SECTION XXVII

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

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	$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 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)	3 PCP office visits with $0 Copayment not subject to Deductible; Subsequent PCP visits 0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Specialist Office Visits (or Home Visits)	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and	See benefit for description

		You pay the full cost	
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
 	
  • Performed in Specialist Office
 	
• All other preventive services required by USPSTF and HRSA
 	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA
	0% Coinsurance after Deductible
	
	0% Coinsurance after Deductible
	
	Covered in full
	
	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
		
		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	

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)	0% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Non-Emergency Ambulance Services	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

Preauthorization required	**Preauthorization required**		
Emergency Department Copayment / Coinsurance waived if Hospital admission	0% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
Urgent Care Center	0% Coinsurance after Deductible	0% Coinsurance after Deductible	See benefit for description
PROFESSIONAL SERVICES and OUTPATIENT CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Freestanding Radiology Facility or Office Setting • Performed as Outpatient Hospital Services **Preauthorization required**	0% Coinsurance after Deductible 0% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Allergy Testing and Treatment • Performed in a PCP Office	0% Coinsurance after Deductible	Non-Participating Provider services	See benefit for description

• Performed in a Specialist Office **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	
Ambulatory Surgical Center Facility Fee **Preauthorization required**	0% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Anesthesia Services (all settings) **Preauthorization required.**	0% Coinsurance after Deductible **Preauthorization required.**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Autologous Blood Banking **Preauthorization required**	0% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Cardiac and Pulmonary Rehabilitation • Performed in a	0% Coinsurance	Non-Participating	See benefit for description

Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services **Preauthorization required**	after Deductible 0% Coinsurance after Deductible Included as part of inpatient Hospital service Cost-Sharing **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 Included as part of inpatient Hospital service Cost-Sharing	
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services **Preauthorization required**	0% Coinsurance after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Chiropractic Services **Preauthorization required**	0% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

Clinical Trials **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	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
Dialysis • Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting	0% Coinsurance after Deductible 0% Coinsurance after Deductible	0% Coinsurance after Deductible 0% Coinsurance after Deductible	See benefit for description Dialysis performed by Non-Participating Providers is limited to 10 visits per calendar year

• Performed as Outpatient Hospital Services **Preauthorization required**	0% Coinsurance after Deductible **Preauthorization required**	0% Coinsurance after Deductible **Preauthorization required**	
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 **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 Specialist Office	 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	See benefit for description

• Performed as Outpatient Hospital Services	0% Coinsurance after Deductible	You pay the full cost 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 PCP Office	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
• Performed in a Freestanding Laboratory Facility or Specialist Office	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Medications Administered in Office or Outpatient Facilities • Performed in a PCP Office	Included as part of the PCP office visit	Non-Participating Provider services	See benefit for description

	Cost-Sharing	are not Covered and You pay the full cost	
• Performed in Specialist Office	Included as part of the Specialist office visit Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in Outpatient Facilities **Preauthorization required**	0% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	
Maternity and Newborn Care			See benefit for description
• Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full	Non-Participating 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	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	0% Coinsurance	Non-Participating	One (1) home care visit is

Services and Birthing Center	per admission after Deductible	Provider services are not Covered and You pay the full cost	Covered at no Cost-Sharing if mother is discharged from Hospital early
• Physician and Midwife Services for Delivery	0% Coinsurance per admission after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Breast Pump	Covered in full	Non-Participating Provider services are not Covered and You pay the full cost	Covered for duration of breast feeding
• 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 **Preauthorization required**	0% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Preadmission 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			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 Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services	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	
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services **Preauthorization required**	0% Coinsurance after Deductible 0% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
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; 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	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	0% Coinsurance after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	

Ambulatory Surgical Center • Office Surgery **Preauthorization required**	0% Coinsurance after Deductible **Preauthorization required**	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**	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	0% Coinsurance after Deductible 0% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services	See benefit for description

Education **Preauthorization required for insulin pump**	after Deductible **Preauthorization required for insulin pump**	are not Covered and You pay the full cost	
Durable Medical Equipment and Braces **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
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**	 0% Coinsurance per admission after Deductible 0% Coinsurance after Deductible **Preauthorization**	 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

required	**required**		
Medical Supplies **Preauthorization required**	0% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Prosthetic Devices • External • Internal **Preauthorization required**	0% Coinsurance after Deductible Included as part of inpatient Hospital service Cost-Sharing **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	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)	0% Coinsurance 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.**		
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	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**

item or service has an “A” or “B” rating from the USPSTF.			
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 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 • Major Dental Care (Oral Surgery,	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 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

Endodontics, Periodontics and Prosthodontics) • Orthodontics **Orthodontics and major dental require Preauthorization**	0% Coinsurance after Deductible **Orthodontics and major dental require Preauthorization**		
Pediatric Vision 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 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;

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.