Experience the **NEW Member Portal**

It’s fast, it’s easy – and it’s available on your smart phone!

**Affinity Health Plan** has launched a new and improved member portal. The new portal offers enhanced features allowing for easier access to your healthcare information, including the status of claims and authorizations.

**Register for an account to:**

- Print a copy of your member ID card
- Select a primary care provider (PCP)
- Check your benefits
- Make a single payment, or set up recurring payments

**You will experience:**

- User friendly navigation
- Enhanced security
- Round-the-clock access, 24 hours-a-day, seven days a week

Visit [AffinityPlan.org](http://AffinityPlan.org) to register.
Welcome to Affinity Health Plan!

We are pleased you have chosen Affinity for your health coverage. For over 30 years, we have proudly served New Yorkers like you. Our focus is on providing you with quality and comprehensive healthcare coverage, and we are proud to welcome you as our member.

Affinity has one of the broadest networks of primary care doctors and specialists, hospitals and other health care facilities to serve you, right in your community. Instead of just treating you when you get sick, they can work with you to keep you healthy and manage any existing health conditions.

This Member Handbook describes your healthcare benefits through Affinity and is designed to make it easy for you to make the most of your benefits and services. Keep this handbook in a safe place for quick and easy reference.

I encourage you to use your Affinity benefits and get the care that you need to stay healthy. In whatever manner most convenient to you, we are available to help you understand the coverage and benefits available to you, help you find a doctor and answer any questions you may have. You can:

• Visit one of our Customer Service Centers – go to AffinityPlan.org to find a center near you.
• Call our Customer Service Department at 8662475678. (TTY users: 8006621220).
  Our staff is available Monday through Friday between 8:30 a.m. and 6:00 p.m.
• Browse our website, AffinityPlan.org, to find a doctor, learn more about programs available to help you stay healthy, and a variety of other useful information.

Once more, welcome to the Affinity community. We are glad you are here!

Sincerely,

Michael G. Murphy
President & Chief Executive Officer
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SECTION 1: INTRODUCTION

This member handbook is full of information about how your health plan works. If you want to know how to get care when you need it, what services are covered, or who to talk to when you have a question, you’ll find the answers in here. This member handbook tells you what you need to know about your plan and how to get the most from your coverage. Every effort has been made to ensure the accuracy of this member handbook and it should answer most of your questions.

Please note: This member handbook is not your subscriber contract. Your subscriber contract defines in greater detail your benefits, as well as the terms, conditions, limitations and exclusions applied to your coverage. Please refer to your subscriber contract when you have questions about your benefits that are not answered in this member handbook. To view your subscriber contract, visit AffinityPlan.org and click on Essential Plans.

Quick Reference Guide

MEMBER CONTACT NUMBERS

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<tr>
<th>Service</th>
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<tbody>
<tr>
<td>Customer Service</td>
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</tr>
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<td>Emergency Hospital Admissions</td>
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PROVIDER CONTACT NUMBERS

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PHARMACY NUMBERS

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<td>Member Customer Care</td>
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OTHER SERVICES

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<td>Dental</td>
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<td>Vision</td>
<td>866.810.3312</td>
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<tr>
<td>Behavioral Health/Substance Abuse Services</td>
<td>888.438.1914</td>
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For important health benefits information and/or help with translation, call us at 866.247.5678, Monday through Friday, from 8 a.m. to 6 p.m. EST. We offer translation services in many languages. Members with partial or total hearing loss can call our TTY line at 800.662.1220.

Para obtener información importante sobre beneficios de salud y/o ayuda de traducción, llámenos al 866.247.5678 de lunes a viernes, de 8 a.m. a 6 p.m. Ofrecemos servicios de traducción en muchos idiomas. Los miembros con pérdida de audición parcial o total pueden llamar a nuestra línea TTY al 800.662.1220.

若需了解更多医疗保险福利的重要信息或者翻译帮助，请致电8662475678联系我们。周一至周五，东部时间上午8点至下午6点。我们提供多语种的翻译服务。部分或者完全失去听力能力的会员，可以拨打听语言障碍服务专线(TTY): 800.662.1220。
SECTION 2: GETTING CARE

YOUR NEW AFFINITY ESSENTIAL PLAN MEMBER ID CARD
Your new Affinity Essential Plan member ID card will arrive within a few weeks of your enrollment. Your card tells you your:

- Member ID number
- Coverage plan
- Copayments (if any) for your plan

Your new card also has phone numbers for your primary care provider (PCP) if you selected one, and benefit providers. If anything on the card is not correct, call us right away. Carry your ID card at all times and show it each time you visit a doctor.
CHOOSING YOUR PRIMARY CARE PROVIDER (PCP)

Your primary care provider (PCP) is your regular doctor. You may choose any PCP found in the Affinity Essential Plan Network.

- Our online provider directory (Providerlookup.affinityplan.org) will show which doctors and providers are taking new patients. It’s always a good idea to call the doctor’s office first to make sure that they are taking new patients.
- If you have a long-lasting illness, you may be able to choose a specialist as your PCP. All you have to do is call customer service at 866.247.5678 and someone can help you make the choice that’s right for you.
- **If you do not choose a PCP for you and your family within 30 days of your enrollment, one will automatically be chosen for you.** You will receive a temporary ID card until you select a PCP.

We also contract with community health centers, which all provide primary and specialty care. Some people prefer these centers because they have a long history in the community or may be easier to get to. You can choose between a community health center or a PCP.

**What can your PCP do for you?**

- Give you regular checkups and health screenings, including mental health and/or substance use screenings
- Make sure you get the health care you need
- Arrange any necessary tests, laboratory procedures, or hospital visits
- Keep your medical records
- Recommend specialists (when necessary)
- Provide information on covered services that need preauthorization (permission) before you get treatment
- Write prescriptions (when necessary)
- Help you get mental health and/or substance use services (when necessary)

If you are in an ongoing course of treatment with a Non-Participating Provider when your coverage under the Affinity Essential Plan becomes effective, you may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to 60 days from the effective date of your coverage under your subscriber contract. This course of treatment must be for a life-threatening disease or condition, or for a degenerative and disabling condition or disease.

In order for you to continue to receive Covered Services for up to 60 days, the Non-Participating Provider must agree to accept our fees as payment for such services. The Provider must also agree to provide Affinity the necessary medical information related to your care, and to adhere to our policies and procedures including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by us. If the Provider agrees to these conditions, you will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network cost-sharing. Your doctor must agree to work with Affinity.

**PREAUTHORIZATION FOR COVERED SERVICES**

When preauthorization is required, your PCP is responsible for getting permission for services from in-network providers. Your PCP will work with your other providers to make sure you get the care you need. For more information about which services need preauthorization, please see the “Summary of Benefits & Coverage” section in this member handbook; or, for the full list, please see your contract and schedule of benefits or visit us at AffinityPlan.org and click on Essential Plans.
**How does the preauthorization process work?**

Affinity will review your PCP's request, as well as your medical records, clinical guidelines and professional opinions before making a decision. We want to make sure that the care you get is necessary. We will notify you and your PCP within 3 days of our decision, clearly stating what services, providers, and locations are approved and/or covered or not covered.

If at any time you do not agree with any part of our determination, you have the right to appeal the decision. You or your PCP can reach customer service at 866.247.5678 to speak with a representative about your case.

**SEEING A SPECIALIST**

Specialists are providers who have extra training and who focus on one kind of care or on one part of the body. Sometimes you may need to visit a specialist, such as a cardiologist (heart doctor), dermatologist (skin doctor), or ophthalmologist (eye doctor). You can visit most specialists without preauthorization as long as the specialist is an in-network specialist. To find a network specialist, talk to your PCP, or call Affinity at 866.247.5678 (TTY: 800.662.1220). We also list specialists in our provider directory, available online at http://providerlookup.affinityplan.org. You may also call us to get a copy.

If we determine that we do not have a participating provider who has the appropriate training and experience to treat your condition that is available and geographically accessible to you, we will approve a referral to an appropriate non-participating provider. Any covered services you receive will be paid as if a participating provider delivered them. You will only have to worry about any applicable cost-sharing associated with your plan.

**What if you need specialty services?**

There is a requirement for some specialty services to be pre-authorized by Affinity. These services include:

- Specific professional services (like a visit to a specialist)
- Outpatient hospital visits
- Ambulatory surgery services
- Home health care services
- Speech/occupational/physical therapy

Your PCP may authorize a standing referral for certain specialty care from a preferred in-network provider if your PCP and the specialist agree on a treatment plan of medically necessary covered services. Remember, your PCP, not the specialist treating you, must request any additional referrals you may need.

Your PCP is responsible for obtaining pre-authorization from Affinity. If you receive care from a service listed above, you should not be billed for more than the applicable copayments or coinsurance amounts as long as the service is rendered by an in-network provider.

Several services, such as the ones listed below, do not require preauthorization:

- Women seeking an OB/GYN doctor (routine checkups twice a year, follow-up care if there is a problem)
- Outpatient treatment for mental health issues (first instance only)
- Refractive eye exams from an optometrist
- Diabetic eye exams from an ophthalmologist
- Emergency care
CONTINUITY OF CARE
You may find that the PCP you first selected is not right for you, your life circumstances change, or your doctor moves or is no longer in practice. That’s OK. You can decide to change your PCP at any time. The change to your new PCP will take place on the first day of the month after the change was requested.

If you want to choose another PCP do the following:

• Call customer service toll-free at 866.247.5678 and ask for help in choosing a PCP. The representative will provide you with a list of PCPs and all their relevant details (e.g., contact information, office hours and locations, the languages they speak, etc.)
• Let customer service know which PCP you chose for yourself and each of your family members. If your PCP has more than one office, make sure to tell customer service which office you want to use.
• Make your “new patient visit” as soon as you can, even if you are not sick. It is important for you to start building a relationship with your new doctor as soon as possible.

If you are in an ongoing course of treatment when your provider leaves our network, you may be able to continue to receive covered services for the ongoing treatment from the former participating provider for up to 90 days from the date your provider’s contractual obligation to provide services to you terminates.

Affinity will continue to work with your provider to make sure your care is continued. When it comes time to select someone new, you can check with your PCP for a recommendation or call customer service at 866.247.5678 for assistance.
SECTION 3: COVERED SERVICES

We cover the medically necessary services listed in this member Handbook. If a service or service category is not specifically listed as covered, then it is not covered under your plan. (See the section “Services Not Covered” on page 19 or refer to your Schedule of Benefits.) The following section lists services we cover for Affinity members.

We’ll authorize, arrange, coordinate, and provide to members all medically necessary covered services. The covered services for your plan type are listed in the section, “Summary of Benefits & Coverage” starting on page 25 and in your Schedule of Benefits. Check the summary for your plan type and for a list of services covered and preauthorization requirements for Affinity Health Plan members. If you have any questions, call us at 8662475678 (TTY: 8006621220), Monday through Friday, from 8:30 a.m. to 6:00 p.m. EST. We can give you more information about any of these covered services.

