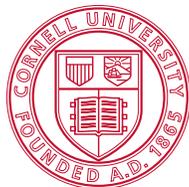


Cornell University

# Student Health Insurance Plan (SHIP)

Rates & Certificate of Coverage

2014 – 2015



Cornell University

## RATES

### CORNELL UNIVERSITY STUDENT HEALTH INSURANCE PLAN (SHIP)

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2014 – 2015 Rates Undergraduates and Graduate Students	
Student	\$2,352
Spouse/Domestic Partner	\$4,709
Child(ren)	\$3,385

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This is Your  
**PARTICIPATING PROVIDER ORGANIZATION STUDENT INSURANCE  
CERTIFICATE**

Issued by

**Cornell University**

This Certificate of Coverage (“Certificate”) explains the benefits available to You under a Contract between Cornell University (hereinafter referred to as “We”, “Us”, or “Our”) and You. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

This Certificate offers You the option to receive Covered Services on three benefit levels:

**In-Area Participating Provider Benefits.** In-Area Participating Provider benefits are the highest level of coverage available. The In-Area Participating Provider Network are those providers located within a defined area (of reasonable proximity), to Cornell University, as defined by travel time, distance, or Zip code. Aetna Student Health has arranged for you to access a Participating Provider Network in the Ithaca area and in your local community. You should consider going to Gannett first and using an In-Area Participating Provider, because it will maximize your savings and reduce your out-of-pocket expenses.

You may obtain information regarding Participating Providers by contacting Aetna Student Health at **(800) 859-8475**, or through the Internet by accessing DocFind at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).

The following zip codes represent In Area:

13045 Cortland  
13053 Dryden  
13068 Freeville  
13073 Groton  
13077 Homer  
14817 Brooktondale  
14850 Ithaca  
14853 Cornell Univ.  
14867 Newfield  
14881 Slaterville Springs  
14882 Lansing  
14886 Trumansburg  
14456 Geneva

**Out-of-Area Participating Provider Benefits.** Out-of-Area Participating Provider Benefits are the intermediate level of coverage available. Out-of-Area Participating

Provider benefits apply when Your care is provided by Participating Providers that are not In-Area Providers and are in the Aetna Student Health network. You should always consider receiving health care services first through In-Area Participating Providers and then from Participating Providers that are Out-of-Area.

**Non-Participating Provider Benefits:** The Non-Participating provider benefits portion of this Certificate provides coverage when You receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You receive Non-Participating Provider benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider's charge. You do not need a Referral to seek Non-Participating Care. Care from Non-Participating Providers may be sought Worldwide and it will be covered at the Non-Participating Provider rate.

**READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE CERTIFICATE. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.**

This Certificate is governed by the laws of New York State.

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## SECTION I

### DEFINITIONS

Defined terms will appear capitalized throughout the Certificate.

**Acute:** The sudden onset of disease or injury, or a sudden change in the Member's condition that would require prompt medical attention.

**Allowed Amount:** The maximum amount on which Our payment is based for Covered Services. See section IV of this Certificate for a description of how the Allowed Amount is calculated. If your Non-Participating Provider charges more than the Allowed Amount You will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to any Cost-Sharing requirements.

**Ambulatory Surgical Center:** A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

**Appeal:** A request for Us to review a Utilization Review decision or a Grievance again.

**Balance Billing:** When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

**Certificate:** This Certificate issued by Cornell, including the Schedule of Benefits and any attached riders.

**Children:** The Student's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the "Who is Covered" section of this Certificate.

**Coinsurance:** Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider.

**Copayment:** A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

**Cost-Sharing:** Amounts You must pay for Covered Services, expressed as Coinsurance, Copayments, and/or Deductibles.

**Cover, Covered or Covered Services:** The Medically Necessary services paid for or arranged for You by Us under the terms and conditions of this Certificate.

**Deductible:** The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Coinsurance or Copayments are applied. The Deductible

may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (for example, a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

**Dependent:** The Student's Spouse and Children.

**Durable Medical Equipment (DME):** Durable Medical Equipment is equipment which is:

- designed and intended for repeated use;
- primarily and customarily used to serve a medical purpose;
- generally not useful to a person in the absence of disease or injury; and
- is appropriate for use in the home.

**Emergency Condition:** A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

**Emergency Department Care:** Emergency Services You get in a Hospital emergency department.

**Emergency Services:** A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn Child (including the placenta).

**Exclusions:** Health care services that We do not pay for or Cover.

**External Appeal Agent:** An entity that has been certified by the Department of Financial Services to perform external Appeals in accordance with New York law.

**Facility:** A Hospital; ambulatory surgery Facility; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; home health agency or home care services agency certified or licensed under Article 36 of the New York Public

Health Law; a comprehensive care center for eating disorders pursuant to article 27-J of the public health law; an institutional Provider of mental health or chemical dependence and abuse treatment operating under Article 31 of the New York Mental Hygiene Law and/or approved by the Office of Alcoholism and Substance Abuse Services, or other Provider certified under Article 28 of the New York Public Health Law (or other comparable state law, if applicable). If You receive treatment for chemical dependence or abuse outside of New York State, the Facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (“JCAHO”) to provide a chemical abuse treatment program.

**Gannett Health Services (Gannett):** The on-campus provider of health services for Cornell University Students. Gannett Health Services operates the Gannett Health Center on campus.

**Grievance:** A complaint that You communicate to Us that does not involve a Utilization Review determination.

**Habilitation Services:** Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

**Health Care Professional:** An appropriately licensed, registered or certified Physician; osteopath; dentist; optometrist; chiropractor; psychologist; psychiatrist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist certified to administer immunizing agents; or any other licensed, registered or certified Health Care Professional under Title 8 of the Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional’s services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Certificate.

**Home Health Agency:** An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

**Hospice Care:** Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to Article 40 of the Public Health Law or under a similar certification process required by the state in which the hospice organization is located.

**Hospital:** A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;

- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in section 1861(k) of United States Public Law 89-97 (42 U.S.C. § 1395x(k));
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitative care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

**Hospitalization:** Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

**In-Area Participating Provider:** A Provider who has a contract with Us to provide services to You at the highest level of coverage available to You. You will pay the least amount of Cost-Sharing to see an In-Area Participating Provider.

**In-Area Participating Provider Coinsurance:** Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the Covered Service that You are required to pay to an In-Area Participating Provider.

**In-Area Participating Provider Copayment:** A fixed amount You pay directly to an In-Area Participating Provider for a Covered Service when You receive the Covered Service. The amount can vary by the type of Covered Service.

**In-Area Participating Provider Deductible:** The amount You owe before We begin to pay for Covered Services received from In-Area Participating Providers. The In-Area In-Network Deductible applies before any Coinsurance or Copayments are applied. The In-Area In-Network Deductible may not apply to all Covered Services. You may also have an In-Area In-Network Deductible that applies to a specific Covered Service (for example, a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

**In-Area Participating Provider Out-of-Pocket Limit:** The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services received from In-Area Participating Providers. This limit never includes Your Premium, Balance Billing charges or services We do not Cover.

**Medically Necessary:** See section II of this Certificate for the definition.

**Medicare:** Title XVIII of the Social Security Act, as amended.

**Member:** The Student and Covered Dependents for whom required Premiums have

been paid. Whenever a Member is required to provide a notice pursuant to a Grievance or emergency department visit or admission, "Member" also means the Member's designee.

**Non-Participating Provider:** A Provider who doesn't have a contract with Us to provide services to You.

**Non-Participating Provider Coinsurance:** Your share of the costs of a Covered Service calculated as a percent of the Allowed Amount for the service that You are required to pay to a Non-Participating Provider.

**Non-Participating Provider Copayment:** A fixed amount You pay directly to a Non-Participating Provider for a Covered Service when You receive the Covered Service. The amount can vary by the type of Covered Service.

**Non-Participating Provider Deductible:** The amount You owe before We begin to pay for Covered Services received from Non-Participating Providers. The Out-of-Network Deductible applies before any Coinsurance or Copayments are applied. The Out-of-Network Deductible may not apply to all Covered Services. You may also have an Out-of-Network Deductible that applies to a specific Covered Service (for example, a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

**Non-Participating Provider Out-of-Pocket Limit:** The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services received from Non-Participating Providers. This limit never includes Your Premium, Balance Billing charges or services We do not Cover. You are also responsible for all differences, if any, between the Allowed Amount and the Non-Participating Provider's charge for Out-of-Network services regardless of whether the Out-of-Pocket Limit has been met.

**Out-of-Area Participating Provider:** A Provider who has a contract with Us and will provide you with the intermediate level of coverage available to you. Out-of-Area Participating Provider benefits apply when Your care is provided by Participating Providers that are not In-Area Providers and are in the Aetna Student Health network. You should always consider receiving health care services first through In-Area Participating Providers and then from Participating Providers that are Out-of-Area.

**Out-of-Area Participating Provider Coinsurance:** Your share of the costs of a Covered Service calculated as a percent of the Allowed Amount for the service that You are required to pay to an Out-of-Area Participating Provider.

**Out-of-Area Participating Provider Copayment:** A fixed amount You pay directly to an Out-of-Area Participating Provider for a Covered Service when You receive the Covered Service. The amount can vary by the type of Covered Service.

**Out-of-Area Participating Provider Deductible:** The amount You owe before We begin to pay for Covered Services received from Out-of-Area Participating Providers. The Out-of-Area Participating Provider Deductible applies before any Coinsurance or Copayments are applied. The Out-of-Area Participating Provider Deductible may not apply to all Covered Services. You may also have an Out-of-Area Participating Provider Deductible that applies to a specific Covered Service (for example, a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

**Out-of-Area Participating Provider Out-of-Pocket Limit:** The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services received from Out-of-Area Participating Providers. This limit never includes Your Premium, Balance Billing charges or services We do not Cover.

**Out-of-Pocket Limit:** The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of health care services We do not Cover.

