

**SECTION XXVII -SCHEDULE OF BENEFITS
NEW YORK UNIVERSITY
BASIC PLAN
Metal Level: Gold
Actuarial Value: 87.83%**

Policy Number: WNY2324NYSHIP03
Group Number: STO645SH

Policyholder Effective Date: August 21, 2023
Policyholder Termination Date: August 20, 2024

Description of Students who are covered:

All domestic undergraduate students registered for 9 or more credits in a degree-granting program; domestic graduate students (including Graduate Assistants, Research Assistants, Teaching Assistants or specifically designated fully-funded graduate students for whom the University has agreed to pay the student health insurance fee) registered for 6 or more credits at: (a) College of Nursing (in a degree-granting program), (b) School of Professional Studies (in a degree-granting program), (c) School of Law (in a degree-granting program), (d) Steinhardt School of Culture, Education, and Human Development (in a degree-granting or advanced certificate program), (e) Tisch School of the Arts (in a degree-granting program), (f) Global Public Health, (g) Wagner Graduate School of Public Service (in a degree-granting program); and domestic graduate students registered for 1 or more credits, or maintaining matriculation at the Graduate School of Art & Science; and domestic graduate students registered for 12 or more credits at the Stern School of Business in a degree-granting program (including Graduate Assistants, Research Assistants, Teaching Assistants or specifically designated fully-funded graduate students for whom the University has agreed to pay the student health insurance fee) are automatically enrolled in and charged for the Basic Plan unless a waiver form showing comparable coverage is received by New York University. Students automatically enrolled in the Basic Plan may choose to upgrade to the Comprehensive Plan.

All domestic undergraduate students registered for less than 9 credits; domestic graduate students registered for less than 6 credits at: (a) College of Dentistry, (b) College of Nursing, (c) Gallatin School of individualized Study, (d) School of Professional Studies, (e) School of Law, (f) Silver School of Social Work, (g) Steinhardt School of Culture, Education, and Human Development, (h) Tisch School of the Arts, or (i) Wagner Graduate School of Public Service; (j) Collee of Global Public Health and domestic graduate students registered for less than 12 credits at the Stern School of Business are eligible to enroll for coverage under the Basic Plan.

COST-SHARING	Student Health Center Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In- Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	
Deductible	None	None	None	None	
Out-of-Pocket Limit: Individual Family	\$7,350 \$14,700	\$7,350 \$14,700	\$7,350 \$14,700	\$14,700 \$29,400	See section IV 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 Out-of-Pocket Limit. You must pay the amount by which the Non-Participating Provider's charge exceeds Our Allowed Amount.	
Benefits Subject to Annual and Lifetime Limits					
Emergency Medical Evacuation \$250,000 Annual Limit					
Repatriation of Remains \$250,000 Annual Limit					
Accidental Death and Dismemberment \$10,000 Annual and Lifetime Maximum					
OFFICE VISITS	Student Health Center Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
Primary Care Office Visits (or Home Visits)	Covered in full	N/A	\$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance	See Benefit For Description
Specialist Office Visits (or Home Visits)	\$20 Copayment per Visit	N/A	\$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance	See Benefit For Description
PREVENTIVE CARE	Student Health Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
• Well Child Visits and Immunizations*					See Benefit For Description

	Students	Covered in full	N/A	Covered in full	30% Coinsurance	
	Dependents	N/A	N/A	Covered in full	30% Coinsurance	
•	Adult Annual Physical Examinations*					
	Students	Covered in full	N/A	Covered in full	30% Coinsurance	
	Dependents	N/A	N/A	Covered in full	30% Coinsurance	
•	Adult Immunizations*					
	Students	Covered in full	N/A	Covered in full	30% Coinsurance	
	Dependents	N/A	N/A	Covered in full	30% Coinsurance	
•	Routine Gynecological Services/Well Woman Exams*					
	Students	Covered in full	Covered in full	Covered in full	30% Coinsurance	
	Dependents	N/A	Covered in full	Covered in full	30% Coinsurance	
•	Mammography Screening and Diagnostic Imaging for the Detection of Breast Cancer					
	Students	N/A	N/A	Covered in full	30% Coinsurance	
	Dependents	N/A	N/A	Covered in full	30% Coinsurance	
•	Sterilization Procedures for Women*					
	Students	N/A	N/A	Covered in full	30% Coinsurance	
	Dependents	N/A	N/A	Covered in full	30% Coinsurance	

