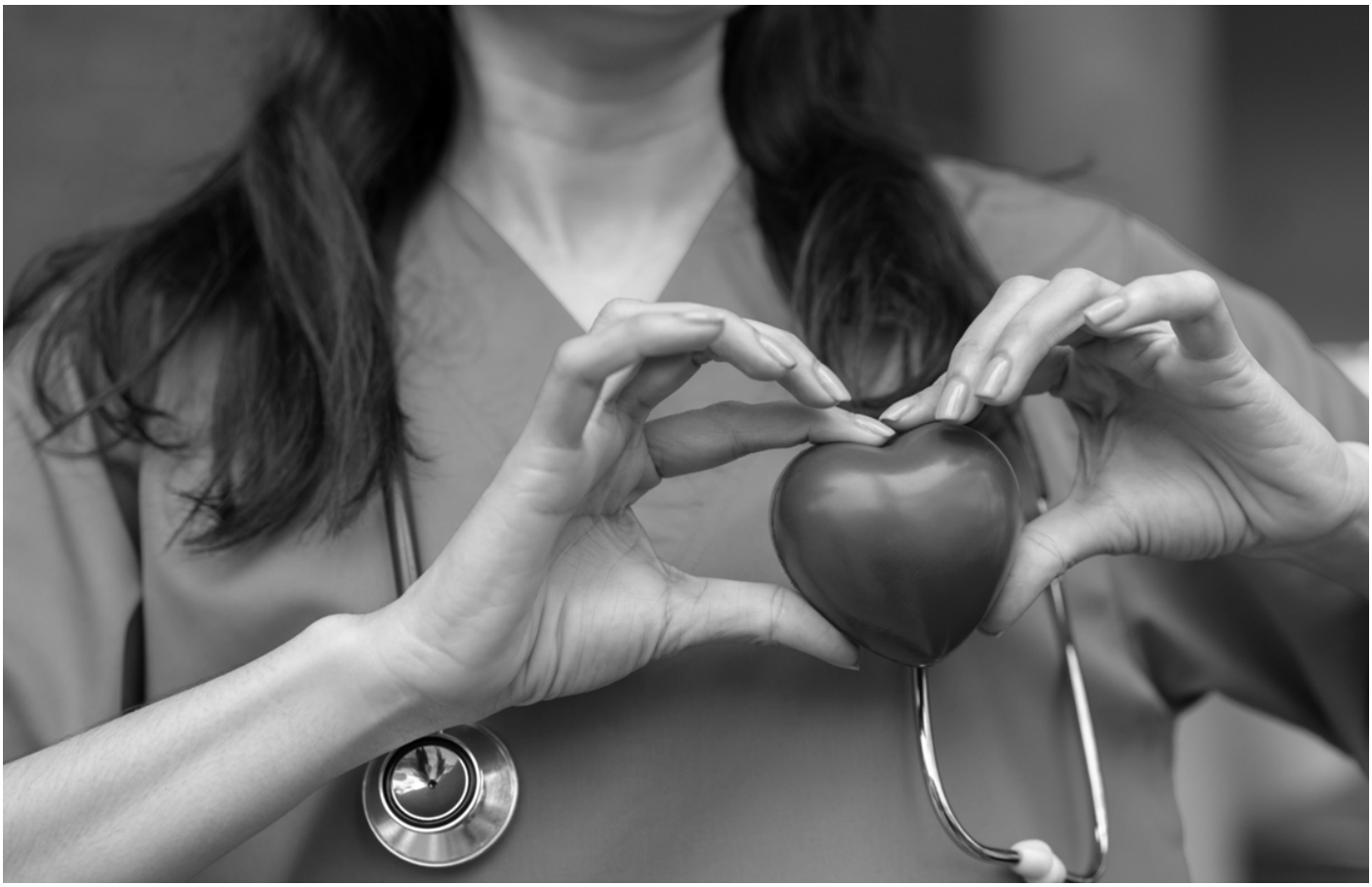
Aetna Student Health
Plan Design and Benefits Summary
Preferred Provider Organization (PPO)

Barnard College

Policy Year: 2025 - 2026
Policy Number: 474925
https://www.aetnastudenthealth.com
(866)725-4396



This is a brief description of the Student Health Plan. The Plan is available for Barnard College students. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Policy issued to you and may be viewed online at **https://www.aetnastudenthealth.com.** If there is a difference between this Benefit Summary and the Policy, the Master Policy will control the payment of benefits.

Barnard College Primary Care Health Services

Health and Wellness at Barnard provides the Barnard student community with holistic health and wellness care**,** information, and programming that supports student success inside and outside the classroom. Students who are registered at Barnard College have unrestricted use of the Barnard College Primary Care Health Service for routine physicals, urgent care, diagnosis and treatment of acute and chronic illness and referrals to off-campus specialists. Use of the Furman Counseling Center is limited to short-term psychotherapy and outside referrals. **Both centers can be used by registered students regardless of their insurance status.** Please visit **https://barnard.edu/health-wellness-0** for more information on our medical and counseling services.