**Partial Hospitalization:** Continuous treatment consisting of not less than four hours and not more than twelve hours in any twenty-four hour period under a program based in a hospital.

**Physician or Physician Services:** Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

**Plan Year:** The 12-month period beginning on the effective date of the Certificate or any anniversary date thereafter, during which the Certificate is in effect.

**Preauthorization:** A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, treatment plan, device or Prescription Drug is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of this Certificate.

**Premium:** The amount that must be paid for Your health insurance coverage.

**Prescription Drugs:** A medication, product or device that has been approved by the Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or refill and is on Our Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

**Primary Care Physician:** A Participating Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who typically is an internal medicine, family practice or pediatric doctor and who directly provides or coordinates a range of health care services

for You.

**Provider:** A Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), licensed Health Care Professional or Facility licensed, certified or accredited as required by state law.

**Referral:** An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a Participating Specialist) in order to arrange for additional care for a Member. A Referral can be transmitted electronically or by Your Provider completing a paper Referral form. Except as provided in section III of this Certificate or as otherwise authorized by Us, a Referral will not be made to a Non-Participating Provider. For Students and Spouses, Gannett serves as the PCP for Referrals. Child Dependents should seek Referrals from their respective PCP outside of Gannett.

**Rehabilitation Services:** Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

**Schedule of Benefits:** The section of this Certificate that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Maximums, Preauthorization requirements, Referral requirements and other limits on Covered Services.

**Service Area:** The geographical area, designated by Us and approved by the State of New York in which We provide coverage. See page one for a description of In-Area.

**Skilled Nursing Facility:** An institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission on Accreditation of Health Care Organizations or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare law; or as otherwise determined by Us to meet the standards of any of these authorities.

**SHIP:** Student Health Insurance Plan.

**Specialist:** A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

**Spouse:** The person to whom the Student is legally married, including a same sex Spouse and a domestic partner.

**Student:** A full-time registered Cornell University Student (as defined and reported by the University Registrar) or Student registered in absentia who is insured under this

plan.

**UCR (Usual, Customary and Reasonable):** The cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

**Urgent Care:** 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. Urgent Care may be rendered in a Physician's office or Urgent Care Center.

**Urgent Care Center:** A licensed Facility that provides Urgent Care.

**Us, We, Our:** Cornell and anyone to whom We legally delegate to perform, on Our behalf, under the Certificate.

**Utilization Review:** The review to determine whether services are or were Medically Necessary or experimental or investigational (including treatment for a rare disease or a clinical trial).

**You, Your:** The Member.

## SECTION II

### HOW YOUR COVERAGE WORKS

**1. Your Coverage under this Certificate.** We will provide the benefits described in this Certificate to Students and their covered Dependents. You should keep this Certificate with Your other important papers so that it is available for Your future reference.

**2. Covered Services.** You will receive Covered Services under the terms and conditions of this Certificate only when the Covered Service is:

- Medically Necessary;
- Provided by a Participating Provider for In-Area Participating Provider benefits and Out-of-Area Participating Provider benefits.
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits in section of this Certificate; and
- Received while Your Certificate is in force.

**3. Participating Providers.** To find out if a Provider is a Participating Provider:

- Call The Office of Student Health Insurance at **(607) 255-6363** or Aetna Health at **(800) 624-5486**
- Visit our website <http://www.studentinsurance.cornell.edu>

**4. In-Area Participating Providers.** Some Participating Providers are located “in area”. Certain services may be obtained from In-Area Participating Providers. See the Schedule of Benefits in section XIV of this Certificate for coverage of In-Area Participating Provider services.

**5. The Role of Primary Care Physicians and Gannett.** For Students and Spouses enrolled in the SHIP and residing in the Ithaca area, Gannett is your Primary Care Provider. Except in an emergency or for OB/GYN services, whenever you need health care, you must begin at Gannett to receive the maximum benefit for medical and mental health services. You do not need a written Referral from a PCP before receiving care from a Participating Provider however, if you do obtain a written Referral, Your Cost-Sharing may be lower. If your care cannot be provided at Gannett, your primary care provider or counselor may refer you to a different Participating Provider. To receive the maximum benefit for services, you must have a written Referral from Gannett before making an appointment with a Participating Provider. See the Schedule of Benefits in section XIV of this Certificate for your Cost-Sharing.

You do not need a Referral to seek care from Aetna’s Participating Provider Network or to seek Out-of-Network Care. You may seek care from a Participating Provider in Aetna’s nationwide network, “Open Choice® PPO.” You also have the option to seek Out-of-Network Care for standard limited coverage.

Dependent Children are not eligible to use Gannett, and as such, no Referral is required. Dependent Children are encouraged to establish a relationship with a Participating Provider and to receive a Referral from them if specialty care is required.

You may need to request Preauthorization before You receive certain services. See the Schedule of Benefits in section XIV of this Certificate for the services that require Preauthorization. Prior Authorization may be required for certain Prescription Drugs and some medications may not be covered under this Plan. For assistance and a complete list of excluded medications, or drugs requiring prior authorization, please contact Aetna Pharmacy Management at **(888) RX-AETNA or (888) 792-3862** (available 24 hours). Prior review and approval for pre-hospitalization must be obtained on a case-by-case basis by contacting Aetna Student Health.

**6. Non-Participating Care (Out-of-Network) Services.** We Cover the services of Non-Participating Providers. See the Schedule of Benefits of this Certificate for the Non-Participating Provider Benefit level and Cost-Sharing. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to in-network and out-of-network services.

**7. Care Outside of the United States.** Claims incurred outside of the United States will be reimbursed at the Out-of-Area Participating Provider level.

**8. Services Subject To Preauthorization.** Our Preauthorization is required before You receive certain Covered Services. Your Participating Provider is 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 in section XIV of this Certificate.

**9. Preauthorization / Notification Procedure.** If You seek coverage for services that require Preauthorization or notification, You or your provider must call our vender at the number indicated on Your ID card.

For assistance and a complete list of excluded medications, or drugs requiring prior authorization, please contact Aetna Pharmacy Management at **(888) RX-AETNA or (888) 792-3862** (available 24 hours).

You or Your Provider must contact Us to request Preauthorization as follows:

- At least three business days prior to a planned admission or surgery when Your Provider recommends inpatient Hospitalization. If that is not possible, then during regular business hours prior to the admission.

You must contact Us to provide notification as follows:

- If You are hospitalized in cases of an Emergency Condition, You must call Us within 48 hours after Your admission or as soon thereafter as reasonably possible.

**10. Medical Management.** The benefits available to You under this Certificate are

subject to pre-service, concurrent and retrospective reviews to determine when services should be covered by Us. Their purpose is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place of service that they are performed. Covered Services must be Medically Necessary for benefits to be provided.

**11. Care Must Be Medically Necessary.** We Cover benefits described in this Certificate as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, “service”) is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of: Your medical records; Our medical policies and clinical guidelines; medical opinions of a professional society, peer review committee or other groups of Physicians; reports in peer-reviewed medical literature; reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data; professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment; the opinion of Health Care Professionals in the generally-recognized health specialty involved; and the opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;

See the section IX of this Certificate for Your right to an internal Appeal and external Appeal of Our determination that a service is not Medically Necessary.

## **12. Important Telephone Numbers and Addresses.**

### **CLAIMS, COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS**

Aetna Student Health  
P.O. Box 14464  
Lexington, KY 40512

\*Submit claim forms to this address or call in the Appeal to Customer Service using the toll-free telephone number shown on the member ID card.

Customer Service Representatives are available 8:30 a.m. to 5:30 p.m., Monday through Friday, ET for any questions.

#### MEDICAL EMERGENCIES AND URGENT CARE

Call **911** or your local emergency hotline, or go directly to an emergency care facility.

For non-emergency situations please visit or call Gannett Health Services at **(607) 255-5155**.

#### MEMBER SERVICES

Aetna's Member Services telephone number is on the Member's ID card. If the Member is required to leave a recorded message; the Member's message will be acknowledged within one business day after the call was recorded.

#### PREAUTHORIZATION

Excluded drugs and Pre-Authorization

Aetna Pharmacy Management

**(888) RX-AETNA or (888) 792-3862** (Available 24 hours)

#### OUR WEBSITE

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

## SECTION III

### ACCESS TO CARE AND TRANSITIONAL CARE

A new Gannett referral is required:

- For each separate medical condition.
- Each Plan Year for continuing treatment with a Non-Gannett Provider.
- For outpatient mental health services with a Non-Gannett Provider.
- For physical therapy services provided by Gannett Physical Therapy Department at Schoellkopf or a participating provider in the Ithaca area if Gannett cannot treat you.
- For follow up care after an Emergency Room visit, when the care is not rendered at Gannett Health Services.

A Gannett referral is not required for the following conditions only:

- An Emergency Medical Condition as defined in the Definitions section of this Brochure; however, you must return to Gannett for any necessary follow-up care, or for a referral to a specialist for follow-up care.
- Maternity care.
- One annual routine Pap smear and two annual visits for women age 18 and older.
- Routine and preventive care services as defined by health care legislation.
- Care received when outside of the Ithaca area or when Gannett is closed.
- Students who are on leave or in absentia and remain in the Ithaca area.

**Note: Expenses for services** incurred for medical treatment received outside Gannett for which no Referral has been obtained are payable at the Out-of-Area Participating Provider or Non-Participating Provider Care rate depending on your provider. No Referral will be issued after the date services are first rendered.

#### **REFERRAL INFORMATION FOR DEPENDENT CHILDREN**

Dependent Children are not eligible to use Gannett, and as such, no Referral is required. Dependent Children are encouraged to establish a relationship with a Participating Provider and to receive a Referral from them if specialty care is required.

