Affinity Health Plan

SUMMARY OF BENEFITS

EFFECTIVE JANUARY 1, 2019 - DECEMBER 31, 2019

2019 | AFFINITY MEDICARE

Ultimate (HMO-SNP) | **Solutions** (HMO-SNP)

This is a summary of drug and health services covered by Affinity Medicare Ultimate (HMO-SNP) and Affinity Medicare Solutions (HMO-SNP).

Affinity Health Plan is an HMO and HMO-SNP Plan with a Medicare contract and a contract with the New York State Medicaid Managed Care Program. Enrollment in Affinity Health Plan depends on contract renewal. This information is not a complete description of benefits. Call 877.234.4499 (TTY: 711) for more information. You must continue to pay your Medicare Part B premium.

The benefit information provided is a summary of what we cover and what you pay. It does not list every service that we cover or list every limitation or exclusion. To get a complete list of the services we cover, please call us to request the "Evidence of Coverage."

To join Affinity Medicare Ultimate (HMO-SNP) you must be entitled to Medicare Part A, be enrolled in Medicare Part B, have full Medicaid, and live in our service area.

To join Affinity Medicare Solutions (HMO-SNP) you must be entitled to Medicare Part A, be enrolled in Medicare Part B, have full or partial Medicaid, and live in our service area.

The Affinity Medicare Ultimate (HMO-SNP) service area includes the following counties in New York: Bronx, Kings, Nassau, New York, Orange, Queens, Richmond, Rockland, Suffolk and Westchester.

The Affinity Medicare Solutions (HMO-SNP) service area includes the following counties in New York: Bronx, Kings, Nassau, New York, Orange, Queens, Richmond, Rockland, Suffolk and Westchester.

If you use providers that are not in our network we may not pay for services.

For coverage and costs of Original Medicare, check your current "Medicare & You" handbook. View it online at http://www.medicare.gov or get a copy by calling 800.MEDICARE (800.633.4227), 24 hours a day, 7 days a week. TTY users should call 877.486.2048.

This document is available in other formats such as braille, large print or audio.

For more information, please call Affinity at **877.234.4499 (TTY 711), or visit AffinityMedicarePlan.org.**

AFFINITY MEDICARE

Benefits & Premiums	Ultimate (HMO-SNP)	Solutions (HMO-SNP)
Monthly Plan Premium	**This plan does not have a premium** **You must continue to pay your Medicare Part B premium** **Medicaid pays your Medicare Part B premium on your behalf**	**This plan does not have a premium** **You must continue to pay your Medicare Part B premium** **Medicaid may pay your Medicare Part B premium on your behalf**
Deductible	**You pay $0**	**You pay $0 or $225**
Maximum Out-of-Pocket Responsibility (does not include prescription drugs)	**You pay no more than $6,700 annually**	**You pay no more than $6,700 annually**
Inpatient Hospital Care*	**You pay $0 copay**	**Our plan covers 90 days for an inpatient hospital stay** **You pay $0 or $310 copay per day for days 1-6**
Outpatient Hospital Care*	**You pay $0 copay**	**You pay $0 or $45 copay for non-surgical services** **You pay $0 or $295 copay for surgical services**
Doctor Visits		
• **Primary**	**You pay $0 copay**	**You pay $0 copay**
• **Specialists**	**You pay $0 copay**	**You pay $0 or $45 copay**
Preventive Care (Other preventive services are available. Some covered services have a cost.)	**You pay $0 copay for:** • **Abdominal aortic aneurysm screening** • **Bone mass measurement** • **Breast cancer screening** • **Cardiovascular disease screening** • **Cervical and vaginal cancer screening** • **Colorectal cancer screening** • **Diabetes screening** • **HIV screening** • **Prostate cancer screening** • **Vaccines against the flu, hepatitis B, and pneumococcus**	**You pay $0 copay for:**

*This benefit requires prior authorization.

