

**SECTION XXVIII**

**New York Student Health Plan SCHEDULE OF BENEFITS**

**Platinum 90.39%**

**SUNY Upstate Medical University**

<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limit</b>
<b>Medical Deductible</b> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul>	\$250 \$500	\$500 \$1,000	
<b>Out-of-Pocket Limit</b> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul>	\$3,000 \$6,000	\$6,000 \$12,000  See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how We calculate the Allowed Amount.  Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount of the Non-Participating Provider's charge that exceeds Our Allowed Amount.	

<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limit</b>
<b>OFFICE VISITS</b>			
Primary Care Office Visits (or Home Visits)	\$25 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
Specialist Office Visits (or Home Visits)	\$25 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<b>PREVENTIVE CARE</b>			
Well Child Visits and Immunizations*	Covered in full	0% Coinsurance not subject to Deductible	See benefit for description
Adult Annual Physical Examinations*	Covered in full	30% Coinsurance not subject to Deductible	See benefit for description
Adult Immunizations*	Covered in full	30% Coinsurance not subject to Deductible	See benefit for description
Routine Gynecological Services/Well Woman Exams*	Covered in full	30% Coinsurance not subject to Deductible	See benefit for description
Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full	30% Coinsurance not subject to Deductible	See benefit for description
Sterilization Procedures for Women*	Covered in full	30% Coinsurance not subject to Deductible	
Vasectomy	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Bone Density Testing*	Covered in full	30% Coinsurance not subject to Deductible	See benefit for description
Prostate Cancer Screening	Covered in full	30% Coinsurance not subject to Deductible	
Screening for Colon Cancer	Covered in full	30% Coinsurance not subject to Deductible	
All other preventive services required by USPSTF and HRSA.	Covered in full	30% Coinsurance not subject to Deductible	See benefit for description

<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limit</b>
*When preventive services are not provided in accordance with the comprehensive guidelines supported by United States Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA).	Use Cost Sharing for Appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Use Cost Sharing for Appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	
<b>EMERGENCY CARE</b>			
Emergency Ambulance Transportation Pre-Hospital Emergency Medical Services and Emergency Transportation including Air Ambulance	\$250 Copayment then You pay 0% not subject to Deductible	Paid the same as Participating Provider	See benefit for description
Non-Emergency Ambulance Services (Ground and Air Ambulance)  <b>Preauthorization Required</b>	\$250 Copayment then You pay 0% not subject to Deductible	\$250 Copayment then You pay 0% not subject to Deductible	See benefit for description
Emergency Department Copayment /Coinsurance waived if Hospital admission.	\$250 Copayment then You pay 0% not subject to Deductible  Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	Paid the same as Participating Provider  Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	See benefit for description
Urgent Care Center	\$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<b>PROFESSIONAL SERVICES AND OUTPATIENT CARE</b>			
Acupuncture	\$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	

<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limit</b>
<b>Advanced Imaging Services</b>			
<ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> </ul> <b>Preauthorization Required</b>	\$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<ul style="list-style-type: none"> <li>Performed in a Freestanding Radiology Facility</li> </ul> <b>Preauthorization Required</b>	\$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul> <b>Preauthorization Required</b>	\$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<b>Allergy Testing &amp; Treatment</b>			
<ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul>	\$25 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> </ul>	\$25 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<b>Ambulatory Surgical Center</b>			
Ambulatory Surgical Center Facility Fee  <b>Preauthorization Required</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
<b>Anesthesia Services</b>			
Anesthesia Services (all settings)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description

<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limit</b>
<b>Cardiac &amp; Pulmonary Rehabilitation</b>			
<ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> </ul>	\$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefits for description
<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul> <p><b>Preauthorization Required</b></p>	\$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefits for description
<ul style="list-style-type: none"> <li>Performed as Inpatient Hospital Services</li> </ul> <p><b>Preauthorization Required</b></p>	Included As Part of Inpatient Hospital Service Cost-Sharing	Included As Part of Inpatient Hospital Service Cost-Sharing	See benefits for description
<b>Chemotherapy and Immunotherapy</b>			
<ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul>	\$25 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefits for description
<ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> </ul>	\$25 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefits for description
<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul> <p><b>Preauthorization Required</b></p>	\$25 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefits for description
<b>Chiropractic Services</b>			
<ul style="list-style-type: none"> <li>Chiropractic Services</li> </ul>	\$25 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefits for description
<b>Clinical Trials</b>			
<ul style="list-style-type: none"> <li>Clinical Trials</li> </ul> <p><b>Preauthorization Required</b></p>	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description