Services are only covered if they are considered medically necessary. Medically necessary services are those covered services that fulfill the following requirements:

- Clinically appropriate in terms of type, frequency, extent, site, and duration; and considered effective for your illness, injury, or disease.
- Required for the direct care and treatment or management of that condition.
- Would adversely affect your condition if the services were not provided.
- Provided in accordance with generally accepted standards of medical practice.
- Not primarily for the convenience of you, your family or your provider.

Note that when setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be considered medically necessary if performed in a higher cost setting. For example, we will not provide coverage for an inpatient admission for a procedure that can be performed on an outpatient basis.

In addition to any limitations in the Summary of Benefits & Coverage and/or the Schedule of Benefits, we may limit, or require preauthorization for, covered services on the basis of medical necessity. Please reference your plan contract for more details.

In-network providers and out-of-network providers require preauthorization from Affinity before you can make an appointment for services.

SERVICES WE COVER

Preventive Care
We cover these services to promote good health and early detection of disease. Preventive services do not require any cost-sharing (copayments and coinsurance) when performed by a participating provider. Preventive services include immunizations, annual physical examinations, well woman exams, sterilization procedures for men and women, bone density testing, prostate cancer screenings and all other preventive services required by the United States Preventive Services Task Force (USPSTF) and by the Health Resources and Services Administration (HRSA).

Ambulance and Pre-hospital Emergency Medical Services
Pre-hospital emergency medical services means the immediate evaluation and treatment of an emergency condition and/or transportation (by air, water or land) to the nearest hospital where emergency services can be performed. These services must be provided by an ambulance service issued a certificate under the N.Y. Public Health Law. Transportation is covered when the absence of such transportation may result in the following:

- Placing the health of the person (or woman and unborn child) in serious jeopardy.
• Placing the health of such a person or others in serious jeopardy (in the case of a behavioral condition)
• Serious impairment to the person’s bodily functions
• Serious dysfunction of any bodily organ or part of the person
• Serious disfigurement of the person

An ambulance service cannot charge or seek reimbursement from you for any of these emergency services except for the collection of any applicable copayment, coinsurance, or deductible. None of these emergency services require preauthorization by your PCP or Affinity.

In a non-emergency situation, we cover transportation by a licensed ambulance service (by ground or air) between facilities when the transport is any of the following:
• From a non-network hospital to a network hospital
• To a hospital that provides a higher level of care not available at the original hospital
• To a more cost-effective acute care facility
• From an acute facility to a sub-acute setting

The Schedule of Benefits & Coverage provides additional details on when preauthorization is required for non-emergency transportation. Your benefits do not include travel or transportation expenses unless connected to an emergency condition or due to a pre-approved facility transfer.

Emergency Services
Emergency conditions are covered. An emergency condition is a medical or behavioral condition that presents itself by acute symptoms of sufficient severity, including severe pain, which can be alleviated by immediate medical attention. An emergency condition may include but is not limited to the following:
• Severe chest pain
• Severe or multiple injuries
• Severe shortness of breath
• Sudden changes in mental status (e.g., disorientation)
• Severe bleeding
• Acute pain or conditions requiring immediate attention (e.g., suspected heart attack or appendicitis)
• Poisonings
• Convulsions/seizures

We do not cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for emergency services. Your emergency condition will be covered by us regardless of whether the provider is a part of the Affinity Essential network of providers or not. Emergency services means the evaluation and treatment of an emergency condition to keep the condition from getting worse. The emergency services and related supplies must still be deemed medically necessary and are performed to treat or stabilize your emergency condition.

Hospital Emergency Department Visits
Seek immediate care at the nearest hospital emergency department or call 911 when you require treatment for an emergency condition. Emergency department care does not require preauthorization. If you are unsure if the emergency department is the most appropriate place to receive care, you can call Affinity before you seek treatment. Our Medical Management case managers are available 24 hours a day, 7 days a week and will help direct you to the right resource for your condition. You can reach Affinity Medical Management at 866.247.5678.

Follow-up care or routine care provided in a hospital emergency department is not covered.
Emergency Hospital Admissions
In the event you are admitted to the hospital, you or someone on your behalf must notify your PCP and Affinity Health Plan at our emergency line at 866.247.5678 within 48 hours of your admission, or as soon as reasonably possible.

Urgent Care
Urgent care means medical care for an illness, injury or condition serious enough that a person would seek care right away, but not so severe that you would need to visit the emergency department. You can get urgent care from a participating physician or participating urgent care center. If receiving urgent care results in an emergency admission, please follow the same guidelines outlined for “Emergency Hospital Admissions” as described above.

Outpatient and Professional Services
Some services may require preauthorization. The Summary of Benefits & Coverage and your Schedule of Benefits have details on preauthorization, cost-sharing requirements, and day or visit limitations that may apply to the following services:

- **Advanced Imaging Services**
  PET, MRI, nuclear medicine and CAT scans

- **Allergy Testing and Treatment**
  Testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. We also cover allergy treatment, including desensitization treatments, routine allergy injections and serums.

- **Ambulatory Surgery Center**
  Surgical procedures performed at ambulatory surgical centers including services and supplies provided by the center the day the surgery is performed.

- **Chemotherapy**
  Chemotherapy is given in an outpatient facility or in a health care professional’s office. Orally-administered anti-cancer drugs are covered under your prescription drug benefit.

- **Chiropractic Services**
  Chiropractic care when performed by a chiropractor in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the related effects. This includes assessment, manipulation and any related procedures.

- **Dialysis**
  Dialysis treatments of an acute or chronic kidney disorder.

- **Habilitation or Rehabilitation Services**
  Services consisting of physical therapy, speech therapy, and occupational therapy as an outpatient or in a health care professional’s office for up to 60 visits per condition, per lifetime. The visit limit applies to all therapies combined. For the purposes of this benefit, “per condition” means the disease or injury causing the need for the therapy.

- **Home Health Care**
  Care provided in your home by a home health agency certified or licensed by the appropriate state agency. The care must be provided based on your PCP’s written treatment plan and must be instead of hospitalization or confinement in a skilled nursing facility.
Interruption of Pregnancy
This refers to therapeutic abortions. We also cover non-therapeutic abortions in cases of rape, incest or fetal malformation. We cover elective abortions for one procedure per member, per plan year.

Infertility Treatment
Basic infertility services will be provided to a member who is an appropriate candidate for infertility treatment. Eligibility is determined using guidelines established by the American College of Obstetrics and Gynecologists, the American Society for Reproductive Medicine, and the State of New York. Members must be between the ages of 21 and 44 (inclusive) to be considered a candidate for these services.

Infusion Therapy
The administration of drugs using specialized delivery systems that otherwise would have required you to be hospitalized. Drugs or nutrients administered directly into the veins are considered infusion therapy. The services must be ordered by a physician or other authorized health care professional and provided in an office or by an agency licensed or certified to provide infusion therapy.

Laboratory Procedures, Diagnostic Testing and Radiology Services
X-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms (EKG or ECG), electroencephalograms (EEG), laboratory tests, and therapeutic radiology services.

Maternity and Newborn Care
As soon as you have confirmed that you are pregnant, we recommend you call the Affinity Health Plan Medical Management Department at 866.247.5678. Affinity has programs that support you and your baby’s health through delivery.

Medications Administered in the PCP Office for Therapeutic or Preventive Purposes
Medications and injectables (excluding self-injectables) used by your provider in the provider’s office for preventive and therapeutic purposes.

Outpatient Hospital Services
Hospital services and supplies as described in the inpatient hospital section that can be provided to you while being treated in an outpatient facility.

Preadmission Testing
Preadmission testing ordered by your physician and performed in hospital outpatient facilities prior to a scheduled surgery in the same hospital provided that the tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed; reservations for a hospital bed and operating room were made prior to the performance of the tests; surgery takes place within seven days of the tests; and the patient is physically present at the hospital for the tests.

Speech and Physical Therapy
When such therapy is related to the treatment or diagnosis of your physical illness or injury, is ordered by a physician and you have been hospitalized or have undergone surgery for such illness or injury. Therapy services must begin within 6 months of the date of injury or illness, hospital discharge or outpatient surgical care is received.
Second Opinions

For cancer: We cover a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer, a recurrence of cancer, or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a non-participating provider on an in-network basis when your attending physician provides a written referral to a non-participating specialist.

For surgery: A second surgical opinion by a qualified physician on the need for surgery. We may also require a second opinion before we preauthorize a surgical procedure. There is no cost to you when we request a second opinion.

Surgical Services
Physicians’ services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or specialist, assistant (including a physician’s assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure, when provided by the surgeon or the surgeon’s assistant.

Oral Surgery
Oral surgery due to accident or injury, congenital disease or anomaly, and removal of tumors or cysts. The covered areas are jaw bones or surrounding tissue and dental services for the repair or replacement of intact natural teeth that are required due to accident or injury (when repair is not possible).

Reconstructive Surgery
Reconstructive breast surgery after a mastectomy or partial mastectomy. Coverage includes all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy. Prosthetic breast implants following a mastectomy or partial mastectomy are also covered.

Other reconstructive and corrective surgeries covered include the repair of a congenital birth defect; an event incidental to surgery; or following surgery that resulted from trauma, infection, or disease or otherwise considered medically necessary.

Transplants
Only those transplants determined to be non-experimental and non-investigational. All transplants must be prescribed by your specialist(s) and must be performed at hospitals that we have specifically approved and designated to perform these procedures.

Additional Benefits, Equipment & Devices

Autism Spectrum Disorder
When ordered or prescribed by a licensed physician or licensed psychologist and determined to be medically necessary. For purposes of this benefit, “autism spectrum disorder” means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) at the time services are received, including autism, Asperger’s, Rett’s, childhood disintegrative disorder, and pervasive developmental disorder not otherwise specified (PDD-NOS).
We cover screening and diagnosis, assistive communication devices (when approved), behavioral health treatment, psychiatric and psychological care, therapeutic care and pharmacy care. You are responsible for any applicable deductible, copayment or coinsurance payments.

**Diabetic Equipment, Supplies and Self-Management Education**
Diabetic equipment, supplies, and self-management education if recommended or prescribed by a physician or other licensed health care professional legally authorized to prescribe under Title 8 of the Education Law. Diabetic equipment and supplies are covered only when obtained from our designated supplier of diabetic equipment or supplies.

We cover education on self-management and nutrition when diabetes is initially diagnosed, a physician diagnoses a significant change in your symptoms or condition that requires a change in your self-management education, or when a refresher course is necessary.

**Durable Medical Equipment**
Durable medical equipment includes the following equipment:

- Designed and intended for repeated use
- Primarily and customarily used to serve a medical purpose
- Generally not useful to a person in the absence of disease or injury
- Appropriate for use in the home

Coverage is for standard equipment only. Repairs or replacement are covered as a result of normal wear and tear only. Affinity Health Plan will determine whether to rent or purchase the equipment.