AFFINITY MEDICARE

Benefits & Premiums	Ultimate (HMO-SNP)	Solutions (HMO-SNP)
Emergency Care	You pay $0 copay	You pay $0 or $90 copay If you are admitted to the hospital within 24 hours after an emergency, you pay $0
Urgently Needed Services	You pay $0 copay	You pay $0 or $30 copay
Diagnostic Services/ Labs/Imaging		
• Diagnostic tests and procedures*	You pay $0 copay	You pay $0 or $15 copay
• Lab services*	You pay $0 copay	You pay $0 or $15 copay
• Diagnostic radiology	You pay $0 copay	You pay $0 or 20% coinsurance
• X-ray	You pay $0 copay	You pay $0 or 20% coinsurance
Hearing Services		
• Medicare-covered hearing exam	You pay $0 copay	You pay $0 or $40 copay
• Routine hearing exam	You pay $0 copay for one routine hearing exam annually	You pay $0 copay for one routine hearing exam annually
• Hearing aid	$750 annual total hearing aid allowance	$350 annual total hearing aid allowance
Dental Services		
• Medicare-covered dental services	You pay $0 copay	You pay $0 copay
• Oral exam and cleaning	Not covered	You pay $0 copay/ one exam every six months
• X-ray	Not covered	You pay $0 copay/ one set per year
• Comprehensive services	Up to $425 per year	Not covered
Vision Services		
• Medicare-covered eye exam	You pay $0 copay	You pay $0 or $45 copay
• Routine eye exam	You pay $0 copay/one exam per year	You pay $0 copay /one exam per year
• Eyeglasses (frames and lenses)	$100 every year towards purchase	$200 every year towards purchase

*This benefit requires prior authorization.

AFFINITY MEDICARE

Benefits & Premiums	Ultimate (HMO-SNP)	Solutions (HMO-SNP)
Mental Health Services*		
• Inpatient mental health	$0 copay per benefit period	$0 or $275 copay per day for days 1-6 $0 copay per day for days 7-90
• Outpatient group therapy	You pay $0 copay	You pay $0 or $40 copay
• Individual therapy	You pay $0 copay	You pay $0 or $40 copay
Inpatient Psychiatric Hospital Care	You pay $0 copay per stay	Our plan covers 90 days for an inpatient psychiatric hospital stay. You pay $0 or $275 copay per day for days 1-6
Skilled Nursing Facility*	You pay $0 copay per stay for up to 100 days	You pay $0 copay per day for days 1-20 You pay $0 or $138 copay per day for days 21-100
Physical Therapy*	You pay $0 copay Authorization required after the first 6 visits	You pay $0 or $40 copay Authorization required after the first 6 visits
Ambulance	You pay $0 copay	You pay $0 or $225 copay
Transportation	Not covered	Limited to 14 one-way trips to plan-approved locations every year
Medicare Part B Drugs*	You pay $0 copay for chemotherapy drugs You pay $0 copay for other Part B drugs	You pay 0% or 20% of the cost of chemotherapy drugs You pay 0% or 20% of the cost of other Part B drugs
Over-the-Counter Items	You pay nothing Monthly benefit of upto $60 per month Month-to-month balance carry-over does NOT apply	Not covered

*This benefit requires prior authorization.

AFFINITY MEDICARE

Prescription Drug Benefits	Ultimate (HMO-SNP)			Solutions (HMO-SNP)		
OUTPATIENT PRESCRIPTION DRUGS						
DEDUCTIBLE						
	You pay $0			**You pay $0**		
INITIAL COVERAGE						
	Standard Retail Rx 30-day supply †	**Mail Order 90-day supply**	**Long Term Care 31-day supply †**	**Standard Retail Rx 30-day supply †**	**Mail Order 90-day supply**	**Long Term Care 31-day supply †**
Tier 1 Preferred Generic	**$0 copay**	**$0 copay**		**$0 copay**	**$0 copay**	
Tier 2 Generic	**$1.25 or $3.40 copay**	**$$1.25 or $3.40 copay**	**$1.25 or $3.40 copay**	**$1.25 or $3.40 copay**	**$1.25 or $3.40 copay or 15%**	**$1.25 or $3.40 copay**
Tier 3 Preferred Brand	**$3.80 or $8.50 copay**	**$3.80 or $8.50 copay**	**$3.80 or $8.50 copay**	**$3.80 or $8.50 copay**	**$1.25 or $3.40 copay or 15%**	**$3.80 or $8.50 copay**
Tier 4 Non-Preferred Drug	**$3.80 or $8.50 copay**	**$3.80 or $8.50 copay**	**$3.80 or $8.50 copay**	**$3.80 or $8.50 copay**	**$1.25 or $3.40 copay or 15%**	**$3.80 or $8.50 copay**
Tier 5 Specialty	**$8.50 copay**	**A long-term supply is not available for drugs in Tier 5**		**$8.50 copay**	**A long-term supply is not available for drugs in Tier 5**	
COVERAGE GAP						
There is no coverage gap for Affinity Medicare Ultimate (HMO-SNP) and Affinity Medicare Solutions (HMO-SNP). Once you leave the Initial Coverage stage, you move on to the Catastrophic Coverage stage.						

