SECTION XXVIII

New York Student Health Plan SCHEDULE OF BENEFITS

Platinum 91.74%

Hamilton College

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limit**
Medical Deductible • Individual	None	$500	
Out-of-Pocket Limit • Individual	$5,000	$10,000 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.	
OFFICE VISITS			
Primary Care Office Visits (or Home Visits)	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	See benefit for description
Specialist Office Visits (or Home Visits)	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	See benefit for description

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
PREVENTIVE CARE			
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 after Deductible	See benefit for description
Adult Immunizations*	Covered in full	30% Coinsurance after Deductible	See benefit for description
Routine Gynecological Services/Well Woman Exams*	Covered in full	30% Coinsurance after Deductible	See benefit for description
Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full	30% Coinsurance after Deductible	See benefit for description
Sterilization Procedures for Women*	Covered in full	30% Coinsurance after Deductible	
Vasectomy	10% Coinsurance	30% Coinsurance after Deductible	See benefit for description
Bone Density Testing*	Covered in full	30% Coinsurance after Deductible	See benefit for description
Prostate Cancer Screening	Covered in full	30% Coinsurance after Deductible	
Screening for Colon Cancer	Covered in full	30% Coinsurance after Deductible	
All other preventive services required by USPSTF and HRSA.	Covered in full	30% Coinsurance after Deductible	See benefit for description
*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)	

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
EMERGENCY CARE			
Emergency Ambulance Transportation Pre-Hospital Emergency Medical Services and Emergency Transportation including Air Ambulance	$100 Copayment then You pay 0%	Paid the same as Participating Provider	See benefit for description
Non-Emergency Ambulance Services (Ground and Air Ambulance) **Preauthorization Required**	$100 Copayment then You pay 0%	$100 Copayment then You pay 0% not subject to Deductible	See benefit for description
Emergency Department Copayment /Coinsurance waived if Hospital admission.	$100 Copayment then You pay 0% 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	$25 Copayment then You pay 0%	$25 Copayment then You pay 0% not subject to Deductible	See benefit for description
PROFESSIONAL SERVICES AND OUTPATIENT CARE			
Advanced Imaging Services			
• Performed in a Specialist Office **Preauthorization Required**	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description
• Performed in a Freestanding Radiology Facility **Preauthorization Required**	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description
• Performed as Outpatient Hospital Services **Preauthorization Required**	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
Allergy Testing & Treatment			
• Performed in a PCP Office	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	See benefit for description
Ambulatory Surgical Center			
Ambulatory Surgical Center Facility Fee **Preauthorization Required**	10% Coinsurance	30% Coinsurance after Deductible	See benefit for description
Anesthesia Services			
Anesthesia Services (all settings)	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description
Cardiac & Pulmonary Rehabilitation			
• Performed in a Specialist Office	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description
• Performed as Outpatient Hospital Services **Preauthorization Required**	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description
• Performed as Inpatient Hospital Services **Preauthorization Required**	Included As Part of Inpatient Hospital Service Cost-Sharing	Included As Part of Inpatient Hospital Service Cost-Sharing	See benefit for description
Chemotherapy and Immunotherapy			
• Performed in a PCP Office	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	See benefit for description
• Performed as Outpatient Hospital Services **Preauthorization Required**	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	See benefit for description

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
Chiropractic Services			
• Chiropractic Services	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	See benefit for description
Clinical Trials			
• Clinical Trials **Preauthorization Required**	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description
Diagnostic Testing			
• Performed in a PCP Office	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description
• Performed as Outpatient Hospital Services **Preauthorization Required**	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description
Dialysis			
• Performed in a PCP Office **Preauthorization Required**	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office **Preauthorization Required**	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	
• Performed in a Freestanding Center **Preauthorization Required**	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	
• Performed as Outpatient Hospital Services **Preauthorization Required**	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)			
• Performed in a PCP Office	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	
• Performed in a Specialist Office	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	
• Performed in an Outpatient Facility **Preauthorization Required**	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	
Home Health Care			
Home Health Care **Preauthorization Required**	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	Sixty (60) visits per Plan Year
Infertility Services			
Infertility Services **Preauthorization Required**	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
Infusion Therapy			
• Performed in a PCP Office	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	See benefit for description
• Performed in Specialist Office	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	See benefit for description
• Performed as Outpatient Hospital Services **Preauthorization Required**	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	See benefit for description
• Home Infusion Therapy **Preauthorization Required**	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	Home infusion counts towards home health care visit limits

