

# Aetna Student Health

## Plan Design and Benefits Summary Columbia University Gold Plan

Policy Year: 2014 - 2015

Policy Number: 704502



[www.aetnastudenthealth.com](http://www.aetnastudenthealth.com)

(800) 859-8471

This Plan Design and Benefits Summary has been updated as of April 1, 2015. All changes are highlighted in yellow below. Please note that, unless otherwise indicated, all changes are retroactive to your plan effective date.



This is a brief description of the Student Health Plan. The Plan is available for Columbia University students and their eligible dependents. 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](http://www.aetnastudenthealth.com) or by scheduling an appointment with the Columbia Student Health Insurance Office. If any discrepancy exists between this Benefit Summary and the Certificate, the Certificate of Coverage will govern and control the payment of benefits.

## Columbia University

Columbia Health offers a wide array of services provided by Medical Services, Counseling and Psychological Services, Disability Services, Sexual Violence Response, and Alice! Health Promotion. Detailed information including hours of operation, student insurance information, and department services can be found at [health.columbia.edu](http://health.columbia.edu).

For more information, call Medical Services and Counseling and Psychological Services at (212) 854-2284 or contact the clinician-on-call at (212) 854-9797 for medical advice when Medical Services is closed.

## Coverage Periods (Morningside Campus)

**Morningside Campus Students:** Coverage for all insured Morningside students enrolled 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
Fall One Month Early Arrival	08/01/2014	08/31/2014	08/31/2014
Fall Two Month Early Arrival	07/01/2014	08/31/2014	07/31/2014
Annual	09/01/2014	08/14/2015	09/19/2014
Fall (Only applies to students completing their degree program in December 2014)	09/01/2014	01/19/2015	09/19/2014
Spring Early Arrival	01/01/2015	01/19/2015	01/19/2015
Spring/Summer (Only applies to students joining the university in the Spring term)	01/20/2015	08/14/2015	01/30/2015

<b>Summer</b> (Only applies to students joining the university in the Summer term)	05/18/2015	08/14/2015	06/12/2015
--	------------	------------	------------

**Eligible Dependents:** Coverage for dependents eligible under 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 for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	09/01/2014	08/14/2015	09/19/2014
Fall	09/01/2014	01/19/2015	09/19/2014
Spring/Summer	01/20/2015	08/14/2015	01/30/2015
Summer	05/18/2015	08/14/2015	06/12/2015

### Morningside Campus Rates

The rates below include both premiums for the student health insurance plan underwritten by Aetna Life Insurance Company, as well as Columbia University fees for dental services provided by Columbia Morningside Dental.

Morningside Campus Rates			
	Fall Semester	Spring/Summer Semester	Summer
Student	\$1,023	\$1,485	\$1,023
Spouse/ Domestic Partner	\$3,231	\$4,688	N/A
Child(ren)	\$1,711	\$2,483	N/A

**Morningside Early Arrival Plan:**Fall 2 months (July 1-August 31): **\$594**Fall 1 month (August 1-August 31): **\$297**Spring (January 1- January 19): **\$136****Coverage Periods (Affiliate Schools)**

**Affiliate Schools (Jewish Theological Seminary, Union Theological Seminary, & Teachers College) Students:** Coverage for all insured Affiliate School students enrolled 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
<b>Fall One Month Early Arrival</b>	08/01/2014	08/31/2014	08/31/2014
<b>Fall Two Month Early Arrival</b>	07/01/2014	08/31/2014	07/31/2014
<b>Annual</b>	09/01/2014	08/14/2015	09/19/2014
<b>Fall</b> (Only applies to students completing their degree program in December 2014)	09/01/2014	01/19/2015	09/19/2014
<b>Spring Early Arrival</b>	01/01/2015	01/19/2015	01/19/2015
<b>Spring/Summer</b> (Only applies to students joining the university in the Spring term)	01/20/2015	08/14/2015	01/30/2015
<b>Summer</b> (Only applies to students joining the university in the Summer term)	05/18/2015	08/14/2015	06/12/2015

