SECTION XXVII

Affinity Health Plan SCHEDULE OF BENEFITS
Bronze Level
[Standard] [Child Only]

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	$4,000 $8,000	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.	$7,150 $14,300		
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)	50% 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)	50% 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	
• 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	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in Specialist Office	50% 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 Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	50% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Non-Emergency Ambulance Services **Preauthorization required**	50% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Emergency	50% Coinsurance	50% Coinsurance	See benefit for description

Department Copayment / Coinsurance waived if Hospital admission	after Deductible	after Deductible	
Urgent Care Center	50% Coinsurance after Deductible	50% 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**	50% Coinsurance after Deductible 50% 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 Treatment • Performed in a PCP Office • Performed in a Specialist Office **Preauthorization required**	50% Coinsurance after Deductible 50% 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
Ambulatory Surgical Center Facility Fee	50% Coinsurance after Deductible	Non-Participating Provider services are	See benefit for description

		not Covered and You pay the full cost	
Anesthesia Services (all settings) **Preauthorization required.**	50% 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**	50% 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 • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services **Preauthorization required**	 50% Coinsurance after Deductible 50% 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	See benefit for description
Chemotherapy			See benefit for description

• Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services **Preauthorization required**	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% 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	
Chiropractic Services **Preauthorization required**	50% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Clinical Trials **Preauthorization required**	Use Cost-Sharing for appropriate service **Preauthorization required**	Use Cost-Sharing for appropriate service **Preauthorization required**	See benefit for description
Diagnostic Testing			See benefit for description

• Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% 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	
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services **Preauthorization required**	50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible **Preauthorization required**	50% Coinsurance after Deductible 50% Coinsurance after Deductible **Preauthorization required**	See benefit for description Dialysis performed by Non-Participating Providers is limited to 10 visits per calendar year
Habilitation Services (Physical Therapy, Occupational	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You	60 visits per condition, per Plan Year combined therapies

Therapy or Speech Therapy) **Preauthorization required after 6 visits**	 **Preauthorization required after 6 visits**	pay the full cost	
Home Health Care **Preauthorization required**	50% 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 **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 • Performed in	 50% Coinsurance after Deductible 50% Coinsurance	 Non-Participating Provider services are not Covered and You pay the full cost Non-Participating	See benefit for description

Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy **Preauthorization required**	after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible **Preauthorization required**	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	Home infusion counts toward home health care visit limits
Inpatient Medical Visits	50% 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 PCP Office • Performed in a Freestanding Laboratory Facility or Specialist Office • Performed as Outpatient	 50% Coinsurance after Deductible 50% Coinsurance after Deductible 50% 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	See benefit for description

Hospital Services		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**	 Included as part of the PCP office visit Cost-Sharing Included as part of the Specialist office visit Cost-Sharing 50% 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 provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA • Prenatal Care that is not provided in accordance with the comprehensive	 Covered in full Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic	 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

guidelines supported by USPSTF and HRSA	Radiology Services; Laboratory Procedures and Diagnostic Testing)		
• Inpatient Hospital Services and Birthing Center	50% Coinsurance per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	One (1) home care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
• Physician and Midwife Services for Delivery	50% 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	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**	50% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preadmission Testing	50% Coinsurance 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	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
• Performed in a Freestanding Radiology Facility or Specialist Office	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
• Performed as Outpatient Hospital Services	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Preauthorization required	**Preauthorization required**		
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	50% Coinsurance after Deductible	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

Preauthorization required after 6 visits	**Preauthorization required after 6 visits**		
Second Opinions on the Diagnosis of Cancer, Surgery and Other **Preauthorization required**	50% 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; 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	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Outpatient Hospital Surgery	50% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

• Surgery Performed at an Ambulatory Surgical Center • Office Surgery **Preauthorization required**	50% Coinsurance after Deductible 50% 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	
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**	50% 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**	50% 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,	 50% Coinsurance after Deductible	 Non-Participating Provider services are	See benefit for description

Supplies and Insulin (30-day supply) • Diabetic Education **Preauthorization required for insulin pump**	 50% Coinsurance after Deductible **Preauthorization required for insulin pump**	not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	
Durable Medical Equipment and Braces **Preauthorization required**	50% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
External Hearing Aids **Preauthorization required**	50% 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**	50% 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	 50% Coinsurance per admission after Deductible	 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

• Outpatient **Preauthorization required**	50% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	
Medical Supplies **Preauthorization required**	50% 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**	50% 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	50% Coinsurance per admission after Deductible	Non-Participating Provider services are not Covered and You	See benefit for description

(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.**	**Preauthorization required. However, Preauthorization is not required for emergency admissions.**	pay the full cost	
Observation Stay	50% 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**	50% 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**	50% 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)	50% Coinsurance per admission after Deductible	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.

Preauthorization required	**Preauthorization required**		
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.**	50% 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)	50% 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.**	50% 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	50% 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**	**Non-Participating Provider Member**	**Limits**

*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.	**Responsibility for Cost-Sharing**	**Responsibility for Cost-Sharing**	
Retail Pharmacy			
30-day supply Tier 1 Tier 2 Tier 3	 $10 Copayment after Deductible $35 Copayment after Deductible $70 Copayment 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	 $25 Copayment after Deductible $87.50 Copayment after Deductible $175 Copayment 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	 $10 Copayment after Deductible $35 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

Tier 3	after Deductible $70 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Gym Reimbursement	Up to $200 per six (6)-month period[; up to an additional $100 per six (6)-month period for Spouse]	Non-Participating Provider services are not Covered and You pay the full cost	Up to $200 per six (6)-month period[; up to an additional $100 per six (6)-month period for Spouse]
PEDIATRIC DENTAL and VISION CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care • Preventive Dental	50% Coinsurance	Non-Participating	See benefit for description

Care	after Deductible	Provider services are	One (1) dental exam and cleaning per six (6)-month period
• Routine Dental Care	50% Coinsurance after Deductible	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
• Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics)	50% Coinsurance after Deductible		
• Orthodontics	50% Coinsurance after Deductible		
Orthodontics and major dental require Preauthorization	**Orthodontics and major dental require Preauthorization**		
Pediatric Vision Care			See benefit for description
• Exams	50% 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	50% Coinsurance after Deductible		One (1) prescribed lenses and frames per 12-month period;
• Contact Lenses	50% Coinsurance after Deductible		
Contact lenses require Preauthorization	**Contact lenses require Preauthorization**		

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.