**Other Covered Benefits**
We cover other medical equipment, devices or services deemed medically necessary, including:

- Braces worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease, or defect
- Hearing aids required for the correction of a hearing impairment
- Hospice care if your PCP has certified that you have 6 months or less to live
- Medical supplies required for the treatment of disease or injury covered under this contract
- Prosthetic devices (internal or external)

**Inpatient Services (For other than Mental Health and Substance Use)**
We cover inpatient hospital services for acute care or treatment given or ordered by a health care professional for an illness, injury, or disease of a severity that must be treated on an inpatient basis. Cost sharing requirements in the Schedule of Benefits apply to a continuous hospital stay. A continuous hospital stay includes consecutive days of in-hospital service received as an inpatient or successive confinements when discharge from and readmission to the hospital occur within a period of not more than 90 days. This includes the following:

- Observation services
- Mastectomy care
- Autologous blood banking services
- Rehabilitation services
- Skilled-nursing facility
- End-of-life care
Mental Health Care

**Inpatient:** We cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders comparable to other similar hospital, medical, and surgical coverage provided under your plan. However, coverage for inpatient services for mental health care is limited to facilities as defined by New York Mental Hygiene Law § 1.03 subdivision 10.

**Outpatient:** We cover outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. The physician or facility must be properly licensed to provide mental health care services.

Substance Use Services

**Inpatient:** We cover inpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. This includes coverage for detoxification and/or rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to facilities in New York State that are certified by the Office of Alcoholism and Substance Abuse Services (OASAS), and in other states (with preauthorization), to those that are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

**Outpatient:** We cover outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency. Such coverage is limited to facilities in New York State, certified by the Office of Alcoholism and Substance Abuse Services (OASAS) or licensed by OASAS as an outpatient facility or medically supervised ambulatory substance abuse programs, and, in other states, to those accredited by the Joint Commission as alcoholism or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services relating to the diagnosis and treatment of alcoholism and/or substance use and/or dependency.

We also cover up to 20 outpatient visits for family counseling.

Prescription Drug Coverage

We cover medically necessary outpatient prescription drugs that can be dispensed only according to a prescription. For a complete drug formulary, you can visit our website at Affinityplan.org. You may also request a copy of our drug formulary or inquire about coverage of a specific drug by contacting us at the telephone number listed on the back of your ID card. You may be responsible for some cost sharing related to prescription drugs that you use. The Summary of Benefits & Coverage starting on page 25 and the Schedule of Benefits have more details on cost-sharing for your prescription drugs.

We will pay for a 30-day supply purchased at a retail pharmacy or designated pharmacy. Benefits will be provided for drugs dispensed by a mail-order pharmacy in a quantity of up to a 90-day supply. **Only maintenance drugs (drugs used to treat chronic conditions) are covered through mail order pharmacy.** We will also provide benefits that apply to drugs dispensed by a mail-order pharmacy to drugs that are purchased from a retail pharmacy when that retail pharmacy has an agreement with us to follow the same terms and conditions as a participating mail order pharmacy.

Preauthorization may be needed for certain prescription drugs to make sure proper use and guidelines for prescription drug coverage are followed. To determine if a prescription drug requires preauthorization, please call customer service at 8662475678 or consult the list of covered medications by visiting our website at Affinityplan.org/Members/Essential-Plan/Plan-Resources/Plan-Resources.
Your Affinity Essential Plan member ID must be presented to the retail pharmacy to utilize the drug benefit plan. A personal ID to verify that you are the cardholder may also be required.

You are responsible for paying the full cost (the amount the pharmacy charges you) for any non-covered prescription drug. We will not pay for any prescription drugs that you purchase at a non-participating retail or mail-order pharmacy, except when our participating pharmacies are unable to provide the covered prescription drug, or cannot order the prescription drug within a reasonable time. Preauthorization may be required.

**Refills**
We cover refills of prescription drugs only when purchased at retail, mail-order, or designated pharmacies as ordered by your doctor, and only after 85% of the original prescription drug has been used. Benefits for refills will not be provided beyond one year from the original prescription date or less if the prescriber designates a shorter time. For prescription eye drop medication, we allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early refill of renewals.

**Prescription Drug Tiering**
The tier status of a prescription drug may change periodically. Changes will generally be quarterly but no more than six times per plan year based on our periodic tiering decisions. This change may occur without prior notice to you. However, if your prescription drug is moving to a higher tier, you will be notified of the change.

**Step Therapy**
Step therapy is a process in which you may need to use one type of prescription drug before we will cover another as medically necessary. We check certain prescription drugs to make sure the proper prescribing guidelines are followed. These guidelines help you get high-quality and cost-effective prescription drugs.

**Limitations/Terms Prescription Drug of Coverage**
1. We reserve the right to limit quantities, days supplied, early refill access and/or duration of therapy for certain medications based on medical necessity, including acceptable medical standards and/or FDA recommended guidelines.

2. If we determine that you may be using a prescription drug in a harmful or abusive manner, or with harmful frequency, your selection of participating pharmacies may be limited. Benefits will be paid only if you use the selected single participating pharmacy.

3. Compounded prescription drugs will be covered only when they contain at least one ingredient that is a covered legend prescription drug, are medically necessary, and are obtained from a pharmacy that is approved for compounding. All compounded prescription drugs over $250 require your provider to obtain preauthorization.

4. Various specific and/or generalized “use management” protocols will be used from time to time in order to ensure appropriate utilization of medications. The primary goal of the protocols is to provide our members with a quality-focused drug benefit. In the event a use management protocol is implemented, and you are taking the drug(s) affected by the protocol, you will be notified in advance.

5. We do not cover drugs that do not by law require a prescription, except for smoking cessation drugs or as otherwise provided in your plan contract.
6. We do not cover prescription drugs that have over-the-counter non-prescription equivalents. Nonprescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.

7. We do not cover prescription drugs to replace those that may have been lost or stolen.

8. We do not cover prescription drugs dispensed to you while in a hospital, nursing home, other institution or facility, or if you are a home care patient, except in those cases where the basis of payment by or on behalf of you to the hospital, nursing home, home health agency or home care services agency or other institution, does not include services for drugs.

9. We reserve the right to deny benefits as not medically necessary or as experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice.

10. A pharmacy need not dispense a prescription order which, in the pharmacist’s professional judgment, should not be filled.

11. We do not cover nutritional supplements (formulas), non-prescription enteral formulas, and modified food solid products, except as described under the covered outpatient prescription drug.

**Wellness Benefits**

We will partially reimburse the member and the member’s covered spouse for certain exercise facility fees or membership fees, but only if such fees are paid to approved exercise facilities that maintain equipment and programs that promote cardiovascular wellness. Reimbursement is limited to actual workout visits. We will not provide reimbursement for equipment, clothing, vitamins or other services (massages, yoga, etc.) that may be offered by the facility.

In order to be eligible for reimbursement, you must:

**(a) Be an active member of the exercise facility**

**(b) Complete 50 visits in a six-month period**

At the end of the 6-month period, you must submit a completed exercise reimbursement form from Affinity’s Customer Service Department (call 8662475678 for information). Each time you visit the exercise facility, a facility representative must sign and date the reimbursement form. Once we receive the completed reimbursement form, and the documentation is approved, you will be reimbursed the lesser of $200 for the member or the actual cost of the membership per six-month period.
ADDITIONAL BENEFITS FOR CERTAIN EP SUBSCRIBERS

Additional benefits apply only to certain Essential Plan subscribers.

NOTE: Please refer to the Schedule of Benefits section of this manual, or your subscriber contract to determine your eligibility, cost-sharing requirements, day or visit limits, and any preauthorization or referral requirements that apply to these benefits.

Dental Services
Covered services include regular and routine dental services such as preventive dental check-ups, cleaning, x-rays, fillings and other services to check for any changes or abnormalities that may require treatment and/or follow-up care. You do not need a referral from your PCP to see a dentist. If you need to find a dentist or change your dentist, please call DentaQuest at 8667318004, Monday through Friday from 8:00AM to 5:00PM; or, please call us at 8662475678, Monday through Friday from 8:30AM to 6:00PM.

Orthodontia Services
Orthodontia is covered when you have a medically necessary surgical treatment, such as reconstructive surgery of your jaw.

Vision Services
We offer vision care through a contract with Superior Vision, an expert in providing high quality vision services. We cover the following vision services:

- Services of an ophthalmologist, ophthalmic dispenser, and optometrist, and coverage for contact lenses, polycarbonate lenses, artificial eyes, and/or replacement of lost or destroyed glasses, including repairs, when medically necessary. Artificial eyes are covered as ordered by a plan provider;
- Eye exams, generally every two years, unless medically needed more often;
- Low-vision exam and vision aids ordered by your doctor;
- Specialist referrals for eye diseases or defects.

If you need to find a vision provider or change your vision provider, please call Superior Vision at 8668103312, Monday through Friday from 9:00AM to 8:00PM; or, please call us at 8662475678, Monday through Friday from 8:30AM to 6:00PM.

Non-prescription Drugs (Over-the-Counter or OTC)
In addition to the prescription drug coverage described above, we also cover non-prescription (OTC) drugs, medical supplies, and hearing aid batteries when ordered by a licensed provider.

Foot Care Services
We cover routine foot care provided by licensed provider types when your physical condition poses a hazard due to the localized presence of an illness, injury or symptoms involving the foot, or when performed as a necessary and integral part of otherwise covered services such as the diagnosis and treatment of diabetes, ulcers and infections. We do not cover routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, or the cleaning or soaking feet, unless you have pathological conditions that require the services.

Orthopedic Footwear
We cover orthopedic footwear when used to correct, accommodate or prevent a physical deformity or range of motion malfunction in a diseased or injured part of the ankle or foot, or to support a weak or deformed structure of the ankle or foot, or to form an integral part of a brace. Coverage includes shoes, shoe modifications or shoe additions. We do not cover sneakers or athletic shoes.
Family Planning Services
You may receive certain additional family planning and reproductive health services either from one of our participating providers or from any appropriate Medicaid health provider of your choice. You do not need a referral from your PCP to obtain these services. If you visit any appropriate Medicaid health provider, the cost to you will be the same as the cost of seeing one of our participating providers. The following are the family planning and reproductive health services that you may receive from any Medicaid health provider or a participating provider:

1. Screening, related diagnosis, ambulatory treatment, and referrals to a participating provider as needed for dysmenorrhea, cervical cancer or other pelvic abnormalities.
2. Screening, related diagnosis, and referral to participating provider for anemia, cervical cancer, glycosuria, proteinuria, hypertension, breast disease and pregnancy.
3. HIV testing and pre-test and post-test counseling when performed as part of a family planning visit.

You must visit a participating provider in order to have the following family planning and reproductive health services covered by us:

1. Infertility Treatment as set forth in the family planning services described in section VI.
2. Routine gynecologic care, including hysterectomies, as set forth in the outpatient services section of your subscriber contract.
3. Any other family planning and reproductive service not specified above.