Consultations, Laboratory Tests and X-Rays

Students with the Aetna Student Health plan are not charged for laboratory tests that are administered at the Barnard Primary Care Health Service and processed at an outside lab. Most other in-house tests are no charge. For laboratory tests, X-Rays and consultations performed outside of Primary Care Health Service, see insurance plan.

Medications

When prescribed by clinicians at Barnard, students will be charged discounted fees for medications available at the Primary Care Health Service Dispensary.

Immunizations

Many immunizations including HPV(Gardasil), COVID-19 and Flu as well as some travel vaccines are available at the Barnard College Primary Care Health Service at no charge with the Aetna Student Health plan. Students who require allergy desensitization shots must contact the Primary Care Health Service for specific instructions regarding delivery of the serum and its administration.

Student Health Insurance Plan

Your student insurance plan was designed to supplement those services available to you both the Primary Care Health Service and the Furman Counseling Center. It is anticipated that the insurance plan will be utilized for most other medical treatment as detailed in this brochure.

Locations:
PRIMARY CARE HEALTH SERVICE (MEDICAL SERVICES)
Brooks Hall, Lower Level
Telephone:
(212) 854- 2091
Website: **www.barnard.edu/health-wellness/student-health**

Hours:
By Appointment Only: Monday-Friday 9:00 a.m. - 5:00 p.m.
After-Hours Emergency Clinician-on-Call: **(212) 854-2091**

THE FURMAN COUNSELING CENTER
Location:
100 Hewitt Hall, First Floor
Telephone:
(212) 854-2092
Website: **www.barnard.edu/health-wellness/student-counseling**

Hours:

Monday - Friday: 9 AM - 5 PM
Crisis Appointment Hours: Monday to Friday 10 AM - 4 PM
Closed on Evenings and Weekends
Call (212) 854-2092 and indicate “urgent” for same day appointment.

After-Hours Psychological Emergency Line at **(212) 854-2092**
Campus Community Safety: **(212) 854-6666**
CAMPUS EMERGENCIES
Barnard Public Safety **(212) 854-6666**

Coverage Periods

Students: Coverage for all insured students enrolled for coverage in the Plan for the following Coverage Periods. Coverage will become effective at 12:01 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicate

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	08/22/2025	08/21/2026	08/22/2025
Fall	08/22/2025	01/11/2026	08/22/2025
Spring/Summer	01/12/2026	08/21/2026	TBD

Rates

Rates
Undergraduate and Graduate Students

	Annual*	Fall Semester*	Spring/Summer
Student	$4,778	$1,872	$2,906

*The Above rates are solely for the Medical plan and do not include any school health clinic or other fees charged by the school.

Per Person Costs NOT included in the above premium include Barnard Administrative Fee Costs of ($50 Annual, $25 Fall, $25 Spring)

All Inclusive Rates are as follows:

	Annual	Fall Semester	Spring/Summer
Student	$4,828	$1,897	$2,931

The Plan Benefits and Rates are still under review with the NY Department of Insurance, we will notify you upon their approval or if any changes are being required to be made. We recommend not publicly posting these rates or benefits until the approval is received.

Student Coverage

Eligibility

All registered and degree seeking students who are enrolled at Barnard College as full-time students and who actively attend classes for at least the first 31 days after the date when coverage becomes effective.
Home study, correspondence, Internet classes, and television (TV) courses, do not fulfill the eligibility requirement that the student actively attend classes. If it is discovered that this eligibility requirement has not been met, our only obligation is to refund premium, less any claims paid.

Enrollment

Eligible students will be automatically enrolled in this Plan, unless the completed waiver application has been received and approved by Barnard College by the specified enrollment deadline dates listed in the next section of this Plan Design and Benefits Summary.

Exception: A Covered Person entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro rata refund of premium will be made for such person, and any covered dependents, upon written request received by Aetna within 90 days of withdrawal from school.

All eligible Barnard College students are automatically enrolled in the student health insurance plan during the academic year unless the policy is waived with comparable insurance coverage for fall semester by 08/22/25. New students must waive for spring by (date TBD). To waive, students should go to www.universityhealthplans.com/Barnard. Student Insurance is designed to help cover the cost of a referral to an off-campus medical specialist or health care facility and some prescriptions unavailable in our dispensary.

Please remember that the Primary Care Health Service and Furman Counseling Center staff members do not file claims, but we will be more than happy to assist you with any of your questions. You may use the following resources:

Call Elliot Wasserman, Director of Operations, at (212) 854-8305 or e-mail at ewasserman@barnard.edu.
www.universityhealthplans.com/Barnard or (800) 437-6448: Access the waiver form or ask general information about enrollment and the plan.

https://www.aetnastudenthealth.com: Aetna Student Health

www.barnard.edu/health: Click on Frequently Asked Questions (FAQ)

Medicare Eligibility Notice

You are not eligible to enroll in the student health plan if you have Medicare at the time of enrollment in this student plan. The plan does not provide coverage for people who have Medicare.

