preauthorization**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description 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) month intervals
Pediatric Vision			See benefit for description

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 • Routine Dental Care • 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	See benefit for description One (1) dental exam and cleaning per six (6)-month period intervals Two (2) bitewing x-rays at six (6)-month period intervals See benefit for description
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.