Non-Emergency Transportation
Certain EP subscribers are also eligible for non-emergency transportation administered by New York State, which includes personal vehicle, bus, taxi, ambulete, and public transportation to medical appointments.
You or your provider must call the vendor listed below to arrange transportation:

- NYC (Bronx, Brooklyn, Manhattan, Queens, Staten Island): Logisticare 8775645922
- Long Island (Nassau and Suffolk): Logisticare 8446781103
- All other counties: Medical Answering Services 8008505340

You can access this information online at:
https://www.emedny.org/ProviderManuals/Transportation/PDFS/Transportation_PA_Guidelines_Contact_List.pdf

If possible, you or your provider should call the vendor at least three days before your medical appointment and provide your appointment date and time, an address, and the doctor you are seeing.
SERVICES NOT COVERED
No coverage is available under this plan for the following services:

Aviation
We do not cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

Convalescent and Custodial Care
We do not cover services related to rest cures, custodial care or transportation. “Custodial care” means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include covered services determined to be medically necessary.

Cosmetic Services
We do not cover cosmetic services, prescription drugs for these services, or surgery, unless otherwise specified. Cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered child which has resulted in a functional defect. We also cover services in connection with reconstructive surgery following a mastectomy, as provided in the subscriber contract. Cosmetic surgery does not include surgery determined to be medically necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the utilization review process in the utilization review and external appeal sections of your subscriber contract unless medical information is submitted.

Coverage Outside of the United States, Canada or Mexico
We do not cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for emergency services, pre-hospital emergency medical services and ambulance services to treat your emergency condition.

Dental Services
We do not cover dental services except for care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the outpatient and professional services section of your subscriber contract.

Experimental or Investigational Treatment
We do not cover any health care service, procedure, treatment, device or prescription drug that is experimental or investigational. However, we will cover experimental or investigational treatments, including treatment for your rare disease or patient costs for your participation in a clinical trial as described in the outpatient and professional services section of your subscriber contract, or when our denial of services is overturned by an external appeal agent certified by the State. However, for clinical trials, we will not cover the costs of any investigational drugs or devices, non-health services required for you to receive the treatment, the costs of managing the research, or costs that would not be covered under your subscriber contract for non-investigational treatments. See the utilization review and external appeal sections of your subscriber contract for a further explanation of your appeal rights.

Felony Participation
We do not cover any illness, treatment or medical condition due to your participation in a felony, riot or insurrection. This exclusion does not apply to coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of your medical condition (including both physical and mental health conditions).
Foot Care
We do not cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, except as stated in your subscriber contract. However, we will cover foot care when you have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in your legs or feet.

Government Facility
We do not cover care or treatment provided in a hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless you are taken to the hospital because it is close to the place where you were injured or became ill and emergency services are provided to treat your emergency condition.

Medically Necessary
In general, we will not cover any health care service, procedure, treatment, test, device or prescription drug that we determine is not medically necessary. If an external appeal agent certified by the State overturns our denial, however, we will cover the service, procedure, treatment, test, device or prescription drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or prescription drug is otherwise covered under the terms of your subscriber contract.

Medicare or Other Governmental Program
We do not cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

Military Service
We do not cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

No-Fault Automobile Insurance
We do not cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if you do not make a proper or timely claim for the benefits available to you under a mandatory no-fault policy.

Services Not Listed
We do not cover services that are not listed in your subscriber contract as being covered.

Services Provided by a Family Member
We do not cover services performed by a member of the covered person’s immediate family. “Immediate family” shall mean a child, spouse, mother, father, sister or brother of you or your spouse.

Services Separately Billed by Hospital Employees
We do not cover services rendered and separately billed by employees of hospitals, laboratories or other institutions.

Services with No Charge
We do not cover services for which no charge is normally made.

Vision Services
We do not cover the examination or fitting of eyeglasses or contact lenses.
War
We do not cover an illness, treatment or medical condition due to war, declared or undeclared.

Workers’ Compensation
We do not cover services if benefits for such services are provided under any state or federal workers’ compensation, employers’ liability or occupational disease law.
SECTION 4: HOW YOUR PLAN WORKS

ENROLLMENT
Starting on January 1, 2019, you can enroll in this plan during any time of the year. If the NY State of Health receives your selection on or before the 15th of any month, your coverage will begin on the 1st of the following month, as long as any applicable premium payment is received by then. If the NYSOH receives your selection on or after the 16th of the month, your coverage will begin on the 1st of the next successive month. For example, if you make a selection on January 16, your coverage will begin on March 1.

PAYING FOR YOUR PLAN
Most Affinity Essential Plans do not require you to pay a premium for your health care coverage. A premium is the monthly bill you pay to Affinity Health Plan for your Affinity Essential Plan health benefits. If you are required to pay a premium, you will be able to begin submitting monthly payments online immediately after selecting the Affinity Essential Plan. You can access payment options on our website at Affinityplan.org/Members/Essential-Plan/Make-A-Payment/Make-A-Payment/.

When you first enroll in a plan, there is a 10-day grace period before your first payment is due. This means that you will have until the 10 day of the month your coverage begins to make your first payment. If your first payment is not received within 10 days, your plan may be cancelled.

WHO IS COVERED BY YOUR PLAN
You, the member to whom this member handbook is issued, are covered under the plan. You must live, work, or reside in our service area to be covered. You must have a household income no greater than 200% of the federal poverty level. If you are enrolled in Medicare or Medicaid, you are not eligible to purchase this plan. Also, you are not eligible to purchase this plan if your income is above 138% of the federal poverty level AND you are:
• under 19 years old, or
• greater than 64 years old.

You must report changes that could affect your eligibility throughout the year.

CLAIMS
A claim is a request that benefits or services be provided or paid according to the terms of your subscriber contract. When you receive services from a participating provider you will not need to submit a claim form. However, if you receive services from an out-of-network provider either you or the provider must file a claim form with Affinity. If the out-of-network provider is not willing to file the claim form, you will need to file the form yourself. Incomplete claims will not be accepted. Claim forms are available online at Affinityplan.org/Members/Essential-Plan/Plan-Resources/Plan-Resources/.

• Claims must include all information we deem necessary to process the claim.
• Claims must be submitted within 120 days of receiving service.
• Claims for prohibited referrals may not be paid by us.
• Claim determinations will be made within 30 calendar days from the receipt of the claim and notice provided to you or your designee, which can be your provider, in writing.

Decisions on preauthorization requests or referrals will be made within 15 days of receipt if all necessary information is included at the time of submission. You or your designee will be notified in writing. For urgent pre-service reviews, a determination will be made and you, your designee or provider will be notified by telephone within 72 hours. This does not include elective services or procedures.
**Claim Determinations.** Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, our claim determination procedure applies to referrals and contractual benefit denials. If you disagree with our determination you may submit a grievance according to the terms of your subscriber contract.

**SUBROGATION**
This means that we have the right, independently of you, to proceed directly against the party who may be responsible for your injury to recover the benefits that we have provided related to that injury, illness or condition. We may have the right of reimbursement if you or anyone on your behalf receives payment from any responsible party from any settlement, verdict or insurance proceeds in connection with the injury, illness, or condition for which we provided benefits. We request that you notify us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition for which we have provided benefits.

**GRIEVANCES**
The grievance procedure applies to any issue not relating to a medical necessity or experimental or investigational determination by us. It applies to contractual benefit denials or issues/concerns you have regarding our administrative policies or access to providers. You or your designee have up to 180 calendar days from the date of the determination to file the grievance.

- We will acknowledge receipt of your grievance within 15 business days with the contact information for your file reviewer.
- All requests and discussions are completely confidential.
- Depending on the urgency and type of grievance, you will be notified within 72 hours (urgent/expedited grievances) or up to 30 calendar days in writing after receipt of all information.

To file a grievance, contact us by phone at 8662475678, in person at one of our Affinity Health Plan community service centers, or in writing. You may submit a verbal grievance in connection with a denial of a referral or a covered benefit determination. If you are unhappy with the determination, you can contact the New York State Department of Health at 800.206.8125, health.ny.gov, by email at managedcarecomplaint@health.ny.gov, or by mail at Corning Tower, Empire State Plaza, Albany, NY 12237.

**External Appeal**
In some cases, you have a right to an external appeal of a denial of coverage. This applies when we have denied coverage on the basis that a service does not meet our requirements for medical necessity, is an experimental or investigational treatment, or is an out-of-network treatment. In order for you to be eligible for an external appeal:

- The service, procedure, or treatment must otherwise be a covered service under your plan.
- You must have received a final adverse determination through our internal appeals process.

You have 4 months from receipt of a final adverse determination or from receipt of a waiver of an internal appeal process to file a written request for an external appeal.

**TERMINATION OF COVERAGE**
Termination of coverage does not impact the right to claim benefits that occurred before the termination of coverage. You can terminate your coverage at any time by providing at least 30 days prior written notice.
Your coverage under this plan shall automatically terminate:

1. Upon your death.
2. When you turn 65. Your coverage will end at the end of the month in which you turn 65 or become Medicare eligible.
3. When you become Medicaid eligible or enroll in the Medicaid Program. Your coverage will end at the end of the month in which you are determined to be Medicaid eligible.
4. When your income exceeds 200% of the federal poverty level. Your coverage will end at the end of the month in which your income has changed.
5. When you have had a change in immigration status that makes you eligible for other coverage, including Medicaid, and your coverage will end at the end of the month before you are determined to be Medicaid eligible.
6. When you have enrolled in a different program through the NY State of Health Marketplace.

For more details on termination of coverage, refer to your subscriber contract. You can find a copy of your subscriber contract online at Affinityplan.org/Members/Essential-Plan/Plan-Details/Plan-Details/.

YOUR RIGHTS & RESPONSIBILITIES

You have the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a physician or other provider in terms you can reasonably understand. Written application procedures and minimum qualification requirements for providers are available to you upon request. When it is not advisable to give such information to you, the information shall be made available to an appropriate person acting on your behalf.

You have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action. You have the right to formulate advance directives regarding your care.

There may come a time when you cannot make decisions regarding your own care. By planning in advance, you can arrange for your wishes to be carried out when and if that time ever comes. Openly communicate your wishes to family, friends and your caregivers, in addition to putting your wishes in writing. We can help you understand or locate these documents, and you can change your mind about your directives at any time. Your advance directives do not change your rights to quality health care benefits.

SUBMITTING FEEDBACK

As a member, you may participate in the development of our policies by calling our customer service at 8662475678. We value your ideas. If you have ideas to share, please tell us about them. You can help us develop policies that best serve our members. If you are interested, you can work with one of our member advisory boards or committees. Call our customer service number to find out how you can be more involved with Affinity.

HEALTH CARE FRAUD NOTICE

Health care fraud affects us all and causes an increase in health care costs. If you suspect any person or company of defrauding or attempting to defraud Affinity Health Plan, please call our toll-free hotline at 8665281505. We are available 24 hours a day, 7 days a week, and all calls are confidential and anonymous.
SECTION 5:
SUMMARY OF BENEFITS & COVERAGE
**Affinity Health Plan: Essential Plan 1 plus Dental/Vision**  
**Coverage for:** Individual | **Plan Type:** HMO

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

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**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the schedule of benefits at [www.affinityplan.org](http://www.affinityplan.org) or by calling 1-866-247-5678.

