SECTION [XXVIII]

*{Drafting Note: Insert the appropriate section number,*

*following the order of provisions in the Table of Contents.}*

[insert health plan name] SCHEDULE OF BENEFITS

[Metal Level]

[Name of College; University]

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **COST-SHARING**  **[Medical] Deductible**   * Individual * Family   **[Prescription Drug Deductible**   * Individual * Family]   **Out-of-Pocket Limit**   * Individual * [Per Person in a Family] * Family   *{Drafting Note: Insert “per person in a family” when a plan embeds an amount other than the individual out-of-pocket limit paragraph in the Cost-Sharing and Allowed Amount section for a full explanation.}*  **[First Dollar Allowance**   * Individual * Family]   **[Benefits Subject to [Annual; Lifetime; Annual and Lifetime] Limits Maximum**  **[Accidental Death and Dismemberment [[Annual; Lifetime; Annual and Lifetime] Maximum]** | **[[Student Health Services; Student Health Center; Preferred Provider] Member Responsibility for Cost-Sharing]**  [None; [$ ]]  [None; [$ ]]  [$ ]  [$ ]  [$ ]  [$ ]  [$ ]  [$ ]  [$ ]  [$ ]  [$ ] | **Participating Provider**  **Member Responsibility for Cost-Sharing**  [None; [$ ]]  [None; [$ ]]  [$ ]  [$ ]  [$ ]  [$ ]  [$ ]  [$ ]  [$ ]  [$ ]  [$ ] | **Non-Participating Provider**  **Member Responsibility for Cost-Sharing**  [None; [$ ]]  [None; [$ ]]  [$ ]  [$ ]  [$ ]  [$ ]  [$ ]  [$ ]  [$ ]  [$ ]  [$ ]  [The Allowed Amount is [XXX]]  [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.] [Non-Participating Provider services are not covered except as required for emergency care [and Urgent Care].] |  |
| **OFFICE VISITS** | **[[Student Health Services; Student Health Center; Preferred Provider] Member Responsibility for Cost-Sharing]** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| Primary Care Office Visits  (or Home Visits) | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [after [$; [XX] visit[s]] for [Primary Care; Office Visit] Allowance]  [in Office]  [by Telehealth] | [Covered in full]  [$ Copayment] [with Referral; without Referral]  [% Coinsurance] [with Referral; without Referral] [[after; not subject to] Deductible]  [after [$; [XX] visit[s]] for [Primary Care; Office Visit] Allowance]  [in Office]  [by Telehealth] | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [in Office]  [by Telehealth]  [Non-Participating Provider services are not covered and You pay the full cost] | See benefit for description |
| Specialist Office Visits  (or Home Visits)  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [after [$; [XX] visit[s]] for [Specialist Care; Office Visit] Allowance]  [in Office]  [by Telehealth]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment] [with Referral] [without Referral]  [% Coinsurance] [with Referral] [without Referral] [[after; not subject to] Deductible]  [after [$; [XX] visit[s]] for [Specialist Care; Office Visit] Allowance]  [in Office]  [by Telehealth]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [in Office]  [by Telehealth]  [[after; not subject to] Deductible] [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | See benefit for description |
| **PREVENTIVE CARE** | **[[Student Health Services; Student Health Center; Preferred Provider] Member Responsibility for Cost-Sharing]** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| * Well Child Visits and Immunizations\* * Adult Annual Physical   Examinations\*   * Adult Immunizations\* * Routine Gynecological Services/Well Woman Exams\* * Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer * Sterilization Procedures for Women\* * Vasectomy * Bone Density Testing\* * Screening for Prostate Cancer * Colon Cancer Screening\* * All other preventive services required by USPSTF and HRSA. * \*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.   **[Referral Required]** | [Covered in full]  [Covered in full]  [Covered in full]  [Covered in full]  [Covered in full]  [Covered in full]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [See Surgical Services Cost-Sharing]  [Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Fee; Outpatient Hospital Surgery Facility Charge)]  [Covered in full]  [Covered in full]  [Covered in full]  [Covered in full]  [Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)]  **[Referral Required]** | Covered in full  Covered in full  Covered in full  Covered in full  Covered in full  Covered in full  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [See Surgical Services Cost-Sharing]  [Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge)]  Covered in full  Covered in full  Covered in full  Covered in full  Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)  **[Referral Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible] [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  See Surgical Services Cost-Sharing]  [Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge)]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)  [Non-Participating Provider services are not covered and You pay the full cost]  **[Referral Required]** | See benefit for description |
| **EMERGENCY CARE** | **[[Student Health Services; Student Health Center; Preferred Provider] Member Responsibility for Cost-Sharing]** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| Pre-Hospital Emergency Medical Services  (Ambulance Services) | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible] | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible] | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible] | See benefit for description |
| Non-Emergency Ambulance Services  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | See benefit for description |
| Emergency Department  [[Copayment] [/] [Coinsurance] waived if admitted to Hospital] | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  Health care forensic examinations performed under Public Health Law § 2805-I are not subject to [Cost-Sharing; Copayment; Coinsurance] | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  Health care forensic examinations performed under Public Health Law § 2805-I are not subject to [Cost-Sharing; Copayment; Coinsurance] | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible  [Health care forensic examinations performed under Public Health Law § 2805-i are not subject to [Cost-Sharing; Copayment; Coinsurance]] | See benefit for description |