<ul style="list-style-type: none"> Vasectomy <ul style="list-style-type: none"> Students Dependents 	N/A	N/A	Covered in full	30% Coinsurance	
	N/A	N/A	Covered in full	30% Coinsurance	
<ul style="list-style-type: none"> Bone Density Testing* <ul style="list-style-type: none"> Students Dependents 	N/A	N/A	Covered in full	30% Coinsurance	
	N/A	N/A	Covered in full	30% Coinsurance	
<ul style="list-style-type: none"> Screening for Prostate Cancer <ul style="list-style-type: none"> Students Dependents 	Covered in full	N/A	Covered in full	30% Coinsurance	
	N/A	N/A	Covered in full	30% Coinsurance	
<ul style="list-style-type: none"> Screening for Colon Cancer <ul style="list-style-type: none"> Students Dependents 	Covered in full	N/A	Covered in full	30% Coinsurance	
	N/A	N/A	Covered in full	30% Coinsurance	
<ul style="list-style-type: none"> All other preventive services required by USPSTF and HRSA. <ul style="list-style-type: none"> Students Dependents 	Covered in full	N/A	Covered in full	30% Coinsurance	
	N/A	N/A	Covered in full	30% Coinsurance	
<ul style="list-style-type: none"> *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and 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)	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)	

EMERGENCY CARE	Student Health Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	N/A	N/A	Covered in full	Covered in full	See Benefit For Description
Non-Emergency Ambulance Services	N/A	N/A	Covered in full	Covered in full	See Benefit For Description
Emergency Department	N/A	N/A	\$250 Copayment per Visit then 20% Coinsurance Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	\$250 Copayment per Visit then 20% Coinsurance Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	See Benefit For Description
Urgent Care Center	N/A	N/A	\$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance	See Benefit For Description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	Student Health Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
Advanced Imaging Services					See Benefit For Description
<ul style="list-style-type: none"> Performed in a Specialist Office 	N/A	N/A	20% Coinsurance	50% Coinsurance	
<ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility 	N/A	N/A	20% Coinsurance	50% Coinsurance	
<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	N/A	N/A	\$40 Copayment per Visit then 20% Coinsurance	50% Coinsurance	
Preauthorization Required					

<p>Allergy Testing & Treatment</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office 	<p>20% Coinsurance</p> <p>N/A</p>	<p>N/A</p> <p>N/A</p>	<p>20% Coinsurance</p> <p>20% Coinsurance</p>	<p>50% Coinsurance</p> <p>50% Coinsurance</p>	<p>See Benefit For Description</p>
<p>Ambulatory Surgical Center Facility Fee</p> <p>Preauthorization Required</p>	<p>N/A</p>	<p>N/A</p>	<p>\$40 Copayment per Visit then 20% Coinsurance</p>	<p>50% Coinsurance</p>	<p>See Benefit For Description</p>
<p>Anesthesia Services (all settings)</p> <p>Preauthorization Required</p>	<p>N/A</p>	<p>N/A</p>	<p>20% Coinsurance</p>	<p>50% Coinsurance</p>	<p>See Benefit For Description</p>
<p>Cardiac & Pulmonary Rehabilitation</p> <ul style="list-style-type: none"> Performed in a Specialist Office Performed as Outpatient Hospital Services Performed as Inpatient Hospital Services 	<p>N/A</p> <p>N/A</p> <p>N/A</p>	<p>N/A</p> <p>N/A</p> <p>N/A</p>	<p>\$35 Copayment per Visit then 20% Coinsurance</p> <p>\$40 Copayment per Visit then 20% Coinsurance</p> <p>Included As Part of Inpatient Hospital Service Cost- Sharing</p>	<p>50% Coinsurance</p> <p>50% Coinsurance</p> <p>Included As Part of Inpatient Hospital Service Cost-Sharing</p>	<p>See Benefits For Description</p>
<p>Chemotherapy and Immunotherapy</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed as Outpatient Hospital Services <p>Preauthorization Required</p>	<p>N/A</p> <p>N/A</p> <p>N/A</p>	<p>N/A</p> <p>N/A</p> <p>N/A</p>	<p>20% Coinsurance</p> <p>20% Coinsurance</p> <p>\$40 Copayment per Visit then 20% Coinsurance</p>	<p>50% Coinsurance</p> <p>50% Coinsurance</p> <p>50% Coinsurance</p>	<p>See Benefit For Description</p>