**Important Questions** | **Answers** | **Why this Matters:**
---|---|---
What is the overall deductible? | $0 | The Affinity Essential Plan does not have any deductible.
Is there an out-of-pocket limit on my expenses? | Yes.  
$2,000 | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit? | Premium payments and health care services that this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays? | No. | Refer to the Schedule of Benefits in the Subscriber Contract for individual service limits.
Does this plan use a network of providers? | Yes. For a list of **preferred providers**, see [http://providerlookup.affinityplan.org](http://providerlookup.affinityplan.org) or call 1-866-247-5678. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. This plan only covers **emergency** out-of-network services.
Do I need a referral to see a specialist? | No. | This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan’s permission before you see the **specialist**.
Are there services this plan doesn’t cover? | Yes. | Some of the services this plan doesn’t cover are listed on page 6. See your schedule of benefits for additional information about **excluded services**.

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**Questions:** Call 1-866-247-5678 or visit us at [www.affinityplan.org](http://www.affinityplan.org)

If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can call to request a copy of the Glossary at 1-866-247-5678.
**Affinity Health Plan: Essential Plan 1 plus Dental/Vision**

**Coverage for:** Individual | **Plan Type:** HMO

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **copayments** and **coinsurance** amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use An In-Network Provider</th>
<th>Cost If You Use An Out Of Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$25 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$25 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>Covered in full</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$15 copayment (if performed in a PCP office); $25 copayment (if performed in a specialist office or as outpatient hospital service)</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Advance Imaging (CT/PET scans, MRIs)</td>
<td>$25 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
</tbody>
</table>

**Questions:** Call 1-866-247-5678 or visit us at [www.affinityplan.org](http://www.affinityplan.org)

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## Affinity Health Plan: Essential Plan 1 plus Dental/Vision

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

<table>
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<th>Cost If You Use An Out Of Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$6 Copayment (retail) $15 Copayment (mail order)</td>
<td>Not covered</td>
<td>Retail prescriptions cover up to a 30 day supply; Mail Order covers a 31-90 day supply</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$15 Copayment (retail) $37.50 copayment (mail order)</td>
<td>Not covered</td>
<td>See full Schedule of Benefits for specialty drugs.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$30 Copayment (retail) $75 Copayment (mail order)</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$50 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. Any surgery involving a transplant must be performed at designated facilities.</td>
</tr>
<tr>
<td></td>
<td>Office Surgery</td>
<td>$15 (when performed at PCP office) $25 (when performed a specialist office)</td>
<td>Not covered</td>
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<td></td>
<td>Physician/surgeon fees</td>
<td>$50 copayment</td>
<td>Not covered</td>
<td>Preauthorization required.</td>
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<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$75 copayment</td>
<td>$75 copayment</td>
<td>Copayment waived if admitted to hospital.</td>
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<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$75 copayment</td>
<td>$75 copayment</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$25 copayment</td>
<td>$25 copayment</td>
<td>None</td>
</tr>
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# Affinity Health Plan: Essential Plan 1 plus Dental/Vision

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

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<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
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<td>Physician/surgeon fee</td>
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<td><strong>If you have mental health, behavioral health, or substance abuse needs</strong></td>
<td>Mental/Behavioral health outpatient services</td>
<td>$15 copayment</td>
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<td>Mental/Behavioral health inpatient services</td>
<td>$150 copayment per admission</td>
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<td><strong>If you are pregnant</strong></td>
<td>Prenatal and postnatal care</td>
<td>$0 (Prenatal); Postnatal Included in Physician and Midwife Services for Delivery Cost-Sharing</td>
<td>Not covered</td>
<td>Preauthorization required</td>
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<td>Delivery and all inpatient services</td>
<td>$150 copayment per admission; $50 Physician and Midwife Services for Delivery</td>
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<td>Home health care</td>
<td>$15 copayment</td>
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<td>Rehabilitation services (Outpatient)</td>
<td>$15 copayment</td>
<td>Not covered</td>
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<td>Habilitation services</td>
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<td>Durable medical equipment</td>
<td>5% Cost Share</td>
<td>Not covered</td>
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<td>Hospice service</td>
<td>$150 per admission copayment (inpatient); $15 copayment (outpatient)</td>
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Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover** (This isn’t a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery (unless corrective or reconstructive)
- Weight loss programs
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care

**Other Covered Services** (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Bariatric surgery
- Hearing Aid
- Infertility Treatment

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Complaint, Grievance & Appeal Unit Quality Management Department, Affinity Health Plan, Metro Center Atrium 1176 Eastchester Road Bronx, NY 10461. Tel: 888-543-9069 Fax: 718-536-3358.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

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The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:
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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

NOTE: The information in these examples is based on the deductible.

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for an individual only.

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ No. Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.
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<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>The Affinity Essential Plan does not have any deductible.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. $2,000</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td>What is not included in the out–of–pocket limit?</td>
<td>Premium payments and health care services that this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>Refer to the Schedule of Benefits in the Subscriber Contract for individual service limits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. For a list of <strong>preferred providers</strong>, see <a href="http://providerlookup.affinityplan.org">http://providerlookup.affinityplan.org</a> or call 1-866-247-5678.</td>
<td>If you use an in-network doctor or other health care <strong>provider</strong>, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <strong>provider</strong> for some services. Plans use the term in-network, <strong>preferred</strong>, or participating for <strong>providers</strong> in their network. This plan only covers emergency out-of-network services.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No.</td>
<td>This plan will pay some or all of the costs to see a <strong>specialist</strong> for covered services but only if you have the plan’s permission before you see the <strong>specialist</strong>.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes.</td>
<td>Some of the services this plan doesn’t cover are listed on page 6. See your schedule of benefits for additional information about <strong>excluded services</strong>.</td>
</tr>
</tbody>
</table>

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**Affinity Health Plan: Essential Plan 1**

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

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<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$15 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$25 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$25 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>Covered in full</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$15 copayment (if performed in a PCP office); $25 copayment (if performed in a specialist office or as outpatient hospital service)</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Advance Imaging (CT/PET scans, MRIs)</td>
<td>$25 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
</tbody>
</table>

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan’s allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use in-network providers by charging you lower copayments and coinsurance amounts.

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<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$6 Copayment (retail) $15 Copayment (mail order)</td>
<td>Not covered</td>
<td>Retail prescriptions cover up to a 30 day supply; Mail Order covers a 31-90 day supply</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$15 Copayment (retail) $37.50 copayment (mail order)</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$30 Copayment (retail) $75 Copayment (mail order)</td>
<td>Not covered</td>
<td>See full Schedule of Benefits for specialty drugs.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$50 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. Any surgery involving a transplant must be performed at designated facilities.</td>
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<td>Office Surgery</td>
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- Routine eye care
- Routine foot care
- Weight loss programs

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What are some of the assumptions behind the Coverage Examples?

- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?

- **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- **No.** Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-866-247-5678 or visit us at www.affinityplan.org
If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You call to request a copy of the Glossary at 1-866-247-5678.
### Important Questions | Answers | Why this Matters:
--- | --- | ---
What is the overall deductible? | $0 | The Affinity Essential Plan does not have any deductible.
Is there an out-of-pocket limit on my expenses? | Yes. $200 | The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit? | Premium payments and health care services that this plan doesn’t cover. | Even though you pay these expenses, they don’t count toward the out-of-pocket limit.
Is there an overall annual limit on what the plan pays? | No. | Refer to the Schedule of Benefits in the Subscriber Contract for individual service limits.
Does this plan use a network of providers? | Yes. For a list of preferred providers, see http://providerlookup.affinityplan.org or call 1-866-247-5678. | If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. This plan only covers emergency out-of-network services.
Do I need a referral to see a specialist? | No. | This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan’s permission before you see the specialist.
Are there services this plan doesn’t cover? | Yes. | Some of the services this plan doesn’t cover are listed on page 6. See your schedule of benefits for additional information about excluded services.

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**Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.

**Coinsurance** is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan’s allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200.

- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)

- This plan may encourage you to use in-network providers by charging you lower copayments and coinsurance amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use An In-Network Provider</th>
<th>Cost If You Use An Out Of Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>Covered in full</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
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<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$1 Copayment (retail) $2.50 Copayment (mail order)</td>
<td>Not covered</td>
<td>Retail prescriptions cover up to a 30 day supply; Mail Order covers a 31-90 day supply</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$3 Copayment (retail) $7.50 Copayment (mail order)</td>
<td>Not covered</td>
<td>See full Schedule of Benefits for specialty drugs.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$3.00 Copayment (retail) $7.50 Copayment (mail order)</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. Any surgery involving a transplant must be performed at designated facilities.</td>
</tr>
<tr>
<td></td>
<td>Office Surgery</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$0 copayment</td>
<td>$0 copayment</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$0 copayment</td>
<td>$0 copayment</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$0 copayment</td>
<td>$0 copayment</td>
<td>None</td>
</tr>
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<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. Any surgery involving a transplant must be performed at designated facilities.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td><strong>If you have mental health, behavioral health, or substance abuse needs</strong></td>
<td>Mental/Behavioral health outpatient services</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. However, preauthorization is not required for emergency admissions.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. However, preauthorization is not required for emergency admissions.</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Prenatal and postnatal care</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. Coverage is limited to 1 home care visit is covered at no cost-sharing if mother is discharged from hospital early.</td>
</tr>
</tbody>
</table>

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<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. Coverage is limited to 40 visits per plan year.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services (Outpatient)</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Coverage is limited to 60 days per Plan Year combined therapies. Speech and physical therapy are only covered following a hospital stay or surgery. Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. Coverage is limited to 60 days per Plan Year combined therapies</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. Coverage is limited to 200 days per plan year.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Coverage is limited to 210 visits per plan year; 5 visits for family bereavement counseling. Copayment per admission is waived if direct transfer from hospital inpatient setting or skilled nursing facility to hospice facility.</td>
</tr>
</tbody>
</table>

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Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery (unless corrective or reconstructive)
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Adult dental care
- Bariatric surgery
- Adult eye care
- Hearing Aid
- Infertility Treatment

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Complaint, Grievance & Appeal Unit Quality Management Department, Affinity Health Plan, Metro Center Atrium 1176 Eastchester Road Bronx, NY 10461. Tel: 888-543-9069 Fax: 718-536-3358.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al Para obtener asistencia en Español, llame al 866-247-5678

Questions: Call 1-866-247-5678 or visit us at www.affinityplan.org
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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,390
- **Patient pays:** $150

#### Sample care costs:

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

#### Patient pays:

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copays</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$150</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$150</strong></td>
</tr>
</tbody>
</table>

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $5,320
- **Patient pays:** $80

#### Sample care costs:

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

#### Patient pays:

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copays</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$80</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$80</strong></td>
</tr>
</tbody>
</table>

NOTE: The information in these examples is based on the deductible.

**Questions:** Call 1-866-247-5678 or visit us at [www.affinityplan.org](http://www.affinityplan.org).

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?