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
Inpatient Medical Visits			
Inpatient Medical Visits **Preauthorization Required**	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description
Interruption of Pregnancy			
Interruption of Pregnancy • Abortion Services	Covered in full	30% Coinsurance after Deductible	See benefit for description
Laboratory Procedures			
• Performed in a PCP Office	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description
• Performed in a Freestanding Laboratory Facility	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description
• Performed as Outpatient Hospital Services	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
Maternity & Newborn Care			
• Prenatal Care • 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)	Covered in full	30% Coinsurance after Deductible	See benefit for description
• 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)	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
• Inpatient Hospital Services and Birthing Center **Preauthorization Required for Inpatient Services**	10% Coinsurance per admission	30% Coinsurance per admission after Deductible	One (1) Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
• Physician and Midwife Services for Delivery	10% Coinsurance per admission	30% Coinsurance per admission after Deductible	
• Breastfeeding Support, Counseling and Supplies including Breast Pumps	Covered in full	30% Coinsurance per item after Deductible	Covered for duration of breast feeding

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
• Postnatal Care • Postnatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full	30% Coinsurance after Deductible Included in Physician and Midwife Services for Delivery Cost-Sharing	
• Postnatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	0% Coinsurance	30% Coinsurance after Deductible Included in Physician and Midwife Services for Delivery Cost-Sharing	
Outpatient Hospital Surgery Facility Charge			
• Outpatient Hospital Surgery Facility Charge **Preauthorization Required**	10% Coinsurance	30% Coinsurance after Deductible	See benefit for description
Preadmission Testing			
Preadmission Testing	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description
Prescription Drugs Administered in Office			
• Performed in a PCP Office **Preauthorization Required**	10% Coinsurance	30% Coinsurance after Deductible	See benefit for description
• Performed in Specialist Office **Preauthorization Required**	10% Coinsurance	30% Coinsurance after Deductible	See benefit for description
Diagnostic Radiology Services			
• Performed in a PCP Office	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
• Performed in a Freestanding Radiology Facility	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description
• Performed as Outpatient Hospital Services	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description
Therapeutic Radiology Services			
• Performed in a Specialist Office	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description
• Performed in a Freestanding Radiology Facility **Preauthorization Required**	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description
• Performed as Outpatient Hospital Services **Preauthorization Required**	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)			
• Performed in a PCP Office	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	Speech and physical therapy are only Covered following a Hospital stay or surgery.
• Performed in a Specialist Office	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	
• Performed in an Outpatient Facility **Preauthorization Required**	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	
Second Opinions on the Diagnosis of Cancer, Surgery & Other			
• Second Opinions on the Diagnosis of Cancer, Surgery & Other	$25 Copayment then You pay 0%	30% Coinsurance after Deductible Second Opinions on Diagnosis of Cancer are Covered at participating Cost-Sharing for non-participating Specialist	See benefit for description

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery and Transplants			
• Inpatient Hospital Surgery **Preauthorization Required**	10% Coinsurance	30% Coinsurance after Deductible	See benefit for description **All transplants must be performed at Designated Facilities**
• Outpatient Hospital Surgery **Preauthorization Required**	10% Coinsurance	30% Coinsurance after Deductible	
• Surgery Performed at an Ambulatory Surgical Center **Preauthorization Required**	10% Coinsurance	30% Coinsurance after Deductible	
• Office Surgery	10% Coinsurance	30% Coinsurance after Deductible	
ADDITIONAL SERVICES, EQUIPMENT & DEVICES			
Diabetic Equipment, Supplies & Self-Management Education			
• Diabetic Equipment Supplies (30-Day Supply)	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	See benefit for description
• Diabetic Insulin (30 Day Supply)	Covered in full	0% Coinsurance not subject to Deductible	See benefit for description
• Oral anti-diabetic agents and injectable anti-diabetic agents (30 day supply)	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description
• Diabetic Education	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	See benefit for description

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
Durable Medical Equipment & Braces			
Durable Medical Equipment & Braces	10% Coinsurance	30% Coinsurance after Deductible	See benefit for description
External Hearing Aids			
External Hearing Aids • **Prescription Hearing Aids**	10% Coinsurance	30% Coinsurance after Deductible	Single purchase once every three (3) years
Cochlear Implants			
Cochlear Implants	10% Coinsurance	30% Coinsurance after Deductible	One (1) per ear per Plan Year
Hospice Care			
Hospice Care • Inpatient **Preauthorization Required**	10% Coinsurance	30% Coinsurance after Deductible	Two hundred ten (210) days per Plan Year
• Outpatient **Preauthorization Required**	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	Five (5) visits for family bereavement counseling
Medical Supplies			
Medical Supplies	10% Coinsurance	30% Coinsurance after Deductible	See benefit for description
Prosthetic Devices			
• External	10% Coinsurance	30% Coinsurance after Deductible	One (1) prosthetic device, per limb, per Plan Year
• Internal	10% Coinsurance	30% Coinsurance after Deductible	See benefit for description
INPATIENT SERVICES & FACILITIES			
Autologous Blood Banking	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) **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.**	10% Coinsurance per admission	30% Coinsurance per admission after Deductible	See benefit for description
Observation Stay **Preauthorization Required**	10% Coinsurance per admission	30% Coinsurance per admission after Deductible	See benefit for description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) **Preauthorization Required**	10% Coinsurance per admission	30% Coinsurance per admission after Deductible	Two hundred (200) days per Plan Year
Inpatient Habilitation Services (Physical Speech and Occupational Therapy) **Preauthorization Required**	10% Coinsurance per admission	30% Coinsurance per admission after Deductible	
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) **Preauthorization Required**	10% Coinsurance per admission	30% Coinsurance per admission after Deductible	Speech and physical therapy are only Covered following a Hospital stay or surgery