<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limit</b>
<b>Diagnostic Testing</b>			
<ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul>	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	See benefits for description
<ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> </ul>	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	See benefits for description
<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul> <p><b>Preauthorization Required</b></p>	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	See benefits for description
<b>Dialysis</b>			
<ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul> <p><b>Preauthorization Required</b></p>	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> </ul> <p><b>Preauthorization Required</b></p>	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	
<ul style="list-style-type: none"> <li>Performed in a Freestanding Center</li> </ul> <p><b>Preauthorization Required</b></p>	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	
<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul> <p><b>Preauthorization Required</b></p>	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	
<b>Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</b>			
<ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul>	\$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	Unlimited visits per Plan Year
<ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> </ul>	\$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	

<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limit</b>
<ul style="list-style-type: none"> <li>Performed in an Outpatient Facility</li> </ul> <b>Preauthorization Required</b>	\$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	
<b>Home Health Care</b>			
Home Health Care <b>Preauthorization Required</b>	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	Unlimited visits per Plan Year
<b>Infertility Services</b>			
Infertility Services <b>Preauthorization Required</b>	Use Cost Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See benefit for description
<b>Infusion Therapy</b>			
<ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul>	\$25 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<ul style="list-style-type: none"> <li>Performed in Specialist Office</li> </ul>	\$25 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul> <b>Preauthorization Required</b>	\$25 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<ul style="list-style-type: none"> <li>Home Infusion Therapy</li> </ul> <b>Preauthorization Required</b>	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	Home infusion counts towards home health care visit limits
<b>Inpatient Medical Visits</b>			
Inpatient Medical Visits <b>Preauthorization Required</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
<b>Interruption of Pregnancy</b>			
Interruption of Pregnancy <ul style="list-style-type: none"> <li>Abortion Services</li> </ul>	Covered in full	30% Coinsurance after Deductible	See benefit for description

<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limit</b>
<b>Laboratory Procedures</b>			
<ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul>	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> </ul>	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<ul style="list-style-type: none"> <li>Performed in a Freestanding Laboratory Facility</li> </ul>	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul>	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<b>Maternity &amp; Newborn Care</b>			
<ul style="list-style-type: none"> <li>Prenatal Care <ul style="list-style-type: none"> <li>Prenatal Care provided in accordance with the comprehensive guidelines supported by United States Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA)</li> </ul> </li> </ul>	Covered In Full	30% Coinsurance after Deductible	See Benefit For Description
<ul style="list-style-type: none"> <li>Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by United States Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA)</li> </ul>	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)	See Benefit For Description

<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limit</b>
<ul style="list-style-type: none"> <li>Inpatient Hospital Services and Birthing Center</li> </ul> <p><b>Preauthorization Required for Inpatient Services</b></p>	20% Coinsurance after Deductible	40% Coinsurance after Deductible	One (1) Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
<ul style="list-style-type: none"> <li>Physician and Midwife Services for Delivery</li> </ul>	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	
<ul style="list-style-type: none"> <li>Breastfeeding Support, Counseling and Supplies including Breast Pumps</li> </ul>	Covered in Full	30% Coinsurance after Deductible	Covered for duration of breast feeding
<ul style="list-style-type: none"> <li>Postnatal Care <ul style="list-style-type: none"> <li>Postnatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> </ul> </li> </ul>	Covered in full	30% Coinsurance after Deductible  Included in Physician and Midwife Services for Delivery Cost-Sharing	
<ul style="list-style-type: none"> <li>Postnatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> </ul>	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible  Included in Physician and Midwife Services for Delivery Cost-Sharing	
<b>Outpatient Hospital Surgery Facility Charge</b>			
<ul style="list-style-type: none"> <li>Outpatient Hospital Surgery Facility Charge</li> </ul> <p><b>Preauthorization Required</b></p>	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
<b>Preadmission Testing</b>			
Preadmission Testing	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	See benefit for description