✓ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✓ No. Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the schedule of benefits at [www.affinityplan.org](http://www.affinityplan.org) or by calling 1-866-247-5678.

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<th>Why this Matters:</th>
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<td>What is the overall deductible?</td>
<td>$0</td>
<td>The Affinity Essential Plan does not have any deductible.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>Yes. $200</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>Premium payments and health care services that this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the <strong>out-of-pocket limit</strong>.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>Refer to the Schedule of Benefits in the Subscriber Contract for individual service limits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. For a list of preferred providers, see <a href="http://providerlookup.affinityplan.org">http://providerlookup.affinityplan.org</a> or call 1-866-247-5678.</td>
<td>If you use an in-network doctor or other health care provider, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred, or participating for providers in their network. This plan only covers emergency out-of-network services.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No.</td>
<td>This plan will pay some or all of the costs to see a specialist for covered services but only if you have the plan’s permission before you see the specialist.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes.</td>
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Affinity Health Plan: Essential Plan 2
Summary of Benefits and Coverage: What this Plan Covers & What it Costs

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **copayments** and **coinsurance** amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use An In-Network Provider</th>
<th>Cost If You Use An Out Of Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>Covered in full</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
</tbody>
</table>

Questions: Call 1-866-247-5678 or visit us at [www.affinityplan.org](http://www.affinityplan.org)
If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [http://www.affinityplan.org/Affinity/What_We_Offer/Health_and_Wellness/Glossary.aspx](http://www.affinityplan.org/Affinity/What_We_Offer/Health_and_Wellness/Glossary.aspx) or call 1-866-247-5678 to request a copy.
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</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$1 Copayment (retail) $2.50 Copayment (mail order)</td>
<td>Not covered</td>
<td>Retail prescriptions cover up to a 30 day supply; Mail Order covers a 31-90 day supply</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$3 Copayment (retail) $7.50 Copayment (mail order)</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$3.00 Copayment (retail) $7.50 Copayment (mail order)</td>
<td>Not covered</td>
<td>See full Schedule of Benefits for specialty drugs.</td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. Any surgery involving a transplant must be performed at designated facilities.</td>
</tr>
<tr>
<td></td>
<td>Office Surgery</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$0 copayment</td>
<td>$0 copayment</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$0 copayment</td>
<td>$0 copayment</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$0 copayment</td>
<td>$0 copayment</td>
<td>None</td>
</tr>
</tbody>
</table>

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### Affinity Health Plan: Essential Plan 2

**Coverage for:** Individual  |  **Plan Type:** HMO

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use An In-Network Provider</th>
<th>Cost If You Use An Out Of Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. Any surgery involving a transplant must be performed at designated facilities.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. However, preauthorization is not required for emergency admissions.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. However, preauthorization is not required for emergency admissions.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required</td>
</tr>
<tr>
<td>Delivery and all inpatient services</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. Coverage is limited to 1 home care visit is covered at no cost-sharing if mother is discharged from hospital early.</td>
<td></td>
</tr>
</tbody>
</table>

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<tr>
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<th>Services You May Need</th>
<th>Your Cost If You Use An In-Network Provider</th>
<th>Cost If You Use An Out Of Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Home health care</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. Coverage is limited to 40 visits per plan year.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Coverage is limited to 60 days per Plan Year combined therapiesSpeech and physical therapy are only covered following a hospital stay or surgery. Preauthorization required.</td>
</tr>
<tr>
<td>Outpatient)</td>
<td>Habilitation services</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. Coverage is limited to 60 days per Plan Year combined therapies</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. Coverage is limited to 200 days per plan year.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Coverage is limited to 210 visits per plan year; 5 visits for family bereavement counseling. Copayment per admission is waived if direct transfer from hospital inpatient setting or skilled nursing facility to hospice facility.</td>
</tr>
</tbody>
</table>

If you need help recovering or have other special health needs:

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**Excluded Services & Other Covered Services:**

### Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)

- Acupuncture
- Cosmetic surgery (unless corrective or reconstructive)
- Dental care (adult)
- Long-term Care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care
- Routine foot care
- Weight loss programs

### Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Chiropractic care
- Bariatric surgery
- Hearing Aid
- Infertility Treatment

**Your Grievance and Appeals Rights:**

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Complaint, Grievance & Appeal Unit Quality Management Department, Affinity Health Plan, Metro Center Atrium 1176 Eastchester Road Bronx, NY 10461. Tel: 888-543-9069 Fax: 718-536-3358.

**Does this Coverage Provide Minimum Essential Coverage?**

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

**Does this Coverage Meet the Minimum Value Standard?**

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al Para obtener asistencia en Español, llame al 866-247-5678

**Questions:** Call 1-866-247-5678 or visit us at [www.affinityplan.org](http://www.affinityplan.org)

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About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

<table>
<thead>
<tr>
<th>Having a baby (normal delivery)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $7,540</td>
</tr>
<tr>
<td><strong>Plan pays:</strong> $7,390</td>
</tr>
<tr>
<td><strong>Patient pays:</strong> $150</td>
</tr>
</tbody>
</table>

**Sample care costs:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copays</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$150</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$150</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Managing type 2 diabetes (routine maintenance of a well-controlled condition)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Amount owed to providers:</strong> $5,400</td>
</tr>
<tr>
<td><strong>Plan pays:</strong> $5,320</td>
</tr>
<tr>
<td><strong>Patient pays:</strong> $80</td>
</tr>
</tbody>
</table>

**Sample care costs:**

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

**Patient pays:**

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copays</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$80</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$80</strong></td>
</tr>
</tbody>
</table>

NOTE: The information in these examples is based on the deductible.

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Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ No. Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ Yes. When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.
## Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why this Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>$0</td>
<td>This Affinity Essential Plan does not have any deductible.</td>
</tr>
<tr>
<td>Is there an out-of-pocket limit on my expenses?</td>
<td>N/A</td>
<td>The <strong>out-of-pocket limit</strong> is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. <strong>Essential Plan 4 is not subject to any out-of-pocket costs so this item is not applicable.</strong></td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit?</td>
<td>N/A</td>
<td>The Affinity Essential Plan 4 does not have a premium payment or any cost share. You, however will be responsible for paying the cost of any <strong>uncovered</strong> health care services in full.</td>
</tr>
<tr>
<td>Is there an overall annual limit on what the plan pays?</td>
<td>No.</td>
<td>Refer to the Schedule of Benefits in the Subscriber Contract for individual service limits.</td>
</tr>
<tr>
<td>Does this plan use a network of providers?</td>
<td>Yes. For a list of <strong>preferred providers</strong>, see <a href="http://providerlookup.affinityplan.org">http://providerlookup.affinityplan.org</a> or call 1-866-247-5678.</td>
<td>If you use an in-network doctor or other health care <strong>provider</strong>, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network <strong>provider</strong> for some services. Plans use the term in-network, <strong>preferred</strong>, or participating for <strong>providers</strong> in their <strong>network</strong>. This plan only covers emergency out-of-network services.</td>
</tr>
<tr>
<td>Do I need a referral to see a specialist?</td>
<td>No.</td>
<td>This plan will pay some or all of the costs to see a <strong>specialist</strong> for covered services but only if you have the plan’s permission before you see the <strong>specialist</strong>.</td>
</tr>
<tr>
<td>Are there services this plan doesn’t cover?</td>
<td>Yes.</td>
<td>Some of the services this plan doesn’t cover are listed on page 6. See your schedule of benefits for additional information about excluded services.</td>
</tr>
</tbody>
</table>

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**Affinity Health Plan: Essential Plan 3**  
**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs  

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the allowed amount for the service. For example, if the plan’s allowed amount for an overnight hospital stay is $1,000, your coinsurance payment of 20% would be $200.
- The amount the plan pays for covered services is based on the allowed amount. If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the allowed amount is $1,000, you may have to pay the $500 difference. (This is called balance billing.)
- This plan may encourage you to use in-network providers by charging you lower copayments and coinsurance amounts.

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<th>Cost If You Use An Out Of Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>Covered in full</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
</tbody>
</table>

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### Affinity Health Plan: Essential Plan 3

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

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<th>Services You May Need</th>
<th>Your Cost If You Use An In-Network Provider</th>
<th>Cost If You Use An Out Of Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$0 Copayment (retail) $0 Copayment (mail order)</td>
<td>Not covered</td>
<td>Retail prescriptions cover up to a 30 day supply; Mail Order covers a 31-90 day supply.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$0 Copayment (retail) $0 Copayment (mail order)</td>
<td>Not covered</td>
<td>See full Schedule of Benefits for specialty drugs.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$0 Copayment (retail) $0 Copayment (mail order)</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. Any surgery involving a transplant must be performed at designated facilities.</td>
</tr>
<tr>
<td></td>
<td>Office Surgery</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$0 copayment</td>
<td>$0 copayment</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$0 copayment</td>
<td>$0 copayment</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$0 copayment</td>
<td>$0 copayment</td>
<td>None</td>
</tr>
</tbody>
</table>

Questions: Call 1-866-247-5678 or visit us at [www.affinityplan.org](http://www.affinityplan.org) If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at http://www.affinityplan.org or call 1-866-247-5678 to request a copy.
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<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use An In-Network Provider</th>
<th>Cost If You Use An Out Of Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. Any surgery involving a transplant must be performed at designated facilities.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td>If you have mental health, behavioral health, or substance abuse needs</td>
<td>Mental/Behavioral health outpatient services</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Pre authorization required.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. However, preauthorization is not required for emergency admissions.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. However, preauthorization is not required for emergency admissions.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Prenatal and postnatal care</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. Coverage is limited to 1 home care visit is covered at no cost-sharing if mother is discharged from hospital early.</td>
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</tbody>
</table>

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### Affinity Health Plan: Essential Plan 3
**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use An In-Network Provider</th>
<th>Cost If You Use An Out Of Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Home health care</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. Coverage is limited to 40 visits per plan year.</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services (Outpatient)</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Coverage is limited to 20 visits per therapy per Plan YearSpeech and physical therapy are only covered following a hospital stay or surgery. Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. Coverage is limited to 20 visits per therapy per Plan Year</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. Coverage is limited to 200 days per plan year.</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Coverage is limited to 210 visits per plan year; 5 visits for family bereavement counseling. Copayment per admission is waived if direct transfer from hospital inpatient setting or skilled nursing facility to hospice facility.</td>
</tr>
</tbody>
</table>

---

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Excluded Services & Other Covered Services:

| Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.) |  |
|---|---|---|
| • Acupuncture | • Long-term Care | • Private-duty nursing |
| • Cosmetic surgery (unless corrective or reconstructive) | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |

| Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.) |  |
|---|---|---|
| • Chiropractic care | • Bariatric surgery | • Hearing Aid |
| • Adult Dental | • Over the Counter Drugs | • Adult Vision |

Your Grievance and Appeals Rights:
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Complaint, Grievance & Appeal Unit Quality Management Department, Affinity Health Plan, Metro Center Atrium 1176 Eastchester Road Bronx, NY 10461. Tel: 866-247-5678 Fax: 718-536-3358.