#### **When Your Provider Leaves the Network**

If You are in an ongoing course of treatment when Your Provider leaves Our Network, then You may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to ninety (90) days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant and in Your second or third trimester, You may be able to continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

In order for You to continue to receive Covered services for up to ninety (90) days or

through a pregnancy with a former Participating Provider, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered services as if they were being provided by an In-Area Participating Provider. You will be responsible only for any applicable in-Network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

### **New Members In a Course of Treatment**

If You are in an ongoing course of treatment with a Non-Participating Provider when Your coverage under this Certificate becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to sixty (60) days from the effective date of Your coverage under this Certificate. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a Non-Participating Provider if You are in the second or third trimester of a pregnancy when Your coverage under this Certificate becomes effective. You may continue care through delivery and any post-partum services directly related to the delivery.

In order for You to continue to receive Covered services for up to sixty (60) days or through pregnancy, the Non-Participating Provider must agree to accept as payment Our fees for such services. The Provider must also agree to provide Us necessary medical information related to Your care and to adhere to Our policies and procedures including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered services as if they were being provided by a Participating Provider. You will be responsible only for any applicable In-Area Participating Provider Cost-Sharing.

## SECTION IV

### COST-SHARING EXPENSES AND ALLOWED AMOUNT

**1. Deductible.** Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Certificate for Covered Out-of-Network services during each Plan Year before We provide coverage. If you have other than Individual coverage, the individual Deductible applies to each person Covered under this Certificate.

**Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible.**

There is no Deductible for Covered In-Area Participating and Out-of-Area Participating Services under this Certificate during each Plan Year.

**2. Copayments.** Except where stated otherwise, after You have satisfied the annual Deductible as described above, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits of this Certificate for Covered Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

**3. Coinsurance.** Except where stated otherwise, after you have satisfied the annual Deductible described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your In-Area Participating Provider, Out-of-Area Participating Provider, and Non-Participating Provider benefit as shown in the Schedule of Benefits in this Certificate. **You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount.**

**4. Participating Provider Out-of-Pocket Limit.** When You have met Your Participating Provider Out-of-Pocket Limit in payment of Participating Provider Deductibles, Copayments, and Coinsurance for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year. If other than Individual coverage applies, when members of the same family covered under this Certificate have collectively met the family Participating Provider Out-of-Pocket Limit in payment of Out-of-Pocket Deductibles, Copayments and Coinsurance for a Plan Year in the Schedule of Benefits, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year.

Cost-Sharing for out-of-network services does not apply towards Your Participating Provider Out-of-Pocket Limit.

**5. Out-of-Network Out-of-Pocket Limit.** This Certificate has a separate Out-of-Network Out-of-Pocket Limit in the Schedule of Benefits in section XIV of this Certificate for out-of-network benefits. When You have met Your Out-of-Network Out-of-Pocket Limit in payment of Out-of-Network Deductibles, Copayments, and

Coinsurance for a Plan year in the Schedule of Benefits, We will provide coverage for 100% of the Allowed Amount for Covered out-of-network Services for the remainder of that Plan Year. If other than Individual coverage applies, when members of the same family covered under this Certificate have collectively met the family Out-of-Network Out-of-Pocket Limit in payment of Out-of-Network Deductibles, Copayments and Coinsurance for a Plan Year in the Schedule of Benefits, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards Your Out-of-Pocket Limit.**

**6. Your Additional Payments for Out-of-Network Benefits.** When You receive Covered Services from a Non-Participating Provider, in addition to the applicable Copayments, Coinsurance, and Deductible described in the Schedule of Benefits of this Certificate, You must also pay the amount, if any, by which the Non-Participating Provider's actual charge exceeds Our Allowed Amount. This means that the total of Our coverage and any amounts You pay under Your applicable Deductible, Copayment, and Coinsurance may be less than the Non-Participating Provider's actual charge.

**7. Allowed Amount.** "Allowed Amount" means the maximum amount we will pay to a Provider for the services or supplies covered under this Certificate before any applicable Deductible, Copayment, 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:

For Facilities, the Allowed Amount will be the rate based on information provided by a third party vendor, which may reflect one or more of the following factors: i) the complexity or severity of treatment; ii) level of skill and experience required for the treatment; or iii) comparable Providers' fees and costs to deliver care.

For all other Providers, the Allowed Amount will be the 80<sup>th</sup> percentile of the Fair Health rate.

See section VI of the Certificate for the Allowed Amount for an Emergency Condition.

## SECTION V

### WHO IS COVERED

**Who is Covered Under this Certificate?** You, to whom this Certificate is issued, are covered under this Certificate. If You selected one of the following types of coverage, members of Your family may also be Covered.

#### Types of Coverage

In addition to Student coverage, We offer the following types of coverage:

**Student and Spouse** - If You selected Individual and Spouse coverage, then You and Your Spouse are covered.

**Student and Child/Children** – If You selected Student and Child/Children coverage, then You and Your Child or Children, as described below, are covered.

**Student, Spouse, and Child/Children** – If You selected Student, Spouse, and Child/Children coverage, then You and Your Spouse and Your Children, as described below, are covered.

#### Student Coverage

The following categories of Students are eligible for coverage under SHIP:

- All full-time registered Students (as defined and reported by the University Registrar).
- Students registered in absentia.
- Students on a University-approved leave of absence are also eligible to enroll prior to **September 30, 2014**, provided that they were enrolled during the previous year. Students on a University-approved leave of absence may only purchase the Student Health Insurance Plan for one year.

**Please Note:** Students on leave and in absentia are not automatically enrolled. They must complete an enrollment form each year.

#### Dependent Coverage

Eligible Students who enroll in the SHIP may also insure their eligible Dependents:

- a) The Student's Spouse living or residing in the United States at the time of eligibility; or
- b) The Student's Child under the age of 26 years. The Child must live or reside in the United States at the time of eligibility.

#### Children Covered Under This Certificate

If You purchase coverage for your Children, "Children" covered under this Certificate include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence,

residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage also includes Children for whom You are a legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order.

Any unmarried Dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly Dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a Child is and continues to qualify under this section.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective Student and all other prospective or Covered Members as they pertain to eligibility for coverage under this Certificate at any time.

### **When Coverage Begins**

Coverage under this Certificate will begin as follows:

Students are automatically enrolled in the Student Health Insurance Plan. In order to waive enrollment in the SHIP, you must demonstrate that you have insurance that meets Cornell's waiver criteria. Please see [Studentinsurance.cornell.edu](http://Studentinsurance.cornell.edu) for more information about the waiver criteria.

Dependents are not automatically enrolled. Insured Students who wish to enroll their eligible Dependents in the Student Health Insurance Plan must stop by the Cornell University Office of Student Health Insurance located at 409 College Ave., Suite 211, Ithaca, NY to fill out the necessary forms and to make appropriate premium payments. An enrollment form must be filled out and returned every year to continue Dependents' enrollment.

### **NEWBORN INFANT AND ADOPTED CHILD COVERAGE**

A Child born to a Student shall be covered for 31 days from the date of birth. At the end of this 31 day period, coverage will cease under the Cornell University Student Health Insurance Plan.

To extend coverage for a newborn past the 31 days, the Student must:

- 1) Enroll the Child within 31 days of birth, and
- 2) Pay the additional premium, starting from the date of birth. Coverage is provided

for a newborn Child legally placed for adoption with a Covered Student for 31 days from the moment of birth provided You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to section 115-c of the New York Domestic Relations Law or other applicable state law within 31 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked.

However, We will not provide Hospital benefits for the newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay.

To extend coverage for a non-newborn adopted Child past the 31 days, the Student must:

- 1) Enroll the Child within 31 days of placement of such Child,
- 2) Pay any additional premium, if necessary, starting from the date of placement.

Please stop by the Office of Student Health Insurance to enroll a newborn infant or a newly adopted Child.

### **Special Enrollment Periods**

You, Your Spouse or Child, can also enroll for coverage within 31 days of the loss of coverage in another 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 towards the health plan were terminated; or
7. A Child no longer qualifies for coverage as a Child under the other health plan.

You, Your Spouse or Child can also enroll 31 days from exhaustion of Your COBRA or continuation coverage.

Enrollment is effective:

- a) In the case of marriage, on the date the completed request for enrollment is received;
- b) In the case of a newborn (natural and adopted), on the date of birth;
- c) In the case of adoption of a non-newborn Child, on the date of the Child's adoption or placement for adoption; and
- d) In the case of court ordered coverage of a Spouse or Child, on the date of the court order.

- e) In the case of lost coverage, on the day after you lost your previous coverage.

In addition, You, Your Spouse or Child, can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. You or Your Spouse or Your Child loses eligibility for Medicaid or a state child health plan.
2. You or Your Spouse or Your Child becomes eligible for Medicaid or a state child health plan.

We must receive notice and premium payment within 60 days of one of these events. The effective date of Your coverage will depend on when You lost Your previous coverage.

### **Late Enrollment**

A “Late Enrollee” is a person for whom the eligible Student does not elect coverage within 31 days of the date the person becomes eligible for such coverage.

The eligible Student may elect coverage for a late enrollee only during the annual late entrant enrollment period established by Cornell University. Coverage for a late enrollee will become effective on the first day of the second calendar month following the end of the late entrant enrollment period during which the eligible Student elects coverage for the late enrollee.