**Eligible Dependents:** Coverage for dependents eligible under 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 for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	09/01/2014	08/14/2015	09/19/2014
Fall	09/01/2014	01/19/2015	09/19/2014
Spring/Summer	01/20/2015	08/14/2015	01/30/2015
Summer	05/18/2015	08/14/2015	06/12/2015

### Affiliate Schools Rates

The rates below include both premiums for the student health insurance plan underwritten by Aetna Life Insurance Company, as well as Columbia University fees for dental services provided by Columbia Morningside Dental.

Affiliate School Rates		
	Fall Semester	Spring/Summer Semester
Student	\$1,282	\$1,861
Spouse/ Domestic Partner	\$4,135	\$5,999
Child(ren)	\$2,162	\$3,137

### Affiliate Schools Early Arrival Plan:

2 months (July 1-August 31): **\$759**

1 month (August 1-August 31): **\$379**

Spring (January 1- January 19): **\$171**

## Student Coverage

### Eligibility

#### Full-Time Students

All registered full-time students are enrolled in the Gold Level of the Columbia Student Health Insurance Plan if no valid waiver request is submitted before the deadline. Full-time students must confirm any specific insurance selection every year by actively enrolling in the Gold or Platinum Level of the Plan or by requesting a waiver from enrollment in the Columbia Student Health Insurance Plan and demonstrating coverage under another comparable policy. Students may choose to upgrade to the Platinum Level of the Plan by indicating their choice through the insurance selection portion of the Student Services OnLine (SSOL) by the published deadline. Enrollment in the Columbia Student Health Insurance Plan, either by default enrollment or online selection, is effective only upon the student's registration for the term for which coverage will be active.

Once the student's insurance coverage decision has been determined for the Fall term, either by online selection, default enrollment, or waiver request, that decision will automatically be continued in the following Spring term as long as the student remains registered at the University. It is not possible to upgrade to the Platinum level or downgrade to the Gold level of coverage in the Spring. For students who do not register for the Spring 2015 Term, their insurance coverage will terminate on January 19, 2015.

#### Part-Time Students

During the open enrollment period part-time students may choose to enroll in the Columbia Student Health Insurance Plan. Enrolling in the plan will automatically initiate enrollment in the Columbia Health, which is required. Please visit [health.columbia.edu](http://health.columbia.edu) for more information about on-campus services and the Columbia Health Fee. Part-time students who have been insured under the Plan in previous years and wish to enroll again must re-enroll by published deadline in order to avoid a break in coverage.

#### Early Arrival

For students arriving on campus earlier than September 1 who have confirmed their University enrollment and registration for Fall term, Aetna Student Health offers an optional Early Arrival Insurance Plan. This plan is recommended for students who will have no other coverage during this period. The plan is offered to students who have confirmed their enrollment in the Columbia Plan for the full benefit period from September 1, 2014 through August 14, 2015. The benefits are comparable to those provided through the Columbia Gold level of the student insurance plan.

NOTE: If it is determined your University enrollment and registration status changes and you are no longer eligible to enroll in the Aetna student insurance plan, you will be refunded the Early Arrival Premium and you will be responsible for all claims paid under this Early Arrival Plan.

### **Funded Graduate Students**

Please contact your departmental administrator, Financial Aid Office, or Fellowship Office for information about whether your school provides funding to cover any portion of the Student Health Insurance Plan premium.

### **Student-Veterans**

Student-veterans may be eligible for health care benefits through the Veterans Administration (VA) for illnesses and injuries related to their service. Columbia Health recommends that Columbia student-veterans confirm their status with the VA and visit the Veterans Affairs website at <http://veteransaffairs.columbia.edu/content/columbia-health>. All students will be enrolled in this plan unless a waiver request is submitted and approved by the waiver request deadline.