† Copays will be pro-rated if less than a one month supply is prescribed.

AFFINITY MEDICARE

Prescription Drug Benefits	Ultimate (HMO-SNP)	Solutions (HMO-SNP)

CATASTROPHIC COVERAGE

(After your out-of-pocket costs have reached the $5,100 limit for the calendar year)

Once you have reached the Catastrophic Coverage stage, you will stay in this payment stage until the end of the calendar year.

During this stage under **Affinity Medicare Ultimate (HMO-SNP)** the plan will pay **all** of the costs of your drugs.

During this stage under **Affinity Medicare Solutions (HMO-SNP)** the plan will pay **most** of the costs of your drugs.

Your share of the cost for a covered drug will be:

- $0; or
- A coinsurance or a copayment, whichever is the larger amount:
  - either a coinsurance of 5% of the cost of the drug
  - or $3.40 for a generic drug or a drug that is treated like a generic and $8.50 for all other drugs.
- **Our plan pays the rest** of the cost.

PLEASE NOTE: Copays and coinsurance may vary based on the level of Extra Help you receive. In New York State, when a non-network provider accepts a Medicaid beneficiary as a patient, the provider is prohibited from requesting any monetary compensation from the beneficiary, except for any applicable Medicaid copayments. Because you have Medicaid, you are entitled to medical benefits, including coverage of cost sharing, from New York State. For a description of what Medicaid covers and what Affinity Medicare Ultimate covers, please refer to the Evidence of Coverage. You can view the Evidence of Coverage on our website at AffinityMedicarePlan.org. For questions about your Medicaid eligibility and the benefits to which you are entitled, please call 718.557.1399.

SUMMARY OF MEDICAID-COVERED BENEFITS

Medicaid-covered benefits are described below. The benefits described in the Covered Medical and Hospital Benefits section of this Summary of Benefits are covered by Medicare. For each benefit listed below, you can see what New York State Medicaid covers and what our plan covers. What you pay for covered services may depend on your level of Medicaid eligibility.

Coverage of the benefits described below depends upon your level of Medicaid eligibility. Benefits marked with an asterisk (*) may not be available to all enrollees. No matter what your level of Medicaid eligibility is, Affinity Medicare Ultimate and Affinity Medicare Solutions will cover the benefits described in the Covered Medical and Hospital Benefits sections of this Summary of Benefits. Your Medicare copayments will vary depending on your level of Medicaid eligibility. If you have questions about your Medicaid eligibility and what benefits you are entitled to call 877.472.8411.

AFFINITY MEDICAID

	Medicaid Fee For Service	Affinity Medicare Ultimate (HMO-SNP)	Affinity Medicare Solutions (HMO-SNP)
Inpatient Hospital Care Including Substance Abuse and Rehabilitation Services Up to 365 days per year (366 days for leap year)	**Covered**	**In-Network** Medicare-covered services covered by plan **Inpatient hospital:** **$0 copay per day for days 1-6** **$0 copay per day for days 7-90** **Inpatient Substance Abuse and Rehabilitation:** **$0 copay per day for days 1-6** **$0 copay per day for days 7-90**	**In-Network** Medicare-covered services covered by plan **Inpatient hospital:** **$0 or $310 copay per day for days 1-6** **$0 copay per day for days 7-90** **Inpatient Substance Abuse and Rehabilitation:** **$0 or $275 copay per day for days 1-6** **$0 copay per day for days 7-90**
Inpatient Mental Health Medically-necessary care, including days in excess of the Medicare 190-day lifetime maximum	**Covered**	**In-Network** Medicare-covered services covered by the plan, up to 90 days in a psychiatric hospital in a lifetime **$0 copay per day for days 1-6** **$0 copay per day for days 7-90**	**In-Network** Medicare-covered services covered by the plan, up to 90 days in a psychiatric hospital in a lifetime **$0 or $275 copay per day for days 1-6** **$0 copay per day for days 7-90**