| Urgent Care Center  **[Preauthorization Required for Out-of-Network Urgent Care;**  **Referral Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [[X] visits [$ Copayment; % Coinsurance; Covered in Full]] [[after; not subject to] Deductible]; additional visits [$ Copayment; % Coinsurance] [[after; not subject to Deductible]]  [in Office]  [by Telehealth]  **[Preauthorization Required for Out-of-Network Urgent Care;**  **Referral Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [[X] visits [$ Copayment; % Coinsurance; Covered in Full]] [[after; not subject to] Deductible]; additional visits [$ Copayment; % Coinsurance] [[after; not subject to Deductible]]  [in Office]  [by Telehealth]  **[Preauthorization Required for Out-of-Network Urgent Care;**  **Referral Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [[X] visits [$ Copayment; % Coinsurance; Covered in Full]] [[after; not subject to] Deductible]; additional visits [$ Copayment; % Coinsurance] [[after; not subject to Deductible]]  [in Office]  [by Telehealth]  [Non-Participating Provider services are not covered and You pay the full cost]  **[Preauthorization Required for Out-of-Network Urgent Care;**  **Referral Required]** | See benefit for description |
| **PROFESSIONAL SERVICES and OUTPATIENT CARE** | **[[Student Health Services; Student Health Center; Preferred Provider] Member Responsibility for Cost-Sharing]** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| [Acupuncture]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance}  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance}  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance}  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and  You pay the full cost]  **[[Preauthorization; Referral] Required]** | [See benefit for description]  [[XX] visits [per condition,] per Plan Year]] |
| Advanced Imaging Services   * Performed in a Specialist Office * Performed in a Freestanding Radiology Facility * Performed as Outpatient Hospital Services     **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | See benefit for description |
| Allergy Testing and Treatment   * Performed in a PCP Office * Performed in a Specialist Office   **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | See benefit for description |
| Ambulatory Surgical Center Facility Fee  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | See benefit for description |
| Anesthesia Services  (all settings)  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | See benefit for description |
| Cardiac and Pulmonary Rehabilitation   * Performed in a Specialist Office * Performed as Outpatient Hospital Services * Performed as Inpatient Hospital Services   **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [Included as part of inpatient Hospital service Cost-Sharing]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [Included as part of inpatient Hospital service Cost-Sharing]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [Included as part of inpatient Hospital service Cost-Sharing]  **[[Preauthorization; Referral] Required]** | See benefit for description |
| Chemotherapy and Immunotherapy   * [Administration] * Performed in a PCP Office * Performed in a Specialist Office      * Performed as Outpatient Hospital Services * [Performed at Home] * [Chemotherapy and Immunotherapy Medications]   **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | See benefit for description |
| Chiropractic Services  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | See benefit for description |
| Clinical Trials    **[[Preauthorization; Referral] Required]** | Use Cost-Sharing for appropriate service  **[[Preauthorization; Referral] Required]** | Use Cost-Sharing for appropriate service  **[[Preauthorization; Referral] Required]** | Use Cost-Sharing for appropriate service  **[[Preauthorization; Referral] Required]** | See benefit for description |
| Diagnostic Testing   * Performed in a PCP Office * Performed in a Specialist Office * Performed as Outpatient Hospital Services   **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]    [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | See benefit for description |
| Dialysis   * Performed in a PCP Office * Performed in a Specialist Office * Performed in a Freestanding Center * Performed as Outpatient Hospital Services * [Performed at Home]   **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | [See benefit for description]  [Dialysis performed by Non-Participating Providers is limited to [10] visits per calendar year. Cost-Sharing for the visits is the same as for a Participating Provider. See benefit description for more information.]] |
| Habilitation Services  (Physical Therapy, Occupational Therapy or Speech Therapy)   * [Performed in a PCP Office] * [Performed in a Specialist Office] * [Performed in an Outpatient Facility]   **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | [60 visits per condition, per Plan Year combined therapies] |
| Home Health Care  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | [[40] visits per Plan Year] |
| Infertility Services    **[[Preauthorization; Referral] Required]** | [Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)]  **[[Preauthorization; Referral] Required]** | Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)  **[[Preauthorization; Referral] Required]** | Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | See benefit for description |
| Infusion Therapy   * [Administration] * Performed in a PCP Office * Performed in Specialist Office * Performed as Outpatient Hospital Services * Home Infusion Therapy * [Infusion Therapy Medication]   **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | See benefit for description  [Home infusion counts toward home health care visit limits] |
| Inpatient Medical Visits  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | See benefit for description |
| Interruption of Pregnancy   * Abortions Services | [Covered in full]  [[after; not subject to] Deductible] | Covered in full  [[after; not subject to] Deductible] | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost] | See benefit for description |
| Laboratory Procedures   * Performed in a PCP Office      * Performed in a Specialist Office * Performed in a Freestanding Laboratory Facility * Performed as Outpatient Hospital Services   **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | See benefit for description |
