SECTION XXVII

Affinity Health Plan SCHEDULE OF BENEFITS
Silver 94 CSR Level 100-150% 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	$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.	$1,000 $2,000		
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)	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Specialist Office Visits (or Home Visits)	$20 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
PREVENTIVE CARE	**Participating**	**Non-Participating**	**Limits**

	Provider Member Responsibility for Cost-Sharing	Provider Member 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	
		Non-Participating	

• Bone Density Testing*	Covered in full	Provider services are not Covered and You pay the full cost	
• Screening for Prostate Cancer • Performed in PCP Office	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in Specialist Office	$20 Copayment	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 CARE	**Participating Provider Member**	**Non-Participating Provider Member**	**Limits**

	Responsibility for Cost-Sharing	**Responsibility for Cost-Sharing**	
Pre-Hospital Emergency Medical Services (Ambulance Services)	$50 Copayment	$50 Copayment	See benefit for description
Non-Emergency Ambulance Services **Preauthorization required**	$50 Copayment **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	$50 Copayment	$50 Copayment	See benefit for description
Urgent Care Center	$30 Copayment	$30 Copayment	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**	$20 Copayment $20 Copayment **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			See benefit for description

• Performed in a PCP Office • Performed in a Specialist Office **Preauthorization required**	$10 Copayment $20 Copayment **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	$25 Copayment	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**	5% Coinsurance **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**	$10 Copayment $10 Copayment 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**	$10 Copayment $10 Copayment $10 Copayment **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	$20 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

Preauthorization required	**Preauthorization required**		
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	 $10 Copayment $20 Copayment $20 Copayment	 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	 $10 Copayment	 $10 Copayment	See benefit for description Dialysis performed by Non-Participating Providers is limited to 10 visits per calendar year

• Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services **Preauthorization required**	$10 Copayment $10 Copayment **Preauthorization required**	$10 Copayment $10 Copayment **Preauthorization required**	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **Preauthorization required after 6 visits**	$15 Copayment **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**	$10 Copayment **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 Radiology Services; Surgery; Laboratory	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

Preauthorization required	& Diagnostic Procedures) **Preauthorization required**		
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy **Preauthorization required**	$10 Copayment $10 Copayment $10 Copayment $10 Copayment **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	See benefit for description Home infusion counts toward home health care visit limits
Inpatient Medical Visits	$0 Copayment	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 • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient Hospital Services	$10 Copayment $20 Copayment $20 Copayment	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	
Medications Administered in Office or Outpatient Facilities • Performed in a PCP Office • Performed in Specialist Office • Performed in Outpatient Facilities **Preauthorization required**	 $10 Copayment $20 Copayment $10 Copayment **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	 Covered in full	 Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

guidelines supported by USPSTF and HRSA			
• Prenatal Care that is 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	
• Inpatient Hospital Services and Birthing Center	$100 Copayment per admission	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	$25 Copayment per admission	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	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	**Preauthorization required for inpatient services**		

and breast pump	**and breast pump**		
Outpatient Hospital Surgery Facility Charge **Preauthorization required**	$25 Copayment **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 **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	 $10 Copayment $20 Copayment $20 Copayment	 Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Therapeutic			See benefit for description

Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services **Preauthorization required**	$10 Copayment $10 Copayment **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **Preauthorization required after 6 visits**	$15 Copayment **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	$20 Copayment	Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist	See benefit for description

Preauthorization required	**Preauthorization required**	**Preauthorization required**	
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)			See benefit for description **All transplants must be performed at designated Facilities**
• Inpatient Hospital Surgery	$25 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Outpatient Hospital Surgery	$25 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Surgery Performed at an Ambulatory Surgical Center	$25 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Office Surgery	$10 Copayment for PCP, $20 Copayment for Specialist based on type of physician performing the service **Preauthorization**	Non-Participating Provider services are not Covered and You pay the full cost	

Preauthorization required	**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**	$10 Copayment **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**	$10 Copayment **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**	 $10 Copayment $10 Copayment **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**	5% Coinsurance **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
External Hearing Aids **Preauthorization**	5% Coinsurance **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	Single purchase once every three (3) years

required			
Cochlear Implants **Preauthorization required**	5% Coinsurance **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**	 $100 Copayment per admission $10 Copayment **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**	5% Coinsurance **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Prosthetic Devices • External • Internal	 5% Coinsurance Included as part of inpatient Hospital service 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 One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements. Unlimited; See benefit for description

Preauthorization required	Sharing **Preauthorization required**		
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.**	$100 Copayment per admission **Preauthorization required. However, Preauthorization is not required for emergency admissions.**	Non-Participating Provider services are not Covered and You pay the full cost	
Observation Stay	$50 Copayment .	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)	$100 Copayment per admission	Non-Participating Provider services are not Covered and You pay the full cost	200 days per Plan Year

Preauthorization required	**Preauthorization required**		
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) **Preauthorization required**	$100 Copayment per admission	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**	$100 Copayment per admission **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.**	$100 Copayment per admission **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)	$10 Copayment	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**	$100 Copayment per admission **Preauthorization**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.	**required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.**		
Outpatient Substance Use Services	$10 Copayment	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 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	 $6 Copayment $15 Copayment $30 Copayment	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	 $15 Copayment $37.50 Copayment $75 Copayment	 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
Enteral Formulas Tier 1 Tier 2 Tier 3	 $6 Copayment $15 Copayment $30 Copayment	 Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	Up to $200 per six (6)-month period[; up to an additional $100 per six (6)-month period for Spouse]	Non-Participating Provider services are not Covered and You pay the full cost	Up to $200 per six (6)-month period[; up to an additional $100 per six (6)-month period for Spouse]
PEDIATRIC DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care • Preventive Dental Care • Routine Dental Care	 $10 Copayment $10 Copayment	 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

• Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics) • Orthodontics **Orthodontics and major dental require Preauthorization**	$10 Copayment $10 Copayment **Orthodontics and major dental require Preauthorization**	Non-Participating Provider services are not Covered and You pay the full cost	
Pediatric Vision Care • Exams • Lenses and Frames • Contact Lenses **Contact lenses require Preauthorization**	$10 Copayment 5% Coinsurance 5% Coinsurance **Contact lenses require Preauthorization**	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; .

Adult Dental Care • Preventive & Diagnostic Dental Care • Routine Dental Care • Whitening Treatment	 $0 Copayment $0 Copayment $0 Copayment	 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	 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.