AFFINITY MEDICAID

	Medicaid Fee For Service	Affinity Medicare Ultimate (HMO-SNP)	Affinity Medicare Solutions (HMO-SNP)
Skilled Nursing Facility Medicare-covered care provided in a skilled nursing facility. No prior hospital stay required.	**Covered**	**In-Network** Plan covers up to 100 days for each benefit period No prior hospital stay is required **$0 copay per day for days 1-20** **$0 or $138 copay per day for days 21-100**	**In-Network** Plan covers up to 100 days for each benefit period No prior hospital stay is required **$0 copay per day for days 1-20** **$0 or $138 copay per day for days 21-100**
Home Health Medically-necessary intermittent skilled nursing care, home health aide services and rehabilitation services. Also includes non-Medicare covered home health services (e.g., home health aide services with nursing supervision for medically unstable individuals).	**Covered**	**In-Network** Medicare-covered home health visits covered by the plan **$0 copay** Covered for 6 hours a day for 7 days following hospitalization without prior authorization Authorization required for all services beyond first week of hospitalization	**In-Network** Medicare-covered home health visits covered by the plan **$0 copay** Covered for 6 hours a day for 7 days following hospitalization without prior authorization Authorization required for all services beyond first week of hospitalization

AFFINITY MEDICAID

	Medicaid Fee For Service	Affinity Medicare Ultimate (HMO-SNP)	Affinity Medicare Solutions (HMO-SNP)
Private Duty Nursing Medically-necessary private duty nursing services can be provided through an approved certified home health agency, or a private practitioner. Nursing services may be intermittent, part-time or continuous and must be provided in an enrollee's home in accordance with the ordering physician, registered physician assistant or certified nurse practitioner's written treatment plan.	**Covered**	**Not covered**	**Not covered**

AFFINITY MEDICAID

	Medicaid Fee For Service	Affinity Medicare Ultimate (HMO-SNP)	Affinity Medicare Solutions (HMO-SNP)
Outpatient Mental Health Individual and group therapy visits. Enrollee must be able to self-refer for one assessment from a network provider in a 12 month period.	**Covered**	**In-Network** Medicare-covered individual or group therapy visits covered by the plan Outpatient individual or group therapy visit: **$0 copay** Authorization required after 20 visits	**In-Network** Medicare-covered individual or group therapy visits covered by the plan Outpatient individual or group therapy visit: **$0 or $40 copay** Authorization required after 20 visits
Outpatient Substance Abuse Individual and group therapy visits. Enrollee must be able to self-refer for one assessment from a network provider in a 12 month period.	**Covered**	**In-Network** Medicare-covered individual or group therapy visits covered by the plan Individual or group therapy visit: **$0 copay** Authorization required after 20 visits	**In-Network** Medicare-covered individual or group therapy visits covered by the plan Individual or group therapy visit: **$0 or $40 copay** Authorization required after 20 visits

AFFINITY MEDICAID

	Medicaid Fee For Service	Affinity Medicare Ultimate (HMO-SNP)	Affinity Medicare Solutions (HMO-SNP)
Durable Medical Equipment (DME) Medicaid-covered durable medical equipment, including devices and equipment other than medical/surgical supplies, enteral formula, and prosthetic or orthotic appliances having the following characteristics: can withstand repeated use for a protracted period of time; are primarily and customarily used for medical purposes; are generally not useful to a person in the absence of illness or injury, and; are usually fitted, designed or fashioned for a particular individual's use. Must be ordered by a qualified practitioner. No homebound prerequisite and including non-Medicare DME covered by Medicaid (e.g., tub stool, grab bars).	**Covered**	**In-Network** Medicare-covered items covered by the plan **0% of the cost** Authorization required for all DME rentals and purchases exceeding $500	**In-Network** Medicare-covered items covered by the plan **0% or 20% of the cost** Authorization required for all DME rentals and purchases exceeding $500

AFFINITY MEDICAID

	Medicaid Fee For Service	Affinity Medicare Ultimate (HMO-SNP)	Affinity Medicare Solutions (HMO-SNP)
Prosthetics Medicaid-covered prosthetics, orthotics and orthopedic footwear.	**Covered**	**In-Network** Medicare-covered items covered by plan **0% of the cost** Authorization required for all prosthetics or medical supply purchases exceeding $500	**In-Network** Medicare-covered items covered by plan **0% or 20% of the cost** Authorization required for all prosthetics or medical supply purchases exceeding $500
Doctor's Office Visits	**Covered**	**In-Network** **$0 copay** for each primary care doctor visit for Medicare-covered benefits **$0 copay** for each specialist visit for Medicare-covered benefits	**In-Network** **$0 copay** for each primary care doctor visit for Medicare-covered benefits **$0 or $45 copay** for each specialist visit for Medicare-covered benefits