Does this Coverage Provide Minimum Essential Coverage?
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." This plan or policy does provide minimum essential coverage.

Does this Coverage Meet the Minimum Value Standard?
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). This health coverage does meet the minimum value standard for the benefits it provides.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al Para obtener asistencia en Español, llame al 866-247-5678

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### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,390
- **Patient pays:** $150

#### Sample care costs:

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

#### Patient pays:

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copays</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$150</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$150</strong></td>
</tr>
</tbody>
</table>

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $5,320
- **Patient pays:** $80

#### Sample care costs:

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

#### Patient pays:

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copays</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$80</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$80</strong></td>
</tr>
</tbody>
</table>

---

**About these Coverage Examples:**

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

---

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don’t include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

### Does the Coverage Example predict my own care needs?

**✓ No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

**✓ No.** Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

- **✓ Yes.** When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

- **✓ Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you’ll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

---

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### Affinity Health Plan: Essential Plan 4

**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage for:** Individual | **Plan Type:** HMO

---

**Important Questions** | **Answers** | **Why this Matters:**
--- | --- | ---
What is the overall deductible? | $0 | This Affinity Essential Plan does not have any deductible.
Is there an out-of-pocket limit on my expenses? | N/A | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. **Essential Plan 4 is not subject to any out-of-pocket costs so this item is not applicable.**
What is not included in the out-of-pocket limit? | N/A | The Affinity Essential Plan 4 does not have a premium payment or any cost share. You, however will be responsible for paying the cost of any **uncovered** health care services in full.
Is there an overall annual limit on what the plan pays? | No. | Refer to the Schedule of Benefits in the Subscriber Contract for individual service limits.
Does this plan use a network of providers? | Yes. For a list of **preferred providers**, see [http://providerlookup.affinityplan.org](http://providerlookup.affinityplan.org) or call 1-866-247-5678. | If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. This plan only covers **emergency out-of-network services.**
Do I need a referral to see a specialist? | No. | This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan’s permission before you see the **specialist.**
Are there services this plan doesn’t cover? | Yes. | Some of the services this plan doesn’t cover are listed on page 6. See your schedule of benefits for additional information about **excluded services.**

---

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**Affinity Health Plan: Essential Plan 4**
**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan’s **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **copayments** and **coinsurance** amounts.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use An In-Network Provider</th>
<th>Cost If You Use An Out Of Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you visit a health care provider’s office or clinic</td>
<td>Primary care visit to treat an injury or illness</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Other practitioner office visit</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>Covered in full</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td>If you have a test</td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>None</td>
</tr>
</tbody>
</table>

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</thead>
<tbody>
<tr>
<td>If you need drugs to treat your illness or condition</td>
<td>Generic drugs</td>
<td>$0 Copayment (retail) $0 Copayment (mail order)</td>
<td>Not covered</td>
<td>Retail prescriptions cover up to a 30 day supply; Mail Order covers a 31-90 day supply.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$0 Copayment (retail) $0 Copayment (mail order)</td>
<td>Not covered</td>
<td>See full Schedule of Benefits for specialty drugs.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$0 Copayment (retail) $0 Copayment (mail order)</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. Any surgery involving a transplant must be performed at designated facilities.</td>
</tr>
<tr>
<td></td>
<td>Office Surgery</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room services</td>
<td>$0 copayment</td>
<td>$0 copayment</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>$0 copayment</td>
<td>$0 copayment</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$0 copayment</td>
<td>$0 copayment</td>
<td>None</td>
</tr>
</tbody>
</table>

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## Affinity Health Plan: Essential Plan 4
**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

### Coverage for: Individual | Plan Type: HMO

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use An In-Network Provider</th>
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<th>Limitations &amp; Exceptions</th>
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</thead>
<tbody>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. Any surgery involving a transplant must be performed at designated facilities.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fee</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td><strong>If you have mental health, behavioral health, or substance abuse needs</strong></td>
<td>Mental/Behavioral health outpatient services</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Mental/Behavioral health inpatient services</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. However, preauthorization is not required for emergency admissions.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder outpatient services</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Substance use disorder inpatient services</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. However, preauthorization is not required for emergency admissions.</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Prenatal and postnatal care</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required.</td>
</tr>
<tr>
<td></td>
<td>Delivery and all inpatient services</td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. Coverage is limited to 1 home care visit is covered at no cost-sharing if mother is discharged from hospital early.</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Your Cost If You Use An In-Network Provider</th>
<th>Cost If You Use An Out Of Network Provider</th>
<th>Limitations &amp; Exceptions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>$0 copayment</td>
<td>Not covered</td>
<td>Preauthorization required. Coverage is limited to 40 visits per plan year.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Coverage is limited to 20 visits per therapy per Plan Year</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Preauthorization required. Coverage is limited to 200 days per plan year.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Preauthorization required. Coverage is limited to 210 visits per plan year; 5 visits for family bereavement counseling. Copayment per admission is waived if direct transfer from hospital inpatient setting or skilled nursing facility to hospice facility.</td>
</tr>
<tr>
<td>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services (Outpatient)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice service</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Excluded Services & Other Covered Services:

#### Services Your Plan Does NOT Cover (This isn’t a complete list. Check your policy or plan document for other excluded services.)

<table>
<thead>
<tr>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture</td>
</tr>
<tr>
<td>• Cosmetic surgery (unless corrective or</td>
</tr>
<tr>
<td>reconstructive)</td>
</tr>
<tr>
<td>• Long-term Care</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside</td>
</tr>
<tr>
<td>the U.S.</td>
</tr>
<tr>
<td>• Private-duty nursing</td>
</tr>
<tr>
<td>• Weight loss programs</td>
</tr>
</tbody>
</table>

#### Other Covered Services (This isn’t a complete list. Check your policy or plan document for other covered services and your costs for these services.)

<table>
<thead>
<tr>
<th>Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Chiropractic care</td>
</tr>
<tr>
<td>• Bariatric surgery</td>
</tr>
<tr>
<td>• Adult Dental</td>
</tr>
<tr>
<td>• Over the Counter Drugs</td>
</tr>
<tr>
<td>• Hearing Aid</td>
</tr>
<tr>
<td>• Adult Vision</td>
</tr>
</tbody>
</table>

### Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Complaint, Grievance & Appeal Unit Quality Management Department, Affinity Health Plan, Metro Center Atrium 1176 Eastchester Road Bronx, NY 10461. Tel: 866-247-5678 Fax: 718-536-3358.

### Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

### Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

### Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 866-247-5678

**Questions:** Call 1-866-247-5678 or visit us at [www.affinityplan.org](http://www.affinityplan.org)

If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [http://www.affinityplan.org](http://www.affinityplan.org) or call 1-866-247-5678 to request a copy.
### About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don’t use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

### Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays:** $7,390
- **Patient pays:** $150

#### Sample care costs:

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital charges (mother)</td>
<td>$2,700</td>
</tr>
<tr>
<td>Routine obstetric care</td>
<td>$2,100</td>
</tr>
<tr>
<td>Hospital charges (baby)</td>
<td>$900</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>$900</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$500</td>
</tr>
<tr>
<td>Prescriptions</td>
<td>$200</td>
</tr>
<tr>
<td>Radiology</td>
<td>$200</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$40</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$7,540</strong></td>
</tr>
</tbody>
</table>

#### Patient pays:

<table>
<thead>
<tr>
<th>Component</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copays</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$150</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$150</strong></td>
</tr>
</tbody>
</table>

### Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays:** $5,320
- **Patient pays:** $80

#### Sample care costs:

<table>
<thead>
<tr>
<th>Service</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>$2,900</td>
</tr>
<tr>
<td>Medical Equipment and Supplies</td>
<td>$1,300</td>
</tr>
<tr>
<td>Office Visits and Procedures</td>
<td>$700</td>
</tr>
<tr>
<td>Education</td>
<td>$300</td>
</tr>
<tr>
<td>Laboratory tests</td>
<td>$100</td>
</tr>
<tr>
<td>Vaccines, other preventive</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$5,400</strong></td>
</tr>
</tbody>
</table>

#### Patient pays:

<table>
<thead>
<tr>
<th>Component</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$0</td>
</tr>
<tr>
<td>Copays</td>
<td>$0</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
<tr>
<td>Limits or exclusions</td>
<td>$80</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$80</strong></td>
</tr>
</tbody>
</table>

---

**NOTE:** The information in these examples is based on the deductible for an individual only.

**Questions:** Call 1-866-247-5678 or visit us at [www.affinityplan.org](http://www.affinityplan.org)

If you aren’t clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at [http://www.affinityplan.org](http://www.affinityplan.org) or call 1-866-247-5678 to request a copy.
Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don’t include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren’t specific to a particular geographic area or health plan.
- The patient’s condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn’t covered or payment is limited.

Does the Coverage Example predict my own care needs?

- **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor’s advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- **No.** Coverage Examples are not cost estimators. You can’t use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you’ll find the same Coverage Examples. When you compare plans, check the “Patient Pays” box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you’ll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.
APPENDIX:
PHARMACY PROGRAM
INFORMATION
90-Day Supplies

Choose savings and convenience

Save on medications you take regularly (such as high blood pressure or diabetes medicine) when you fill them in 90-day supplies. You’ll have the medication you need, when you need it – with the choice of delivery by mail or pharmacy pick up.

Save money
Because one 90-day supply typically costs less than three 30-day supplies, you can be sure you’re paying a lower price.

Save time
Eliminate the need for monthly trips to the pharmacy by having your medication delivered to your door. Or pick it up in person just once every three months – the choice is yours.

Choose delivery by mail or pick up
We’ll deliver your 90-day supplies anywhere you like, with no-cost shipping (and status alerts for tracking). Our discreet packages are tamper-proof, weather-proof and temperature controlled, so it’s a safe option for you.

- OR -

Pick them up at any CVS Pharmacy® (including those inside Target stores). Either way you get the same quality, price and convenience.

Two easy ways to get started

Online
Visit Caremark.com/90day

- OR -

By phone
Call the number on your member ID card

We'll contact your doctor for a new prescription and handle all the details.

Manage all your refills at Caremark.com or the CVS Caremark mobile app.
Get Access Anytime, Anywhere You Need It

At Caremark.com we offer many tools and resources that make accessing your prescription benefits easier and more convenient. Register at Caremark.com to get all this and more:

- Refill medications and check order status
- See your prescription and spending history
- Check drug costs and find savings opportunities
- Find pharmacies in your network
- Download our mobile app

Personalized Support with Specialty Care

You can count on CVS Specialty® to support your needs. Every year more people with chronic or genetic health conditions such as multiple sclerosis or hemophilia are being prescribed specialty or biotech medicines.

CVS Caremark offers home delivery of specialty medicine and supplies and provides personalized support to help you successfully manage your condition.

To see if the services you require are covered by your plan talk to your benefit plan sponsor, visit Caremark.com or call the Customer Care number on your prescription benefit ID card.

Let Us Help You

We’re always here to help you find ways to save on your prescriptions, assist with refills and get your long-term supplies delivered to your door.