### **Students Studying Abroad**

Students expecting to participate in any Study Abroad program are encouraged to consult with an Insurance Specialist at the Columbia Student Health Insurance Office about the type of insurance coverage the student will rely on while traveling.

## **How to Enroll**

### **Morningside Campus**

Eligible students will be enrolled in this Plan, unless the completed waiver application has been received by Columbia University by the published enrollment deadline. To confirm enrollment in the Columbia Gold Level of the Plan (full-time students) or to request enrollment in the Columbia Gold Level (part-time students), a student must enter the confirmation or request by indicating their choice through the insurance selection of Student Services OnLine (SSOL).

### **Teachers College (TC)**

Full-time and residential students are enrolled in the Columbia Health Program and the Columbia Plan. Full-time students may upgrade to the Platinum level or request a waiver from the Columbia Plan before the deadline. Part-time students enrolled in degree-granting programs may elect enrollment in the Columbia Student Health Insurance Plan, which also initiates enrollment in Columbia Health. Enrollment is coordinated by the TC Insurance and Immunization Records Office. For questions about Columbia Health and the Columbia Student Health Insurance Plan, please visit [www.tc.edu/health](http://www.tc.edu/health).

### **Jewish Theological Seminary (JTS)**

Full-time and residential students are enrolled in Columbia Health and the Columbia Student Health Insurance Plan if no valid waiver request is submitted by the enrollment/waiver deadlines. Part-time and exempt status students may elect enrollment in the Columbia Student Health Insurance Plan, which initiates enrollment in Columbia Health. Enrollment for JTS students is coordinated by the JTS Office of Human Resources. Please note that student health insurance for Double Degree Barnard College students is administered through Barnard. For questions about

Columbia Health and the Columbia Student Health Insurance Plan, refer to the JTS Office of Human Resources' Student Health Insurance website at [http://jtsa.edu/Campus\\_Life/Student\\_Services/Student\\_Health\\_Insurance.xml](http://jtsa.edu/Campus_Life/Student_Services/Student_Health_Insurance.xml).

### **Union Theological Seminary (UTS)**

Full-time and residential UTS students are enrolled in Columbia Health and the Columbia Student Health Insurance Plan. Part-time students may elect enrollment in the Columbia Student Health Insurance Plan, which initiates enrollment in Columbia Health. Enrollment is coordinated by the UTS Office of Student Life. For questions about enrollment, please refer to the UTS Office of Student Life. For questions about Columbia Health and the Columbia Student Health Insurance Plan, please contact the UTS Office of Student Life.

## **Dependent Coverage**

### **Eligibility**

Covered students may also enroll their lawful spouse, same-sex or opposite-sex domestic partner and dependent children up to the age of 26.

### **Enrollment**

To enroll the dependent(s) of a covered student, please complete the [Dependent Enrollment Form on the Columbia Health website](#). The form, along with supporting documentation, should be submitted to the Columbia Student Health Insurance Office, 503 Alfred Lerner Hall, MC2605, 2920 Broadway, New York, NY 10027. Please bring both the form and supporting documentation at the same time to ensure timely enrollment.

Dependent enrollment applications will not be accepted after the enrollment deadline unless there is a significant life change that directly affects their insurance coverage. An example of a significant life change would be loss of health coverage under another health plan.

Please contact the Columbia Health Insurance Office at [studentinsurance@columbia.edu](mailto:studentinsurance@columbia.edu) or **212-854-3286** for more information or with any questions.

## **Special Enrollment Periods**

You, your Spouse or Child can also enroll for coverage within 31 days of the loss of coverage in a health plan if coverage was terminated because you, your Spouse or Child 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, your Spouse or Child can also enroll 31 days from exhaustion of your COBRA or continuation coverage.

We must receive notice and premium payment within 31 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, your Spouse or Child, can also enroll for coverage within 31 days of the following event:

1. You, or your Spouse or Child lose[s] eligibility for Medicaid or a state child health plan.

We must receive notice and premium payment within 31 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.