AFFINITY MEDICAID

	Medicaid Fee For Service	Affinity Medicare Ultimate (HMO-SNP)	Affinity Medicare Solutions (HMO-SNP)
Outpatient Services/ Surgery	**Covered**	**In-Network** **$0 copay** for each Medicare-covered ambulatory surgical center visit **$0 copay** for non-surgical services, such as screenings **$0 copay** for Medicare-covered surgery performed at an outpatient hospital facility for each Medicare-covered outpatient hospital facility visit Authorization is required	**In-Network** **$0 or $195 copay** for each Medicare-covered ambulatory surgical center visit **$0 or $45 copay** for non-surgical services, such as screenings **$0 or $295 copay** for Medicare-covered surgery performed at an outpatient hospital facility for each Medicare-covered outpatient hospital facility visit Authorization is required

AFFINITY MEDICAID

	Medicaid Fee For Service	Affinity Medicare Ultimate (HMO-SNP)	Affinity Medicare Solutions (HMO-SNP)
Outpatient Rehabilitation Services Occupational, physical and speech therapy sessions are limited to 20 visits per therapy per year, except for children under age 21, unless you have been determined to be developmentally disabled by the Office for People with Developmental Disabilities, or if you have a traumatic brain injury.	**Covered**	**In-Network** **$0 copay** for Medicare-covered occupational therapy, physical and/or speech and language therapy visits One occupational therapy visit is covered without authorization during the first week after hospitalization, based on discharge diagnoses. This visit is to evaluate the need for additional services Authorization will be required after the first six visits	**In-Network** **$0 or $40 copay** for Medicare-covered occupational therapy, physical and/or speech and language therapy visits One occupational therapy visit is covered without authorization during the first week after hospitalization, based on discharge diagnoses. This visit is to evaluate the need for additional services Authorization will be required after the first six visits
Ambulance Services	**Covered**	**In-Network** **$0 copay** for Medicare-covered ambulance benefits	**In-Network** **$0 or $225 copay** for Medicare-covered ambulance benefits

AFFINITY MEDICAID

	Medicaid Fee For Service	Affinity Medicare Ultimate (HMO-SNP)	Affinity Medicare Solutions (HMO-SNP)
Emergency Care	**Covered** Not covered outside the U.S.	**Covered** **$0 copay** for Medicare-covered emergency room visits $6,000 plan coverage limit for emergency services outside the U.S. every year	**Covered** **$0 or $90 copay** for Medicare-covered emergency room visits $6,000 plan coverage limit for emergency services outside the U.S. every year If you are admitted to the hospital within 24 hours for the same condition, you pay $0 copay
Urgent Care	**Covered**	**Covered** **$0 copay** for Medicare-covered urgent care visits	**Covered** **$0 or $20 copay** for Medicare-covered urgent care visits If you are admitted to the hospital within 24 hours for the same condition, you pay $0 copay

AFFINITY MEDICAID

	Medicaid Fee For Service	Affinity Medicare Ultimate (HMO-SNP)	Affinity Medicare Solutions (HMO-SNP)
Dental Medicaid-covered dental services including necessary preventive, prophylactic and other routine dental care, as well as services, supplies and dental prosthetics to alleviate a serious health condition. Ambulatory or inpatient surgical dental services subject to prior authorization.	**Covered**	**In-Network** Medicare-covered dental benefits covered by plan In general, preventative dental benefits (such as cleaning) are not covered by the plan Plan covers **up to $425** of comprehensive dental benefits	**In-Network** Medicare-covered dental benefits covered by plan **$0 copay** for the following preventative dental benefits • one oral exam every six months • one cleaning every six months • one dental X-ray every year

