BARNARD
THE LIBERAL ARTS COLLEGE
FOR WOMEN
IN NEW YORK CITY

Aetna Student Health

Plan Design and Benefits Summary
Barnard College

Policy Year: 2015 - 2016
Policy Number: 474925

aetna®
www.aetnastudenthealth.com
(877) 850-6038

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 governing this insurance are contained in the Certificate of Coverage issued to you and may be viewed online at **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Certificate, the Certificate of coverage will govern and control the payment of benefits.

Barnard College Primary Care Health Services

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 **www.barnard.edu/counsel** for more information on the services available at the Furman Counseling Center.

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

Students will be charged discounted fees for medications available at the Primary Care Health Service Dispensary.

Immunizations

Many immunizations including HPV(Gardasil) 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 at the Barnard College Primary Care Health Service in Brooks Hall. It is anticipated that the insurance plan will be utilized for most other medical treatment as detailed in this brochure.

Location:
Brooks Hall, Lower Level
Telephone:
(212) 854-2091
Fax **(212) 854-2702**
Website: **www.barnard.edu/primarycare**

Hours:
Medical Appointments and Urgent Care Walk-In: Monday-Friday 9:00 a.m. - 5:00 p.m.
Closed Thursday, 12:00 p.m. - 1:30 p.m. Weekly Staff Meeting
After-Hours Emergency Clinician-on-Call: **(855) 622-1903**

Columbia Health Reimbursement Procedure

There are certain times during the year (winter, spring, and summer breaks) when Barnard Primary Care Health Services will be closed. During these times, students can utilize Columbia Health (3rd floor of John Jay Hall) **for any urgent care services only**. Students will be charged a fee of **$75.00** to be seen at Columbia's health services which can be reimbursed by completing a claim form (**http://barnard.edu/primarycare/forms**) and attaching the superbill that contains the diagnosis codes, CPT or HCPC code, Tax ID, provider's name/title, date of service and the cost of the exam.

Please send the completed form along with the receipt to:

Aetna Student Health
Claims Department
P.O. Box 981106
El Paso TX, 79998

PLEASE NOTE: Barnard Primary Care Health Services cannot directly reimburse you. You must send your claim form and receipt directly to Aetna Student Health.

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

Hours:
Monday-Friday 9 a.m. – 5 p.m.
Pre scheduled evening appointments: Monday –Thursday 5 p.m. – 7 p.m.
Drop-In Listening Hours: Plimpton Hall, Mondays 7 p.m. – 9:30 p.m.; Elliot Hall, Thursdays 7 p.m. – 9:30 p.m.

After-Hours Psychological Emergency: **(855) 622-1903**

CAMPUS EMERGENCIES
Barnard Public Safety **(212) 854-3362**

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 indicated.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	08/22/2015	08/21/2016	08/28/2015
Fall	08/22/2015	01/11/2016	08/28/2015
Spring/Summer	01/12/2016	08/21/2016	01/15/2016

Rates

The rates below include both premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna), as well as a Barnard College administrative fee.

	Annual	Spring/Summer Semester
Student	**$2,550**	**$1,542**

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 Form has been received by the University, by the specified enrollment deadline dates listed in the Coverage Period section of this Plan Summary of Benefits.

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.

WAIVER PROCESS/PROCEDURE

Eligible students will automatically be enrolled in This Plan, unless a completed Waiver Form has been received by Barnard College by the specified deadline dates listed below:

Category	Waiver Deadline Date
Annual	08/28/15
Spring (New Students Only)	01/15/16

ENROLLMENT

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 08/28/15. New students must waive for spring by 01/15/16. 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.

www.aetnastudenthealth.com: Aetna Student Health

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

Waiver submissions: may be audited by Barnard College, University Health Plans, and/or their contractors or representatives. You may be required to provide, upon request, any coverage documents and/or other records demonstrating that you meet the school's requirements for waiving the student health insurance plan. By submitting the

waiver request, you agree that your current insurance plan may be contacted for confirmation that your coverage is in force for the applicable policy year and that it meets the school's waiver requirements.