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES			
Inpatient Mental Health Care for a continuous confinement when in a Hospital (or Residential Facility) **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.**	10% Coinsurance per admission	30% Coinsurance per admission after Deductible	See benefit for description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)			
• Office Visits	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	See benefit for description
• All Other Outpatient Services	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description
ABA Treatment for Autism Spectrum Disorder **Preauthorization Required**	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	0% Coinsurance	30% Coinsurance after Deductible	See benefit for description
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment) **Preauthorization Required. However, Preauthorization is not required for Emergency Admissions or for Participating Facilities licensed, certified or otherwise authorized by OASAS**	10% Coinsurance per admission	30% Coinsurance per admission after Deductible	See benefit for description

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)			
• Office Visits	$25 Copayment then You pay 0%	30% Coinsurance after Deductible	Up to twenty (20) visits a plan year may be used for family counseling
• All Other Outpatient Services • Opioid Treatment Programs	Covered in full	30% Coinsurance after Deductible	
• All Other Outpatient Services	0% Coinsurance	30% Coinsurance after Deductible	
PRESCRIPTION DRUGS *****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			
Retail Pharmacy			
30-day supply			
Tier 1 **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.**	$10 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See benefit for description

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
Tier 2 **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.**	$45 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3 **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.**	$75 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
The Deductible does not apply to certain Prescription Drugs. Visit Our website at Aetna.com to review Our formulary or call the number on Your ID card to learn more.			
Mail Order Pharmacy			
Up to a 90-day supply			
Tier 1	$25 Copayment then You pay 0% not subject to Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See benefit for description
Tier 2	$112.50 Copayment then You pay 0% not subject to Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See benefit for description
Tier 3	$187.50 Copayment then You pay 0% not subject to Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See benefit for description
The Deductible does not apply to certain Prescription Drugs. Visit Our website at Aetna.com to review Our formulary or call the number on Your ID card to learn more.			

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
Enteral Formulas			
Tier 1	$10 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See benefit for description
Tier 2	$45 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3	$75 Copayment	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
WELLNESS BENEFITS			
Exercise Facility Reimbursement	Up to $200 per six (6) month period		
PEDIATRIC DENTAL & VISION CARE			
Pediatric Dental Care			
• Preventive Dental Care	$20 Copayment then You pay 0%	30% Coinsurance after 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
• Routine Dental Care	20% Coinsurance	20% Coinsurance after Deductible	
• Major Dental Care (Oral Surgery, Endodontics, Periodontics & Prosthodontics)	50% Coinsurance	50% Coinsurance after Deductible	
• Orthodontics	50% Coinsurance	50% Coinsurance after Deductible	

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
Pediatric Vision Care			
• Exams	$20 Copayment then You pay 0%	30% Coinsurance after Deductible	One (1) exam per twelve (12)-month period
• Lenses & Frames	10% Coinsurance	10% Coinsurance after Deductible	One (1) prescribed lenses & frames per twelve (12)-month period
• Contact Lenses	10% Coinsurance	10% Coinsurance after Deductible	
Adult Vision Care			
• Exams	$20 Copayment then You pay 0%	30% Coinsurance after Deductible	One (1) exam per twelve (12)-month period
OTHER COVERED SERVICES			
Emergency Medical Evacuation	0% Coinsurance of actual cost not subject to Deductible		
Medical Repatriation	0% Coinsurance of actual cost not subject to Deductible		
Transportation to Join a Hospitalized Member	0% Coinsurance of actual cost not subject to Deductible		
Return of Minor Children	% Coinsurance of actual cost not subject to Deductible		
Repatriation of Mortal Remains	0% Coinsurance of actual cost not subject to Deductible		

Accidental Death and Dismemberment Benefits

Loss	Benefit Amount
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