AFFINITY MEDICAID

	Medicaid Fee For Service	Affinity Medicare Ultimate (HMO-SNP)	Affinity Medicare Solutions (HMO-SNP)
Hearing Services Medicaid hearing services and products when medically necessary to alleviate disability caused by the loss or impairment of hearing. Services include hearing aid selecting, fitting, and dispensing; hearing aid checks following dispensing, conformity evaluations and hearing aid repairs; audiology services including examinations and testing, hearing aid evaluations and hearing aid prescriptions; and hearing aid products including hearing aids, ear molds, special fittings and replacement parts.	**Covered**	**In-Network** Medicare-covered diagnostic hearing exams are covered by plan **$0 copay** for Medicare-covered diagnostic hearing exams **$0 copay** for routine hearing tests (one every year). Hearing and fitting/evaluations for a hearing aid (one every year) are covered **$750 allowance** for hearing aids per year, for both ears combined	**In-Network** Medicare-covered diagnostic hearing exams are covered by plan **$0 or $40 copay** for Medicare-covered diagnostic hearing exams **$0 copay** for routine hearing tests (one every year). Hearing and fitting/evaluations for a hearing aid (one every year) are covered **$350 allowance** for hearing aids per year, for both ears combined

AFFINITY MEDICAID

	Medicaid Fee For Service	Affinity Medicare Ultimate (HMO-SNP)	Affinity Medicare Solutions (HMO-SNP)
Vision Care Services Services of optometrists, ophthalmologists and ophthalmic dispensers including eyeglasses, medically-necessary contact lenses and poly-carbonate lenses, artificial eyes (stock or custom-made), low vision aids and low vision services. Coverage also includes the repair or replacement of parts, and examinations for diagnosis and treatment for visual defects and/or eye disease. Examinations for refraction are limited to every two years unless otherwise justified as medically necessary. Eyeglasses do not require changing more frequently than every two years unless medically necessary or unless the glasses are lost, damaged or destroyed.	**Covered**	**In-Network** **$0 copay** for diagnosis and treatment for diseases and conditions of the eye **$0 copay** for one routine eye exam every year **$100 allowance for eyewear per year**. Eyewear includes contact lenses, eyeglasses, frames, lenses, and eyeglasses or contact lenses after cataract surgery	**In-Network** **$0 or $45 copay** for diagnosis and treatment for diseases and conditions of the eye **$0 copay** for one routine eye exam per year **$200 allowance for eyewear per year.** Eyewear includes contact lenses, eyeglasses, frames, lenses, and eyeglasses or contact lenses after cataract surgery

AFFINITY MEDICAID

	Medicaid Fee For Service	Affinity Medicare Ultimate (HMO-SNP)	Affinity Medicare Solutions (HMO-SNP)
Diagnostic Tests, X-Rays, Lab Services and Radiology Services	**Covered**	**In-Network** **$0 copay**	**In-Network** **For Medicare-covered:** • **Lab services: $0 or $15 copay** • **Diagnostic procedures and tests: $0 or $15 copay** • **Outpatient X-rays: 0% or 20% of the cost** • **Diagnostic radiology services: 0% or 20% of the cost** • **Therapeutic radiology services: 0% or 20% of the cost**
Bone Mass Measurement	**Covered**	**Covered**	**Covered**
Colorectal Screening Exams	**Covered**	**Covered**	**Covered**
Immunizations	Medicaid covers Medicare deductibles, copays and coinsurances	**Covered** Medicare LIS copayment applies for Part D vaccines	Flu, hepatitis B and pneumococcal vaccines covered at no cost to you Medicare LIS copayment applies for Part D vaccines

AFFINITY MEDICAID

	Medicaid Fee For Service	Affinity Medicare Ultimate (HMO-SNP)	Affinity Medicare Solutions (HMO-SNP)
Mammograms	Medicaid covers Medicare deductibles, copays and coinsurances	**Covered**	**Covered**
Pap Smears and Pelvic Exams	Medicaid covers Medicare deductibles, copays and coinsurances	**Covered**	**Covered**
Prostate Cancer Screening	Medicaid covers Medicare deductibles, copays and coinsurances	**Covered**	**Covered**
Prescription Drugs	Medicaid does **not** cover Part D covered drugs or copays. Medicaid Pharmacy Benefits allowed by state law (select drug categories are excluded from the Medicare Part D benefit). Certain medical supplies and enteral formula are covered when not covered by Medicare.	**Covered**	**Covered**