| Maternity and Newborn Care     * Prenatal Care * Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA * Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA * Inpatient Hospital Services and Birthing Center * Physician and Midwife Services for Delivery * Breastfeeding Support, Counseling and Supplies, Including Breast Pumps * Postnatal Care   **[Preauthorization Required] [for Inpatient Services; Breast Pump]** | [Covered in full]  [Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit; Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)]  [Covered in full]  [$ Copayment]  [% Coinsurance] [per admission]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance] [per admission]  [[after; not subject to] Deductible]  [Covered in full]    [Covered in full]  [$ Copayment]  [% Coinsurance] [per admission]  [[after; not subject to] Deductible]  [Included in Physician and Midwife Services for Delivery Cost-Sharing]  **[Preauthorization Required] [for Inpatient Services; Breast Pump]** | Covered in full  Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)  [Covered in full]  [$ Copayment]  [% Coinsurance] [per admission]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance] [per admission]  [[after; not subject to] Deductible]  Covered in full    [Covered in full]  [$ Copayment]  [% Coinsurance] [per admission]  [[after; not subject to] Deductible]  [Included in Physician and Midwife Services for Delivery Cost-Sharing]  **[Preauthorization Required] [for Inpatient Services; Breast Pump]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [Included in Physician and Midwife Services for Delivery Cost-Sharing]  **[Preauthorization Required] [for Inpatient Services; Breast Pump]** | See benefit for description  [One (1)] home care visit[s] is covered at no Cost-Sharing if mother is discharged from Hospital early  Covered for duration of breast feeding |
| Outpatient Hospital Surgery Facility Charge  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | See benefit for description |
| Preadmission Testing  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Use Cost-Sharing for appropriate service (Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Use Cost-Sharing for appropriate service (Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [Use Cost-Sharing for appropriate service (Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)]  **[[Preauthorization; Referral] Required]** | See benefit for description |
| Prescription Drugs Administered in Office [or Outpatient Facilities]   * [Administration] * Performed in a PCP Office * Performed in Specialist Office * [Performed in Outpatient Facilities] * [Prescription Drug Cost-Sharing]   **[[Preauthorization; Referral] required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Included as part of the PCP office visit Cost-Sharing]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Included as part of the Specialist office visit Cost-Sharing]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible] [Included as part of the [PCP] [or] [Specialist] office visit Cost-Sharing] | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Included as part of the PCP office visit Cost-Sharing]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Included as part of the Specialist office visit Cost-Sharing]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible] [Included as part of the [PCP] [or] [Specialist] office visit Cost-Sharing] | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Included as part of the PCP office visit Cost-Sharing]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Included as part of the Specialist office visit Cost-Sharing]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost] | See benefit for description |
| Diagnostic Radiology Services   * Performed in a PCP Office * Performed in a Specialist Office * Performed in a Freestanding Radiology Facility * Performed as Outpatient Hospital Services   **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | See benefit for description |
| Therapeutic Radiology Services   * Performed in a Specialist Office * Performed in a Freestanding Radiology Facility * Performed as Outpatient Hospital Services   **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]    [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]    [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | See benefit for description |
| Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)   * [Performed in a PCP Office] * [Performed in a Specialist Office] * [Performed in an Outpatient Facility]   **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | [60 visits per condition, per Plan Year combined therapies] [Speech and physical therapy are only Covered following a Hospital stay or surgery] |
| [Retail Health Clinic Care]  **[[Preauthorization; Referral] required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] required]** | [See benefit for description] |
| Second Opinions on the Diagnosis of Cancer,  Surgery and Other  **[[Preauthorization; Referral] Required]]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist [when a Referral is obtained].  **[[Preauthorization; Referral] Required]** | See benefit for description |
| Surgical Services  (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants)   * Inpatient Hospital Surgery * Outpatient Hospital Surgery * Surgery Performed at an Ambulatory Surgical Center * Office Surgery   **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]    [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | See benefit for description  **[All transplants must be performed at designated Facilities]** |
| [Telemedicine Program] | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible] | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible] | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not Covered an You pay the full cost] | [See benefit for description] |