Chiropractic Services Preauthorization Required	N/A	N/A	\$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance	See Benefit For Description
Clinical Trials	Use Cost- Sharing for appropriate service.	N/A	Use Cost- Sharing for appropriate service.	Use Cost- Sharing for appropriate service.	See Benefit For Description
Diagnostic Testing					See Benefit For Description
<ul style="list-style-type: none"> Performed in a PCP Office 	20% Coinsurance	N/A	20% Coinsurance	50% Coinsurance	
<ul style="list-style-type: none"> Performed in a Specialist Office 	20% Coinsurance	N/A	20% Coinsurance	50% Coinsurance	
<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	N/A	N/A	\$40 Copayment per Visit then 20% Coinsurance	50% Coinsurance	
Dialysis					See Benefit For Description
<ul style="list-style-type: none"> Performed in a PCP Office 	N/A	N/A	20% Coinsurance	50% Coinsurance	
<ul style="list-style-type: none"> Performed in a Specialist Office 	N/A	N/A	20% Coinsurance	50% Coinsurance	
<ul style="list-style-type: none"> Performed in a Freestanding Center 	N/A	N/A	20% Coinsurance	50% Coinsurance	
<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	N/A	N/A	\$40 Copayment per Visit then 20% Coinsurance	50% Coinsurance	
<ul style="list-style-type: none"> Performed at Home 	N/A	N/A	20% Coinsurance	50% Coinsurance	
Habilitation Services (Physical Therapy, Occupational Therapy)	\$20 Copayment per Visit	N/A	\$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance	60 visits per condition per Plan Year (combined therapies)

(Speech or Hearing Therapy)	N/A	N/A	\$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance	
Home Health Care	N/A	N/A	20% Coinsurance	20% Coinsurance	Unlimited Visits
Preauthorization Required					
Infertility Services	Use Cost Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	N/A	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					See Benefit For Description
<ul style="list-style-type: none"> Performed in a PCP Office 	\$20 Copayment per Visit then 20% Coinsurance	N/A	\$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance	
<ul style="list-style-type: none"> Performed in Specialist Office 	\$20 Copayment per Visit then 20% Coinsurance	N/A	\$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance	
<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	N/A	N/A	\$40 Copayment per Visit then 20% Coinsurance	50% Coinsurance	
<ul style="list-style-type: none"> Home Infusion Therapy 	N/A	N/A	20% Coinsurance	50% Coinsurance	
Inpatient Medical Visits	N/A	N/A	20% Coinsurance	50% Coinsurance	See Benefit For Description
Interruption of Pregnancy					See Benefit For Description
<ul style="list-style-type: none"> Abortion Services 	N/A	N/A	Covered in full	30% Coinsurance	
Laboratory Procedures					See Benefit For Description
<ul style="list-style-type: none"> Performed in a PCP Office 	20% Coinsurance	N/A	20% Coinsurance	50% Coinsurance	

<ul style="list-style-type: none"> Performed in a Specialist Office 	N/A	N/A	20% Coinsurance	50% Coinsurance	
<ul style="list-style-type: none"> Performed in a Freestanding Laboratory Facility 	N/A	N/A	20% Coinsurance	50% Coinsurance	
<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	N/A	N/A	\$40 Copayment per Visit then 20% Coinsurance	50% Coinsurance	
Maternity & Newborn Care					See Benefit For Description
<ul style="list-style-type: none"> Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA 	N/A	Covered in full	Covered in full	30% Coinsurance	
<ul style="list-style-type: none"> Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and 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)	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)	
<ul style="list-style-type: none"> Inpatient Hospital Services and Birthing Center 	N/A	Covered in full	20% Coinsurance	50% Coinsurance	One (1) home care visit is Covered at no Cost- Sharing if mother is discharged from Hospital early
<ul style="list-style-type: none"> Physician and Midwife Services for Delivery 	N/A	Covered in full	20% Coinsurance	50% Coinsurance	