AFFINITY MEDICAID

	Medicaid Fee For Service	Affinity Medicare Ultimate (HMO-SNP)	Affinity Medicare Solutions (HMO-SNP)
Over-the-Counter Drugs	Certain over-the-counter medications are covered using your Medicaid benefit card	**$60 allowance every month** for over-the-counter items Month-to-month balance carry-over does NOT apply	**Not covered**
Hospice	**Covered**	**Not covered**	**Not covered**
Non-Emergency Transportation Transportation essential for an enrollee to obtain necessary medical care and services under the plan's benefits. Includes ambulette, invalid coach, taxicab, livery, public transportation, or other means appropriate to the enrollee's medical condition and a transportation attendant to accompany the enrollee, if necessary.	**Covered**	**Not covered**	**Up to 14 one-way trips per year** to plan-approved locations covered by the plan

AFFINITY MEDICAID

	Medicaid Fee For Service	Affinity Medicare Ultimate (HMO-SNP)	Affinity Medicare Solutions (HMO-SNP)
Out-of-Network Family Planning Services Provided under the direct access provisions of the waiver	**Covered**	**Not covered**	**Not covered**
Personal Care Services	**Covered**	**Not covered**	**Not covered**
Mental Health Services	**Covered**	Covered services include **up to 190 days** in a lifetime for inpatient mental health care in a psychiatric hospital **Inpatient hospital:** **$0 copay per day for days 1-6** **$0 copay per day for days 7-90** **Outpatient individual or group therapy visit:** **$0 copay** Authorization is required after 20 visits	Covered services include **up to 190 days** in a lifetime for inpatient mental health care in a psychiatric hospital **Inpatient hospital:** **$0 or $275 copay per day for days 1-6** **$0 copay per day for days 7-90** **Outpatient individual or group therapy visit:** **$0 or $40 copay** Authorization is required after 20 visits

AFFINITY MEDICAID

	Medicaid Fee For Service	Affinity Medicare Ultimate (HMO-SNP)	Affinity Medicare Solutions (HMO-SNP)
Methadone Maintenance Treatment Programs (MMTP)	Covered	Not covered	Not covered
Comprehensive Medicaid Case Management	Covered	Not covered	Not covered
Directly Observed Therapy for Tuberculosis (TB) Disease	Covered	Not covered	Not covered
AIDS Adult Day Health Care	Covered	Not covered	Not covered
HIV COBRA Case Management	Covered	Not covered	Not covered
Adult Day Health Care	Covered	Not covered	Not covered
Personal Emergency Response Services (PERS)	Covered	Not covered	Not covered

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 866.247.5678. For TTY services, call 711.

If you believe that Affinity Health Plan has not given you these services or has 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:** 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/PrivacyPolicy/ or you can request a paper copy by calling our Customer Service Department at 866.247.5678 (TTY: 711).

LANGUAGE ASSISTANCE SERVICES

English:
ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-234-4499 (TTY: 711).

Español (Spanish):
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-234-4499 (TTY: 711).

繁體中文 (Chinese):
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-234-4499 (TTY: 711).）。

Русский (Russian):
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-234-4499 (телетайп: 711).

Italiano (Italian)
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-234-4499 (TTY: 711).

한국어 (Korean):
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-234-4499 (TTY: 711)번으로 전화해 주십시오.

Kreyòl Ayisyen (French Creole):
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-877-234-4499 (TTY: 711).

Polski (Polish):
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-234-4499 (TTY: 711).

אידיש (Yiddish):
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט 1-
.877-234-4499 (TTY: 711)

বাংলা (Bengali):
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-877-234-4499 (TTY: 711)

Français (French):
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-234-4499 (ATS : 711).

العربية (Arabic):

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-234-4499 (رقم هاتف الصم والبكم: 711.

ελληνικά (Greek):
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-877-234-4499 (TTY: 711).

اُردُو (Urdu):

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-877-234-4499 (TTY: 711).

Tagalog (Tagalog – Filipino):
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-234-4499 (TTY: 711).

Shqip (Albanian):
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-877-234-4499 (TTY: 711).

PRE-ENROLLMENT CHECKLIST

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you may call and speak to a customer service representative at 877.234.499 (TTY: 711).

Understanding the Benefits

- ☐ Review the full list of benefits found in the Evidence of Coverage (EOC), especially for those services for which you routinely see a doctor. Visit AffinityPlan.org or call 877.234.4499 (TTY: 711) to view a copy of the EOC.
- ☐ Review the provider directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.
- ☐ Review the pharmacy directory to make sure the pharmacy you use for any prescription medicines is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

Understanding Important Rules

- ☐ In addition to your monthly plan premium, you must continue to pay your Medicare Part B premium. This premium is normally taken out of your Social Security check each month.
- ☐ Benefits, premiums and/or copayments/coinsurance may change on January 1, 2020.
- ☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the provider directory).
- ☐ This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid or assistance with Medicare Part B premiums.