You can also access our “Ask a Pharmacist” online tool at Caremark.com, email a pharmacist with your questions 24/7 or view the Online Pharmacists FAQs for answers to many common questions.

Visit Caremark.com or call Customer Care and we’ll help you get more from your prescription benefits.

Register today at Caremark.com.
The Benefits of Your Benefits

At CVS Caremark® we provide quality pharmacy care that can help save you time and money. We make sure you get the prescriptions you need, when you need them. We also provide you with:

- Convenient choices
- Savings opportunities
- Online tools
- Specialty care

Convenient Choices

When it comes to how you fill your prescriptions you have options – choose between visiting your local pharmacy or our mail service.

With 9,500 CVS Pharmacy locations and 68,000 network pharmacies, including independent pharmacies and chains it’s easy to find and visit your local pharmacy.

If your medication is long-term you can choose to have it delivered right to your door with our 90-day supplies – and one 90-day supply of your medicine typically costs less than three 30-day supplies. You can sign up for mail service delivery at Caremark.com.

If you need additional help getting your 90-day prescriptions, please call our Customer Care team at 1-888-769-9030.

Saving with Generics

By choosing generic medicines you can take more control of your health care costs and start saving. Generic medicine is high quality medicine that costs up to 80 to 85 percent less than its brand-name counterpart. The FDA requires that generic medicines have the same active ingredients, strength and dosage as their brand-name counterparts, which means they have the same quality and performance. And today nearly eight in 10 prescriptions filled in the U.S. are for generic medicine.¹

Generics are the number one way your doctor or pharmacist can help save you money.

- Ask your doctor if there is a generic option for any brand-name drugs you are currently taking
- Ask if there is a generic for the next new prescription your doctor writes
- Ask your pharmacist about your generic options next time you refill a medicine

We're committed to making sure you have access to the medications you need at the lowest possible cost. One way is to consider a generic equivalent to your brand-name medication. Generics are just as safe and effective as brand-name medications, and offer savings of up to 80%. In fact, nearly nine in 10 prescriptions filled through CVS Caremark are for generic medications.*1

Generic facts you can trust from the U.S. Food and Drug Administration (FDA)

- The FDA requires generics to have the same active ingredients, strength and dosage form as their brand-name counterparts
- The FDA requires proof that a generic performs the same as its brand-name counterpart
- The FDA monitors adverse effects and conducts ongoing quality control
- Many generic drugs are made in the same manufacturing plants as brand-name drug products and must pass the same quality standards

Ready to save with generics?

Current prescriptions
If you are currently taking a brand-name medication, ask your doctor if a generic is available to replace it. Or you can ask the pharmacist when you are refilling it.

New prescriptions
Any time you are prescribed a new medication, be sure to ask if a generic is available when it is being written.

Use the Check Drug Cost tool on Caremark.com to do a side-by-side cost comparison.

1. Research shows that individuals on average can save 30 to 80 percent by using generics. Your savings will vary based on your plan and/or drug prescribed. Source: Generic Pharmaceutical Association website, 2015. http://www.gphaonline.org/about/generic-medicines.
©2019 CVS Caremark. All rights reserved. This document contains confidential and proprietary information of CVS Caremark and cannot be reproduced, distributed or printed without written permission from CVS Caremark. Your privacy is important to us. Our employees are trained regarding the appropriate way to handle your private health information.
Save on medications you take regularly (such as high blood pressure or diabetes medicine) when you have them delivered by mail, in 90-day supplies, from CVS Caremark Mail Service Pharmacy. It’s an easy way to make sure you have the medication you need, when you need it, with one less thing to worry about.

**Savings**
One 90-day supply typically costs less than three 30-day supplies, so you can be sure you’re paying a lower price. And we deliver by mail, anywhere you choose, with no-cost shipping.

**Convenience**
Mail delivery means no more monthly trips to the pharmacy, and with automatic refills, you won’t need to keep track of refill schedules either. We alert you 10 days before a refill in case you need to change the delivery date or location.

**Safety**
Every order is filled by a licensed pharmacist, then quality checked before shipping. Our discreet packages are tamper-proof, weather-proof and temperature controlled. Plus, we’ll send status alerts by email, phone or text – so there’s nothing to worry about.

**Two easy ways to get started**

**Online**
Visit Caremark.com/mailservice

- OR -

**By phone**
Call the number on your member ID card for live help getting set up

Be sure to have a prescription bottle in hand, all the information needed to get started is on the label.

Download the CVS Caremark mobile app to manage mail orders anytime, anywhere.
Mail Service Order Form

Mail this form to:

CVS Caremark
PO BOX 94467
PALATINE, IL 60094-4467

Member ID # (if not shown or if different from above)

Prescription Plan Sponsor or Company Name

Instructions:
Please use blue or black ink and print in capital letters. Fill in both sides of this form.

New Prescriptions – Mail your new prescriptions with this form. Number of New prescriptions: 

Refills – Order by Web, phone, or write in Rx number(s) below. Number of Refill prescriptions: 

TO RECEIVE YOUR ORDER SOONER request refills or new prescriptions online at www.caremark.com or call the toll-free number on your member ID card.

A Shipping Address. To ship to an address different from the one printed above, enter the changes here.

Last Name

First Name

MI

Suffix (JR, SR)

Street Address

Apt./Suite #

Use shipping address for this order only.

City

State

ZIP Code

Daytime Phone #: Evening Phone #:

B Refills. To order mail service refills, enter your prescription number(s) here.

1) 2) 3) 4) 5) 6) 7) 8)

CVS Caremark wants to provide you with high quality medicines at the best possible price. In order to do this, we will substitute equivalent generic medicines for brand name medicines whenever possible. If you do not want us to substitute generics, please provide specific instructions, including drug names, in the “Special Instructions” section of this form.

We may package all of these prescriptions together unless you tell us not to.

All claims for prescriptions submitted to CVS Caremark Mail Service Pharmacy using this form will be submitted to your prescription benefit plan for payment. If you do not want them submitted to your plan, do not use this form. You may call Customer Care to make alternate arrangements for submission of your order and payment.

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Tell us about the people ordering prescriptions. If there are more than two people, please complete another form.

**First person** with a refill or new prescription.

- **Last name**: [ ]
- **First name**: [ ]
- **Nickname**: [ ]
- **Gender**: M F [ ]
- **Date of birth**: [ ]
- **Date new prescription written**: [ ]
- **E-mail address**: [ ]
- **Doctor's last name**: [ ]
- **Doctor's first name**: [ ]
- **Doctor's phone #**: [ ]
- **Allergies**: [None] [Aspirin] [Cephalosporin] [Codeine] [Erythromycin] [Peanuts] [Penicillin] [Sulfa]
- **Medical conditions**: [Arthritis] [Asthma] [Diabetes] [Acid reflux] [Glaucoma] [Heart problem] [High blood pressure] [High cholesterol] [Migraine] [Osteoporosis] [Prostate issues] [Thyroid]
- **Special instructions**: [ ]

**Second person** with a refill or new prescription.

- **Last name**: [ ]
- **First name**: [ ]
- **Nickname**: [ ]
- **Gender**: M F [ ]
- **Date of birth**: [ ]
- **Date new prescription written**: [ ]
- **E-mail address**: [ ]
- **Doctor's last name**: [ ]
- **Doctor's first name**: [ ]
- **Doctor's phone #**: [ ]
- **Allergies**: [None] [Aspirin] [Cephalosporin] [Codeine] [Erythromycin] [Peanuts] [Penicillin] [Sulfa]
- **Medical conditions**: [Arthritis] [Asthma] [Diabetes] [Acid reflux] [Glaucoma] [Heart problem] [High blood pressure] [High cholesterol] [Migraine] [Osteoporosis] [Prostate issues] [Thyroid]
- **Special instructions**: [ ]

**Special instructions:** [ ]

**How would you like to pay for this order?** (If your copay is $0, you do not need to provide payment information.)

- **Electronic check.** Pay from your bank account. (You must first register online or call Customer Care.)

- **Credit or debit card.** (VISA®, MasterCard®, Discover®, or American Express®)
  - Use your card on file.
  - Use a new card or update your card’s expiration date.
  - **Card number**: [ ]
  - **Exp. Date**: [MM YY]
- **Check or money order.** Amount: $[ ]

  - Make check or money order payable to CVS Caremark.
  - Write your prescription benefit ID number on your check or money order.
  - If your check is returned, we will charge you up to $40.

**Payment for balance due and future orders:** If you choose electronic check or a credit or debit card, we will use it to pay for any balance due and for future orders unless you provide another form of payment.

- **Fill in this oval if you DO NOT want us to use this payment method for future orders.**

**Credit card holder signature/Date**

Regular delivery is free and takes up to 5 days after your order is processed. If you want faster delivery, choose:

- **2nd business day ($17)**
- **Next business day ($23)**

Expected processing time from receipt of this form:

- Refills: 1-2 days
- New/renewed prescriptions: Within 5 days unless additional information is needed from your doctor

(Charges subject to change)

49-MOF 0316 MTP
NOTICE OF NON-DISCRIMINATION

Affinity Health Plan complies with Federal civil rights laws. Affinity Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Affinity Health Plan provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Affinity Health Plan at 1-866-247-5678. For TTY/TDD services, call 711.

If you believe that Affinity Health Plan has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with Affinity Health Plan by:

- Mail: 1776 Eastchester Road, Bronx, New York 10461,
- Phone: (718) 794-7569 (for TTY/TDD services, call 711)
- Fax: (718) 536-3390
- In person: 1776 Eastchester Road, Bronx, New York 10461
- Email: 928notice@affinityplan.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

- Web: Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Mail: U.S. Department of Health and Human Services
  200 Independence Avenue SW., Room 509F, HHH Building
  Washington, DC 20201
  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
- Phone: 1-800-368-1019 (TTY/TDD 800-537-7697)
Affinity Health Plan is required by law to protect the privacy of your health information, and to provide you with a Notice of Privacy Practice (NPP) that outlines your rights and our duties with respect to your information. A copy of Affinity Health Plan’s NPP can be found on our website at http://www.affinityplan.org or you can request a paper copy by calling our Customer Service Department at 1-866-247-5678 (TTY: 711).
<table>
<thead>
<tr>
<th>Language</th>
<th>Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>ATTENTION: Language assistance services, free of charge, are available to you. Call 1-866-247-5678 TTY/TDD: 711.</td>
</tr>
<tr>
<td>Arabic</td>
<td>ممکن است استخدام خدمات مترجم رایگان باشد. میتوانید به شماره 1-866-247-5678 مکالمه نمایند (TTY/TDD: 711).</td>
</tr>
<tr>
<td>Yiddish</td>
<td>אויפמערקזאם שפראך הילף סערוויסעס זענען אוועילעבל ארפ. TTY/TDD: 711.</td>
</tr>
</tbody>
</table>

লক্ষ্য করুনঃ আপনার জন্য বিনিমূল্যমিত ভাষা সহায়তা প্রদর্শিত হয়েছে ফান করুন 1-866-247-5678 TTY/TDD: 711