WAIVER PROCESS/PROCEDURE

All Barnard students (domestic and international) are automatically charged for and enrolled in the Barnard College Aetna Student Health Insurance plan (SHIP). If you are covered by a comprehensive health insurance plan, you may opt out of the SHIP by completing the waiver request form, located in the left-hand side navigation menu

Category	Waiver Deadline Date
Annual	08/22/2025
Spring **(New Students Only)**	TBD

Waiver request form submissions will be reviewed by Barnard College or the Plan Broker and Administrator, University Health Plans. As part of the review process, you may be required to provide proof that your plan meets the waiver requirements. By submitting the waiver request form, you agree that your comprehensive health insurance plan may be contacted for confirmation that you have coverage for the applicable 2025-2026 Policy Year, and it meets the waiver requirements. After successfully submitting the waiver request form, University Health Plans will send a decision to the student's Barnard e-mail account stating the waiver request form has either been approved or denied. Students should check their Barnard e-mail account regularly. The decision takes 5-7 business days after the waiver request form has been submitted.

Special Enrollment Periods

You can also enroll for coverage within 60 days of the loss of coverage in a health plan if coverage was terminated because you are no longer eligible for coverage under the other health plan due to:

- Termination of employment;
- Termination of the other health plan;
- Death of the spouse;
- Legal separation, divorce or annulment;
- Reduction of hours of employment;
- Employer contributions toward a health plan were terminated; or
- A Child no longer qualifies for coverage as a Child under another health plan.

You can also enroll 60 days from exhaustion of your COBRA or continuation coverage.

We must receive notice and premium payment within 60 days of the loss of coverage. The effective date of your coverage will depend on when we receive your application. If your application is received between the first and fifteenth day of the month, your coverage will begin on the first day of the following month. If your application is received between the sixteenth day and the last day of the month, your coverage will begin on the first day of the second month.

In addition, you can also enroll for coverage within 60 days of losing (or gaining) eligibility for Medicaid or a state child health plan.

We must receive notice and premium payment within 60 days of this event.

Participating Providers

Aetna Student Health offers Aetna's broad network of Participating Providers. You can save money by seeing Participating Providers because Aetna has negotiated special rates with them, and because the Plan's benefits are better your out-of-pocket expenses will generally be lower when You receive benefits from a Participating Provider, and some benefits under the Plan may only be covered when received from a Participating Provider.

If you need care that is covered under the Plan but not available from a Participating Provider, contact Member Services for assistance at the toll-free number on the back of your ID card. In this situation, Aetna may issue a pre-approval for you to receive the care from a Non- Participating Provider. When a pre-approval is issued by Aetna, the benefit level is the same as for Participating Providers.

Preauthorization

Some services have to be preauthorized by Aetna beforehand if you want the Plan to cover them. Participating Providers are responsible for requesting preauthorization for their services. You are responsible for requesting preauthorization if you seek care from a Non- Participating Provider for any of the services listed in the Schedule of Benefits section of the Certificate. Preauthorization is not required for Participating facilities certified by the New York office of alcoholism and substance abuse services.

If you want the Plan to cover a service from a Non- Participating Provider that requires preauthorization, you must call Aetna at the number on your ID card. After Aetna receives a request for preauthorization, we will review the reasons for your planned treatment and determine if benefits are available.

You must contact Aetna to request preauthorization as follows:

- At least two (2) weeks prior to a planned admission or surgery when your provider recommends inpatient hospitalization. If that is not possible, then as soon as reasonably possible during regular business hours prior to the admission.
- At least two (2) weeks prior to ambulatory surgery or any ambulatory care procedure when your provider recommends the surgery or procedure be performed in an ambulatory surgical unit of a hospital or in an ambulatory surgical center.
- Within the first three (3) months of a pregnancy, or as soon as reasonably possible and again within 48 hours after the actual delivery date if your hospital stay is expected to extend beyond 48 hours for a vaginal birth or 96 hours for cesarean birth.
- Before air ambulance services are rendered for a non-emergency condition.

You must also contact Aetna to provide notification after the fact as follows:

- As soon as reasonably possible when air ambulance services are rendered for an emergency condition.
- If you are hospitalized in cases of an emergency condition, you must call Aetna within 48 hours after your admission or as soon thereafter as reasonably possible.

Description of Benefits

The Plan excludes coverage for certain services and has limitations on the amounts it will pay. While this Plan Design and Benefits Summary document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. To look at the full Plan description, which is contained in the Policy issued to you, go to **https://www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Policy, the Master Policy will control.

All coverage is based on the **Allowed Amount.**

"Allowed Amount" means the maximum amount Aetna will pay for the services or supplies covered under the certificate, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted.

- The Allowed Amount for Non-Participating Providers will be determined as follows:
  Facilities -For Facilities, the Allowed Amount will be 140% of an amount based on cost information from the Centers for Medicare and Medicaid Services.
- **For All Other Providers-**For all other Providers, the Allowed Amount will be 105% of an amount based on cost information from the Centers for Medicare and Medicaid Services.