| **ADDITIONAL SERVICES, EQUIPMENT and DEVICES** | **[[Student Health Services; Student Health center; Preferred Provider] Member Responsibility for Cost-Sharing]** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| Diabetic Equipment, Supplies and Self-Management Education   * [Retail] Diabetic Equipment, [and] Supplies [and Insulin]   ([30-day; Up to a 90-day] supply)   * [Diabetic Insulin (30-day supply)] * [Oral anti-diabetic agents and injectable anti-diabetic agents (30-day supply)] * [Mail Order Diabetic Equipment, Supplies and Insulin (90-day supply)] * Diabetic Education   **[[Preauthorization; Referral] Required][for Insulin Pump]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [[See; or] the Prescription Drug Cost-Sharing[, whichever is less]]  [but not more than $100 for a 30-day supply of insulin.]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [[See; or] the Prescription Drug Cost-Sharing[, whichever is less]]  [but not more than $100 for a 30-day supply of insulin.]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [[See; or] the Prescription Drug Cost-Sharing[, whichever is less]]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [[See; or] the Prescription Drug Cost-Sharing[, whichever is less]]  [but not more than $100 for a 30-day supply of insulin.]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [[See; or] the Prescription Drug Cost-Sharing[, whichever is less]]  [but not more than $100 for a 30-day supply of insulin.]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [[See; or] the Prescription Drug Cost-Sharing[, whichever is less]]  [but not more than $100 for a 30-day supply of insulin.]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [[See; or] the Prescription Drug Cost-Sharing[, whichever is less]]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [[See; or] the Prescription Drug Cost-Sharing[, whichever is less]]  [but not more than $100 for a 30-day supply of insulin.]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [[See; or] the Prescription Drug Cost-Sharing[, whichever is less]]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [[See; or] the Prescription Drug Cost-Sharing[, whichever is less]]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [[See; or] the Prescription Drug Cost-Sharing[, whichever is less]]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [[See; or] the Prescription Drug Cost-Sharing[, whichever is less]]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | See benefit for description  [See Prescription Drug benefit] |
| Durable Medical Equipment and Braces  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | See benefit for description |
| External Hearing Aids   * Prescription Hearing Aids * [Over-the-Counter Hearing Aids]   **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | [Single purchase once every three (3) years] |
| Cochlear Implants  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing]  [Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing]  [Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing]  [Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | [One (1) per ear per time Covered] |
| Hospice Care   * Inpatient * Outpatient   **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance] [per admission]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance] [per admission]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance] per admission  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | [[210] days per Plan Year]  [Five (5)] visits for family bereavement counseling |
| Medical Supplies  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | See benefit for description |
| Prosthetic Devices   * External * Internal   **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Included as part of inpatient Hospital Cost-Sharing]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Included as part of inpatient Hospital Cost-Sharing]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Included as part of inpatient Hospital Cost-Sharing]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | [One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements]  Unlimited;  See benefit for description |
| [Shoe Inserts]  **[[Preauthorization; Referral] required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider Services are not Covered and You pay the full cost]  **[[Preauthorization; Referral] required]** | [See benefit for description] |
| **INPATIENT SERVICES and FACILITIES** | **[[Student Health Services; Student Health Center; Preferred Provider] Member Responsibility for Cost-Sharing]** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| Autologous Blood Banking  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | See benefit for description |
| Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)  **[[Preauthorization; Referral] 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.]]** | [Covered in full]  [$ Copayment]  [% Coinsurance] [per admission]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] 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.]]** | [Covered in full]  [$ Copayment]  [% Coinsurance] [per admission]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] 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.]]** | [$ Copayment]  [% Coinsurance] [per admission]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] 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.]]** | See benefit for description |
| Observation Stay | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible] | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible] | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost] | See benefit for description |
| Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance] [per admission]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance] [per admission]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance] [per admission]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | [[200] days per Plan Year] |
| Inpatient Habilitation Services (Physical Speech and Occupational Therapy)  **[[Preauthorization; Referral] required]** | [Covered in full]  [$ Copayment]  [% Coinsurance][per admission]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] required]** | [Covered in full]  [$ Copayment]  [% Coinsurance] [per admission]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] required]** | [$ Copayment]  [% Coinsurance][per admission]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not Covered and You pay the full cost]  **[Preauthorization; Referral] required]** | [60 days per Plan Year combined therapies] |
| Inpatient Rehabilitation Services  (Physical, Speech and Occupational Therapy)  **[[Preauthorization; Referral] Required]** | [Covered in full] [$ Copayment]  [% Coinsurance] [per admission]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance] [per admission]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance] [per admission]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | [60 days per Plan Year combined therapies]  [Speech and physical therapy are only Covered following a Hospital stay or surgery] |