### **Domestic Partner Coverage**

This Certificate covers domestic partners of Subscribers as Spouses. If You selected Spouse coverage, “Children” covered under this Certificate also include the Children of Your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six months, where such registry exists, or
2. For partners residing where registration does not exist, by an alternative affidavit of domestic partnership.
  - a. The affidavit must be notarized and must contain the following:
    - The partners are both eighteen years of age or older and are mentally competent to consent to contract.
    - The partners are not related by blood in a manner that would bar marriage under laws of the State of New York
    - The partners have been living together on a continuous basis prior to the date of the application;
    - Neither individual has been registered as a member of another domestic partnership within the last six months; and
  - b. Proof of cohabitation (e.g., a driver’s license, tax return or other sufficient proof);

and

- c. Proof that the partners are financially interdependent. Two or more of the following are collectively sufficient to establish financial interdependence:
- A joint bank account
  - A joint credit card or charge card
  - Joint obligation on a loan
  - Status as an authorized signatory on the partner's bank account, credit card or charge card
  - Joint ownership of holdings or investments
  - Joint ownership of residence
  - Joint ownership of real estate other than residence
  - Listing of both partners as tenants on the lease of the shared residence
  - Shared rental payments of residence (need not be shared 50/50)
  - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence
  - A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50)
  - Shared household budget for purposes of receiving government benefits
  - Status of one as representative payee for the other's government benefits
  - Joint ownership of major items of personal property (e.g., appliances, furniture)
  - Joint ownership of a motor vehicle
  - Joint responsibility for child care (e.g., school documents, guardianship)
  - Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50)
  - Execution of wills naming each other as executor and/or beneficiary
  - Designation as beneficiary under the other's life insurance policy
  - Designation as beneficiary under the other's retirement benefits account
  - Mutual grant of durable power of attorney
  - Mutual grant of authority to make health care decisions (e.g., health care power of attorney)
  - Affidavit by creditor or other individual able to testify to partners' financial interdependence
  - Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.



## SECTION VI

### COVERED SERVICES

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

#### PREVENTIVE CARE.

We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles, and 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”). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at **(607) 255-6363** or visit Our website at **[www.studentinsurance.cornell.edu](http://www.studentinsurance.cornell.edu)** 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.

#### A. Well-Baby and Well-Child Care

We Cover well-baby and well-Child care which consist of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF. If the schedule of well-Child visits referenced above permits one well-Child visit per calendar year, We will not deny a well-Child visit if 365 days have not passed since the previous well-Child visit. Immunizations and boosters as required by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age 19 and is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

#### B. Adult Annual Physical Examinations

We Cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF.

Examples of items or services with an “A” or “B” rating from USPSTF include, but are

not limited to, blood pressure screening for adults, cholesterol screening, colorectal cancer screening and diabetes screening. A complete list of the Covered preventive services is available on Our website at [www.gannett.cornell.edu](http://www.gannett.cornell.edu) or will be mailed to You upon request.

You are eligible for a physical examination once every Plan Year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF and when provided by a Participating Provider.

### **C. Adult Immunizations Expense**

We Cover adult immunizations as recommended by ACIP. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the recommendations of ACIP and when provided by a Participating Provider.

### **D. Well-Woman Examinations**

We Cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual Pap smear, including laboratory and diagnostic services in connection with evaluating the Pap smear. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF. A complete list of the Covered preventive services is available on Our website at [www.studentinsurance.cornell.edu](http://www.studentinsurance.cornell.edu) or will be mailed to You upon request. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF and when provided by a Participating Provider.

### **E. Mammograms**

We Cover mammograms for the screening of breast cancer as follows:

- One baseline screening mammogram for women age 35 through 39;
- One baseline screening mammogram annually for women age 40 and over.

If a woman of any age has a history of breast cancer or her first degree relative has a history of breast cancer, We Cover mammograms as recommended by her Provider. However, in no event will more than one preventive screening, per Plan Year, be Covered.

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive

guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, which may be less frequent than the above schedule, and when provided by a Participating Provider.

Diagnostic mammograms (mammograms that are performed in connection with the treatment or follow-up of breast cancer) are unlimited and are Covered whenever they are Medically Necessary. However, diagnostic mammograms may be subject to Copayments, Deductibles or Coinsurance.

## **F. Family Planning & 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 benefit in Section VI of the Certificate counseling on use of contraceptives, related topics and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF and when provided by a Participating Provider.

We also Cover vasectomies subject to Copayments, Deductibles or Coinsurance.

We do not Cover services related to the reversal of elective sterilizations.

## **G. Bone Mineral Density Measurements or Testing**

We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to section VI of the Certificate. Bone mineral density measurements or tests, drugs or devices shall include those covered for individuals meeting the criteria under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. You will also qualify for coverage of bone mineral density measurements and testing if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis; or
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis; or
- On a prescribed drug regimen posing a significant risk of osteoporosis; or
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or,
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

We also Cover bone mineral density measurements or tests, and Prescription Drugs and devices as provided for in the comprehensive guidelines supported by HRSA”) and items or services with an “A” or “B” rating from USPSTF.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, which may not include all of the above services such as drugs and devices and when provided by a Participating Provider.

#### **H. Screening for Prostate Cancer**

We Cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. We also Cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided by a Participating Provider.

#### **PRE-HOSPITAL EMERGENCY MEDICAL SERVICES AND AMBULANCE SERVICES**

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

We Cover Pre-Hospital Emergency Medical Services for the treatment of an Emergency Condition when such services are provided by an ambulance service. We also Cover emergency ambulance transportation by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Services can be performed.

“Pre-Hospital Emergency Medical Services” means the prompt evaluation and treatment of an Emergency Condition and/or transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the N.Y. Public Health Law. We will, however, only Cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

- Placing the health of the person afflicted with such condition or, with
- respect to a pregnant woman, the health of the woman or her unborn Child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person’s bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

An ambulance service may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services relating to non-airborne transportation to a Hospital except for the collection of any applicable Copayment, Coinsurance, or

Deductible. Coverage for ambulance expenses is shown in the Schedule of Benefits.

Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

### **Non-Emergency Ambulance Transportation:**

We Cover non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:

- From a Non-Participating Hospital to a Participating Hospital.
- To a Hospital that provides a higher level of care that was not available at the original Hospital.
- To a more cost-effective acute care Facility.
- From an acute Facility to a sub-acute setting.

See the schedule of benefits in section XIV of this Certificate for any Preauthorization requirements for non-emergency transportation.

### **Limitations/Terms of Coverage:**

Benefits do not include 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. Non-ambulance transportation such as ambulance, van or taxi cab is not Covered.

Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; **and** Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; **and** one of the following is met:

- The point of pick-up is inaccessible by land vehicle; or
- Great distances or other obstacles (for example, heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

### **EMERGENCY SERVICES**

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

We Cover Emergency Services for the treatment of an Emergency Condition.

We define an **Emergency Condition** to mean: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn Child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain;
- Severe or multiple injuries;
- Severe shortness of breath;
- Sudden change in mental status (e.g., disorientation);
- Severe bleeding;
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis;
- Poisonings; or
- Convulsions.

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. We will also Cover Emergency Services to treat Your Emergency Condition worldwide. However, We will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition.

We define **Emergency Services** to mean: Evaluation of an Emergency Condition and treatment to keep the condition from getting worse including:

- A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and
- Within the capabilities of the staff and Facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn Child (including the placenta).

Please follow the instructions listed below regardless of whether or not You are in Our Service Area at the time Your Emergency Condition occurs.

## **A. Hospital Emergency Department Visits**

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, as defined above, are Covered in an emergency department. If You are uncertain whether this is the most appropriate place to receive care You can call Us before You seek treatment.

Follow-up care or routine care provided in a Hospital emergency department is not Covered. You should contact Us to make sure You receive the appropriate follow-up care.

## **B. Emergency Hospital Admissions**

In the event You are admitted to the Hospital: You or someone on Your behalf must notify Us at the telephone number listed in this Certificate and on Your ID card within 48 hours of Your admission, or as soon as is reasonably possible.

## **C. Payments Relating to Emergency Services Rendered**

The amount We pay a Non-Participating Provider for Emergency Services will be the greater of: (1) the amount We have negotiated with Participating Providers for the Emergency Service received (and if more than one amount is negotiated, the median of the amounts); (2) 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 (3) 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 Deductible, Coinsurance or Copayment.

## **Worldwide Travel Assistance Services**

### **On Call International**

Chickering Claims Administrators, Inc. (CCA) has contracted with On Call International (On Call) to provide Members with access to certain accidental death and dismemberment benefits, worldwide emergency medical, travel and security assistance services and other benefits.

**Services rendered without On Call International's coordination and approval are not covered. No claims for reimbursement will be accepted. If the Member is able to leave the Member's host country by normal means, On Call International will assist the Member in rebooking flights or other transportation. Expenses for non-emergency transportation are the Member's responsibility.**

**On Call phone number: 1-866-525-1956 or collect 1-603-328-1956**

A brief description of these benefits is outlined below.

### **Accidental Death and Dismemberment (ADD) Benefits**

These benefits are underwritten by United States Fire Insurance Company (USFIC) and include the following:

Benefits are payable for the Accidental Death and Dismemberment of Members, up to a maximum of \$10,000.

### **Medical Evacuation and Repatriation (MER) Benefits**

The following benefits are underwritten by United States Fire Insurance Company (USFIC) with medical and travel assistance services provided by On Call. These benefits are designed to assist Members when traveling more than 100 miles from home, anywhere in the world.

- Unlimited Emergency Medical Evacuation
- Unlimited Medically Supervised Repatriation
- Unlimited Return of Deceased Remains
- Unlimited Family Reunion (airfare only)
- \$2,500 Return of Traveling Companion
- \$2,500 Return of Dependent Children
- \$2,500 Bereavement Reunion - in the event of a Member's death, On Call will fly a family member to identify
- the remains and accompany the remains back to the deceased's home country
- \$2,500 Emergency Return Home in the event of death or life-threatening illness of a parent, sibling or Spouse
- \$1,000 Return of Personal Belongings

### **Natural Disaster and Political Evacuation Services (NDPE)**

The following benefits are underwritten by United States Fire Insurance Company (USFIC) with medical, travel, and security assistance services provided by On Call.

If a Member requires emergency evacuation due to governmental or social upheaval, which places him/her in imminent bodily harm (as determined by On Call security personnel in accordance with local and U.S. authorities), On Call will arrange and pay for his/her transportation to the nearest safe location, and then a one-way economy class airline ticket to his/her home country.