<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limit</b>
<b>Prescription Drugs Administered in Office or Outpatient Facilities</b>			
<ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul> <b>Preauthorization Required</b>	\$25 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<ul style="list-style-type: none"> <li>Performed in Specialist Office</li> </ul> <b>Preauthorization Required</b>	\$25 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<ul style="list-style-type: none"> <li>Performed in Outpatient Facilities</li> </ul> <b>Preauthorization Required</b>	\$25 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<b>Diagnostic Radiology Services</b>			
<ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul>	\$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> </ul>	\$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<ul style="list-style-type: none"> <li>Performed in a Freestanding Radiology Facility</li> </ul>	\$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul>	\$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<b>Therapeutic Radiology Services</b>			
<ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> </ul>	\$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<ul style="list-style-type: none"> <li>Performed in a Freestanding Radiology Facility</li> </ul> <b>Preauthorization Required</b>	\$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefit for description

<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limit</b>
<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul> <p><b>Preauthorization Required</b></p>	\$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<b>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</b>			
<ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul>	\$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	Speech and physical therapy are only Covered following a Hospital stay or surgery.
<ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> </ul>	\$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	
<ul style="list-style-type: none"> <li>Performed in an Outpatient Facility</li> </ul> <p><b>Preauthorization Required</b></p>	\$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	
<b>Second Opinions on the Diagnosis of Cancer, Surgery &amp; Other</b>			
<ul style="list-style-type: none"> <li>Second Opinions on the Diagnosis of Cancer, Surgery &amp; Other</li> </ul>	\$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible  Second Opinions on Diagnosis of Cancer are Covered at participating Cost-Sharing for non-participating Specialist	See benefit for description
<b>Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive &amp; Corrective Surgery and Transplants</b>			
<ul style="list-style-type: none"> <li>Inpatient Hospital Surgery</li> </ul> <p><b>Preauthorization Required</b></p>	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
<ul style="list-style-type: none"> <li>Outpatient Hospital Surgery</li> </ul> <p><b>Preauthorization Required</b></p>	20% Coinsurance after Deductible	40% Coinsurance after Deductible	<b>All transplants must be performed at Designated Facilities</b>

<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limit</b>
<ul style="list-style-type: none"> <li>Surgery Performed at an Ambulatory Surgical Center</li> </ul> <p><b>Preauthorization Required</b></p>	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
<ul style="list-style-type: none"> <li>Office Surgery</li> </ul>	\$25 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	
<b>ADDITIONAL SERVICES, EQUIPMENT &amp; DEVICES</b>			
<b>Diabetic Equipment, Supplies &amp; Self-Management Education</b>			
<ul style="list-style-type: none"> <li>Diabetic Equipment Supplies (30-Day Supply)</li> </ul>	\$10 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<ul style="list-style-type: none"> <li>Diabetic Insulin (30 Day Supply)</li> </ul>	Covered in full	30% Coinsurance after Deductible	See benefit for description
<ul style="list-style-type: none"> <li>Oral anti-diabetic agents and injectable anti-diabetic agents (30 day supply)</li> </ul>	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<ul style="list-style-type: none"> <li>Diabetic Education</li> </ul>	\$10 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
<b>Durable Medical Equipment &amp; Braces</b>			
Durable Medical Equipment & Braces	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
<b>External Hearing Aids</b>			
<ul style="list-style-type: none"> <li><b>Prescription Hearing Aids</b></li> </ul>	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Single purchase once every three (3) years
<b>Cochlear Implants</b>			
Cochlear Implants	20% Coinsurance after Deductible	40% Coinsurance after Deductible	One (1) per ear per Plan Year