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.

**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](http://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](http://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

Columbia Health Medical Services is your primary care provider (including for any enrolled Spouse/Partner) and responsible for determining the most appropriate treatment for your health care needs. **Most off-campus care requires a referral from Columbia Health.**

You do not need a Referral from Columbia Health to a Participating Provider for the following services:

- 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 more than 50 miles from the Morningside campus

Dependent children do not need a referral.

A penalty for failure to obtain a referral will be applied 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
<b>Deductible*</b> <b>Individual</b> <b>Family</b>  <b>Out-of-Pocket Limit**</b> <b>Individual</b> <b>Family</b>	\$150 None  \$5,000 \$12,700	\$500 None  \$6,000 None
*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.		

<b>OUTPATIENT AND PROFESSIONAL SERVICES (for other than Mental Health and Substance Use)</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>
<b>Office Visits - Primary Care (or home visits)</b>	\$40 Copayment then you pay 0% Coinsurance with Referral or 30% Coinsurance without Referral  Not subject to Deductible	30% Coinsurance
<b>Office Visits - Specialists (or home visits)</b>	\$40 Copayment then you pay 0% Coinsurance with Referral or 30% Coinsurance without Referral  Not subject to Deductible	30% Coinsurance
<b>PREVENTIVE CARE</b> 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”).	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>
<b>Well-Baby and Well-Child Care</b>	Covered in Full Not subject to Deductible	30% Coinsurance

<b>OUTPATIENT AND PROFESSIONAL SERVICES (for other than Mental Health and Substance Use) (continued)</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>
<b>Adult Annual Physical Examinations</b>	Covered in Full Not subject to Deductible	30% Coinsurance
<b>Adult Immunizations</b>	Covered in Full Not subject to Deductible	30% Coinsurance
<b>Well-Woman Examinations</b>	Covered in Full Not subject to Deductible	30% Coinsurance
<b>Mammograms</b>	Covered in Full Not subject to Deductible	30% Coinsurance
<b>Family Planning and Reproductive Health Services</b> 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 Not subject to Deductible	30% Coinsurance
<b>Vasectomy</b> We do not cover services related to the reversal of elective sterilizations.	20% Coinsurance	30% Coinsurance
<b>Bone Mineral Density Measurements or Testing</b>	Covered in Full Not subject to Deductible	30% Coinsurance
<b>Screening for Prostate Cancer</b>	Covered in Full Not subject to Deductible	30% Coinsurance

<b>OUTPATIENT AND PROFESSIONAL SERVICES (for other than Mental Health and Substance Use) (continued)</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>
<b>All other preventive services required by USPSTF and HRSA</b>	Covered in Full Not subject to Deductible	30% Coinsurance
<b>When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</b> You may contact us at the number on your ID card or visit our website at <a href="http://www.aetnastudenthealth.com">www.aetnastudenthealth.com</a> 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)
<b>EMERGENCY CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>
<b>Emergency Ambulance Transportation (Pre-Hospital Emergency Medical Services)</b> 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	20% Coinsurance
<b>Non-Emergency Ambulance Services</b>	20% Coinsurance	20% Coinsurance

EMERGENCY CARE (continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost- Sharing
<p><b>Emergency Services</b></p> <p>The copayment is waived if admitted to the Hospital.</p> <p>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.</p> <p>We do not cover follow-up care or routine care provided in a Hospital emergency department.</p> <p><i>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.</i></p> <p><i>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.</i></p>	<p>\$100 Copayment then you pay 0% Coinsurance</p> <p>Not subject to Deductible</p>	<p>\$100 Copayment then you pay 0% Coinsurance</p> <p>Not subject to Deductible</p>
<p><b>Urgent Care Center</b></p> <p>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.</p>	<p>\$40 Copayment then you pay 0% Coinsurance</p> <p>Not subject to Deductible</p>	<p>30% Coinsurance</p>