<ul style="list-style-type: none"> Breastfeeding Support, Counseling and Supplies, Including Breast Pumps Postnatal Care <p>Preauthorization Required for Inpatient Services; Breast Pump</p>	N/A	N/A	Covered in full	30% Coinsurance	Covered for duration of breast feeding
<p>Outpatient Hospital Surgery Facility Charge</p> <p>Preauthorization; Required</p>	N/A	N/A	\$40 Copayment per Visit then 20% Coinsurance	50% Coinsurance	See Benefit For Description
Preadmission Testing	N/A	N/A	20% Coinsurance	50% Coinsurance	See Benefit For Description
<p>Prescription Drugs Administrated in Office or Outpatient Facilities</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in Specialist Office Performed in Outpatient Facilities 	20% Coinsurance	N/A	20% Coinsurance	50% Coinsurance	See Benefit For Description
<p>Diagnostic Radiology Services</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office 	20% Coinsurance	N/A	20% Coinsurance	50% Coinsurance	See Benefit For Description
<ul style="list-style-type: none"> Performed in a Specialist Office 	N/A	N/A	20% Coinsurance	50% Coinsurance	

<ul style="list-style-type: none"> Performed in a Freestanding Radiology Facility Performed as Outpatient Hospital Services <p>Preauthorization Required</p>	N/A	N/A	20% Coinsurance	50% Coinsurance	
<ul style="list-style-type: none"> Performed in a Specialist Office Performed in a Freestanding Radiology Facility Performed as Outpatient Hospital Services <p>Preauthorization Required</p>	N/A	N/A	20% Coinsurance	50% Coinsurance	See Benefit For Description
<p>Rehabilitation Services:</p> <p>(Physical Therapy, Occupational Therapy)</p> <p>(Speech or Hearing Therapy)</p>	\$20 Copayment per Visit	N/A	\$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance	60 visits per condition per Plan Year (combined therapies)
<p>Second Opinions on the Diagnosis of Cancer, Surgery & Other</p>	\$20 Copayment per Visit 20% Coinsurance	N/A	\$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance Second Opinions on Diagnosis of Cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained.	See Benefit For Description

<p>Surgical Services (Including Oral Surgery, Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants)</p> <ul style="list-style-type: none"> Inpatient Hospital Surgery Outpatient Hospital Surgery Surgery Performed at an Ambulatory Surgical Center Office Surgery <p>Preauthorization Required</p>	<p>N/A</p> <p>N/A</p> <p>N/A</p> <p>20% Coinsurance</p>	<p>N/A</p> <p>N/A</p> <p>N/A</p> <p>N/A</p>	<p>20% Coinsurance</p> <p>20% Coinsurance</p> <p>20% Coinsurance</p> <p>20% Coinsurance</p>	<p>50% Coinsurance</p> <p>50% Coinsurance</p> <p>50% Coinsurance</p> <p>50% Coinsurance</p>	<p>See Benefit For Description</p>
<p>ADDITIONAL SERVICES, EQUIPMENT & DEVICES</p>	<p>Student Health Center Responsibility for Cost-Sharing</p>	<p>Preferred Provider Responsibility for Cost-Sharing</p>	<p>In-Network Responsibility for Cost-Sharing</p>	<p>Out-of-Network Responsibility for Cost-Sharing</p>	<p>Limits</p>
<p>Diabetic Equipment, Supplies and Self-Management Education</p> <ul style="list-style-type: none"> Diabetic Equipment, Supplies and Insulin (30-Day Supply) Diabetic Education 	<p>\$20 Copayment per prescription or the Prescription Drug Cost-Sharing, whichever is less but not more than \$100 for a 30-day supply of insulin</p> <p>20% Coinsurance</p>	<p>N/A</p> <p>N/A</p>	<p>\$20 Copayment per prescription or the Prescription Drug Cost-Sharing, whichever is less but not more than \$100 for a 30-day supply of insulin</p> <p>20% Coinsurance</p>	<p>30% Coinsurance or the Prescription Drug Cost-Sharing, whichever is less but not more than \$100 for a 30-day supply of insulin</p> <p>50% Coinsurance</p>	<p>See Benefit For Description</p> <p>See Prescription Drug Benefit</p>
<p>Durable Medical Equipment & Braces</p>	<p>20% Coinsurance</p>	<p>N/A</p>	<p>20% Coinsurance</p>	<p>20% Coinsurance</p>	<p>See Benefit For Description</p>

