SECTION XXVII

Affinity Health Plan SCHEDULE OF BENEFITS
Silver 94 CSR Level 100-150% FPL
[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	$1,000 $2,000		
Deductibles, Coinsurance and Copayments that make up Your Out-of-Pocket Limit accumulate on a calendar year ending on December 31 of each year.			
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	
• Bone Density	Covered in full	Non-Participating	

Testing*
 	
• 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
	
	$10 Copayment
	
	$20 Copayment
	
	Covered in full
	
	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)
		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	

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 Copayment	$50 Copayment	See benefit for description
Non-Emergency Ambulance Services	$50 Copayment	Non-Participating Provider services	See benefit for description

Preauthorization required	**Preauthorization required**	are not Covered and You pay the full cost	
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 • Performed in a PCP Office • Performed in a Specialist Office	$10 Copayment $20 Copayment	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

Preauthorization required	**Preauthorization required**	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 • 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	See benefit for description
Chemotherapy • Performed in a PCP Office	 $10 Copayment	 Non-Participating Provider services	See benefit for description

		are not Covered and You pay the full cost	
• Performed in a Specialist Office	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services **Preauthorization required**	$10 Copayment **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	
Chiropractic Services **Preauthorization required**	$20 Copayment **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	 $10 Copayment	 Non-Participating Provider services	See benefit for description

		are not Covered and You pay the full cost	
• Performed in a Specialist Office	$20 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
• Performed as Outpatient Hospital Services	$20 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Dialysis			See benefit for description
• Performed in a PCP Office	$10 Copayment	$10 Copayment	Dialysis performed by Non-Participating Providers is limited to 10 visits per calendar year
• Performed in a Freestanding Center or Specialist Office Setting	$10 Copayment	$10 Copayment	
• Performed as Outpatient Hospital Services	$10 Copayment	$10 Copayment	
Preauthorization required	**Preauthorization required**	**Preauthorization required**	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech	$15 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	60 visits per condition, per Plan Year combined therapies

Therapy) **Preauthorization required after 6 visits**	**Preauthorization required after 6 visits**		
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 **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	$10 Copayment	Non-Participating Provider services are not Covered and	See benefit for description

• Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy **Preauthorization required**	$10 Copayment $10 Copayment $10 Copayment **Preauthorization required**	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	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 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
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

• Performed in Specialist Office • Performed in Outpatient Facilities **Preauthorization required**	Cost-Sharing Included as part of the Specialist office visit Cost-Sharing $10 Copayment **Preauthorization required**	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	
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 guidelines	Covered in full Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services;	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

supported by USPSTF and HRSA	Laboratory Procedures and Diagnostic Testing)		
• 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 and breast pump	**Preauthorization required for inpatient services and breast pump**		
Outpatient Hospital Surgery Facility Charge	$25 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

Preauthorization required	**Preauthorization required**		
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 Radiology Services • Performed in a Freestanding Radiology Facility or Specialist Office	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

• Performed as Outpatient Hospital Services **Preauthorization required**	$10 Copayment **Preauthorization required**	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 **Preauthorization required**	$20 Copayment **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			See benefit for description **All transplants must be performed at designated Facilities**

Interruption of Pregnancy) • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery **Preauthorization required**	 $25 Copayment $25 Copayment $25 Copayment $10 Copayment for PCP, $20 Copayment for Specialist based on type of physician performing the service **Preauthorization required**	 Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	
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**	$10 Copayment **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

required			
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 required**	5% Coinsurance **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**	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	 $100 Copayment	 Non-Participating	See benefit for description 210 days per Plan Year

	per admission	Provider services are not Covered and You pay the full cost	Five (5) visits for family bereavement counseling
• Outpatient **Preauthorization required**	$10 Copayment **Preauthorization required**	Non-Participating Provider services are not Covered and You pay the full cost	
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			See benefit for description
• External	5% Coinsurance	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.
• Internal	Included as part of	Non-Participating Provider services	Unlimited; See benefit for

Preauthorization required	inpatient Hospital service Cost-Sharing **Preauthorization required**	are not Covered and You pay the full cost	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.**	$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
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	$100 Copayment per admission	Non-Participating Provider services are not Covered and You pay the full cost	200 days per Plan Year

Rehabilitation) **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)	$100 Copayment per admission	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 or for Participating OASAS-certified Facilities.	**Preauthorization 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	 $6 Copayment $15 Copayment	 Non-Participating Provider services are not Covered and You pay the full cost	 See benefit for description

Tier 3	$30 Copayment		
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	**Participating**	**Non-Participating**	**Limits**

DENTAL and VISION CARE	Provider Member Responsibility for Cost-Sharing	Provider Member Responsibility for Cost-Sharing	
Pediatric Dental Care			See benefit for description
• Preventive Dental Care	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	One (1) dental exam and cleaning per six (6)-month period
• Routine Dental Care	$10 Copayment		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)	$10 Copayment		
• Orthodontics	$10 Copayment	Non-Participating Provider services are not Covered and You pay the full cost	
Orthodontics and major dental require Preauthorization	**Orthodontics and major dental require Preauthorization**		
Pediatric Vision Care			See benefit for description
• Exams	$10 Copayment		One (1) exam per 12-month period
• Lenses and Frames	5% Coinsurance	Non-Participating Provider services are not Covered and You pay the full cost	One (1) prescribed lenses and frames per 12-month period;
• Contact Lenses	5% Coinsurance		
Contact lenses	**Contact lenses**		

require Preauthorization	**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.