



SCHEDULE OF BENEFITS

STATE UNIVERSITY OF NEW YORK (SUNY)

SCHEDULE OF BENEFITS

The Schedule of Benefits is a summary outline of the benefits covered under this insurance Plan. The benefits are divided into two sections: Medical Expense Benefits and Non-Medical Expense Benefits. Please read the Description of Benefits sections for full details. All benefits described are subject to the definitions, exclusions and provisions.

ELIGIBLE PERSONS

Eligible Person is an individual who meets all the requirements of one of the covered Classes shown below:

Class 1

A registered full time undergraduate or a graduate student attending classes who is a minimum age of 16 years and maximum of 40 years:

- Student must have a current passport and be travelling outside their Home Country; and
- Student must have a valid F, M, or Q visa. F1 visa holder on OPT are not eligible.

Class 2

- The spouse or domestic partner of a Class 1 Insured Person

Class 3

- The Dependent child(ren) of a Class 1 Insured Person

MEDICAL EXPENSE BENEFITS

The following Medical Expense Benefits are subject to the Insured Person’s Deductible, Copayment, and Coinsurance amount. After satisfaction of the Deductible and applicable Copayments, the Insurer will pay eligible benefits set forth in this Schedule at the specified Plan Coinsurance and reimbursement level.

GENERAL FEATURES AND PLAN SPECIFICATIONS

U.S. Provider Network

United Healthcare

Area of Coverage

Worldwide Basis Excluding Home Country

Maximum Benefit Payable per covered Illness or Injury

\$500,000

Lifetime Maximum

Unlimited

Individual Deductible per covered Illness or Injury

- | | |
|---------------------------|---|
| • In-Network Provider | \$50 per Insured Person, 2x Individual per family |
| • Out-of-Network Provider | \$50 per Insured Person, 2x Individual per family |
| • Student Health Center | \$45 per Insured Person, 2x Individual per family |

The Deductible for In-Network does not accrue towards the Out-of-Network Deductible.

COPAYMENTS

Copayments do not apply to the Deductible or the Out-of-Pocket Maximum.

• Student Health Center Copayment	\$0
• Physician Office Visit Copayment	\$20
• Hospital Copayment per Admission	\$300
• Emergency Room Copayment (waived if admitted)	\$300 per Occurrence
Out-of-Pocket-Maximum per Period of Insurance	Unlimited per Insured Person

Pre-Existing Condition Limitation

(12 months Lookback Period)

Student: Pre-Existing Conditions are covered without a Waiting Period.

Dependents: Pre-Existing Conditions are covered after a 24 months Waiting Period.

COVERED SERVICES AND BENEFIT LEVELS

Subject to Deductible, Coinsurance, Copayment, and Maximum Benefit per Period of Insurance

WHAT THE INSURANCE PLAN COVERS

The following Coinsurance applies for In-Network Providers in the U.S. or for expenses incurred outside the U.S. (if available). Coinsurance reduces to 70% UCR when Out-of-Network Providers in the U.S. are used.

HOSPITALIZATION AND INPATIENT BENEFITS

Accommodations including semi-private room • Copayment applies	100% Preferred Allowance
Intensive Care/Cardiac Care	100% Preferred Allowance
Mental Health	100% Preferred Allowance
Inpatient Consultation/Visit by a Physician or Specialist	100% Preferred Allowance
Diagnostic Testing and Hospital Miscellaneous Expense	100% Preferred Allowance
Pre-Admission Testing	100% Preferred Allowance

OUTPATIENT BENEFITS

Physician Visit or Consultation by Specialist

- Office visit Copayment applies 100% Preferred Allowance

Diagnostic Testing

- X-Ray and Laboratory
 - MRI, PET, and CT Scans
 - Office visit Copayment applies when testing is done outside an office visit
- 100% Preferred Allowance

Physical Therapy

- Office visit Copayment applies 100% Preferred Allowance

Mental Health

- Office visit Copayment applies 100% Preferred Allowance

SURGICAL BENEFITS (INPATIENT/OUTPATIENT)

Inpatient, Outpatient or Ambulatory Surgery Includes:

- Surgeon's Fees
- Out-of-network Assistant Surgeon or Anesthesiologist (up to 25% of Usual, Customary & Reasonable for surgery) 100% Preferred Allowance
- Facility fees
- Laboratory tests
- Medications and dressings
- Other medical services and supplies

EMERGENCY BENEFITS

Emergency Room and Medical Services

- Copayment waived, if admitted
 - Non-emergency use of the emergency room is **Not Covered**
- 100% Preferred Allowance

Ambulance Services

- Emergency local ground ambulance 100% Preferred Allowance

Emergency Dental

- Limited to accidental Injury of sound natural teeth sustained while covered 100% Preferred Allowance

MATERNITY CARE

- Normal delivery** or Medically Necessary C-Section, pre-natal, post-natal care, and Complications of Pregnancy 100% Preferred Allowance

OTHER BENEFITS (INPATIENT/OUTPATIENT)

- Cancer Care and Oncology** 100% Preferred Allowance

- Kidney Dialysis** 100% Preferred Allowance

Diabetic Medical Supplies

- Includes Insulin Pumps and associated supplies 100% UCR
- Maximum Benefit per Period of Insurance: \$7,500

Acquired Immunodeficiency Syndrome (AIDS) Human Immunodeficiency Virus (HIV+), AIDS Related Complex (ARC), Sexually transmitted diseases and all related conditions 100% Preferred Allowance

Durable Medical Equipment 100% UCR
 • Reimbursement of rental up to the purchase price

Alcohol and Substance Abuse 100% Preferred Allowance
 • Rehabilitative treatment only
 • Office visit Copayment applies

Prescription Medications 100% of charges
 • Up to 31-day supply per prescription
 • \$30 Copayment per prescription
 • CVS/Caremark network pharmacy is required

Motor Vehicle Accident 100% Preferred Allowance
 • Injuries caused by Accident

Passive War and Terrorism Included

NON-MEDICAL EXPENSE BENEFITS

Non-Medical Expense Benefits do not accumulate towards the Medical Expense Maximum Benefit payable per Period of Insurance or toward the Lifetime Maximum.

ADDITIONAL BENEFITS

Medical Evacuation and Repatriation 100%
 • Maximum Benefit per Period of Insurance: \$60,000

Return of Mortal Remains 100%
 • Maximum Benefit per Period of Insurance: \$50,000

ACCIDENTAL DEATH AND DISMEMBERMENT

ACCIDENTAL DEATH AND DISMEMBERMENT

Principal Sum for Primary Insured Person \$10,000

Time Period for Loss 90 days from the date of the covered Accident

Loss of: **Benefit: Percentage of Principal Sum**

Accidental Death 100%

Loss of Both Hands or Feet, or Loss of Entire Sight of Both Eyes 100%

Loss of One Hand and One Foot 100%

Loss of One Hand or Foot and Entire Sight of One Eye 100%

Loss of One Hand or Foot 50%

Loss of Sight of One Eye 50%