<b>OUTPATIENT AND PROFESSIONAL SERVICES (for other than Mental Health and Substance Use)</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost- Sharing</b>
<b>Advanced Imaging Services (Performed in a Freestanding Radiology Facility or Office Setting)</b>	20% Coinsurance	30% Coinsurance
<b>Advanced Imaging Services (Performed as Outpatient Hospital Services)</b>	20% Coinsurance	30% Coinsurance
<b>Allergy Testing and Treatment (Performed in a PCP Office)</b> Effective 5/1/15.	20% Coinsurance	30% Coinsurance
<b>Allergy Testing and Treatment (Performed in a Specialist Office)</b> Effective 5/1/15.	20% Coinsurance	30% Coinsurance
<b>Ambulatory Surgery Center</b>	20% Coinsurance	30% Coinsurance
<b>Anesthesia Services (all settings)</b>	20% Coinsurance	30% Coinsurance
<b>Autologous Blood Banking Services</b>	20% Coinsurance	30% Coinsurance
<b>Cardiac &amp; Pulmonary Rehabilitation (Performed in a Specialist Office)</b>	\$40 Copayment then you pay 0% Coinsurance  Not subject to Deductible	30% Coinsurance
<b>Cardiac &amp; Pulmonary Rehabilitation (Performed as Outpatient Hospital Services)</b>	\$40 Copayment then you pay 0% Coinsurance  Not subject to Deductible	30% Coinsurance



<b>OUTPATIENT AND PROFESSIONAL SERVICES (continued)</b> <b>(for other than Mental Health and Substance Use)</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost- Sharing</b>
<b>Cardiac &amp; Pulmonary Rehabilitation (Performed as Inpatient Hospital Services)</b>	Included As Part of Inpatient Hospital Service Cost-Sharing	Included As Part of Inpatient Hospital Service Cost-Sharing
<b>Chemotherapy (Performed in a PCP Office)</b>	\$40 Copayment then you pay 0% Coinsurance  Not subject to Deductible	30% Coinsurance
<b>Chemotherapy (Performed in a Specialist Office)</b>	\$40 Copayment then you pay 0% Coinsurance  Not subject to Deductible	30% Coinsurance
<b>Chemotherapy (Performed as Outpatient Hospital Services)</b>	\$40 Copayment then you pay 0% Coinsurance  Not subject to Deductible	30% Coinsurance
<b>Chiropractic Services</b>	\$40 Copayment then you pay 0% Coinsurance  Not subject to Deductible	30% Coinsurance

<b>OUTPATIENT AND PROFESSIONAL SERVICES (continued) (for other than Mental Health and Substance Use)</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost- Sharing</b>
<b>Clinical Trials</b>	Use Cost-Sharing for Appropriate Service	Use Cost-Sharing for Appropriate Service
<b>Diagnostic Testing - Performed in a PCP Office</b>  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	30% Coinsurance
<b>Diagnostic Testing - Performed in a Specialists Office</b>	20% Coinsurance	30% Coinsurance
<b>Diagnostic Testing - Performed as Outpatient Hospital Services</b>	20% Coinsurance	30% Coinsurance
<b>Dialysis - Performed in a PCP Office</b>	\$40 Copayment then you pay 0% Coinsurance  Not subject to Deductible	30% Coinsurance
<b>Dialysis - Performed in a Freestanding Center or Specialist Office Setting</b>	\$40 Copayment then you pay 0% Coinsurance  Not subject to Deductible	30% Coinsurance
<b>Dialysis - Performed as Outpatient Hospital Services</b>	\$40 Copayment then you pay 0% Coinsurance  Not subject to Deductible	30% Coinsurance