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:

1. Termination of employment;
2. Termination of the other health plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions toward a health plan were terminated; or
7. 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 the following event:

1. You, or eligibility for Medicaid or a state child health plan.

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

Participating Provider Network

Aetna Student Health has arranged for you to access a Participating Provider Network in your local community. To maximize your savings and reduce your out-of-pocket expenses, select a Participating Provider. It is to your advantage to use a Participating Provider because savings may be achieved from the Negotiated Charges these providers have agreed to accept as payment for their services.

Services Subject to Preauthorization

Preauthorization is required before you receive certain covered services. You are responsible for requesting preauthorization for the out-of-network services listed in the Schedule of Benefits section of the Certificate. Participating Providers are responsible for requesting preauthorization for in-network services and you are responsible for requesting preauthorization for the out-of-network services listed in the Schedule of Benefits section of the Certificate.

Preauthorization /Notification Procedure

If you seek coverage for services that require preauthorization, you must call Aetna at the number on your ID card.

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 contact Aetna to provide notification 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.

After receiving a request for approval, Aetna will review the reasons for your planned treatment and determine if benefits are available. Criteria will be based on multiple sources which may include medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

Failure to Seek Preauthorization or Provide Notification

If you fail to seek Our Preauthorization or provide notification for benefits subject to this section, we will pay an amount of **$500** less than we would otherwise have paid for the care, or we will pay only **50%** of the amount we would otherwise have paid for the care, whichever results in a greater benefit for you.

Description of Benefits

The Plan excludes coverage for certain services and contains 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 Certificate of Coverage issued to you, you may access it online at **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Certificate, the Certificate of Coverage will govern and control the payment of benefits.

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

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

The Allowed Amount for Participating Providers will be the amount we have negotiated with the Participating Provider.

The Allowed Amount for Non-Participating Providers will be determined as follows:

1. Facilities.
   For Facilities, the Allowed Amount will be 100% of the Medicare rate.

2. For All Other Providers.
   For all other Providers, the Allowed Amount will be 100% of the Medicare rate.

Our Allowed Amount is not based on UCR. The Non-Participating Provider's actual charge may exceed Our Allowed Amount. You must pay the difference between Our Allowed Amount and the Non-Participating Provider's charge.

Contact us at the number on your ID card or visit our website **www.aetnastudenthealth.com** for information on your financial responsibility when you receive services from a Non-Participating Provider.

Medicare based rates referenced in and applied under this section shall be updated no less than annually.

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

Referral Requirement		
The requirement to obtain a referral can apply to all services except: • Primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, treatment of acute gynecologic conditions, or for any care related to a pregnancy from a qualified Participating Provider of such services; • Emergency Services; • Pre-Hospital Emergency Medical Services and emergency ambulance transportation; • When the Student Health Center is closed; • Students in the Study Abroad program do not require a referral; • Foreign claims do not require referrals; • Preventive/Routine Services (services considered preventive according to Health Care Reform and/or services rendered not to diagnosis or treat an Accident or Sickness). A penalty for failure to obtain a referral can only apply to Preferred Care benefits for the services listed below. • Primary Care or Specialists Office Visits • Allergy Testing & Treatment – specialist office visit		
COST-SHARING	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**
Deductible* **Individual** **Family** **Out-of-Pocket Limit**** **Individual** **Family** *Applicable to benefits unless indicated otherwise below. **This limit never includes your Premium, Balance Billing charges or the cost of health care services We do not cover.	 $300 N/A $4,000 N/A	 $500 N/A N/A N/A
Outpatient and Professional Services (for other than Mental Health and Substance Use)	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**
Office Visits - Primary Care (or home visits)	$40 Copayment then You pay 0% with Referral or 30% Coinsurance without Referral Not Subject to Deductible	30% Coinsurance after Deductible

Outpatient and Professional Services (continued) (for other than Mental Health and Substance Use)	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Office Visits - Specialists (or home visits)	$40 Copayment then you pay 0% with Referral or 30% Coinsurance without Referral Not Subject to Deductible	30% Coinsurance after Deductible
PREVENTIVE CARE Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP").	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**
Adult Annual Physical Examinations*	Covered in full	30% Coinsurance after Deductible
Adult Immunizations*	Covered in full	30% Coinsurance after Deductible
Well-Woman Examinations *	Covered in full	30% Coinsurance after Deductible
Mammograms*	Covered in full	30% Coinsurance after Deductible
Family Planning and Reproductive Health Services * We cover family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise covered under the Prescription Drug Coverage section of the certificate, counseling on use of contraceptives and related topics, and sterilization procedures for women. We do not cover services related to the reversal of elective sterilizations.	Covered in full	30% Coinsurance after Deductible
Vasectomy We do not cover services related to the reversal of elective sterilizations	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Bone Mineral Density Measurements or Testing*	Covered in full	30% Coinsurance after Deductible