Our Allowed Amount is not based on the "usual, customary and reasonable charge." If a Non-Participating Provider's actual charge is more than the Allowed Amount, you are responsible for the difference. Call us at the number on your ID card or visit **https://www.aetnastudenthealth.com** for information on your financial responsibility when you receive services from a Non-Participating Provider.

This Plan will pay benefits in accordance with any applicable **New York** Insurance Law(s).

REFERRAL REQUIREMENT

Although You are encouraged to receive care from Your PCP, You do not need a Referral from Student Health Services; a PCP before receiving Specialist care from a Participating Provider.

However, if You do obtain a written Referral, select a PCP and notify us of Your PCP, Your Cost-Sharing may be lower. See the Schedule of Benefits section of this Certificate for Your Cost-Sharing.

You may select any participating PCP who is available from the list of PCPs in the PPO Network. Each Member may select a different PCP. Children covered under this Certificate may designate a participating PCP who specializes in pediatric care. In certain circumstances, you may designate a Specialist as Your PCP. See the Access to Care and Transitional Care section of this Certificate for more information about designating a Specialist. To select a PCP, visit Our website at www.aetnastudenthealth.com. If You do not select a PCP, we will assign one to You.
For purposes of Cost-Sharing, if You seek services from a PCP (or a Physician covering for a PCP) who has a primary or secondary specialty other than general practice, family practice, internal medicine, pediatrics and OB/GYN, You must pay the specialty office visit Cost-Sharing in the Schedule of Benefits section of this Certificate when the services provided are related to specialty care.

However, the Participating Provider must discuss the services and treatment plan with Your PCP; Student Health Services; agree to follow Our policies and procedures including any procedures regarding Referrals or Preauthorization for services other than obstetric and gynecologic services rendered by such Participating Provider; and agree to provide services pursuant to a treatment plan (if any) approved by Us. See the Schedule of Benefits section of this Certificate for the services that require a Referral.

You may need to request Preauthorization before You receive certain services. See the Schedule of Benefits section of this Certificate for the services that require Preauthorization.

If We do not have a Participating Provider for certain provider types in the county in which You live or in a bordering county that is within approved time and distance standards, We will approve a Referral to a specific Non-Participating Provider until You no longer need the care or We have a Participating Provider in Our network that meets the time and distance standards and Your care has been transitioned to that Participating Provider. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible for any applicable in-network Cost-Sharing.

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Medical Deductible			
• Individual	$300	$500	
Out-of-Pocket Limit			
• Individual	$9,100	$10,000 See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how We calculate the Allowed Amount.	

OFFICE VISITS	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Primary Care Office Visits (or Home Visits)	$40 Copayment, then You pay 0% Not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
Specialist Office Visits (or Home Visits)	$40 Copayment then You pay 0% Not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
PREVENTIVE CARE	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Well Child Visits and Immunizations*	Covered in full	30% Coinsurance after Deductible	
Adult Annual Physical Examinations*	Covered in full	30% Coinsurance after Deductible	
Adult Immunizations*	Covered in full	30% Coinsurance after Deductible	
Routine Gynecological Services/Well Woman Exams*	Covered in full	30% Coinsurance after Deductible	
Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full	30% Coinsurance after Deductible	
Sterilization Procedures for Women *	Covered in full	30% Coinsurance after Deductible	
Vasectomy	20% Coinsurance after Deductible	30% Coinsurance after Deductible	
We do not Cover services related to the reversal of elective sterilizations.			
Bone Density Testing*	Covered in full	30% Coinsurance after Deductible	
Prostate Cancer screening	Covered in full	30% Coinsurance after Deductible	
Screening for Colon Cancer	Covered in full	30% Coinsurance after Deductible	
All other preventive services required by USPSTF and HRSA.	Covered in full	30% Coinsurance after Deductible	
*When preventive services are not provided in accordance with the comprehensive guidelines supported by United States Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA).	Use Cost Sharing for Appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Use Cost Sharing for Appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	

EMERGENCY CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Emergency Ambulance Transportation (Pre-Hospital Emergency Medical Services and Emergency Transportation including Air Ambulance Services)	$150 Copayment then you pay 0%, not subject to Deductible	Paid the same as Participating Provider	See benefit for description
Non-Emergency Ambulance Services (Ground and Air Ambulance)	$150 Copayment then you pay 0%, not subject to Deductible	$150 Copayment then you pay 0%, not subject to Deductible	See benefit for description
Limitations/Terms of Coverage: • We do not Cover travel or transportation expenses, unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician. • We do not Cover non-ambulance transportation such as ambulette, van or taxi cab. • Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; and Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met: o The point of pick-up is inaccessible by land vehicle; or o Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.			
Emergency Department Copayment /Coinsurance waived if admitted to Hospital.	$150 Copayment then you pay 0%, not subject to Deductible Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	Paid the same as Participating Provider	See benefit for description
We do not Cover follow-up care or routine care provided in a Hospital emergency department.			
Urgent Care Center	$60 Copayment then you pay 0% Not subject to Deductible	30% Coinsurance after Deductible	See benefit for description