<b>OUTPATIENT AND PROFESSIONAL SERVICES (continued)</b> <b>(for other than Mental Health and Substance Use)</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost- Sharing</b>
<b>Habilitation Services - Physical Therapy, Occupational Therapy, or Speech Therapy</b>	\$40 Copayment then you pay 0% Coinsurance  Not subject to Deductible	30% Coinsurance
<b>Home Health Care</b> Unlimited visits per Plan Year.	20% Coinsurance	30% Coinsurance
<b>Infertility Services</b> 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:  <b>Basic Infertility Services.</b> 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 appropriate treatment of ovulatory dysfunction.  Additional tests may be covered if the tests are determined to be Medically Necessary.  <b>Comprehensive Infertility Services.</b> 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.	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)

<b>OUTPATIENT AND PROFESSIONAL SERVICES (continued)</b> <b>(for other than Mental Health and Substance Use)</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost- Sharing</b>
<b>Infertility Services (continued)</b> <b>Exclusions and Limitations.</b> 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)
<b>Infusion Therapy - Performed in a PCP Office</b> 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.	\$40 Copayment then you pay 0% Coinsurance  Not subject to Deductible	30% Coinsurance
<b>Infusion Therapy - Performed in a Specialists Office</b> 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.	\$40 Copayment then you pay 0% Coinsurance  Not subject to Deductible	30% Coinsurance
<b>Infusion Therapy - Performed as Outpatient Hospital Services</b> 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.	\$40 Copayment then you pay 0% Coinsurance  Not subject to Deductible	30% Coinsurance

<b>OUTPATIENT AND PROFESSIONAL SERVICES (continued) (for other than Mental Health and Substance Use)</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost- Sharing</b>
<b>Infusion Therapy - Home Infusion Therapy</b>	20% Coinsurance	30% Coinsurance
<b>Laboratory Procedures - Performed in a PCP Office</b>	20% Coinsurance	30% Coinsurance
<b>Laboratory Procedures - Performed in a Specialist Office</b>	20% Coinsurance	30% Coinsurance
<b>Laboratory Procedures - Performed as Outpatient Hospital Services</b>	20% Coinsurance	30% Coinsurance
<b>Maternity and Newborn Care - Prenatal Care</b>	Covered in Full Not subject to Deductible	30% Coinsurance
<b>Maternity and Newborn Care - Inpatient Hospital Services and Birthing Center</b> Home Care visit is covered at no Cost-Sharing if mother is discharged from hospital early.	20% Coinsurance	30% Coinsurance
<b>Maternity and Newborn Care - Physician and Midwife Services for Delivery</b>	20% Coinsurance	30% Coinsurance
<b>Maternity and Newborn Care - Breast Pump</b> We cover the cost of renting one breast pump per pregnancy for duration of breast feeding.	Covered in Full Not subject to Deductible	30% Coinsurance
<b>Maternity and Newborn Care - Postnatal Care</b>	0% Coinsurance  Not subject to Deductible	30% Coinsurance
<b>Outpatient Hospital Surgery Facility Charge</b>	20% Coinsurance	30% Coinsurance
<b>Preadmission Testing</b>	20% Coinsurance	30% Coinsurance
<b>Diagnostic Radiology Services - Performed in a Freestanding Radiology Facility or Specialist Office</b>	20% Coinsurance	30% Coinsurance
<b>Diagnostic Radiology Services - Performed as Outpatient Hospital Services</b>	20% Coinsurance	30% Coinsurance
<b>Diagnostic Testing - Performed as Outpatient Hospital Services</b>	20% Coinsurance	30% Coinsurance
<b>Therapeutic Radiology Services - Performed in a Freestanding Radiology Facility or Specialist Office</b>	20% Coinsurance	30% Coinsurance