If a Member requires emergency evacuation due to a natural disaster, which makes his/her location Uninhabitable, On Call will arrange and pay for his/her evacuation from a safe departure point to the nearest safe haven, and then home. If the Member is delayed at the safe haven, On Call shall arrange and pay for reasonable lodging expenses up to \$100 per day for a maximum of three days. (Economy airfare and lodging costs shall not exceed a combined single limit of \$5,000 USD per Member).

Subject to a maximum benefit of \$100,000 per Member per Event.

**Worldwide Emergency Travel Assistance (WETA) Services.** On Call provides the following travel assistance services:

- 24/7 Emergency Travel Arrangements
- Translation Assistance
- Emergency Travel Funds Assistance
- Lost Luggage and Travel Documents Assistance
- Assistance with Replacement of Credit Card/Travelers Checks
- Medical/Dental/Pharmacy Referral Service
- Hospital Deposit Arrangements
- Dispatch of Physician
- Emergency Medical Record Assistance
- Legal Consultation and Referral
- Bail Bonds Assistance

The On Call International Global Response Center can be reached 24 hours a day, 365 days a year.

**The information contained above is a just summary of the ADD, MER, WETA, and NDPE benefits and services available through On Call. For a copy of the plan documents applicable to the ADD, MER, WETA and NDPE coverage, including a full description of coverage, exclusions and limitations, please contact Aetna Student Health at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com) or (800) 859-8475.**

NOTE: In order to obtain coverage, all MER, WETA and NDPE services must be provided and arranged through On Call. Reimbursement will not be provided for any services not provided and arranged through On Call. Although certain emergency medical services may be covered under the terms of the Member's student health insurance plan (the "Plan"), neither On Call nor its contracted insurance providers provide coverage for emergency medical treatment rendered by doctors, hospitals, pharmacies or other health care providers. Coverage for such services will be provided in accordance with the terms of the Plan and exclusions, limitations and benefit maximums may apply. Neither CCA, nor Aetna Life Insurance Company, nor their affiliates provide medical care or treatment and they are not responsible for outcomes. To file a claim for ADD benefits, or to obtain MER, WETA or NDPE benefits/services, or for any questions related to those benefits/services, please call On Call International at the following numbers listed on the On Call ID card provided to Members when they enroll in the Plan: Toll Free at **(866) 525-1956** or Collect at **(603) 328-1956**. All Members should carry their On Call ID card when traveling.

Chickering Claims Administrators, Inc. (CCA) provides access to certain Accidental Death and Dismemberment (AD&D); Medical Evacuation/Repatriation (MER); Natural Disaster and Political Evacuation (NDPE); and Worldwide Emergency Travel Assistance (WETA) coverages and services through a contractual relationship with On Call International, LLC (On Call). AD&D coverage is underwritten by Fairmont Specialty dba

United States Fire Insurance Company (USFIC). MER, NDPE and WETA membership services are administered by On Call.

CCA and On Call are independent contractors and not employees or agents of the each other. Neither CCA nor any of its affiliates provides or administers ADD, MER, NPDE and WETA benefits/services and neither CCA nor any of its affiliates is responsible in any way for the benefits/services provided by or through On Call.

These services, programs or benefits are offered by vendors who are independent contractors and not employees or agents of Aetna.

## **Urgent Care**

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. **Urgent Care is Covered in or out of Our Service Area.**

### **A. In-Area Participating Provider**

You may obtain Urgent Care from a Participating Physician or a Participating Urgent Care Center.

### **B. Out-of-Area Participating Provider or Non-Participating Provider**

You may obtain Urgent Care from an Out-of-Area Participating Provider or a Non-Participating Urgent Care Center.

**If Urgent Care results in an Emergency admission please follow the instructions for Emergency Hospital admissions described above.**

## **OUTPATIENT AND PROFESSIONAL SERVICES**

(For other than Mental Health and Substance Use)

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

**Acupuncture:** Acupuncture is covered when it is administered for the following indications by a health care provider, who is a legally qualified physician, who is practicing within the scope of their license:

- Adult postoperative and chemotherapy nausea and vomiting
- Nausea of pregnancy
- Postoperative dental pain
- Fibromyalgia/myofascial pain
- Chronic low back pain secondary to osteoarthritis.

The acupuncture must be administered by a health care provider.

**Advanced Imaging Services:** We Cover PET scans, MRI, nuclear medicine, and CAT scans.

**Allergy Testing and Treatment:** We Cover testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. We also Cover allergy treatment, including desensitization treatments, routine allergy injections and serums.

**Ambulatory Surgery Center:** We Cover surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the Center the day the surgery is performed.

**Chemotherapy:** We Cover Chemotherapy in an outpatient Facility or in a Health Care Professional's office. Orally-administered anti-cancer drugs are Covered under the Prescription Drug section of this Certificate.

**Chiropractic Services:** We Cover chiropractic care when performed by a Doctor of Chiropractic ("Chiropractor") or a Physician in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any Medically Necessary laboratory tests will be Covered in accordance with the terms and conditions of this Certificate.

**Dialysis:** We Cover dialysis treatments of an acute or chronic kidney ailment.

**Habilitation Services:** We Cover Habilitation Services consisting of physical therapy, speech therapy, and occupational therapy, in the outpatient department of a Facility or in a Health Care Professional's office.

**Home Health Care:** We Cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes (i) part-time or intermittent nursing care by or under the supervision of a Registered Professional Nurse (RN), (ii) part-time or intermittent services of a home health aide, (iii) physical, occupational, or speech therapy provided by the Home Health Agency, and (iv) medical supplies, drugs, and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

Home Health Care is limited to 40 visits per Plan year. Each visit by a member of the Home Health Agency is considered one visit. Each visit of up to four hours by a home health aide is one visit. Please note: Any rehabilitation services received under this

benefit will not reduce the amount of services available under “Rehabilitation and Habilitation Services”

**Interruption of Pregnancy:** We Cover therapeutic abortions. We also Cover non-therapeutic abortions in cases of rape, incest or fetal malformation. We cover elective abortions.

**Infertility Treatment:** 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. Basic Infertility Services consist of: 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 Services do not result in increased fertility, We Cover Comprehensive Infertility Services. These services include: ovulation induction and monitoring; pelvic ultra sound; artificial insemination; hysteroscopy; laparoscopy; and laparotomy.
- **Exclusions and Limitations**
  - a. In vitro, GIFT and ZIFT procedures.
  - b. Cost for an ovum donor or donor sperm.
  - c. Sperm storage costs.
  - d. Cryopreservation and storage of embryos.
  - e. Ovulation predictor kits.
  - f. Reversal of tubal ligations. Reversal of vasectomies.
  - g. All costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers).
  - h. Sex change procedures.
  - i. Cloning.
  - j. Medical and surgical procedures that are experimental or investigational unless Our denial is overturned by an External Appeal Agent.
  - k. 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.

**Infusion Therapy.** 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. Drugs taken by mouth or self-injected into the muscles are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an office or by an agency licensed or certified to provide infusion therapy.

**Laboratory Procedures, Diagnostic Testing and Radiology Services:** 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.

**Maternity and Newborn Care:** We Cover services for maternity care provided by a Physician or nurse midwife, nurse practitioner, Hospital or birthing center. We Cover prenatal care (including one visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a nurse midwife to be Covered, the nurse midwife must be licensed pursuant to Article 140 of the Education Law, practicing consistent with Section 6951 of the Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the Public Health Law. We will not pay for duplicative routine services provided by both a nurse midwife and a Physician. See the Schedule of Benefits of the Certificate for coverage of inpatient maternity care.

We Cover the cost of renting or the purchase of one breast pump per pregnancy for the duration of breast feeding

**Medications for Use in the Office:** We Cover medications and injectables (excluding self-injectables) used by Your Provider in the Provider's office for preventive and therapeutic purposes.

**Office Visits:** We Cover office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls.

**Outpatient Hospital Services:** We Cover Hospital services and supplies as described in the Inpatient Hospital section that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation.

**Preadmission Testing:** We Cover preadmission testing ordered by Your Physician and performed in Hospital outpatient facilities prior to a scheduled surgery in the same Hospital provided that: the tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed; reservations for a Hospital bed and operating room were made prior to the performance of the tests; surgery takes place within seven days of the tests; and the patient is physically present at the Hospital for the tests.

**Rehabilitation Services:** We Cover Rehabilitation Services consisting of physical therapy, speech therapy, and occupational therapy, in the outpatient department of a Facility or in a Health Care Professional's office.

We Cover speech and physical therapy only when:

- Such therapy is related to the treatment or diagnosis of Your physical illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
- It is ordered by a Physician; and
- You have been Hospitalized or have undergone surgery for such illness or injury.

Covered speech, physical and occupational therapy services must begin within six months of the later to occur:

- The date of the injury or illness that caused the need for the therapy;
- The date You are discharged from a Hospital where surgical treatment was rendered; or
- The date outpatient surgical care is rendered.

In no event will the therapy continue beyond 365 days after such event.

### **Second Opinions:**

- Second Cancer Opinion. We Cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a Non-participating Provider on an In-Network basis.
- Second Surgical Opinion. We Cover a second surgical opinion by a qualified Physician on the need for surgery.
- Second Opinions in other Cases. There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that we designate another Provider to render a second opinion. If the first and second opinions do not agree, We will designate another Provider to render a third opinion. After completion of the second opinion process, We will approve Covered Services supported by a majority of the Providers reviewing Your case.

**Surgical Services:** We Cover Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care.

Benefits are not available for anesthesia services provided as part of a surgical procedure, when rendered by the surgeon or the surgeon's assistant.

Sometimes two or more surgical procedures can be performed during the same operation.

