Schedule of Benefits

Hartwick College

2025-820-61

METALLIC LEVEL - PLATINUM WITH ACTUARIAL VALUE OF 89.560%

Injury and Sickness Benefits

$0

Deductible Preferred Provider	**$150 (Per Insured Person, Per Policy Year)**
Deductible Out-of-Network Provider	**$500 (Per Insured Person, Per Policy Year)**
Coinsurance Preferred Provider	**90% except as noted below**
Coinsurance Out-of-Network Provider	**60% except as noted below**
Out-of-Pocket Maximum Preferred Provider	**$5,000 (Per Insured Person, Per Policy Year)**
Out-of-Pocket Maximum Preferred Provider	**$10,000 (For all Insureds in a Family, Per Policy Year)**
Out-of-Pocket Maximum Out-of-Network Provider	**$8,000 (Per Insured Person, Per Policy Year)**

Inpatient	Preferred Provider	Out-of-Network Provider
Room and Board Expense	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Hospital Miscellaneous Expenses	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Routine Newborn Care	Paid as any other Sickness	Paid as any other Sickness
Surgery	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Assistant Surgeon Fees	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Anesthetist Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Registered Nurse's Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Physician's Visits	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Pre-admission Testing	10% Coinsurance after Deductible	40% Coinsurance after Deductible

Outpatient	Preferred Provider	Out-of-Network Provider
Surgery	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Day Surgery Miscellaneous	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Assistant Surgeon Fees	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Anesthetist Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Physician's Visits	$25 Copay Not subject to Deductible	30% Coinsurance after Deductible
Medical Emergency Expenses	$100 Copay 10% Coinsurance Not subject to Deductible	$100 Copay 10% Coinsurance Not subject to Deductible

Outpatient	Preferred Provider	Out-of-Network Provider
Diagnostic X-ray Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Radiation Therapy	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Laboratory Procedures	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Tests and Procedures	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Injections	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Chemotherapy	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Prescription Drugs	UHCP Retail Network Pharmacy $15 Copay per prescription Tier 1 $40 Copay per prescription Tier 2 $75 Copay per prescription Tier 3 up to a 30 day supply per prescription Mail Order Network Pharmacy or Preferred 90 Day Retail Network Pharmacy at 2.5 times the retail Copay up to a 90-day supply	$75 Copay per prescription brand-name drug $20 Copay per prescription generic drug Not subject to Deductible

Other	Preferred Provider	Out-of-Network Provider
Ambulance Services	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Durable Medical Equipment	10% Coinsurance after Deductible	10% Coinsurance after Deductible
Consultant Physician Fees	$25 Copay Not subject to Deductible	30% Coinsurance after Deductible
Mental Illness Treatment	Inpatient $25 Copay 10% Coinsurance after Deductible Outpatient office visits 10% Coinsurance after Deductible All other outpatient services, except Medical Emergency Expenses and Prescription Drugs Not subject to Deductible	Inpatient 30% Coinsurance after Deductible Outpatient office visits 40% Coinsurance after Deductible All other outpatient services, except Medical Emergency Expenses and Prescription Drugs 40% Coinsurance after Deductible
Substance Use Disorder Treatment	Inpatient $25 Copay 10% Coinsurance after Deductible Outpatient office visits 10% Coinsurance after Deductible All other outpatient services, except Medical Emergency Expenses and Prescription Drugs Not subject to Deductible	Inpatient 40% Coinsurance after Deductible Outpatient office visits 30% Coinsurance after Deductible All other outpatient services, except Medical Emergency Expenses and Prescription Drugs 40% Coinsurance after Deductible
Maternity	Paid as any other Sickness	Paid as any other Sickness
Complications of Pregnancy	Paid as any other Sickness	Paid as any other Sickness
Preventive Care Services	Covered in full	30% Coinsurance after Deductible

Other	Preferred Provider	Out-of-Network Provider
Reconstructive Breast Surgery Following Mastectomy	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Diabetes Services	$25 Copay Not subject to Deductible	30% Coinsurance after Deductible
Home Health Care 365 days per Plan Year	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Hospice Care 365 days per Plan Year	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Rehabilitation Facility	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Skilled Nursing Facility 365 days per Plan Year	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Urgent Care Center	$50 Copay 10% Coinsurance Not subject to Deductible	$50 Copay 40% Coinsurance Not subject to Deductible
Hospital Outpatient Facility or Clinic	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Approved Clinical Trials	Paid as any other Sickness	Paid as any other Sickness
Transplantation Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Pediatric Dental and Vision Services	See riders attached for Pediatric Dental and Vision Services benefits	See riders attached for Pediatric Dental and Vision Services benefits
Chiropractor Services	$25 Copay per visit Not subject to Deductible	40% Coinsurance after Deductible
Hearing Aids	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Infertility Services	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Medical Supplies	10% Coinsurance after Deductible	40% Coinsurance after Deductible
Acupuncture	10% Coinsurance after Deductible	30% Coinsurance after Deductible