<b>OUTPATIENT AND PROFESSIONAL SERVICES (continued) (for other than Mental Health and Substance Use)</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost- Sharing</b>
<b>Therapeutic Radiology Services - Performed as Outpatient Hospital Services</b>	20% Coinsurance	30% Coinsurance
<b>Rehabilitation Services - Physical Therapy, Occupational Therapy or Speech Therapy</b> Unlimited visits per condition per Plan Year combined therapies.  Speech and Physical Therapy are only covered following a Hospital stay or surgery.	\$40 Copayment then you pay 0% Coinsurance  Not subject to Deductible	30% Coinsurance
<b>Second Opinions on the Diagnosis of Cancer, Surgery &amp; Other</b>  Second Opinions on Diagnosis of Cancer are Covered at Participating Cost-Sharing for Non-Participating Specialist when a Referral is obtained.	\$40 Copayment then you pay 0% Coinsurance  Not subject to Deductible	30% Coinsurance
<b>SURGICAL SERVICES (surgeon, assistant surgeon, anesthetist) - Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive &amp; Corrective Surgery; Transplants &amp; Interruption of Pregnancy</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost- Sharing</b>
<b>Inpatient Hospital Surgery</b>	20% Coinsurance  Preauthorization Required	30% Coinsurance  Preauthorization Required
<b>Outpatient Hospital Surgery</b>	20% Coinsurance	30% Coinsurance
<b>Surgery Performed at an Ambulatory Surgical Center</b>	20% Coinsurance	30% Coinsurance
<b>Office Surgery</b>	20% Coinsurance	30% Coinsurance

<b>ADDITIONAL BENEFITS, EQUIPMENT AND DEVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost- Sharing</b>
<b>Applied Behavioral Analysis Treatment for Autism Spectrum Disorder</b> “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.	20% Coinsurance	30% Coinsurance
<b>Assistive Communication Devices for Autism Spectrum Disorder</b> 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	30% Coinsurance
<b>Diabetic Equipment, Supplies and Insulin (30 day supply)</b>	20% Coinsurance	30% Coinsurance
<b>Diabetic Education</b>	\$40 Copayment then you pay 0% Coinsurance  Not subject to Deductible	30% Coinsurance
<b>Durable Medical Equipment and Braces</b>	20% Coinsurance	30% Coinsurance

<b>ADDITIONAL BENEFITS, EQUIPMENT AND DEVICES (continued)</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost- Sharing</b>
<b>Hearing Aids – External</b> Single purchase once every plan year.	20% Coinsurance	30% Coinsurance
<b>Hearing Aids - Cochlear Implants</b> One per Ear per time covered.	20% Coinsurance	30% Coinsurance
<b>Hospice Care – Inpatient</b> Unlimited Days per Plan Year.	20% Coinsurance  Preauthorization Required	30% Coinsurance  Preauthorization Required
<b>Hospice Care – Outpatient</b> 5 Visits for Family Bereavement Counseling.	20% Coinsurance	30% Coinsurance
<b>Medical Supplies</b>  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	30% Coinsurance
<b>Prosthetics – External</b>  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	30% Coinsurance
<b>Prosthetics - Internal</b>	20% Coinsurance	30% Coinsurance



<b>INPATIENT SERVICES (for other than Mental Health and Substance Use)</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost- Sharing</b>
<b>Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac &amp; Pulmonary Rehabilitation, &amp; End of Life Care)</b>	20% Coinsurance  Preauthorization Required	30% Coinsurance  Preauthorization Required
<b>Observation Services</b>	20% Coinsurance	30% Coinsurance
<b>Inpatient Medical Visits Services</b>	20% Coinsurance  Preauthorization Required	30% Coinsurance  Preauthorization Required
<b>Skilled Nursing Facility</b>	20% Coinsurance  Preauthorization Required	30% Coinsurance  Preauthorization Required
<b>Inpatient Rehabilitation Services - Physical Therapy, Occupational Therapy or Speech Therapy</b>	20% Coinsurance  Preauthorization Required	30% Coinsurance  Preauthorization Required
<b>MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost- Sharing</b>
<b>Mental Health Care Inpatient Services</b>  Preauthorization is Not Required for Emergency Admissions.	20% Coinsurance  Preauthorization Required	30% Coinsurance  Preauthorization Required

