SECTION XXVII • SCHEDULE OF BENEFITS
NEW YORK UNIVERSITY
COMPREHENSIVE PLAN
Metal Level: Platinum
Actuarial Value: 94.0%

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	$5,000 $10,000	$5,000 $10,000	$5,000 $10,000	$10,000 $20,000 See section IV of this Policy 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. The Member 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 $1,000,000 Annual Limit					
Repatriation of Remains $1,000,000 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	$30 Copayment per Visit then 10% Coinsurance	40% Coinsurance	See Benefit For Description
Specialist Office Visits (or Home Visits)	$20 Copayment per Visit	N/A	$30 Copayment per Visit then 10% Coinsurance	40% 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	
• Vasectomy					
Students	N/A	N/A	Covered in full	30% Coinsurance	
Dependents	N/A	N/A	Covered in full	30% Coinsurance	
• Bone Density Testing*					
Students	N/A	N/A	Covered in full	30% Coinsurance	
Dependents	N/A	N/A	Covered in full	30% Coinsurance	
• Screening for Prostate Cancer					
Students	Covered in full	N/A	Covered in full	30% Coinsurance	
Dependents	N/A	N/A	Covered in full	30% Coinsurance	
• All other preventive services required by USPSTF and HRSA.					
Students	Covered in full	N/A	Covered in full	30% Coinsurance	
Dependents	N/A	N/A	Covered in full	30% Coinsurance	

• *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	$100 Copayment per Visit then 10% Coinsurance Health care forensic examinations performed under Public Health Law § 2805-l are not subject to Cost-Sharing	$100 Copayment per Visit then 10% Coinsurance	See Benefit For Description
Urgent Care Center	N/A	N/A	$30 Copayment per Visit then 10% Coinsurance	40% 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

• Performed in a Specialist Office	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Performed in a Freestanding Radiology Facility	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Performed as Outpatient Hospital Services **Preauthorization Required**	N/A	N/A	$35 Copayment per Visit then 10% Coinsurance	40% Coinsurance	
Allergy Testing & Treatment					See Benefit For Description
• Performed in a PCP Office	10% Coinsurance	N/A	10% Coinsurance	40% Coinsurance	
• Performed in a Specialist Office	10% Coinsurance	N/A	10% Coinsurance	40% Coinsurance	
Ambulatory Surgical Center Facility Fee **Preauthorization Required**	N/A	N/A	$35 Copayment per Visit then 10% Coinsurance	40% Coinsurance	See Benefit For Description
Anesthesia Services (all settings) **Preauthorization Required**	N/A	N/A	10% Coinsurance	40% Coinsurance	See Benefit For Description
Autologous Blood Banking	N/A	N/A	10% Coinsurance	40% Coinsurance	See Benefit For Description
Cardiac & Pulmonary Rehabilitation					See Benefit For Description
• Performed in a Specialist Office	N/A	N/A	$30 Copayment per Visit then 10% Coinsurance	40% Coinsurance	
• Performed as Outpatient Hospital Services	N/A	N/A	$35 Copayment per Visit then 10% Coinsurance	40% Coinsurance	

• Performed as Inpatient Hospital Services	N/A	N/A	Included As Part of Inpatient Hospital Service Cost-Sharing	Included As Part of Inpatient Hospital Service Cost-Sharing	
Chemotherapy and Immunotherapy					See Benefit For Description
• Performed in a PCP Office	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Performed in a Specialist Office	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Performed as Outpatient Hospital Services	N/A	N/A	$35 Copayment per Visit then 10% Coinsurance	40% Coinsurance	
Preauthorization Required					
Chiropractic Services **Preauthorization Required**	N/A	N/A	$30 Copayment per Visit then 10% Coinsurance	40% 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
• Performed in a PCP Office	10% Coinsurance	N/A	10% Coinsurance	40% Coinsurance	
• Performed in a Specialist Office	10% Coinsurance	N/A	10% Coinsurance	40% Coinsurance	
• Performed as Outpatient Hospital Services	N/A	N/A	$35 Copayment per Visit then 10% Coinsurance	40% Coinsurance	
Dialysis					See Benefit For Description
• Performed in a PCP Office	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Performed in a Specialist Office	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Performed in a Freestanding Center	N/A	N/A	10% Coinsurance	40% Coinsurance	