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Advanced Imaging Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services Referral Required	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Allergy Testing & Treatment • Performed in a PCP Office • Performed in a Specialist Office	0% Coinsurance after Deductible with Referral or 30% Coinsurance after Deductible without referral 0% Coinsurance after Deductible with Referral or 30% Coinsurance after Deductible without referral	30% Coinsurance after Deductible Referral required 30% Coinsurance after Deductible Referral required	See benefit for description
Ambulatory Surgical Center Facility Fee	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible Included as Part of Inpatient Hospital Service Cost-Sharing	40% Coinsurance after Deductible 40% Coinsurance after Deductible Included as Part of Inpatient Hospital Service Cost-Sharing	See benefits for description

PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Chiropractic Services	$40 Copayment, then You pay 0% Not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
Clinical Trials	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description
We do not Cover: the costs of the investigational drugs or devices; the costs of non-health services required for You to receive the treatment; the costs of managing the research; or costs that would not be covered under this Certificate for non-investigational treatments provided in the clinical trial.			
Diagnostic Testing • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Dialysis • Performed in a PCP Offic • Performed in a Specialist Office • Performed in a Freestanding Center • Performed as Outpatient Hospital Service	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description

PROFESSIONAL SERVICES AND OUTPATIENT CARE (Continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in a PCP Office • Performed in a Specialist Office • Performed in an Outpatient Facility Referral Required	 $40 Copayment then You pay 0% Not subject to Deductible $40 Copayment then You pay 0% Not subject to Deductible $40 Copayment then You pay 0% Not subject to Deductible	 30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	unlimited
Home Health Care Referral Required	25% Coinsurance after Deductible	25% Coinsurance after Deductible	unlimited
Infertility Services	Use Cost Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See benefit for description

We do not Cover:

- In vitro fertilization;
- Gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
- Costs associated with an ovum or sperm donor including the donor's medical expenses;
- Cryopreservation and storage of sperm and ova except when performed as fertility preservation services;
- Cryopreservation and storage of embryos;
- Ovulation predictor kits;
- Reversal of tubal ligations;
- Reversal of vasectomies;
- Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
- Cloning; or
- Medical and surgical procedures that are experimental or investigational unless Our denial is overturned by an External Appeal Agent.

PROFESSIONAL SERVICES AND OUTPATIENT CARE (Continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Infusion Therapy • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy Referral Required	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description Counts towards Home Health Care Visit Limits
Inpatient Medical Visits Referral Required	20% Coinsurance subject to Deductible	40% Coinsurance subject to Deductible	See benefit for description
Interruption of Pregnancy • Abortion services	Covered in full	30% Coinsurance after Deductible	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 Referral Required	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See Benefit for Description

PROFESSIONAL SERVICES AND OUTPATIENT CARE (Continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Maternity & Newborn Care • Prenatal Care • Prenatal Care provided in accordance with the comprehensive guidelines supported by United States Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA)	Covered in full	30% Coinsurance After Deductible	See Benefit For Description
• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by United States Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA)	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)	
• Inpatient Hospital Services and Birthing Center	20% Coinsurance after Deductible	40% Coinsurance after Deductible	One (1) Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
• Physician and Midwife Services for Delivery	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Breastfeeding Support, Counseling and Supplies including Breast Pumps, Nursing Bras	Covered in full	30% Coinsurance after Deductible	Covered for duration of breast feeding
• Postnatal Care- Postnatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSAP	Covered in full	30% Coinsurance after Deductible	

PROFESSIONAL SERVICES AND OUTPATIENT CARE (Continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
• Postnatal Care- Postnatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	0% Coinsurance Not subject to Deductible	30% Coinsurance after Deductible	
Outpatient Hospital Surgery Facility Charge Referral Required	20% Coinsurance subject to Deductible	40% Coinsurance subject to Deductible	See benefit for description
Preadmission Testing Referral Required	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities			See benefit for description
• Performed in a PCP Office	$40 Copayment then You pay 0% with referral or 30% Coinsurance not subject to Deductible without referral	30% Coinsurance after Deductible	
• Performed in Specialist Office	$40 Copayment then You pay 0% with referral or 30% Coinsurance not subject to Deductible without referral	30% Coinsurance after Deductible	
• Performed in Outpatient Facilities Referral required	$40 Copayment then You pay 0% with referral or 30% Coinsurance not subject to Deductible without referral	30% Coinsurance after Deductible	

PROFESSIONAL SERVICES AND OUTPATIENT CARE (Continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Diagnostic Radiology Services • Performed in a PCP Office • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services Referral Required	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Therapeutic Radiology Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility • Performed as Outpatient Hospital Services Referral Required	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	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 Referral Required	$40 Copayment then You pay 0% Not subject to Deductible $40 Copayment then You pay 0% Not subject to Deductible $40 Copayment then You pay 0% Not subject to Deductible	30% Coinsurance after Deductible 30% Coinsurance after Deductible 30% Coinsurance after Deductible	Speech and physical therapy are only Covered following a Hospital stay or surgery.

