SECTION XXVII

Affinity Health Plan SCHEDULE OF BENEFITS
Silver 73 CSR Level
[Non-Standard] [Child-Only]

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Deductible • Individual • Family	$1,650 $3,300	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.	$5,700 $11,400		
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)	$30 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)	$50 Copayment after Deductible	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	
• 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	$30 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in Specialist Office	$50 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)	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)	$150 Copayment after Deductible	$150 Copayment after Deductible	See benefit for description
Non-Emergency Ambulance Services **Preauthorization required**	$150 Copayment after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Emergency Department	$250 Copayment after Deductible	$250 Copayment after Deductible	See benefit for description

Copayment / Coinsurance waived if Hospital admission			
Urgent Care Center	$70 Copayment after Deductible	$70 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**	$50 Copayment after Deductible $50 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 Treatment • Performed in a PCP Office • Performed in a Specialist Office **Preauthorization required**	$30 Copayment after Deductible $50 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
Ambulatory Surgical Center Facility Fee	$100 Copayment 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.**	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**	25% 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**	 $30 Copayment after Deductible $30 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	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**	$30 Copayment after Deductible $30 Copayment after Deductible $30 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	
Chiropractic Services **Preauthorization required**	$50 Copayment 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	 $30 Copayment after Deductible $50 Copayment after Deductible $50 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			See benefit for description

• Performed in a PCP Office • Performed in a Freestanding Center or Specialist Office Setting • Performed as Outpatient Hospital Services **Preauthorization required**	$30 Copayment after Deductible $30 Copayment after Deductible $30 Copayment after Deductible **Preauthorization required**	$30 Copayment after Deductible $30 Copayment after Deductible $30 Copayment after Deductible **Preauthorization required**	Dialysis performed by Non-Participating Providers is limited to 10 visits per calendar year
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **Preauthorization required after 6 visits**	$30 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**	$30 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			See benefit for description

• Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy **Preauthorization required**	$30 Copayment after Deductible $30 Copayment after Deductible $30 Copayment after Deductible $30 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 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	$30 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	$50 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$50 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Medications Administered in Office or Outpatient Facilities			See benefit for description
• Performed in a PCP Office	Included as part of the PCP office visit Cost-Sharing	Non-Participating Provider services 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**	$30 Copayment 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 Services and Birthing Center	$1,500 Copayment 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	$100 Copayment 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	Non-Participating Provider services are	

Preauthorization required for inpatient services and breast pump	Midwife Services for Delivery Cost-Sharing **Preauthorization required for inpatient services and breast pump**	not Covered and You pay the full cost	
Outpatient Hospital Surgery Facility Charge **Preauthorization required**	$100 Copayment 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 Copayment 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	$30 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed in a Freestanding Radiology Facility or Specialist Office	$50 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$50 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
Therapeutic Radiology Services			See benefit for description

• Performed in a Freestanding Radiology Facility or Specialist Office • Performed as Outpatient Hospital Services **Preauthorization required**	$30 Copayment after Deductible $30 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	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **Preauthorization required after 6 visits**	$30 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**	$50 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			See benefit for description

Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; Transplants; and Interruption of Pregnancy)			**All transplants must be performed at designated Facilities**
• Inpatient Hospital Surgery	$100 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Outpatient Hospital Surgery	$100 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Surgery Performed at an Ambulatory Surgical Center	$100 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Office Surgery	$30 Copayment after Deductible for PCP, $50 Copayment after Deductible for Specialist based on type of physician performing the service	Non-Participating Provider services are not Covered and You pay the full cost	
Preauthorization required	**Preauthorization required**		
ADDITIONAL SERVICES,	**Participating Provider Member**	**Non-Participating Provider Member**	**Limits**

EQUIPMENT and DEVICES	Responsibility for Cost-Sharing	Responsibility for Cost-Sharing	
ABA Treatment for Autism Spectrum Disorder **Preauthorization required**	$30 Copayment 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**	$30 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			See benefit for description
• Diabetic Equipment, Supplies and Insulin (30-day supply)	$30 Copayment after Deductible	Non-Participating Provider services are not Covered and You pay the full cost	
• Diabetic Education **Preauthorization required for insulin pump**	$30 Copayment after Deductible **Preauthorization required for insulin pump**	Non-Participating Provider services are not Covered and You pay the full cost	
Durable Medical Equipment and Braces **Preauthorization required**	25% 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	25% Coinsurance after Deductible	Non-Participating Provider services are	Single purchase once every three (3) years

Preauthorization required	**Preauthorization required**	not Covered and You pay the full cost	
Cochlear Implants **Preauthorization required**	25% 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**	 $1,500 Copayment per admission after Deductible $30 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**	25% Coinsurance after Deductible **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Prosthetic Devices			See benefit for description

• External • Internal **Preauthorization required**	25% 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	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.**	$1,500 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	$250 Copayment 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**	$1,500 Copayment 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**	$1,500 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.
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) **Preauthorization required**	$1,500 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) **Preauthorization required. However, Preauthorization is not required for emergency admissions.**	$1,500 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
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	$30 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.**	$1,500 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	$30 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 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	 $10 Copayment not subject to Deductible $35 Copayment not subject to Deductible $70 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 Tier 2 Tier 3	 $25 Copayment not subject to Deductible $87.50 Copayment not subject to Deductible $175 Copayment not subject to 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	See benefit for description

Enteral Formulas Tier 1 Tier 2 Tier 3	 $10 Copayment not subject to Deductible $35 Copayment not subject to Deductible $70 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 • Routine Dental Care • Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics)	 $30 Copayment after Deductible $30 Copayment after Deductible $30 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 Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) month intervals

• Orthodontics **Orthodontics and major dental require Preauthorization**	$30 Copayment after Deductible **Orthodontics and major dental require Preauthorization**		
Pediatric Vision Care • Exams • Lenses and Frames • • Contact Lenses **Contact lenses require Preauthorization**	$30 Copayment after Deductible 25% Coinsurance after Deductible 25% Coinsurance after Deductible **Contact lenses require Preauthorization**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description . One (1) prescribed lenses and frames per 12-month period; .

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.