PREVENTIVE CARE (continued)	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Screening for Prostate 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 USPSTF and HRSA.** You may contact us at the number on your ID card or visit Our website at www.aetnastudenthealth.com for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.	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 Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**
Emergency Ambulance Transportation (Pre-Hospital Emergency Medical Services) 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.	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Non-Emergency Ambulance Services	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Emergency Services	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**
*Copayment /Coinsurance waived if Hospital admission. In the event that you require treatment for an Emergency Condition, seek immediate care at the nearest hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. However, only Emergency Services for the treatment of an Emergency Condition are covered in an emergency department. We do not cover follow-up care or routine care provided in a Hospital emergency department.	$150 Copayment then you pay 0% Not subject to Deductible	$150 Copayment then you pay 0% Not subject to Deductible

Emergency Services (continued)	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
The amount we pay a Non-Participating Provider for Emergency Services will be the greater of: the amount we have negotiated with Participating Providers for the Emergency Service (and if more than one amount is negotiated, the median of the amounts); 100% of the Allowed Amount for services provided by a Non-Participating Provider (i.e., the amount we would pay in the absence of any Cost-Sharing that would otherwise apply for services of Non-Participating Providers);or the amount that would be paid under Medicare. The amounts described above exclude any Copayment or Coinsurance that applies to Emergency Services provided by a Participating Provider. You are responsible for any Copayment, Deductible or Coinsurance. You will be held harmless for any Non-Participating Provider charges that exceed your Copayment, Deductible or Coinsurance.	$150 Copayment then you pay 0% Not subject to Deductible	$150 Copayment then you pay 0% Not subject to Deductible
Urgent Care Center Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care.	$60 Copayment then you pay 0% Not subject to Deductible	30% Coinsurance after Deductible
Outpatient and Professional Services (for other than Mental Health and Substance Use)	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**
Advanced Imaging Services (Performed in a Freestanding Radiology Facility or Office Setting)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Advanced Imaging Services (Performed as Outpatient Hospital Services)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Allergy Testing and Treatment (Performed in a PCP Office)	0% Coinsurance after Deductible with Referral or 30% Coinsurance after Deductible without Referral	30% Coinsurance after Deductible
Allergy Testing and Treatment (Performed in a Specialist Office)	0% Coinsurance after Deductible with Referral or 30% Coinsurance after Deductible without Referral	30% Coinsurance after Deductible

Outpatient and Professional Services (continued) (for other than Mental Health and Substance Use)	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Ambulatory Surgery Center	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Anesthesia Services (all settings)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Cardiac & Pulmonary Rehabilitation (Performed in a Specialist Office)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Cardiac & Pulmonary Rehabilitation (Performed as Outpatient Hospital Services)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Cardiac & Pulmonary Rehabilitation (Performed as Inpatient Hospital Services)	Included as part of Inpatient Hospital Service Cost-Sharing	Included as part of Inpatient Hospital Service Cost-Sharing
Chemotherapy (Performed in a PCP Office)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Chemotherapy (Performed in a Specialist Office)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Chemotherapy (Performed as Outpatient Hospital Services)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Chiropractic Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Clinical Trials	Use Cost-Sharing for Appropriate Service	Use Cost-Sharing for Appropriate Service
Diagnostic Testing - Performed in a PCP Office We cover x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic Testing - Performed in a Specialists Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic Testing - Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Dialysis - Performed in a PCP Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Dialysis - Performed in a Freestanding Center or Specialist Office Setting	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Dialysis - Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Outpatient and Professional Services (continued) (for other than Mental Health and Substance Use)	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Habilitation Services - Physical Therapy, Occupational Therapy, or Speech Therapy	$40 Copayment then you pay 0% Not subject to Deductible	30% Coinsurance after Deductible
Home Health Care	25% Coinsurance after Deductible	25% Coinsurance after Deductible
Infertility Services We cover services for the diagnosis and treatment (surgical and medical) of infertility when such infertility is the result of malformation, disease or dysfunction. Such coverage is available as follows: **Basic Infertility Services.** Basic infertility services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York. However, Members must be between the ages of 21 and 44 (inclusive) in order to be considered a candidate for these services. Services include: Initial evaluation; Semen analysis; Laboratory evaluation; Evaluation of ovulatory function; Postcoital test; Endometrial biopsy; Pelvic ultra sound; Hysterosalpingogram; Sono-hystogram; Testis biopsy; Blood tests; and Medically appropriate treatment of ovulatory dysfunction. Additional tests may be covered if the tests are determined to be Medically Necessary. **Comprehensive Infertility Services.** If the basic infertility services do not result in increased fertility, we cover comprehensive infertility services. Services include: Ovulation induction and monitoring; Pelvic ultra sound; Artificial insemination; Hysteroscopy; Laparoscopy; and Laparotomy. **Exclusions and Limitations.** We do not cover: In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers; Costs for an ovum donor or donor sperm; Sperm storage costs; 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. All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine.	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)