- Through the Same Incision. If Covered multiple surgical procedures are through the same incision, We will pay for the procedure with the highest Allowed Amount and 50% of the amount We would otherwise pay under this Certificate for the secondary procedures, except for secondary procedures that, according to nationally-recognized coding rules, are exempt from multiple surgical procedure reductions. We will not pay anything for a secondary procedure that is billed with a primary procedure when that secondary procedure is incidental to the primary procedure.
- Through Different Incisions. If Covered multiple surgical procedures are performed during the same operative session but through different incisions, We will pay:
  - a. For the procedure with the highest Allowed Amount; and
  - b. 50% of the amount We would otherwise pay for the other procedures.

**Oral Surgery:** We Cover the following limited dental and oral surgical procedures:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when repair is not possible. Dental services must be obtained within 12 months of the injury.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not Covered.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

**Reconstructive Breast Surgery:** We Cover breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate. Implanted breast prostheses following a mastectomy or partial mastectomy are also Covered.

**Other Reconstructive and Corrective Surgery:** We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when:

- It is performed to correct a congenital birth defect of a covered Child which has resulted in a functional defect; or
- It is incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or
- It is otherwise Medically Necessary.

**Transplants:** We Cover only those transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.

**All transplants must be prescribed by Your Specialist(s). Additionally, all transplants must be performed at Hospitals that We have specifically approved and designated to perform these procedures.**

We Cover the Hospital and medical expenses, including donor search fees, of the Member-recipient. We Cover transplant services required by You when You serve as an organ donor only if the recipient is a Member. The medical expenses of a non-Member acting as a donor for You are not Covered if the non-Member's expenses will be Covered under another health plan or program.

We do not Cover travel expenses, lodging, meals, or other accommodations for donors or guests. We do not Cover donor fees in connection with organ transplant surgery. We do not Cover routine harvesting and storage of stem cells from newborn cord blood.

**Non-Medically Necessary Gender Reassignment Surgery:** We cover all surgical expenses related to Non-Medically Necessary gender reassignment. Coverage is subject to clinical guidelines.

## **ADDITIONAL BENEFITS, EQUIPMENT, AND DEVICES**

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

**Autism Spectrum Disorder:** We Cover the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this benefit, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered, including autistic disorder; Asperger's disorder; Rett's disorder; Childhood disintegrative disorder; and pervasive developmental disorder not otherwise specified (PDD-NOS).

- Screening and Diagnosis. We Cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.
- Assistive Communication Devices. We Cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, 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 a communication impairment. We will 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. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

Repair, replacement fitting and adjustments of such devices are Covered when made necessary by normal wear and tear or significant change in Your physical condition. Repair and replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft are not Covered. Coverage will be provided for the device most appropriate to Your current functional level. We will not provide Coverage for delivery or service charges or for routine maintenance.

- Behavioral Health Treatment. We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such Coverage when provided by a licensed Provider. We Cover applied behavior analysis when provided by an applied behavior analysis Provider as defined and described in 11 NYCRR 440, a regulation promulgated by the New York State Department of Financial Services. “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. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.

Our Coverage of applied behavior analysis services is limited to 680 hours per Member per Plan Year.

- Psychiatric and Psychological Care. We Cover direct or consultative services provided by a psychiatrist, psychologist, or a licensed clinical social worker with the experience required by the Insurance Law, licensed in the state in which they are practicing.
- Therapeutic Care. We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists, and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this Certificate. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Certificate.
- Pharmacy Care. We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a provider legally authorized to prescribe under Title 8 of the Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug Benefits under this Certificate.

We will not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the Public Health Law, an individualized education plan under Article 89 of the Education Law, or an individualized service plan pursuant to regulations of the Office for Persons With Developmental Disabilities shall not affect coverage under the Certificate for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

You are responsible for any applicable Deductible, Copayment, or Coinsurance provisions under this Certificate for similar services. For example, any Deductible, Copayment, or Coinsurance that applies to physical therapy visits generally will also apply to physical therapy services Covered under this benefit; and any Deductible, Copayment, or Coinsurance for Prescription Drugs generally will also apply to Prescription Drugs Covered under this benefit. Any Deductible, Copayment, or Coinsurance that applies to office visits will apply to assistive communication devices Covered under this paragraph.

Nothing in this Certificate shall be construed to affect any obligation to provide coverage for otherwise-covered services solely on the basis that the services constitute early intervention program services pursuant to Section 3235-a of the Insurance Law or an individualized service plan pursuant to regulations of the Office for Persons with Developmental Disabilities.

**Diabetic Equipment, Supplies and Self-Management Education:** We Cover diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under Title 8 of the Education Law as described below:

### Supplies

We Cover the following equipment and related supplies for the treatment of diabetes when prescribed by Your Physician or other provider legally authorized to prescribe:

- Acetone Reagent Strips
- Acetone Reagent Tablets
- Alcohol or Peroxide by the pint
- Alcohol Wipes
- All insulin preparations
- Automatic Blood Lance Kit
- Blood Glucose Kit
- Blood Glucose Strips (Test or Reagent)
- Blood Glucose Monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor
- Cartridges for the visually impaired
- Diabetes data management systems
- Disposable insulin and pen cartridges
- Drawing-up devices for the visually impaired
- Equipment for use of the Pump
- Glucose Acetone Reagent Strips
- Glucose Reagent Strips
- Glucose Reagent Tape
- Injection aides
- Injector (Busher) Automatic
- Insulin
- Insulin Cartridge Delivery
- Insulin infusion devices
- Insulin Pump
- Lancets
- Oral agents such as glucose tablets and gels
- Glucagon for injection to increase blood glucose concentration
- Oral anti-diabetic agents used to reduce blood sugar levels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones
- Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

### Self-Management Education

Diabetes self-management education is education designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition including information on proper diets. We Cover education on self-management and

nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:

- By a Physician, other health care provider authorized to prescribe under Title 8 of the Education Law, or their staff during an office visit;
- Upon the Referral of Your Physician or other health care provider authorized to prescribe under Title 8 of the Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
- Education will also be provided in Your home when Medically Necessary.

### Limitations

The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We Cover only basic models of blood glucose monitors unless You have special needs relating to poor vision or blindness.

**Durable Medical Equipment and Braces:** We Cover the rental or purchase of durable medical equipment and braces.

### Durable Medical Equipment

Durable Medical Equipment is equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Is appropriate for use in the home.

Coverage is for standard equipment only. Repairs or replacement are covered when made necessary by normal wear and tear. We do not Cover the cost of repairs or replacement that are the result of misuse or abuse by You. We will determine whether to rent or purchase such equipment.

Customized or motorized equipment, or equipment designed for Your comfort or convenience (such as pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment) are not Covered as they do not meet the definition of durable medical equipment.

### Braces

We Cover braces that are worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease or defect. Coverage is for standard equipment only. We Cover replacements when growth or a change in Your medical condition make replacement necessary. We do not Cover the cost of repairs or replacement that are the result of misuse or abuse by You.

**Hearing Aids:** We Cover hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Covered services are available for a hearing aid that is purchased as a result of a written recommendation by a Physician and include the hearing aid and the charges for associated fitting and testing. We Cover a single purchase (including repair and/or replacement) of hearing aids for one or both ears.

Bone anchored hearing aids are Covered only if You have either of the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

If You meet the criteria for a bone anchored hearing aid, Coverage is provided for one hearing aid per ear. Replacements and/or repairs for a bone anchored hearing aid are Covered only for malfunctions.

**Hospice:** Hospice Care is available if Your primary attending Physician has certified that You have six months or less to live. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of Hospice Care. We also Cover five visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We Cover Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the N.Y. Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located. Coverage is not provided for: funeral arrangements; pastoral, financial, or legal counseling; homemaker, caretaker, or respite care.

**Medical Supplies:** We Cover medical supplies that are required for the treatment of a disease or injury which is Covered under this Certificate. We also Cover maintenance supplies (e.g., ostomy supplies) for conditions Covered under this 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. Please see the “Diabetic Supplies, Education and Self-Management” section of this Certificate for a description of diabetic supply Coverage.

**Prosthetics:**

**External Prosthetic Devices:** We Cover prosthetic devices (including wigs) that are

worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials. Dentures or other devices used in connection with the teeth are not Covered unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly. Eyeglasses and contact lenses are not Covered under this section of the Certificate and are only covered under the pediatric vision benefit in section VI of this Certificate.

Coverage is for standard equipment only.

We also Cover external breast prostheses following a mastectomy,.

**Internal Prosthetic Devices:** We Cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate. Coverage also includes repair and replacement due to normal growth or normal wear and tear.

## **INPATIENT SERVICES**

(For other than Mental Health and Substance Use)

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

**Hospital Services:** We Cover inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for an illness, injury or disease of a severity that must be treated on an inpatient basis including:

- Semiprivate room and board;
- General, special, and critical nursing care;
- Meals and special diets;
- The use of operating, recovery, and cystoscopic rooms and equipment;
- The use of intensive care, special care, or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and plaster casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, X-ray examinations and radiation therapy, laboratory and pathological examinations;

- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

The Cost-Sharing requirements in the Schedule of Benefits apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than 90 days.

**Observation Services:** We Cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge You. The services include use of a bed and periodic monitoring by nursing or other licensed staff.

**Inpatient Medical Services:** We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this Certificate.

**Inpatient Stay for Maternity Care.** We Cover inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also Cover any additional days of such care that We determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage period, We will Cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or the time of the mother's request, whichever is later. Our Coverage of this home care visit shall be in addition to home health care visits under this Certificate and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits that apply to home care benefits.

**Inpatient Stay for Mastectomy Care:** We Cover inpatient services for Members undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period time determined to be medically appropriate by You and Your attending Physician.

**Autologous Blood Banking Services:** We Cover autologous blood banking services only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury. In such instances, We Cover storage fees for a reasonable storage period that is appropriate for having the blood available

when it is needed.

**Rehabilitation Services:** We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy.

We Cover speech and physical therapy only when:

- Such therapy is related to the treatment or diagnosis of Your physical illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
- It is ordered by a Physician; and
- You have been Hospitalized or have undergone surgery for such illness or injury.