<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limit</b>
<b>Hospice Care</b>			
Hospice Care <ul style="list-style-type: none"> <li>Inpatient</li> </ul> <b>Preauthorization Required</b>	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	Two hundred ten (210) days per Plan Year
<ul style="list-style-type: none"> <li>Outpatient</li> </ul> <b>Preauthorization Required</b>	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	Five (5) visits for family bereavement counseling
<b>Medical Supplies</b>			
Medical Supplies	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
<b>Prosthetic Devices</b>			
<ul style="list-style-type: none"> <li>External</li> </ul>	20% Coinsurance after Deductible	40% Coinsurance after Deductible	One (1) prosthetic device, per limb, per Plan Year
<ul style="list-style-type: none"> <li>Internal</li> </ul>	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
<b>INPATIENT SERVICES &amp; FACILITIES</b>			
Autologous Blood Banking	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefits for description
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)  <b>Preauthorization Required. However, Preauthorization is not required for emergency admissions or services provided in a neonatal intensive care unit of a Hospital certified pursuant to Article 28 of the Public Health Law.</b>	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	See benefit for description

<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limit</b>
Observation Stay <b>Preauthorization Required</b>	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	See benefit for description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) <b>Preauthorization Required</b>	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	Two hundred (200) days per Plan Year
Inpatient Habilitation Services (Physical Speech and Occupational Therapy) <b>Preauthorization Required</b>	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) <b>Preauthorization Required</b>	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	Speech and physical therapy are only Covered following a Hospital stay or surgery
<b>MENTAL HEALTH &amp; SUBSTANCE USE DISORDER SERVICES</b>			
Inpatient Mental Health Care for a continuous confinement when in a Hospital (or Residential Facility) <b>Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions or for admissions at Participating Hospitals or crisis residence facilities licensed or operated by OMH.</b>	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	See benefit for description
<b>Outpatient Mental Health Care (Including Partial Hospitalization &amp; Intensive Outpatient Program Services)</b>			
• Office Visits	\$25 Copayment then You pay 0% after Deductible	30% Coinsurance after Deductible	See benefit for description
• All Other Outpatient Services	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	See benefit for description

<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limit</b>
ABA Treatment for Autism Spectrum Disorder  <b>Preauthorization Required</b>	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)  <b>Preauthorization Required. However, Preauthorization is not required for Emergency Admissions or for Participating Facilities licensed, certified or otherwise authorized by OASAS</b>	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	See benefit for description
<b>Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)</b>			
<ul style="list-style-type: none"> <li>Office Visits</li> </ul>	\$25 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	Up to twenty (20) visits a plan year may be used for family counseling
<ul style="list-style-type: none"> <li>All Other Outpatient Services <ul style="list-style-type: none"> <li>Opioid Treatment Programs</li> </ul> </li> </ul>	Covered in full	30% Coinsurance after Deductible	
<ul style="list-style-type: none"> <li>All Other Outpatient Services</li> </ul>	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
<p><b>PRESCRIPTION DRUGS</b></p> <p>*Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by Health Resources and Services Administration (HRSA) or if the item or service has an “A” or “B” rating from the United States Preventive Services Task Force (USPSTF) and obtained at a participating pharmacy</p>			
<p><b>Retail Pharmacy</b></p>			
<p>30-day supply</p>			
<p>Tier 1</p> <p><b>Preauthorization is not required for a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.</b></p>	<p>\$5 Copayment then You pay 0% not subject to the Deductible</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	<p>See benefit for description</p>
<p>Tier 2</p> <p><b>Preauthorization is not required for a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.</b></p>	<p>\$35 Copayment then You pay 0% not subject to the Deductible</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	
<p>Tier 3</p> <p><b>Preauthorization is not required for a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.</b></p>	<p>\$70 Copayment then You pay 0% not subject to the Deductible</p>	<p>Non-Participating Provider Services Are Not Covered and You Pay the Full Cost</p>	
<p>The Deductible does not apply to certain Prescription Drugs. Visit Our website at <a href="http://Aetna.com">Aetna.com</a> to review Our formulary or call the number on Your ID card to learn more.</p>			

<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limit</b>
<b>Mail Order Pharmacy</b>			
Up to a 90-day supply			
Tier 1	\$10 Copayment then You pay 0% not subject to the Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See benefit for description
Tier 2	\$70 Copayment then You pay 0% not subject to the Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	\$140 Copayment then You pay 0% not subject to the Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<b>Enteral Formulas</b>			
Tier 1	\$5 Copayment then You pay 0% not subject to the Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See benefit for description
Tier 2	\$35 Copayment then You pay 0% not subject to the Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	\$70 Copayment then You pay 0% not subject to the Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<b>WELLNESS BENEFITS</b>			
Exercise Facility Reimbursement	Up to \$200 per six (6) month period; up to an additional \$100 per six (6) month period for Covered Dependent.		