Outpatient and Professional Services (continued) (for other than Mental Health and Substance Use)	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Infusion Therapy - Performed in a PCP Office We cover infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required you to be hospitalized. Drugs or nutrients administered directly into the veins are considered infusion therapy.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Infusion Therapy - Performed in a Specialists Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Infusion Therapy - Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Infusion Therapy - Home Infusion Therapy	25% Coinsurance after Deductible	25% Coinsurance after Deductible
Laboratory Procedures - Performed in a PCP Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Laboratory Procedures - Performed in a Specialist Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Laboratory Procedures - Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Maternity and Newborn Care - Prenatal Care	Covered In Full	30% Coinsurance after Deductible
Maternity and Newborn Care - Inpatient Hospital Services and Birthing Center 1 Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Maternity and Newborn Care - Physician and Midwife Services for Delivery	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Maternity and Newborn Care - Breast Pump We cover the cost of renting one breast pump per pregnancy for duration of breast feeding.	Covered in Full	30% Coinsurance after Deductible
Maternity and Newborn Care - Postnatal Care	0% Coinsurance Not subject to Deductible	30% Coinsurance after Deductible
Outpatient Hospital Surgery Facility Charge	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Preadmission Testing	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic Radiology Services - Performed in a PCP Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic Radiology Services - Performed in a Specialists Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Outpatient and Professional Services (continued) (for other than Mental Health and Substance Use)	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Diagnostic Radiology Services - Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Therapeutic Radiology Services - Performed in a Freestanding Radiology Facility or Specialist Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Therapeutic Radiology Services - Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Rehabilitation Services - Physical Therapy, Occupational Therapy or Speech Therapy	$40 Copayment then you pay 0% Not subject to Deductible	30% Coinsurance after Deductible
Second Opinions on the Diagnosis of Cancer, Surgery & Other	$40 Copayment then you pay 0% Not subject to Deductible	30% Coinsurance after Deductible Second Opinions on Diagnosis of Cancer are Covered at Participating Cost-Sharing for Non-Participating Specialist with referral.
Surgical Services (surgeon, assistant surgeon, anesthetist) - Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants & Interruption of Pregnancy	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**
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	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Additional Benefits, Equipment and Devices	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**
Applied Behavioral Analysis Treatment for Autism Spectrum Disorder "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.	$40 Copayment then you pay 0% Not subject to Deductible	30% Coinsurance after Deductible