| **MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES** | **[[Student Health Services; Student Health Center; Preferred Provider] Member Responsibility for Cost-Sharing]** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment)  **[[Preauthorization; Referral] Required. However, Preauthorization is not required for emergency admissions or for admissions at Participating OMH-licensed Facilities for Members under 18.]** | [Covered in full]  [$ Copayment]  [% Coinsurance] [per admission]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required. However, Preauthorization is not required for emergency admissions or for admissions at Participating OMH-licensed Facilities for Members under 18.].]]** | [Covered in full]  [$ Copayment]  [% Coinsurance] [per admission]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required. However, Preauthorization is not required for emergency admissions or for admissions at Participating OMH-licensed Facilities for Members under 18.].]]** | [$ Copayment]  [% Coinsurance] [per admission]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required. However, Preauthorization is not required for emergency admissions or for admissions].]]** | See benefit for description |
| Outpatient Mental Health Care  (including Partial Hospitalization and Intensive Outpatient Program Services)   * [Office Visits] * [All Other Outpatient Services] * [Outpatient Services provided in a Facility licensed, certified, or otherwise authorized by OMH] * [All Other Outpatient Services]   **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [after [$; [XX] visit[s]] for [Primary Care; Office Visit] Allowance]  [in Office]  [by Telehealth  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [in Office]  [by Telehealth]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [in Office]  [by Telehealth]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [after [$; [XX] visit[s]] for [Primary Care; Office Visit] Allowance]  [in Office]  [by Telehealth  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [in Office]  [by Telehealth]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [in Office]  [by Telehealth]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [in Office]  [by Telehealth  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [in Office]  [by Telehealth]  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [in Office]  [by Telehealth]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | See benefit for description |
| ABA Treatment for Autism Spectrum Disorder  **[[Preauthorization; Referral] required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [in Office]  [by Telehealth]  **[[Preauthorization; Referral] required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [in Office]  [by Telehealth]  **[[Preauthorization; Referral] required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [in Office]  [by Telehealth]  [Non-Participating Provider services are not Covered and You pay the full cost]  **[[Preauthorization; Referral] required]** | See benefit for description |
| Assistive Communication Devices for Autism Spectrum Disorder  **[[Preauthorization; Referral] required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [in Office]  [by Telehealth]  **[[Preauthorization; Referral] required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [in Office]  [by Telehealth]  **[[Preauthorization; Referral] required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [in Office]  [by Telehealth]  [Non-Participating Provider services are not Covered and You pay the full cost]  **[[Preauthorization; Referral] required]** | See benefit for description |
| Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)  **[[Preauthorization; Referral] Required. However, Preauthorization is Not Required for Emergency Admissions or for Participating OASAS-certified Facilities.]** | [Covered in full]  [$ Copayment]  [% Coinsurance] [per admission]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required. However, Preauthorization is Not Required for Emergency Admissions or for Participating OASAS-certified Facilities.]** | [Covered in full]  [$ Copayment]  [% Coinsurance] [per admission]  [[after; not subject to] Deductible]  **[[Preauthorization; Referral] Required. However, Preauthorization is Not Required for Emergency Admissions or for Participating OASAS-certified Facilities.]** | [$ Copayment]  [% Coinsurance] [per admission]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required. However, Preauthorization is Not Required for Emergency Admissions.]** | See benefit for description |
| Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)   * [Office Visits] * [All Other Outpatient Services] * [Opioid Treatment Programs] * [All Other Outpatient Services]   **[[Preauthorization; Referral] Required. However, Preauthorization is not required for Participating OASAS-certified Facilities.]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [after [$; [XX] visit[s]] for [Primary Care; Office Visit] Allowance]  [in Office]  [by Telehealth  [Covered in full]  [$0 Copayment]  [0% Coinsurance]  [[after; not subject to] Deductible]  [in Office]  [by Telehealth]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [in Office]  [by Telehealth]  **[[Preauthorization; Referral] Required]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [after [$; [XX] visit[s]] for [Primary Care; Office Visit] Allowance]  [in Office]  [by Telehealth  [Covered in full]  [$0 Copayment]  [0% Coinsurance]  [[after; not subject to] Deductible]  [in Office]  [by Telehealth]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [in Office]  [by Telehealth]  **[[Preauthorization; Referral] Required]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [in Office]  [by Telehealth  [Non-Participating Provider services are not covered and You pay the full cost]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not Covered and You pay the full cost]  [in Office]  [by Telehealth]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [in Office]  [by Telehealth]  [Non-Participating Provider services are not covered and You pay the full cost]  **[[Preauthorization; Referral] Required]** | Unlimited; Up to [20] visits per Plan Year may be used for family counseling |
| **PRESCRIPTION DRUGS**  **\***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 [and obtained at a participating pharmacy] | **[[Student Health Services; Student Health Center; Preferred Provider] Member Responsibility for Cost-Sharing]** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| **Retail Pharmacy** |  |  |  |  |