Covered speech, physical and occupational therapy services must begin within six months of the later to occur:

- The date of the injury or illness that caused the need for the therapy;
- The date You are discharged from a Hospital where surgical treatment was rendered; or
- The date outpatient surgical care is rendered.

**Skilled Nursing Facility:** We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent or domiciliary care is not Covered (see the "Exclusions and Limitations" section of this Certificate. An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. We Cover an unlimited number of days, per Plan Year, for non-custodial care.

**End of Life Care:** If You are diagnosed with advanced cancer and You have fewer than 60 days to live, We will Cover Acute care provided in a licensed Article 28 facility or Acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the Facility. If We disagree with Your admission to the Facility, We have the right to initiate an expedited Appeal to an External Appeal Agent. We will Cover and reimburse the Facility for Your care, subject to any applicable limitations in this Certificate until the External Appeal Agent renders a decision in Our favor.

We will reimburse Non-Participating Providers for this end of life care as follows:

1. We will reimburse a rate that has been negotiated between Us and the Provider.
2. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare acute care service rates.
3. Or if it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare rates.

**Limitations/Terms of Coverage:**

1. When You are receiving inpatient care in a Hospital or other Facility as described above, We will not cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the charge for the private room.
2. We do not Cover radio, telephone and television expenses, or beauty or barber services.
3. We do not Cover any charges incurred after the day We advise You it is no longer Medically Necessary for you to receive inpatient care, unless Our denial is overturned by an External Appeal Agent.

**Mental Health Care and Substance Use Services**

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

**Mental Health Care Services****A. Mental Health Care Services.**

1. **Inpatient Services.** We Cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders comparable to other similar Hospital, medical and surgical coverage provided under this Certificate. Coverage for inpatient services for mental health care is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:
  - A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
  - A state or local government run psychiatric inpatient Facility;
  - A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
  - A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health;

and, in other states, to similarly licensed or certified Facilities.

We also Cover inpatient mental health care services relating to the diagnosis and treatment of mental, nervous and emotional disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for

residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(33) and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to Article 27-J of the Public Health Law; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment.

**2. Outpatient Services.** We Cover outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental, nervous and emotional disorders. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to Article 31 of the New York Mental Hygiene Law or are operated by the Office of Mental Health and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker or a professional corporation or a university faculty practice corporation thereof.

**3. Limitations/Terms of Coverage.** We do not Cover:

- Benefits or services deemed to be cosmetic in nature on the grounds that changing or improving an individual's appearance is justified by the individual's mental health needs;
- Mental health benefits or services for individuals who are incarcerated, confined or committed to a local correctional facility or prison, or a custodial facility for youth operated by the New York State Office of Children and Family Services; or
- Services solely because they are ordered by a court.

## **B. Substance Use Services.**

**1. Inpatient Services.** We Cover inpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency. This includes Coverage for detoxification and rehabilitation services as a consequence of chemical use and/or substance use. Inpatient substance use services are limited to Facilities in New York State which are certified by the Office of Alcoholism and Substance Abuse Services ("OASAS"); and, in other states, to those Facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

We also Cover inpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to OASAS-certified Facilities defined in 14 NYCRR 819.2(a)(1); and, in other states, to those Facilities that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

**2. Outpatient Services.** We Cover outpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency, including methadone treatment. Such Coverage is limited to Facilities in New York State that are certified by OASAS or licensed by OASAS as outpatient clinics or medically supervised ambulatory substance abuse programs, and, in other states, to those that are licensed or certified by a similar state agency or which are accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs. Coverage is also available in a professional office setting for outpatient substance use services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

We also Cover up to 20 outpatient visits per calendar year for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member: 1) identifies himself or herself as a family member of a person suffering from substance use and/or dependency; and 2) is covered under the same family Certificate that covers the person receiving, or in need of, treatment for substance use and/or dependency. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

## **PRESCRIPTION DRUG COVERAGE**

The Student Health Insurance Plan uses a 3 Tier Open Formulary developed by Aetna Student Health. For information about the formulary, please visit [www.aetna.com](http://www.aetna.com) or call Aetna Pharmacy Management **(888) RX-AETNA or (888) 792-3862** (available 24 hours). Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

### **Covered Outpatient Prescription Drugs**

We Cover Medically Necessary Outpatient Prescription Drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

- Required by law to bear the legend “Caution – Federal Law prohibits dispensing without a prescription”;
- FDA approved;
- Ordered by a Provider authorized to prescribe and within the Provider’s scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines; and

- Dispensed by a licensed pharmacy.

Covered Prescription Drugs include, but are not limited to:

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Nutritional supplements (formulas) for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Non-prescription enteral formulas for home use for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen for patients whose condition would cause them to become malnourished or suffer from disorders resulting in chronic disability, mental retardation, or death, if left untreated, including but not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux with failure to thrive; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies.
- Modified solid food products that are low in protein or which contain modified protein to treat certain inherited diseases of amino acid and organic acid metabolism.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the Infertility section of this Certificate
- Off-Label Cancer drugs, so long as, the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Prescription Drugs for smoking cessation.
- Contraceptive drugs or devices or generic equivalents approved as substitutes by the FDA.

Information on Preferred Drugs can be found at [www.aetna.com/pharmacyinsurance/individuals-families/index.html](http://www.aetna.com/pharmacyinsurance/individuals-families/index.html) (click on "Preferred Drug List" and select "3 Tier Open Formulary"). To locate a prescribed medication, you can access information by either using the "Medication Search" function or by reviewing the 3-Tier Aetna Preferred Drug

Guide. You may also call Aetna Pharmacy Management **(888) RX-AETNA or (888) 792-3862** (available 24 hours).

## Refills

We Cover Refills of Prescription Drugs only when dispensed at a retail pharmacy as ordered by an authorized Provider. Benefits for Refills will not be provided beyond one year from the original prescription date. For prescription eye drop medication, We allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. To the extent practicable, the quantity of eye drops in the early Refill will be limited to the amount remaining on the dosage that was initially dispensed. Your Cost-Sharing for the limited Refill is the amount that applies to each prescription or Refill as set forth in the Schedule of Benefits in section XIV of this Certificate.

## Benefit and Payment Information

1. **Cost-Sharing Expenses:** You are responsible for paying the costs outlined in the Schedule of Benefits section of this Certificate when Covered Prescription Drugs are obtained from a retail pharmacy.
  - You have a three tier plan design, which means that Your Out-of-Pocket Expenses will generally be lowest for Prescription Drugs on Tier 1 (Generics) and highest for Prescription Drugs on Tier 3 (Non-Preferred Brand Name). Your Out-of-Pocket Expense for Prescription Drugs on Tier 2 (Preferred Brand Name) will generally be more than for Tier 1 but less than Tier 3.
  - **Important note:** Brand-Name Prescription Drug or Devices will be covered at 100% of the Allowed Amount, including waiver of Annual Deductible if a Generic Prescription Drug or Device is not available in the same therapeutic drug class or the prescriber specifies Dispense as Written.
  - You are responsible for paying the full cost (the amount the pharmacy charges You) for any non-Covered Prescription Drug and Our contracted rates (Our Prescription Drug Cost) will not be available to You.
2. **Preferred Pharmacies:** For Prescription Drugs purchased at a retail Preferred Pharmacy, You are responsible for paying the lower of:
  - The applicable Cost-Sharing; or
  - The Preferred Pharmacy's Usual and Customary Charge (which includes a dispensing fee and sales tax) for the Prescription Drug.(Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)
3. **Non-Preferred Pharmacies:** If You purchase a Prescription Drug from a Non-Preferred Pharmacy, You must pay for the Prescription Drug at the time it is

dispensed and then file a claim for reimbursement with Us. We will not reimburse You for the difference between what You pay the Non-Preferred Pharmacy and Our price for the Prescription Drug. In most cases You will pay more if You purchase Prescription Drugs from a Non-Preferred Pharmacy.

4. **Tier Status:** The tier status of a Prescription Drug may change periodically. Changes will generally be quarterly, but no more than six times per Plan Year, based on Our periodic tiering decisions. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier (other than a Brand-Name Drug that becomes available as a Generic as described below) We will notify You. When such changes occur, Your out-of-pocket expense may change. You may access the most up to date tier status on Our website at **www.aetna.com** or by calling **800-859-8475**; the Customer Service number on Your ID card.
5. **When a Brand-Name Drug Becomes Available As a Generic:** When a Brand-Name Drug becomes available as a Generic, the tier placement of the Brand-Name Prescription Drug may change. If this happens, You will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned. Please note, if You are taking a Brand-Name Drug that is being excluded due to a generic becoming available You will receive advance written notice of the Brand-Name Drug exclusion. If coverage is denied, You are entitled to an Appeal as outlined in section IX of the Certificate.
6. **Supply Limits:** We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy. You are responsible for one Cost-Sharing amount for up to a 30-day supply. For FDA-approved female over-the-counter contraceptive methods that are prescribed by your physician, the prescription must be submitted to the pharmacist for processing. These items are limited to one per day and a 30 day supply per prescription. However, for maintenance drugs we may pay for up to a 90-day supply of a drug purchased at a retail pharmacy in some circumstances. You are responsible for up to three Cost-Sharing amounts for a 90-day supply at a retail pharmacy.
7. **Cost-Sharing for Orally-Administered Anti-cancer Drugs.** Your Cost-Sharing for orally-administered anti-cancer drugs is the lesser of the applicable Prescription Drug Cost-Sharing amount specified in the Schedule of Benefits in section XIV of this Certificate or the Cost-Sharing amount, if any, that applies to intravenous or injectable chemotherapy agents Covered under section VI of this Certificate.

## **Medical Management**

This Certificate includes certain features to determine when Prescription Drugs should be Covered, which are described below. As part of these features, Your prescribing Provider may be asked to give more details before We can decide if the Prescription Drug is Medically Necessary.