PROFESSIONAL SERVICES AND OUTPATIENT CARE (Continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Second Opinions on the Diagnosis of Cancer, Surgery & Other Referral Required	$40 Copayment then You pay 0% Not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery and Transplants			See benefit for description All transplants must be performed at Designated Facilities
• Inpatient Hospital Surgery	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Outpatient Hospital Surgery	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Surgery Performed at an Ambulatory Surgical Center	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Office Surgery Referral Required	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
We do not Cover: travel expenses, lodging, meals, or other accommodations for donors or guests; donor fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.			
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Diabetic Equipment, Supplies & Self-Management Education			See benefit for description
• Diabetic Equipment and Supplies (30 day supply)	$40 Copayment then You pay 0% Not subject to Deductible	30% Coinsurance after Deductible	
• Diabetic Education	$40 Copayment then You pay 0% Not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
• Diabetic Insulin (30 Day Supply)	Covered in full	30% Coinsurance after Deductible	

ADDITIONAL SERVICES, EQUIPMENT & DEVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
• Oral anti-diabetic agents and injectable anti-diabetic agents (30 day supply) Referral Required	Covered in full	30% Coinsurance after Deductible	
Limitations The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We Cover only basic models of blood glucose monitors unless You have special needs relating to poor vision or blindness or otherwise Medically Necessary.			
Durable Medical Equipment & Braces Referral Required	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
We do not Cover: equipment designed for Your comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment), as it does not meet the definition of durable medical equipment. **Braces.** We do not Cover: the cost of repair or replacement that is the result of misuse or abuse by You.			
External Hearing Aids • Prescription Hearing Aids Referral Required	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Single purchase once every three (3) years
Cochlear Implants Referral Required	20% Coinsurance after Deductible	40% Coinsurance after Deductible	One (1) per ear per plan year
Hospice Care • Inpatient • Outpatient Referral Required	20% Coinsurance subject to Deductible 20% Coinsurance subject to Deductible	25% Coinsurance subject to Deductible 25% Coinsurance subject to Deductible	210 days per policy year (combined inpatient and outpatient) Five (5) visits for family bereavement counseling
We do not Cover: funeral arrangements; pastoral, financial, or legal counseling; or homemaker, caretaker, or respite care.			
Medical Supplies Referral Required	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
We do not Cover over-the-counter medical supplies.			

ADDITIONAL SERVICES, EQUIPMENT & DEVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Prosthetic Devices • External • Internal Referral Required	20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible	One (1) prosthetic device, per limb, per Plan Year Unlimited
We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials. We do not Cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly. Eyeglasses and contact lenses are not Covered under this section of the Certificate and are only Covered under the Pediatric Vision Care section of this Certificate. We do not Cover the cost of repair or replacement covered under warranty or if the repair or replacement is the result of misuse or abuse by You. We do not Cover shoe inserts.			
INPATIENT SERVICES & FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Autologous Blood Banking Referral Required	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefits for description
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) 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.	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	See benefit for description
Observation Stay Referral Required	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	See benefit for description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) Referral Required	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	unlimited

INPATIENT SERVICES & FACILITIES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Habilitation Services (Physical Speech and Occupational Therapy) Referral required	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	unlimited
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) Referral Required	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	Unlimited Speech and physical therapy are only Covered following a Hospital stay or surgery
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	**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 or Residential Facility Referral Required	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	See benefit for description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services) • Office Visits • All Other Outpatient Services Referral Required	 $40 Copayment not subject to the Deductible then You pay 0% 0% Coinsurance Not subject to Deductible	 30% Coinsurance after Deductible 30% Coinsurance after Deductible	See benefit for description
ABA Treatment for Autism Spectrum Disorder Referral Required	0% Coinsurance Not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder Referral Required	0% Coinsurance Not subject to Deductible	30% Coinsurance after Deductible	See benefit for description

Limitations. We do not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the New York Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the New York Public Health Law, an individualized education plan under Article 89 of the New York Education Law, or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities shall not affect coverage under this Certificate for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist			
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Substance Use Services including Residential Treatment (for a continuous confinement when in a Hospital) Referral Required	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	See benefit for description
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)			unlimited
• Office Visits	$40 Copayment not subject to the Deductible then You pay 0%	30% Coinsurance after Deductible	
• Opioid Treatment Programs	Covered in full	30% Coinsurance after Deductible	
• All Other Outpatient Services	0% Coinsurance Not subject to Deductible	30% Coinsurance after Deductible	
Referral Required			

PRESCRIPTION DRUGS Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by Health Resources and Services Administration (HRSA) or if the item or service has an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF) and obtained at a participating pharmacy	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Cost-Sharing Expenses. You are responsible for paying the costs outlined in the Schedule of Benefits section of this Certificate when Covered Prescription Drugs are obtained from a retail or mail order pharmacy. You have a three (3) tier plan design, which means that Your out-of-pocket expenses will generally be lowest for Prescription Drugs on tier 1 and highest for Prescription Drugs on tier 3. Your out-of-pocket expense for Prescription Drugs on tier 2 will generally be more than for tier 1 but less than tier 3.			
PRESCRIPTION DRUGS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Retail Pharmacy			
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.			
30-day supply Tier 1 Tier 2 Tier 3	 20% Coinsurance Not subject to Deductible 35% Coinsurance Not subject to Deductible 50% Coinsurance Not subject to Deductible	 20% Coinsurance Not subject to Deductible 35% Coinsurance Not subject to Deductible 50% Coinsurance Not subject to Deductible	See benefit for description