External Hearing Aids	N/A	N/A	20% Coinsurance	20% Coinsurance	Single Purchase Once Every three (3) Years
Cochlear Implants Preauthorization Required	N/A	N/A	20% Coinsurance	50% Coinsurance	One (1) Per Ear Per Time Covered
Hospice Care • Inpatient Preauthorization Required • Outpatient	N/A N/A	N/A N/A	Covered in full Covered in full	Covered in full Covered in full	210 days per Plan Year Unlimited Visits for Family Bereavement Counseling
Medical Supplies	20% Coinsurance	N/A	20% Coinsurance	50% Coinsurance	See Benefit For Description
Prosthetic Devices • External • Internal	20% Coinsurance N/A	N/A N/A	20% Coinsurance 20% Coinsurance	20% Coinsurance 20% Coinsurance	One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements Unlimited; See Benefit For Description
INPATIENT SERVICES and FACILITIES	Student Health Center Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
Autologous Blood Banking	N/A	N/A	20% Coinsurance	50% Coinsurance	See Benefits For Description

Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, and 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.	N/A	N/A	20% Coinsurance	50% Coinsurance	See Benefit For Description
Observation Stay	N/A	N/A	20% Coinsurance	50% Coinsurance	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) Preauthorization Required	N/A	N/A	20% Coinsurance	50% Coinsurance	200 days per Plan Year
Inpatient Habilitation Services (Physical, Speech & Occupational therapy) Preauthorization Required	N/A	N/A	20% Coinsurance	50% Coinsurance	
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) Preauthorization Required	N/A	N/A	20% Coinsurance	50% Coinsurance	

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	Student Health Center Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
<p>Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment)</p> <p>Preauthorization Required. However, Preauthorization is not required for emergency admissions or for admissions at Participating OMH-licensed Facilities for Members under 18.</p>	N/A	Covered in full	20% Coinsurance	50% Coinsurance	See Benefit For Description
<p>Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)</p> <ul style="list-style-type: none"> • Office Visits • All Other Outpatient Services <p>Preauthorization Required for surgical services.</p>	<p>Use Cost-Sharing for appropriate service (For neuropsych testing only, Covered in full.)</p> <p>Use Cost-Sharing for appropriate service</p>	<p>\$5 Copayment per Visit (Copayment waived for neuropsych testing only.)</p> <p>N/A</p>	<p>20% Coinsurance (For neuropsych testing only, Covered in full.)</p> <p>20% Coinsurance</p>	<p>50% Coinsurance (For neuropsych testing only, Covered in full.)</p> <p>50% Coinsurance</p>	See Benefit For Description

ABA Treatment for Autism Spectrum Disorder	Covered in full	N/A	\$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance	See Benefit For Description
Assistive Communication Devices for Autism Spectrum Disorder	Covered in full	N/A	\$35 Copayment per Visit then 20% Coinsurance	50% Coinsurance	See Benefit For Description
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)	N/A	N/A	20% Coinsurance	50% Coinsurance	See Benefit For Description
Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions or for Participating OASAS-certified Facilities					
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)					Unlimited days per Plan Year may be Used For Family Counseling
<ul style="list-style-type: none"> Office Visits 	N/A	N/A	Covered in full	Covered in full	
<ul style="list-style-type: none"> All Other Outpatient Services 	N/A	N/A	Covered in full	Covered in full	
<ul style="list-style-type: none"> Opioid Treatment Programs 	N/A	N/A	Covered in full	Covered in full	