| 30-day supply  [Tier 1  Tier 2  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]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [The Deductible does not apply to preventive Prescription Drugs used to manage [asthma, diabetes, high blood pressure, high cholesterol, osteoporosis and stroke]. Visit Our website [at XXX] or call [XXX; the number on Your ID card] to find out if a particular Prescription Drug is on the preventive drug list]  [The Deductible does not apply to certain Prescription Drugs. Visit Our website [at XXX] to review Our formulary or call [XXX; the number on Your ID card] to learn more.] | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [The Deductible does not apply to preventive Prescription Drugs used to manage [asthma, diabetes, high blood pressure, high cholesterol, osteoporosis and stroke]. Visit Our website [at XXX] or call [XXX; the number on Your ID card] to find out if a particular Prescription Drug is on the preventive drug list]  [The Deductible does not apply to certain Prescription Drugs. Visit Our website [at XXX] to review Our formulary or call [XXX; the number on Your ID card] to learn more.] | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [The Deductible does not apply to preventive Prescription Drugs used to manage [asthma, diabetes, high blood pressure, high cholesterol, osteoporosis and stroke]. Visit Our website [at XXX] or call [XXX; the number on Your ID card] to find out if a particular Prescription Drug is on the preventive drug list] | See benefit for description |
| [Up to a 90-day supply for Maintenance Drugs]  [Tier 1  Tier 2  Tier 3] | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [The Deductible does not apply to preventive Prescription Drugs used to manage [asthma, diabetes, high blood pressure, high cholesterol, osteoporosis and stroke]. Visit Our website [at XXX] or call [XXX; the number on Your ID card] to find out if a particular Prescription Drug is on the preventive drug list]  [The Deductible does not apply to certain Prescription Drugs. Visit Our website [at XXX] to review Our formulary or call [XXX; the number on Your ID card] to learn more.] | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [The Deductible does not apply to preventive Prescription Drugs used to manage [asthma, diabetes, high blood pressure, high cholesterol, osteoporosis and stroke]. Visit Our website [at XXX] or call [XXX; the number on Your ID card] to find out if a particular Prescription Drug is on the preventive drug list]  [The Deductible does not apply to certain Prescription Drugs. Visit Our website [at XXX] to review Our formulary or call [XXX; the number on Your ID card] to learn more.] | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [The Deductible does not apply to preventive Prescription Drugs used to manage [asthma, diabetes, high blood pressure, high cholesterol, osteoporosis and stroke]. Visit Our website [at XXX] or call [XXX; the number on Your ID card] to find out if a particular Prescription Drug is on the preventive drug list] | [See benefit for description] |
| **[Mail Order Pharmacy]** |  |  |  |  |
| [Up to a 30-day supply  Tier 1  Tier 2  Tier 3 | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to ] Deductible]  [The Deductible does not apply to preventive Prescription Drugs used to manage [asthma, diabetes, high blood pressure, high cholesterol, osteoporosis and stroke]. Visit Our website [at XXX] or call [XXX; the number on Your ID card] to find out if a particular Prescription Drug is on the preventive drug.]  [The Deductible does not apply to certain Prescription Drugs. Visit Our website [at XXX] to review Our formulary or call [XXX; the number on Your ID card] to learn more.] | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to ] Deductible]  [The Deductible does not apply to preventive Prescription Drugs used to manage [asthma, diabetes, high blood pressure, high cholesterol, osteoporosis and stroke]. Visit Our website [at XXX] or call [XXX; the number on Your ID card] to find out if a particular Prescription Drug is on the preventive drug.]  [The Deductible does not apply to certain Prescription Drugs. Visit Our website [at XXX] to review Our formulary or call [XXX; the number on Your ID card] to learn more.] | [$ Copayment]  [% Coinsurance]  [[after; not subject to Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to ] Deductible]  [Non-Participating Provider services are not Covered and You pay the full cost]  [The Deductible does not apply to preventive Prescription Drugs used to manage [asthma, diabetes, high blood pressure, high cholesterol, osteoporosis and stroke]. Visit Our website [at XXX] or call [XXX; the number on Your ID card] to find out if a particular Prescription Drug is on the preventive drug.] |  |
| [Up to a 90-day supply  Tier 1  Tier 2  Tier 3] | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [The Deductible does not apply to preventive Prescription Drugs used to manage [asthma, diabetes, high blood pressure, high cholesterol, osteoporosis and stroke]. Visit Our website [at XXX] or call [XXX; the number on Your ID card] to find out if a particular Prescription Drug is on the preventive drug.]  [The Deductible does not apply to certain Prescription Drugs. Visit Our website [at XXX] to review Our formulary or call [XXX; the number on Your ID card] to learn more.] | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [The Deductible does not apply to preventive Prescription Drugs used to manage [asthma, diabetes, high blood pressure, high cholesterol, osteoporosis and stroke]. Visit Our website [at XXX] or call [XXX; the number on Your ID card] to find out if a particular Prescription Drug is on the preventive drug.]  [The Deductible does not apply to certain Prescription Drugs. Visit Our website [at XXX] to review Our formulary or call [XXX; the number on Your ID card] to learn more.] | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  [The Deductible does not apply to preventive Prescription Drugs used to manage [asthma, diabetes, high blood pressure, high cholesterol, osteoporosis and stroke]. Visit Our website [at XXX] or call [XXX; the number on Your ID card] to find out if a particular Prescription Drug is on the preventive drug.] | [See benefit for description] |
| Enteral Formulas  [Tier 1  Tier 2  Tier 3 | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible] | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible] | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost] | See benefit for description |