• Performed as Outpatient Hospital Services	N/A	N/A	$35 Copayment per Visit then 10% Coinsurance	40% Coinsurance	
• Performed at Home	N/A	N/A	10% Coinsurance	40% Coinsurance	
Habilitation Services (Physical Therapy, Occupational Therapy)	$20 Copayment per Visit	N/A	$30 Copayment per Visit then 10% Coinsurance	40% Coinsurance	60 visits per condition per Plan Year (combined therapies)
(Speech or Hearing Therapy)	N/A	N/A	$30 Copayment per Visit then 10% Coinsurance	40% Coinsurance	
Home Health Care **Preauthorization Required**	N/A	N/A	10% Coinsurance	10% Coinsurance	40 Visits per Plan Year
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 • Performed in a PCP Office	$20 Copayment per Visit then 10% Coinsurance	N/A	$30 Copayment per Visit then 10% Coinsurance	40% Coinsurance	See Benefit For Description
• Performed in Specialist Office	$20 Copayment per Visit then 10% Coinsurance	N/A	$30 Copayment per Visit then 10% Coinsurance	40% Coinsurance	
• Performed as Outpatient Hospital Services	N/A	N/A	$35 Copayment per Visit then 10% Coinsurance	40% Coinsurance	Home infusion counts toward home health care visit limits
• Home Infusion Therapy	N/A	N/A	10% Coinsurance	40% Coinsurance	
Inpatient Medical Visits	N/A	N/A	10% Coinsurance	40% Coinsurance	See Benefit For Description

Interruption of Pregnancy • Medically Necessary Abortions	N/A	N/A	Covered in full	30% Coinsurance	Unlimited
• Elective Abortions	N/A	N/A	10% Coinsurance	40% Coinsurance	One (1) procedure per Plan Year
Laboratory Procedures • Performed in a PCP Office	10% Coinsurance	N/A	10% Coinsurance	40% Coinsurance	See Benefit For Description
• Performed in a Specialist Office	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Performed in a Freestanding Laboratory Facility	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Performed as Outpatient Hospital Services	N/A	N/A	$35 Copayment per Visit then 10% Coinsurance	40% Coinsurance	
Maternity & Newborn Care • Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	N/A	Covered in full	Covered in full	30% Coinsurance	See Benefit For Description
• 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)	

• Inpatient Hospital Services and Birthing Center	N/A	Covered in full	10% Coinsurance	40% Coinsurance	One (1) home care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
• Physician and Midwife Services for Delivery	N/A	Covered in full	10% Coinsurance	40% Coinsurance	
• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps	N/A	N/A	Covered in full	30% Coinsurance	Covered for duration of breast feeding
• Postnatal Care **Preauthorization Required for Inpatient Services; Breast Pump**	N/A	Covered in full	10% Coinsurance	40% Coinsurance	
Outpatient Hospital Surgery Facility Charge **Preauthorization Required**	N/A	N/A	$35 Copayment per Visit then 10% Coinsurance	40% Coinsurance	See Benefit For Description
Preadmission Testing	N/A	N/A	10% Coinsurance	40% Coinsurance	See Benefit For Description
Prescription Drugs Administrated in Office or Outpatient Facilities					See Benefit For Description
• Performed in a PCP Office	10% Coinsurance	N/A	10% Coinsurance	40% Coinsurance	
• Performed in Specialist Office	10% Coinsurance	N/A	10% Coinsurance	40% Coinsurance	
• Performed in Outpatient Facilities	N/A	N/A	10% Coinsurance	40% Coinsurance	

Diagnostic Radiology Services • Performed in a PCP Office	10% Coinsurance	N/A	10% Coinsurance	40% Coinsurance	See Benefit For Description
• Performed in a Specialist Office	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Performed in a Freestanding Radiology Facility	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Performed as Outpatient Hospital Services **Preauthorization Required**	N/A	N/A	$35 Copayment per Visit then 10% Coinsurance	40% Coinsurance	
Therapeutic Radiology Services • Performed in a Specialist Office	N/A	N/A	10% Coinsurance	40% Coinsurance	See Benefit For Description
• Performed in a Freestanding Radiology Facility	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Performed as Outpatient Hospital Services **Preauthorization Required**	N/A	N/A	$35 Copayment per Visit then 10% Coinsurance	40% Coinsurance	
Rehabilitation Services: (Physical Therapy, Occupational Therapy)	$20 Copayment per Visit	N/A	$30 Copayment per Visit then 10% Coinsurance	40% Coinsurance	60 visits per condition per Plan Year (combined therapies)
(Speech or Hearing Therapy)	N/A	N/A	$30 Copayment per Visit then 10% Coinsurance	40% Coinsurance	

Second Opinions on the Diagnosis of Cancer, Surgery & Other	$20 Copayment per Visit then 10% Coinsurance	N/A	$30 Copayment per Visit then 10% Coinsurance	40% 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
Surgical Services (Including Oral Surgery, Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants)					See Benefit For Description
• Inpatient Hospital Surgery	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Outpatient Hospital Surgery	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Surgery Performed at an Ambulatory Surgical Center	N/A	N/A	10% Coinsurance	40% Coinsurance	
• Office Surgery	10% Coinsurance	N/A	10% Coinsurance	40% Coinsurance	
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**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**
ABA Treatment for Autism Spectrum Disorder	Covered in full	N/A	$30 Copayment per Visit then 10% Coinsurance	40% Coinsurance	See Benefit For Description
Assistive Communication Devices for Autism Spectrum Disorder	Covered in full	N/A	$30 Copayment per Visit then 10% Coinsurance	40% Coinsurance	See Benefit For Description
Diabetic Equipment, Supplies and Self-Management Education					See Benefit For Description