Additional Benefits, Equipment and Devices (continued)	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Assistive Communication Devices for Autism Spectrum Disorder We cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed physician or a licensed psychologist if you are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide you with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. We will only cover devices that generally are not useful to a person in the absence of communication impairment. We do not cover items, such as, but not limited to, laptops, desktop, or tablet computers. We cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diabetic Equipment, Supplies and Insulin (30 day supply)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diabetic Education	$40 Copayment then you pay 0% Not subject to Deductible	30% Coinsurance after Deductible
Durable Medical Equipment and Braces	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Hearing Aids – External Single Purchase Once Every Plan Year	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Hearing Aids - Cochlear Implants One Per Ear Per Time Covered	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Hospice Care – Inpatient 210 Days per Plan Year	20% Coinsurance after Deductible	25% Coinsurance after Deductible
Hospice Care – Outpatient 5 Visits for Family Bereavement Counseling	20% Coinsurance after Deductible	25% Coinsurance after Deductible
Medical Supplies We cover medical supplies that are required for the treatment of a disease or injury which is covered under the certificate. We also cover maintenance supplies (e.g., ostomy supplies) for conditions covered under the certificate. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not cover over-the-counter medical supplies.	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Additional Benefits, Equipment and Devices (continued)	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Prosthetics – External 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. We do not cover orthotics (e.g., shoe inserts). One prosthetic device, per limb, per Plan Year.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Prosthetics – Internal	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Services (for other than Mental Health and Substance Use)	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Observation Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Medical Visits Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Autologous Blood Banking Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Skilled Nursing Facility	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Rehabilitation Services - Physical Therapy, Occupational Therapy or Speech Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Mental Health Care and Substance Use Services	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**
Mental Health Care Services Inpatient Services Preauthorization is Not Required for Emergency Admissions	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Mental Health Care Services Outpatient Services	$40 Copayment then you pay 0% Not subject to Deductible	30% Coinsurance after Deductible
Substance Use Services Inpatient Services Preauthorization is Not Required for Emergency Admissions	20% Coinsurance after Deductible	40% Coinsurance after Deductible

Mental Health Care and Substance Use Services (continued)	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Substance Use Services Outpatient Services **20 Visits May Be Used For Family Counseling**	$40 Copayment then you pay 0% Not subject to Deductible	30% Coinsurance after Deductible
Prescription Drug Coverage	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**
Retail Pharmacy (30 day supply) - Tier 1 (generic)	$20 Copayment per supply Not subject to Deductible	$20 Copayment per supply Not subject to Deductible
Retail Pharmacy (30 day supply) - Tier 2 (formulary brand)	$40 Copayment per supply Not subject to Deductible	$40 Copayment per supply Not subject to Deductible
Retail Pharmacy (30 day supply) - Tier 3 (non-formulary brand)	$40 Copayment per supply Not subject to Deductible	$40 Copayment per supply Not subject to Deductible
Enteral Formulas - Tier 1 (Generic)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Enteral Formulas - Tier 2 (formulary brand)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Enteral Formulas - Tier 3 (non-formulary brand)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
WELLNESS BENEFITS	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**
Exercise Facility Reimbursement Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited to actual workout visits. We will not provide reimbursement for equipment, clothing, vitamins or other services that may be offered by the facility (e.g., massages, etc.).	Up to $200 per 6 month period	

Pediatric Vision Care: We cover emergency, preventive and routine vision care for Members up to age 19.	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Vision Examinations One Exam per 12-Month Period	0% Coinsurance Not subject to Deductible	30% Coinsurance Not subject to Deductible
Prescribed Lenses and Frames We cover standard prescription lenses or contact lenses, one (1) time in any twelve (12) month period, unless it is Medically Necessary for you to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic. We also cover standard frames adequate to hold lenses one (1) time in any twelve (12) month period, unless it is Medically Necessary for you to have new frames more frequently, as evidenced by appropriate documentation.	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
Pediatric Dental Care: We cover the following dental care services for Members up to age 19	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**
Preventive/Routine Dental Care One Dental Exam & Cleaning Per 6-Month Period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals	Covered in Full	30% Coinsurance after Deductible
Major Dental - Endodontics, Periodontics and Prosthodontics	30% Coinsurance Not subject to Deductible	50% Coinsurance after Deductible
Orthodontia	50% Coinsurance Not subject to Deductible	50% Coinsurance after Deductible

Exclusions

No coverage is available under the certificate for the following:

A. 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.

B. 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.

C. 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.

D. 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 except as specifically stated in the Outpatient and Professional Services and Pediatric Dental Care sections of this Certificate.

E. 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, or 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 the Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of your Appeal rights.

F. 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).

G. 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.

H. 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.

I. 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.

J. 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).

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

L. 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.

M. Services not Listed.
We do not cover services that are not listed in this Certificate as being covered.

N. Services Provided by a Family Member.
We do not cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of you or your Spouse.

O. Services Separately Billed by Hospital Employees.
We do not cover services rendered and separately billed by employees of hospitals, laboratories or other institutions.

P. Services with No Charge.
We do not cover services for which no charge is normally made.

Q. 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 of this Certificate.

R. 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^{SM} is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).