Mail Order Pharmacy			
Up to a 90-day supply Tier 1 Up to a 90-day supply Tier 2 Up to a 90-day supply Tier 3	20% Coinsurance Not subject to Deductible 35% Coinsurance Not subject to Deductible 50% Coinsurance Not subject to Deductible	Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost Non-Participating Provider services are not covered and You pay the full cost	See benefit for description
Enteral Formulas Tier 1 Tier 2 Tier 3	 20% Coinsurance after the Deductible 20% Coinsurance after the Deductible 20% Coinsurance after the Deductible	 40% Coinsurance after the Deductible 40% Coinsurance after the Deductible 40% Coinsurance after the Deductible	See benefit for description

Limitations/Terms of Coverage.

1. We reserve the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended diabeticguidelines.
2. If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies and prescribing Providers may be limited. If this happens, We may require You to select a single Participating Pharmacy and a single Provider that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. Benefits will be paid only if Your Prescription Order or Refills are written by the selected Provider or a Provider authorized by Your selected provider. If You do not make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy and/or prescribing Provider for You.
3. Compounded Prescription Drugs will be Covered only when they contain at least one (1) ingredient that is a Covered legend Prescription Drug, they are not essentially the same as a Prescription Drug from a manufacturer and are obtained from a pharmacy that is approved for compounding.
4. Various specific and/or generalized “use management” protocols will be used from time to time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our Members with a quality-focused Prescription Drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.
5. Injectable drugs (other than self-administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies and equipment are not Covered under this section but are Covered under other sections of this Certificate.
6. We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician’s office are Covered under the Outpatient and Professional Services section of this Certificate.

7. We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs, over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an "A" or "B" rating from USPSTF, or as otherwise provided in this Certificate. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as Covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts. We do not Cover repackaged products such as therapeutic kits or convenience packs that contain a Covered Prescription Drug unless the Prescription Drug is only available as part of a therapeutic kit or convenience pack. Therapeutic kits or convenience packs contain one or more Prescription Drug(s) and may be packaged with over-the-counter items, such as glove, finger cots, hygienic wipes or topical emollients.
8. We do not Cover Prescription Drugs to replace those that may have been lost or stolen.
9. We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.
10. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in the Utilization Review and External Appeal sections of this Certificate.
11. A pharmacy need not dispense a Prescription Order that, in the pharmacist's professional judgment, should not be filled.

WELLNESS BENEFITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Exercise Facility Reimbursement	Up to $200 per six (6) month period		

Reimbursement is limited to actual workout visits. We do not reimburse:

- Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities;
- Lifetime memberships;
- Equipment, clothing, vitamins or other services that may be offered by the facility (e.g., massages, etc.); or
- Services that are amenities, such as a gym, that are included in Your rent or homeowners association fees.

In order to be eligible for reimbursement, You must:

- Be an active member of the exercise facility, and
- Complete 50 visits in a six (6)-month period.

PEDIATRIC DENTAL & PEDIATRIC VISION CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care			One (1) dental exam & cleaning per six (6)-month period Full mouth x-rays or panoramic x-rays at thirty-six (36) month intervals and bitewing x-rays at six (6) month intervals
• Preventive	Covered in Full	30% Coinsurance after Deductible	
• Routine Dental Care	Covered in Full	30% Coinsurance after Deductible	
• Major Dental Care (Oral Surgery, Endodontics, Periodontics & Prosthodontics)	30% Coinsurance Not subject to Deductible	50% Coinsurance after Deductible	
• Orthodontics	50% Coinsurance Not subject to Deductible	50% Coinsurance after Deductible	
Pediatric Vision Care			One (1) exam per twelve (12)-month period One (1) prescribed lenses & frames per twelve (12)-month period
• Exams	0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	
• Lenses & Frames	0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	
• Contact Lenses	0% Coinsurance not subject to Deductible	30% Coinsurance not subject to Deductible	

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.

Travel Assistance Services

Complete benefit information is found in the Certificate of Coverage.