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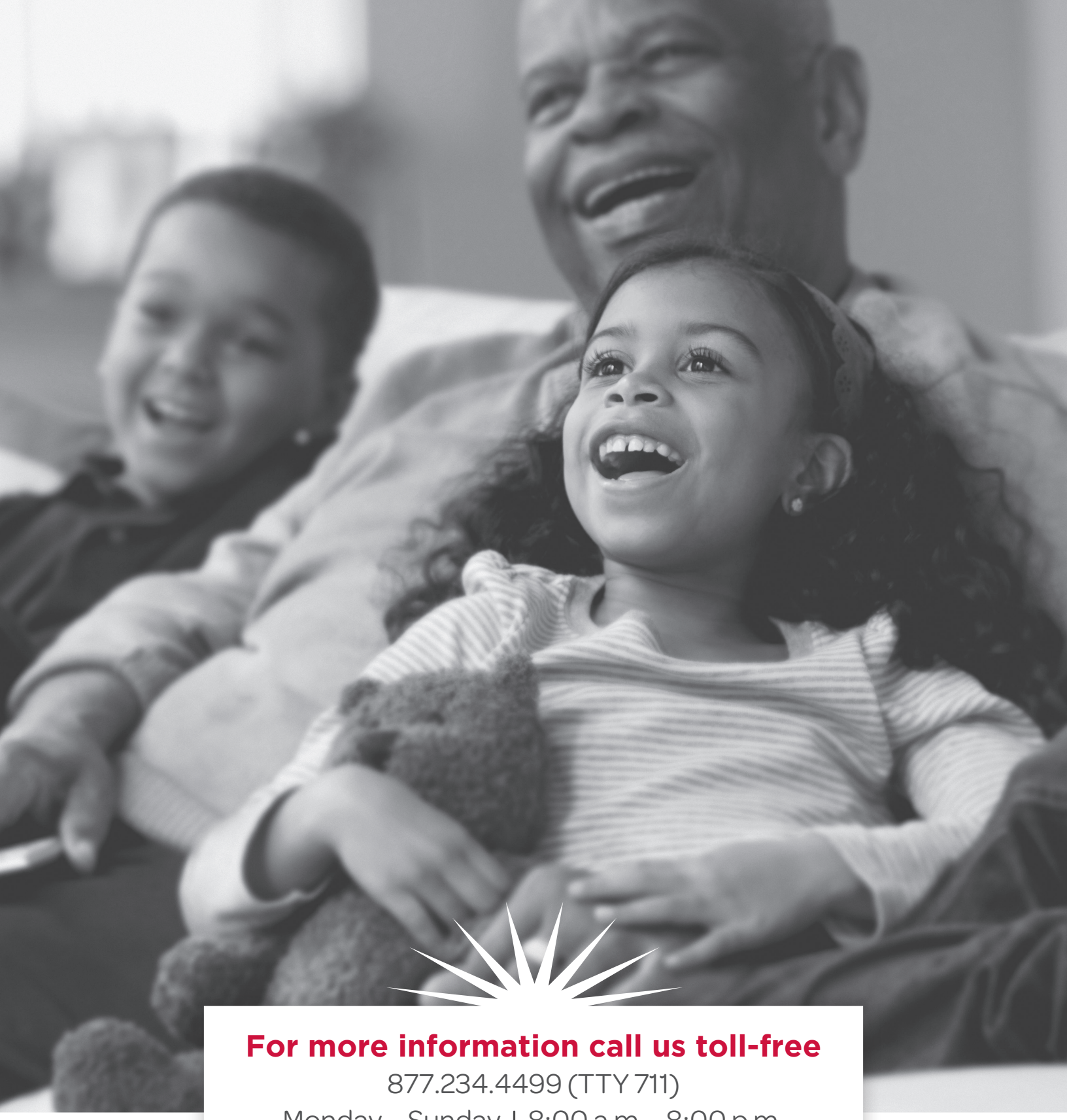

For more information call us toll-free

877.234.4499 (TTY 711)

Monday – Sunday | 8:00 a.m. - 8:00 p.m.

Affinity Health Plan

AffinityMedicarePlan.org