• Diabetic Equipment, Supplies and Insulin (30-Day Supply)	$20 Copayment per prescription but not more than $100 in Cost-Sharing for a 30-day supply for an insulin drug	N/A	$20 Copayment per prescription but not more than $100 in Cost-Sharing for a 30-day supply for an insulin drug	30% Coinsurance but not more than $100 in Cost-Sharing for a 30-day supply for an insulin drug	See Prescription Drug Benefit.
• Diabetic Education	10% Coinsurance	N/A	10% Coinsurance	40% Coinsurance	
Durable Medical Equipment & Braces	10% Coinsurance	N/A	10% Coinsurance	10% Coinsurance	See Benefit For Description
External Hearing Aids	N/A	N/A	10% Coinsurance	10% Coinsurance	Single Purchase Once Every three (3) Years
Cochlear Implants **Preauthorization Required**	N/A	N/A	10% Coinsurance	40% Coinsurance	One (1) Per Ear Per Time Covered
Hospice Care					
• Inpatient **Preauthorization Required**	N/A	N/A	Covered in full	Covered in full	210 days per Plan Year
Outpatient	N/A	N/A	Covered in full	Covered in full	Five (5) Visits for Family Bereave-ment Counseling
Medical Supplies	10% Coinsurance	N/A	10% Coinsurance	40% Coinsurance	See Benefit For Description
Prosthetic Devices					
• External	10% Coinsurance	N/A	10% Coinsurance	10% Coinsurance	One (1) prosthetic device, per limb, per lifetime

Internal	N/A	N/A	10% Coinsurance	10% Coinsurance	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**
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	10% Coinsurance	40% Coinsurance	See Benefit For Description
Observation Stay	N/A	N/A	10% Coinsurance	40% Coinsurance	See Benefit For Description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) **Preauthorization Required**	N/A	N/A	10% Coinsurance	40% Coinsurance	200 days per Plan Year
Inpatient Habilitation Services (Physical, Speech & Occupational therapy) **Preauthorization Required**	N/A	N/A	10% Coinsurance	40% Coinsurance	

Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) **Preauthorization Required**	N/A	N/A	10% Coinsurance	40% 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**
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment) **Preauthorization Required. However, Preauthorization is not required for emergency admissions or for admissions at Participating OMH-licensed Facilities for Members under 18.**	N/A	Covered in full	10% Coinsurance	40% Coinsurance	See Benefit For Description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services) • Office Visits	Use Cost-Sharing for appropriate service (For neuropsych testing only, Covered in full.)	$5 Copayment per Visit (Copayment waived for neuropsych testing only.)	10% Coinsurance (For neuropsych testing only, Covered in full.)	40% Coinsurance (For neuropsych testing only, Covered in full)	See Benefit For Description

• All Other Outpatient Services **Preauthorization Required for partial hospitalization program services, intensive outpatient program services, ambulatory surgical center facility fee, and outpatient hospital surgery facility charge.**	Use Cost-Sharing for appropriate service	N/A	10% Coinsurance	40% Coinsurance	
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 OASAS-certified Facilities.**	N/A	N/A	10% Coinsurance	40% Coinsurance	See Benefit For Description
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)					Up to 20 visits a Plan Year may be Used For Family Counseling
• Office Visits	N/A	N/A	Covered in full	Covered in full	

• All Other Outpatient Services **Preauthorization Required for partial hospitalization program services and intensive outpatient program services. However, Preauthorization is not required for Participating OASAS-certified Facilities.**	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 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.	Covered in full	N/A	Covered in full	30% Coinsurance	
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**	**Limits**
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**	**Limits**
Pediatric Dental Care (Members through the end of the month in which the Member turns 19 years of age) • Preventive Dental Care	N/A	N/A	$40 Copayment per Visit then 20% Coinsurance	40% Coinsurance	One (1) dental exam and cleaning per six (6)-month period Full mouth x-rays or panoramic x-rays at

• Routine Dental Care	N/A	N/A	$40 Copayment per Visit then 20% Coinsurance	40% Coinsurance	36 month intervals and bitewing x-rays at six (6) month intervals
• Major Dental (Endodontics, Periodontics. Oral Surgery and Prosthodontics)	N/A	N/A	$40 Copayment per Visit then 20% Coinsurance	40% Coinsurance	
• Orthodontia **Orthodontics and Major Dental Require Preauthorization; Referral**	N/A	N/A	$40 Copayment per Visit then 20% Coinsurance	40% Coinsurance	
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 **Contact Lenses Require Preauthorization**	$30 Copayment then 20% Coinsurance	N/A	$50 Copayment then 20% Coinsurance	40% Coinsurance	
Adult Vision Care (Members over age 18)					One (1) exam per Plan Yea
Exams	$20 Copayment per Visit	N/A	Not Covered	Not Covered	

Benefits Subject to Limits					
Emergency Medical Evacuation	N/A				See Benefit for Description
Repatriation of Remains	N/A				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.