| **WELLNESS BENEFITS** | **[[Student Health Services; Student Health Center; Preferred Provider] Member Responsibility for Cost-Sharing]** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** |  |
| [Gym Reimbursement] | [Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for [Spouse; Covered Dependents]]  [Not applicable] | [Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for [Spouse; Covered Dependents]]  [Not applicable] | [Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for [Spouse; Covered Dependents]]  [Not applicable]  [Non-Participating Provider services are not covered and You pay the full cost] | [Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for [Spouse; Covered Dependents]] |
| **[PEDIATRIC] DENTAL and VISION CARE** | **[[Student Health Services; Student Health Center; Preferred Provider] Member Responsibility for Cost-Sharing]** | **Participating Provider Member Responsibility for Cost-Sharing** | **Non-Participating Provider Member Responsibility for Cost-Sharing** | **Limits** |
| **[Pediatric] Dental Care**   * Preventive Dental Care * Routine Dental Care * Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics) * Orthodontics   **[Orthodontics and Major Dental Require [Preauthorization;**  **Referral]]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[Orthodontics and Major Dental Require [Preauthorization;**  **Referral]]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[Orthodontics and Major Dental Require [Preauthorization;**  **Referral]]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[Orthodontics and Major Dental Require [Preauthorization;**  **Referral]]** | [One (1) dental exam and cleaning per six (6)-month period]  [Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at six (6) month intervals] |
| **[Adult Dental Care]**   * [Preventive Dental Care] * [Routine Dental Care] * [Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics)] * [Orthodontics]   **[Orthodontics and major dental require [Preauthorization;**  **Referral]]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[Orthodontics and major dental require [Preauthorization;**  **Referral]]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[Orthodontics and major dental require [Preauthorization;**  **Referral]]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not Covered and You pay the full cost]  **[Orthodontics and major dental require [Preauthorization;**  **Referral]]** | [One (1) dental exam and cleaning per six (6) month period]  [Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) month intervals] |
| **Pediatric Vision Care**   * Exams * [Lenses] * [Frames] * [Lenses and Frames] * Contact Lenses   **[Contact Lenses Require [Preauthorization; Referral]]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[Contact Lenses Require [Preauthorization; Referral]]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  **[Contact Lenses Require [Preauthorization; Referral]]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Non-Participating Provider services are not covered and You pay the full cost]  **[Contact Lenses Require [Preauthorization; Referral]]** | One (1) exam per [12-month period; Plan Year];  One (1) prescribed lenses and frames per [12-month period; Plan Year] |
| **[Adult Vision Care]**   * [Exams] * [Lenses] * [Frames] * [Lenses and Frames] * [Contact Lenses] * [Lenses, frames and Contact Lenses] * [Adult LASIK/Refractive Keratoplasty]   **[Contact Lenses Require [Preauthorization; Referral]]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Allowance]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [% Discount off retail price]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [% Discount off retail price]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Allowance]  [% Discount off retail price]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Allowance]  [% Discount off retail price]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [Up to $ per Member, per lifetime]  [[after; not subject to] Deductible]  [% Discount off retail price]  **[Contact Lenses Require [Preauthorization; Referral]]** | [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Allowance]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [% Discount off retail price]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [% Discount off retail price]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Allowance]  [% Discount off retail price]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Allowance]  [% Discount off retail price]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [Up to $ per Member, per lifetime]  [[after; not subject to] Deductible]  [% Discount off retail price]  **[Contact Lenses Require [Preauthorization; Referral]]** | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Allowance]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [% Discount off retail price]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [% Discount off retail price]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Allowance]  [% Discount off retail price]  [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible]  [$ Allowance]  [% Discount off retail price]  [Covered in full]  [$ Copayment]  [% Coinsurance]  [Up to $ per Member, per lifetime]  [[after; not subject to] Deductible]  [% Discount off retail price]  [Non-Participating Provider services are not Covered and You pay the full cost]  **[Contact lenses require [Preauthorization; Referral]]** | [One (1); exam per [[12;24]-month period; [Every Other] Plan Year; calendar year]]  [One (1) prescribed lenses and frames per [[12;24]-month period; [Every Other] Plan Year; calendar year]] |
| **Benefits Subject to Limits** *{Drafting Note:**Insert additional non-EHB benefits if covered}* | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible] | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible] | [$ Copayment]  [% Coinsurance]  [[after; not subject to] Deductible] | [$ ]  [Annual; Lifetime; Annual and Lifetime] Limits |
| **[Accidental Death and Dismemberment Benefits]**  ***{****Drafting Note: If Accidental Death and Dismemberment Benefits are covered insert description and limitations}* |  |  |  |  |

[All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider’s failure to obtain a required Preauthorization. However, if services are not covered under the Certificate, You will be responsible for the full cost of the services.]

