SECTION XXVII

Affinity Health Plan SCHEDULE OF BENEFITS
Silver 87 CSR Level 150-200%FPL
[Non-Standard] [Child-Only]

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	$300 $600	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.	$2,350 $4,700		
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)	$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	
• 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	$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)		
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)	$75 Copayment after Deductible	$75 Copayment after Deductible	See benefit for description
Non-Emergency Ambulance Services **Preauthorization required**	$75 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	$75 Copayment after Deductible	$75 Copayment after Deductible	See benefit for description
Urgent Care Center	$50 Copayment after Deductible	$50 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			See benefit for description

Treatment • Performed in a PCP Office • Performed in a Specialist Office **Preauthorization required**	 $15 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	
Ambulatory Surgical Center Facility Fee	$75 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 benefit for description
Cardiac and			See benefit for description

Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services **Preauthorization required**	$15 Copayment after Deductible $15 Copayment 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**	$15 Copayment after Deductible $15 Copayment after Deductible $15 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 Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Chiropractic Services	$35 Copayment	Non-Participating	See benefit for description

Preauthorization required	after Deductible **Preauthorization required**	Provider services are not Covered 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 • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 $15 Copayment after Deductible $35 Copayment after Deductible $35 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 Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
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

• Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services **Preauthorization required**	$15 Copayment after Deductible $15 Copayment after Deductible **Preauthorization required**	$15 Copayment after Deductible $15 Copayment after Deductible **Preauthorization required**	limited to 10 visits per calendar year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **Preauthorization required after 6 visits**	$25 Copayment 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**	$15 Copayment after Deductible **Preauthorization required**	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 • Performed in a PCP Office	 $15 Copayment after Deductible	 Non-Participating Provider services	See benefit for description

		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 Therapy **Preauthorization required**	$15 Copayment 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 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Laboratory Procedures			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 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	$35 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

Hospital Services			
Medications Administered in Office or Outpatient Facilities • Performed in a PCP Office • Performed in Specialist Office • Performed in Outpatient Facilities **Preauthorization required**	 $15 Copayment after Deductible $35 Copayment after Deductible $15 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 Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Maternity and Newborn Care • Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA • Prenatal Care that is not provided in accordance with the	 Covered in full Use Cost-Sharing for appropriate service (Primary Care Office Visit;	 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

comprehensive guidelines supported by USPSTF and HRSA • Inpatient Hospital Services and Birthing Center • Physician and Midwife Services for Delivery • Breast Pump • Postnatal Care **Preauthorization required for inpatient services and breast pump**	Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing) $250 Copayment per admission after Deductible $75 Copayment per admission after Deductible Covered in full 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 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	One (1) home care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge **Preauthorization required**	$75 Copayment after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preadmission Testing	$0 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

Preauthorization required	**Preauthorization required**		
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	 $15 Copayment after Deductible $35 Copayment after Deductible $35 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 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	 $15 Copayment after Deductible	 Non-Participating Provider services are not Covered and	See benefit for description

or Specialist Office • Performed as Outpatient Hospital Services **Preauthorization required**	 $15 Copayment after Deductible **Preauthorization required**	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**	$25 Copayment 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**	$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			See benefit for description

and Corrective Surgery; Transplants; and Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery **Preauthorization required**	 $75 Copayment after Deductible $75 Copayment after Deductible $75 Copayment after Deductible $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 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	**All transplants must be performed at designated Facilities**
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	$15 Copayment after Deductible	Non-Participating Provider services are not Covered and	See benefit for description

Preauthorization required	**Preauthorization required**	You pay the full cost	
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**	10% Coinsurance after Deductible **Preauthorization**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

required	**required**		
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 • Outpatient **Preauthorization required**	 $250 Copayment per admission after Deductible $15 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 210 days per Plan Year Five (5) visits for family bereavement counseling
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 • Internal **Preauthorization required**	10% 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.**	$250 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	$75 Copayment after Deductible.	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Skilled Nursing Facility (including	$250 Copayment per admission after	Non-Participating Provider services	200 days per Plan Year

Cardiac and Pulmonary Rehabilitation) **Preauthorization required**	Deductible **Preauthorization required**	are not Covered and You pay the full cost	
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) **Preauthorization required**	$250 Copayment per admission after Deductible	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**	$250 Copayment 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)	$250 Copayment per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

Preauthorization required. However, Preauthorization is not required for emergency admissions.	**Preauthorization required. However, Preauthorization is not required for emergency admissions.**		
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 or for Participating OASAS-certified Facilities.**	$250 Copayment 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	$15 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	Up to 20 visits per Plan Year may be used for family counseling
PRESCRIPTION DRUGS *Certain Prescription Drugs are not subject	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**

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.			
Retail Pharmacy			
30-day supply Tier 1 Tier 2 Tier 3	 $9 Copayment not subject to Deductible $20 Copayment not subject to Deductible $40 Copayment not subject to 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	 $22.50 Copayment not subject to Deductible	 Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

Tier 2 Tier 3	$50 Copayment not subject to Deductible $100 Copayment not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Enteral Formulas Tier 1 Tier 2 Tier 3	 $9 Copayment not subject to Deductible $20 Copayment not subject to Deductible $40 Copayment not subject to Deductible	 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	 $15 Copayment after 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

• Routine Dental Care • Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics) • Orthodontics **Orthodontics and major dental require Preauthorization**	$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	Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) month intervals
Pediatric Vision Care • Exams • Lenses and Frames • Contact Lenses **Contact lenses**	$15 Copayment after Deductible 10% Coinsurance after Deductible 10% Coinsurance after Deductible **Contact lenses**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description One (1) exam per 12-month period One (1) prescribed lenses and frames per 12-month period; .

require Preauthorization	require Preauthorization		
Adult Dental Care • Preventive & Diagnostic Dental Care • Routine Dental Care • 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	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 Copayment not subject to Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description 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.