<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limit</b>
<b>PEDIATRIC DENTAL &amp; VISION CARE</b>			
<b>Pediatric Dental Care</b>			
<ul style="list-style-type: none"> <li>Preventive Dental Care</li> </ul>	0% Coinsurance not subject to Deductible	0% Coinsurance not subject to Deductible	One (1) dental exam & cleaning per six (6)-month period  Full mouth x-rays or panoramic x-rays at thirty-six (36) month intervals and bitewing x-rays at six (6) month intervals
<ul style="list-style-type: none"> <li>Routine Dental Care</li> </ul>	0% Coinsurance not subject to Deductible	0% Coinsurance not subject to Deductible	
<ul style="list-style-type: none"> <li>Major Dental Care (Oral Surgery, Endodontics, Periodontics &amp; Prosthodontics)</li> </ul>	50% Coinsurance after Deductible	50% Coinsurance after Deductible	
<ul style="list-style-type: none"> <li>Orthodontics</li> </ul>	50% Coinsurance after Deductible	50% Coinsurance after Deductible	
<b>Pediatric Vision Care</b>			
<ul style="list-style-type: none"> <li>Exams</li> </ul>	\$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	One (1) exam per twelve (12)-month period
<ul style="list-style-type: none"> <li>Lenses &amp; Frames</li> </ul>	20% Coinsurance after Deductible	40% Coinsurance after Deductible	One (1) prescribed lenses & frames per twelve (12)-month period

<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limit</b>
<ul style="list-style-type: none"> <li>Contact Lenses</li> </ul>	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
<b>Adult Vision Care</b>			
<ul style="list-style-type: none"> <li>Exams</li> </ul>	\$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance after Deductible	One (1) exam per twelve (12)-month period
<ul style="list-style-type: none"> <li>Lenses &amp; Frames</li> </ul>	20% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost.	
<ul style="list-style-type: none"> <li>Contact Lenses</li> </ul>	20% Coinsurance after Deductible	Non-Participating Provider services are not covered and You pay the full cost.	
<b>OTHER COVERED SERVICES</b>			
<b>Emergency Medical Evacuation</b>	0% Coinsurance of actual cost not subject to Deductible		
<b>Medical Repatriation</b>	0% Coinsurance of actual cost not subject to Deductible		
<b>Transportation to Join a Hospitalized Member</b>	0% Coinsurance of actual cost not subject to Deductible		
<b>Return of Minor Children</b>	0% Coinsurance of actual cost not subject to Deductible		
<b>Repatriation of Mortal Remains</b>	0% Coinsurance of actual cost not subject to Deductible		

### Accidental Death and Dismemberment Benefits

<u>Loss</u>	<u>Benefit Amount</u>
Life.....	\$10,000
Loss of Two or More Hands or Feet.....	\$10,000
Loss of Use of Two or More Hands or Feet.....	\$10,000
Loss of Sight in Both Eyes.....	\$10,000
Loss of Speech and Hearing (in Both Ears).....	\$5,000
Loss of one Hand or Foot and Sight in One Eye.....	\$10,000
Loss of One Hand or Foot.....	\$5,000
Loss of Sight in One Eye.....	\$5,000
Loss of Speech.....	\$2,500
Loss of Hearing (in Both Ears).....	\$2,500
Loss of Thumb and Index Finger on the Same Hand.....	\$2,500
Loss of all Four Fingers on the Same Hand.....	\$2,500
Loss of all Toes on the Same Foot.....	\$2,500
Loss of Thumb.....	\$2,500