*{Drafting Note: EPO gatekeeper products may not impose preauthorization requirements on the member for in-network coverage. Only include preauthorization language if applicable. If plans only require preauthorization for certain services or items (e.g., specific DME items), they must list those specific services or items in the schedule.}*

*{Drafting Notes:*

1. *Under state law and the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the financial requirements (deductibles, copayments, coinsurance, and out-of-pocket expenses) and treatment limitations applicable to the mental health or substance use disorder benefits must be no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical and surgical benefits covered by the plan. Further, if the health plan provides coverage for out-of-network services, then it also must provide coverage for out-of-network services for the treatment of mental health conditions and substance use disorders consistent with the MHPAEA.*
2. *Coinsurance imposed on an insured may not exceed 50%.*
3. *Cost-sharing for services delivered using telehealth shall be at least as favorable to the insured as cost-sharing for the same service when not delivered via telehealth, pursuant to Insurance Law §§ 3217-h(a) and 4306-g(a).*
4. *Plans have the flexibility to decide when a referral is required on a gated product.*
5. *If a preferred provider network is used, preventive services required by USPSTF and HRSA must be Covered in full on the preferred and participating provider tiers.*
6. *If out-of-network coverage is offered, all state mandated benefits must be Covered out-of-network.*
7. *The cost-sharing for emergency services in a hospital must be the same for in-network and out-of-network services.*
8. *The cost-sharing for ABA treatment and assistive communication devices must be the PCP copayment or the specialist cost-sharing. Additionally, any financial requirements, treatment limitations, preauthorization requirements, or other utilization review standards for services to treat autism spectrum disorder must be no more restrictive than the standards for medical benefits in the same classification as the autism spectrum disorder benefits, consistent with the requirements of the federal Mental Health Parity & Addiction Equity Act.*
9. *The cost-sharing for diabetic equipment, supplies, and self-management education must be the PCP copayment or the specialist cost-sharing, or if, more favorable the prescription drug cost-sharing.* *An insured’s out-of-pocket costs for prescription insulin drugs shall not exceed $100 per 30-day supply, regardless of the amount or type of insulin that is needed to fill such insured’s prescription. Plans may choose to break diabetic equipment, supplies and insulin into three bullets (one for equipment and supplies, one for insulin, and one for oral anti-diabetic agents and injectable anti-diabetic agents) or use a single bullet, but however listed, must comply with the applicable cost-sharing requirements.*
10. *The bracketed language in the prescription drug boxes regarding preventive drugs not subject to the deductible is optional. Plans may add or subtract from the list of drugs or conditions specified in that paragraph.}*
11. *Abortion services and health care forensic examinations performed under Public Health Law § 2805-i may not be subject to a copayment or coinsurance and may only be subject to a deductible in a high deductible health plan.*
12. *Insurance Law §§ 3216(i)(12-a), 3221(l)(12-a) and 4303(q-1) require policies to provide coverage for oral anti-cancer medications, subject to cost-sharing that is at least as favorable to an insured as the cost-sharing that applies to IV anti-cancer medications. Those sections also provide that an issuer shall not achieve compliance with the law by imposing an increase in cost-sharing for IV anti-cancer medications.* *Therefore, an increase in cost-sharing for IV anti-cancer medications may not be applied to oral anti-cancer medications.*
13. *For pediatric vision care, plans may choose to list the cost-sharing for lenses and frames separately or combined but both items must be covered as essential health benefits.*
14. *Insurance Law §§ 3216(i)(31-b), 3221(l)(7-b), and 4303(l-2) provide that every policy that provides coverage for treatment at an opioid treatment program shall not impose a copayment or coinsurance during the course of treatment on an insured for such treatment. “Opioid treatment program” means a program or practitioner engaged in opioid treatment of individuals with an opioid agonist treatment medication.*