PRESCRIPTION DRUGS	Student Health Center Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	Limits
*Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF					
Retail Pharmacy					
30 Day Supply (except contraceptive drugs or devices)*					See Benefit For Description
Tier 1 (Including Enteral Formulas)	\$15 Copayment per prescription	N/A	\$15 Copayment per prescription	30% Coinsurance	
Tier 2 (Including Enteral Formulas)	\$40 Copayment per prescription	N/A	\$40 Copayment per prescription	30% Coinsurance	
Tier 3 (Including Enteral Formulas)	\$60 Copayment per prescription	N/A	\$60 Copayment per prescription	30% Coinsurance	
*Contraceptive Drugs or Devices: Up to a 90 Day Supply					
Tier 1	Covered in full	N/A	Covered in full	30% Coinsurance	
Tier 2	Covered in full	N/A	Covered in full	30% Coinsurance	
Tier 3	Covered in full	N/A	Covered in full	30% Coinsurance	
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.					

WELLNESS BENEFITS	Student Health Center Responsibility for Cost- Sharing	Preferred Provider Responsibility for Cost- Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	
Gym Reimbursement	N/A	N/A	Up to \$200 per six (6) month period; up to an additional \$100 per six (6) month period for Covered Dependents	Up to \$200 per six (6) month period; up to an additional \$100 per six (6) month period for Covered Dependents	Up to \$200 per six (6) month period; up to an additional \$100 per six (6) month period for Covered Dependents
DENTAL and ROUTINE VISION CARE	Student Health Center Responsibility for Cost-Sharing	Preferred Provider Responsibility for Cost-Sharing	In-Network Responsibility for Cost-Sharing	Out-of-Network Responsibility for Cost-Sharing	
Pediatric Dental Care (Members through the end of the month in which the Member turns 19 years of age)					
<ul style="list-style-type: none"> Preventive Dental Care 	N/A	N/A	\$40 Copayment per Visit then 20% Coinsurance	40% Coinsurance	Two (2) dental exams and cleanings per Plan Year
<ul style="list-style-type: none"> Routine Dental Care 	N/A	N/A	\$40 Copayment per Visit then 20% Coinsurance	40% Coinsurance	Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at six (6) - month intervals
<ul style="list-style-type: none"> Major Dental (Endodontics, Periodontics, Oral Surgery and Prosthodontics) 	N/A	N/A	\$40 Copayment per Visit then 20% Coinsurance	40% Coinsurance	
<ul style="list-style-type: none"> Orthodontia 	N/A	N/A	\$40 Copayment per Visit then 20% Coinsurance	40% Coinsurance	
Orthodontics and Major Dental Require Preauthorization; Referral					

Pediatric Vision Care (Members through the end of the month in which the Member turns 19 years of age):					
Exams	Covered in full	N/A	\$30 Copayment per Visit then 20% Coinsurance	40% Coinsurance	One (1) exam per Plan Year
Lenses and Frames	\$30 Copayment then 20% Coinsurance	N/A	\$50 Copayment then 20% Coinsurance	40% Coinsurance	One (1) prescribed lenses and frames per Plan Year
Contact Lenses	\$30 Copayment then 20% Coinsurance	N/A	\$50 Copayment then 20% Coinsurance	40% Coinsurance	
Contact Lenses Require Preauthorization					
Adult Vision Care (Members over age 18)					
Exams	\$20 Copayment per Visit	N/A	N/A	N/A	One (1) exam per Plan Year
Benefits Subject to Limits					
Emergency Medical Evacuation	0% coinsurance of Actual Cost				See Benefit for Description
Repatriation of Remains	0% coinsurance of Actual Cost				See Benefit for Description
Accidental Death and Dismemberment	N/A				See Benefit for Description

Section XXVIII

Accidental Death and Dismemberment

If, as the result of a covered Accident, You sustain any of the following losses, We will pay the benefit shown. The loss must occur within 90 days of the Accident.

	Percentage of Maximum Amount
Loss of Life	100%
Loss of Hand.....	50%
Loss of Foot.....	50%
Loss of either one hand, one foot or sight of one eye	50%
Loss of more than one of the above losses due to one Accident	100%

Accident means a sudden, unforeseeable external event which directly and from no other cause, results in loss of life, hand, foot or sight.

Loss of hand or foot means the complete severance through or above the wrist or ankle joint. Loss of eye means the total permanent loss of sight in the eye. The maximum amount is the largest amount payable under this benefit for all losses resulting from any one Accident.