<b>MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES (continued)</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost- Sharing</b>
<b>Mental Health Care Outpatient Services</b>	\$20 Copayment then you pay 0% Coinsurance  Not subject to Deductible	30% Coinsurance
<b>Substance Use Inpatient Services</b>  Preauthorization is Not Required for Emergency Admissions.	20% Coinsurance  Preauthorization Required	30% Coinsurance  Preauthorization Required
<b>Substance Use Outpatient Services</b>  Unlimited Visits a Plan Year May Be Used For Family Counseling.	\$20 Copayment then you pay 0% Coinsurance  Not subject to Deductible	30% Coinsurance
<b>PRESCRIPTION DRUG COVERAGE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost- Sharing</b>
<b>Retail Pharmacy (30 day supply) - Tier 1 (generic)</b>	\$20 Copayment	Copayment per supply of 30% of the Allowed Amount
<b>Retail Pharmacy (30 day supply) - Tier 2 (formulary brand)</b>	\$50 Copayment	Copayment per supply of 30% of the Allowed Amount
<b>Retail Pharmacy (30 day supply) - Tier 3 (non-formulary brand)</b>	\$75 Copayment	Copayment per supply of 30% of the Allowed Amount

<b>PRESCRIPTION DRUG COVERAGE (continued)</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost- Sharing</b>
<b>Mail Order Pharmacy (30 day supply) - Tier 1 (generic)</b>	Not Covered	Not Covered
<b>Mail Order Pharmacy (30 day supply) - Tier 2 (formulary brand)</b>	Not Covered	Not Covered
<b>Mail Order Pharmacy (30 day supply) - Tier 3 (non-formulary brand)</b>	Not Covered	Not Covered
<b>Mail Order More than 30-day supply Up to a 90-day supply - Tier 1 (generic)</b>	Not Covered	Not Covered
<b>Mail Order More than 30-day supply Up to a 90-day supply - Tier 2 (formulary brand)</b>	Not Covered	Not Covered
<b>Mail Order More than 30-day supply Up to a 90-day supply - Tier 3 (non-formulary brand)</b>	Not Covered	Not Covered
<b>Enteral Formulas - Tier 1 (Generic)</b>	20% Coinsurance	30% Coinsurance
<b>Enteral Formulas - Tier 2 (formulary brand)</b>	20% Coinsurance	30% Coinsurance
<b>Enteral Formulas - Tier 3 (non-formulary brand)</b>	20% Coinsurance	30% Coinsurance
<b>WELLNESS BENEFITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost- Sharing</b>
<b>Exercise Facility Reimbursement</b> 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, up to an additional \$100 per 6 month period for Spouse	
<b>PEDIATRIC VISION CARE</b> We cover emergency, preventive and routine vision care for members up to age 19.	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost- Sharing</b>
<b>Vision Examinations</b> One Exam per 12-Month Period	0% Coinsurance  Not subject to Deductible	30% Coinsurance  Not subject to Deductible

<b>PEDIATRIC VISION CARE (continued)</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost- Sharing</b>
<b>Prescribed Lenses and Frames</b> 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
<b>Contact Lenses</b>	0% Coinsurance  Not subject to Deductible	30% Coinsurance  Not subject to Deductible
<b>PEDIATRIC DENTAL CARE</b> We cover the following dental care services for members up to age 19.	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost- Sharing</b>
<b>Preventive/Routine Dental Care</b> 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  Not Subject to Deductible	Covered in full
<b>Major Dental - Endodontics, Periodontics and Prosthodontics</b>	30% Coinsurance  Not subject to Deductible	50% Coinsurance
<b>Orthodontia</b>	50% Coinsurance  Not subject to Deductible	50% Coinsurance

## 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.

## Exclusions (continued)

### 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.

## Exclusions (continued)

### 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. War.

We will not cover an illness, treatment or medical condition due to war, declared or undeclared.

### S. 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 Columbia University Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health<sup>SM</sup> is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).