OTHER COVERED SERVICES	Authorized Vendor Approved Services Member Responsibility for Cost-Sharing
Emergency Medical Evacuation	0% Coinsurance of actual cost not subject to Deductible
Medical Repatriation	0% Coinsurance of actual cost not subject to Deductible
Transportation to Join a Hospitalized Member	0% Coinsurance of actual cost not subject to Deductible
Return of Minor Children	0% Coinsurance of actual cost not subject to Deductible
Repatriation of Mortal Remains	0% Coinsurance of actual cost not subject to Deductible

Accidental Death and Dismemberment Benefits

Loss	Benefit Amount
Life	$10,000
Loss of Two or More Hands or Feet	$10,000
Loss of Use of Two or More Hands or Feet	$10,000
Loss of Sight in Both Eyes	$10,000
Loss of Speech and Hearing (in Both Ears)	$5,000
Loss of one Hand or Foot and Sight in One Eye	$10,000
Loss of One Hand or Foot	$5,000
Loss of Sight in One Eye	$5,000
Loss of Speech	$2,500
Loss of Hearing (in Both Ears)	$2,500
Loss of Thumb and Index Finger on the Same Hand	$2,500
Loss of all Four Fingers on the Same Hand	$2,500
Loss of all Toes on the Same Foot	$2,500
Loss of Thumb	$2,500

Exclusions

No coverage is available under the certificate for the following:

Aviation.

We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

Convalescent and Custodial Care.

We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

Conversion Therapy.

We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for any individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

Cosmetic Services.

We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.

Coverage Outside of the United States, Canada or Mexico.

We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

Dental Services.

We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services and Pediatric Dental Care sections of this Certificate.

Experimental or Investigational Treatment.

We do not Cover any health care service, procedure, treatment, device or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

Felony Participation.

We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

Foot Care.

We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

Government Facility.

We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

Medically Necessary.

In general, We will not Cover any health care service, procedure, treatment, test, device or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Certificate.

Medicare or Other Governmental Program.

We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid). When You are enrolled for Medicare, We will reduce Our benefits by the amount Medicare pays for Covered Services. Benefits for Covered Services will not be reduced if We are required by federal law to pay first or if You are not enrolled for premium-free Medicare.

Military Service.

We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

No-Fault Automobile Insurance.

We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

Services Not Listed.

We do not Cover services that are not listed in this Certificate as being Covered.

Services Provided by a Family Member.

We do not Cover services performed by a covered person's immediate family member. "Immediate family member" means a child, stepchild, spouse, parent, stepparent, sibling, stepsibling, parent-in-law, child-in-law, sibling-in-law, grandparent, grandparent's spouse, grandchild, or grandchild's spouse.

Services Separately Billed by Hospital Employees.

We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

Services with No Charge.

We do not Cover services for which no charge is normally made.

Vision Services.

We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in the Pediatric Vision Care section(s) of this Certificate.

War.

We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

Workers' Compensation.

We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

The Barnard College Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health℠ is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).

Sanctioned Countries

If coverage provided by this policy violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a written Office of Foreign Asset Control (OFAC) license. For more information, visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-877-480-4161.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna is committed to being an inclusive health care company. Aetna does not discriminate on the basis of ancestry, race, ethnicity, color, religion, sex/gender (including pregnancy), national origin, sexual orientation, gender identity or expression, physical or mental disability, medical condition, age, veteran status, military status, marital status, genetic information, citizenship status, unemployment status, political affiliation, or on any other basis or characteristic prohibited by applicable federal, state or local law.

Aetna provides free aids and services to people with disabilities and free language services to people whose primary language is not English.

These aids and services include:

- Qualified language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Qualified interpreters
- Information written in other languages

If you need these services, contact the number on your ID card. Not an Aetna member? Call us at 1-877-480-4161.

If you have questions about our nondiscrimination policy or have a discrimination-related concern that you would like to discuss, please call us at 1-877-480-4161.

Please note, Aetna covers health services in compliance with applicable federal and state laws. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations, and conditions of coverage.

Language accessibility statement

TTY: **711**

English	**To access language services at no cost to you, call the number on your ID card.**
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ።
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով ավվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէրախոսահամարով հէրախոսահամարով
Carolinian (Kapasal Falawasch)	Ngir mëna am sarwis lakk yi te doo fay, woo nimero bi am ci sa kàrt.
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf, lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Greek	Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισής σας.
Gujarati	તમારે કોઇ પણ જાતના ખર્ચ વિના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇડી કાર્ડ પર રહેલ નંબર પર કૉલ કરવો.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	**無料の言語サービスは、IDカードにある番号にお電話ください。**
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Laotian	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T'11 ni nizaad k'ehj7 bee n7k1 a'doowo[doo b33h 7l7n7g00 naaltsoos bee atah n7l98go nanitin7g77 bee n44ho'd0lzin7g77 b44sh bee hane'7 bik1'7g77 1aj8' h0lne'.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian-Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Samoan	Mō le mauaina o 'au'aunaga tau gagana e aunoa ma se totogi, vala'au le numera i luga o lau pepa ID.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Syriac-Assyrian	ܒܝܢ ܗܫܩܐ ܬܠܘܢ ܥܠ ܝܠܦܢܘܬܐ ܕܬܘܪܓܡܐ ܕܠܫܢܐ ܡܓܢܢܐܝܬ، ܡܪܝܡܘܢ ܡܢܝܢܐ ܥܠ ܦܬܩܐ ܕܝܕܥܬܐ ܕܝܠܘܟܘܢ.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.

Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน
Ukrainian	Щоб безкоштовнj отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.

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