1. **Preauthorization.** Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. When appropriate, ask Your Provider to complete a Preauthorization form. Should You choose to purchase the Prescription Drug without obtaining Preauthorization, You must pay for the cost of the entire Prescription Drug and submit a claim to Us for reimbursement.

For a list of Prescription Drugs that need Preauthorization, please call Aetna Pharmacy Management: **(888) RX-AETNA** or **(888) 792-3862**. The list will be reviewed and updated from time to time. We also reserve the right to require Preauthorization for any new Prescription Drug on the market or of any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification. Including a Prescription Drug or related item on the list does not promise coverage under Your Plan. Your Provider may check with Us to find out which Prescription Drugs are Covered.

### **Limitations/Terms of Coverage**

1. We reserve the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.
2. Various specific and/or generalized “use management” protocols will be used from time-to-time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our Members with a quality-focused drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.
3. We do not Cover drugs that do not by law require a prescription, except as otherwise provided in this Certificate.
4. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts.
5. We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.

6. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in the Appeals section of this Certificate.
7. We do not Cover nutritional supplements (formulas), non-prescription enteral formulas, and modified food solid products except as described under the Covered Outpatient Prescription Drug Section.

## General Conditions

1. You must show Your ID card to a retail pharmacy at the time You obtain Your Prescription Drug or You must provide the pharmacy with identifying information that can be verified by Us during regular business hours.

## Definitions

Terms used in this section are defined as follows. (Other defined terms can be found in the definitions section of this Certificate).

**Brand-Name Drug:** A Prescription Drug that (1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or (2) that We identify as a Brand-Name Prescription Drug, based on available data resources. All Prescription Drugs identified as a “brand name” by the manufacturer, pharmacy, or Your Physician may not be classified as Brand-Name Drug by Us.

**Designated Pharmacy:** A pharmacy that has entered into an agreement with Us or with an organization contracting on Our behalf, to provide specific Prescription Drugs, including, but not limited to, Specialty Prescription Drugs. The fact that a pharmacy is a Preferred Pharmacy does not mean that it is a Designated Pharmacy.

**Formulary:** The list that identifies those Prescription Drugs for which Coverage may be available under this Certificate. This list is subject to Our periodic review and modification (generally quarterly, but no more than six times per Plan Year). You may determine to which tier a particular Prescription Drug has been assigned by visiting Our website or by calling the Customer Service number on Your ID card.

**Generic Drug:** A Prescription Drug that (1) is chemically equivalent to a Brand-Name Drug; or (2) that We identify as a Generic Prescription Drug based on available data resources. All Prescription Drugs identified as a “generic” by the manufacturer, pharmacy, or Your Physician may not be classified as a Generic Drug by Us.

**Non-Preferred Pharmacy:** A pharmacy that has not entered into an agreement with Us to provide Prescription Drugs to Members.

**Preferred Pharmacy:** A pharmacy that has:

- Entered into an agreement with Us or Our designee to provide Prescription Drugs to Members;
- Agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
- Has been designated by Us as a Preferred Pharmacy.

**Prescription Drug:** A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

**Prescription Drug Cost:** The rate We have agreed to pay Our Preferred Pharmacies, including a dispensing fee and any sales tax, for a Covered Prescription Drug dispensed at a Preferred Pharmacy. If Your Plan includes Coverage at Non-Preferred Pharmacies, the Prescription Drug Cost for a Prescription Drug dispensed at a Non-Preferred Pharmacy is calculated using the Prescription Drug Cost that applies for that particular Prescription Drug at most Preferred Pharmacies.

**Prescription Order or Refill:** The directive to dispense a Prescription Drug issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

**Usual and Customary Charge:** The usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties as required by Section 6826-a of the Education Law.

## WELLNESS

### Exercise Facility Reimbursement

We will partially reimburse the Student and the Student's Covered Spouse for certain exercise facility fees or membership fees but only if such fees are paid to exercise facilities that We have an agreement with and which maintain equipment and programs that promote cardiovascular wellness. For Students attending classes on the Ithaca Campus, this benefit applies only to Cornell Fitness Centers.

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 work-out visits. We will not provide reimbursement for equipment, clothing, vitamins or other services that may be offered by the facility (massages, yoga, etc.).

In order to be eligible for reimbursement, You must:

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

For Students attending classes on the Ithaca Campus and their Spouses, in order to be eligible to obtain reimbursement at the end of the six-month period you must submit a reimbursement form. Once We receive your reimbursement form You may be reimbursed half of the Cornell Fitness Centers' full year fee. Your reimbursement will be provided through your Bursar account. Your visit count will be provided by Cornell Fitness Centers.

For Students not attending classes in the Ithaca Campus and their Spouses, in order to obtain reimbursement, at the end of the six-month period You must:

- Submit documentation of the visits from the facility and,
- A copy of Your current facility bill which shows the fee paid for Your membership.

For Out-of-Area Students and Spouses, once We receive documentation of the visits and the bill, You will be reimbursed the lesser of \$200 for the Subscriber and \$100 for the Student's Spouse or the actual cost of the membership per six-month period.

### **Additional Services and Discounts**

As a member of the Plan, you can also take advantage of additional services, discounts, and programs. These are not underwritten by Aetna and are not insurance. To learn more about these additional services and search for providers visit **the Aetna Student Health Website**, [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com) (search Cornell University).

Please note that these programs are subject to change.

### **PEDIATRIC VISION CARE**

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

**Pediatric Vision Care:** We Cover emergency, preventive and routine vision care for Children up to age 19.

**Vision Examinations:** We Cover vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover one vision examination in any twelve (12) month period, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:

- Case history;
- External examination of the eye or internal examination of the eye;
- Ophthalmoscopic exam;
- Determination of refractive status;
- Binocular distance;
- Tonometry tests for glaucoma;
- Gross visual fields and color vision testing; and

- Summary findings and recommendation for corrective lenses.

**Prescribed Lenses & Frames:** We Cover standard prescription lenses or contact lenses once 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 once in any twelve (12) month period, unless it is Medically Necessary for You to have new frames more frequently, as evidenced by appropriate documentation.

## **PEDIATRIC DENTAL CARE**

Please refer to the Schedule of Benefits for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

We Cover the following dental care services for Children up to age 19:

**Emergency Dental Care:** We Cover emergency dental care, which includes emergency treatment required to alleviate pain and suffering caused by dental disease or trauma. Emergency dental care is not subject to Our Preauthorization.

**Preventive Dental Care:** We Cover preventive dental care, that includes procedures which help to prevent oral disease from occurring, including:

- Prophylaxis (scaling and polishing the teeth at six (6) month intervals);
- Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated;
- Sealants on unrestored permanent molar teeth; and
- Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

**Routine Dental Care:** We Cover routine dental care provided in the office of a dentist, including:

- Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
- X-ray, full mouth x-rays at thirty-six (36) month intervals, bitewing x-rays at six (6) to twelve (12) month intervals, or panoramic x-rays at thirty-six (36) month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
- Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
- In-office conscious sedation;
- Amalgam, composite restorations and stainless steel crowns; and
- Other restorative materials appropriate for Children.

**Endodontics:** We Cover endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required.

**Prosthodontics:** We Cover prosthodontic services as follows:

- Removable complete or partial dentures, including six (6) months follow-up care; and
- Additional services include insertion of identification slips, repairs, relines and rebases and treatment of cleft palate.

Fixed bridges are not Covered unless they are required:

- For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth
- For cleft palate stabilization; or
- Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

**Orthodontics:** We Cover orthodontics used to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasias.

Procedures include but are not limited to:

- Rapid Palatal Expansion (RPE);
- Placement of component parts (e.g. brackets, bands);
- Interceptive orthodontic treatment;
- Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted);
- Removable appliance therapy; and
- Orthodontic retention (removal of appliances, construction and placement of retainers).

## SECTION VII

### EXCLUSIONS AND LIMITATIONS

No Coverage is available under this Certificate for the following:

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

**Convalescent and Custodial Care.** We do not Cover services related to rest cures, custodial care and 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.

**Cosmetic Services.** We do not Cover cosmetic services, Prescription Drugs, or surgery 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 (for example, 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 section IX of this Certificate.

**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 oral surgery or pediatric dental care section of this Certificate.

**Experimental or Investigational Treatment.** We do not Cover any health care service, procedure, treatment, device, or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial, 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 section IX of this Certificate for a further explanation of Your Appeal rights.

**Felony Participation.** We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence.

**Foot Care.** We do not Cover foot care, in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet, except as specifically listed in this Certificate. For foot care related to diabetes, see section VI of this Certificate.

**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.

**Intercollegiate Sports.** We do not cover expenses incurred for injury resulting from the play or practice of intercollegiate sports (participating in sports clubs or intramural athletic activities is not excluded).

**Medically Necessary.** In general, We will not Cover any health care service, procedure, treatment, 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 procedure, treatment, service, or Prescription Drug for which Coverage has been denied, to the extent that such procedure, treatment, service, or Prescription Drug is otherwise Covered under the terms of this Certificate.

**Medicare or Other Governmental Program.** We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

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

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

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

**Services Provided by a Family Member.** We do not Cover services performed by a member of the Member's immediate family. "Immediate family" shall mean a Child, Spouse, mother, father, sister, or brother of You or Your Spouse.

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

**Vision Services.** We do not Cover the examination or fitting of eyeglasses or contact lenses, except as specifically stated in section VI of this Certificate.

**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.

## SECTION VIII

### CLAIM DETERMINATIONS

**Claims.** A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider you will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us.

**Notice of Claim.** Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to, Member identification number, name, date of birth, date of service, type of service, the charge for each service, procedure code for the service as applicable, diagnosis code, name and address of the Provider making the charge, and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us through the Office of Student Insurance.

**Timeframe for Filing Claims.** Claims for services must be submitted to Us for payment within 120 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120 days period, You must submit it as soon as reasonably possible.

**Claims for Prohibited Referrals.** We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a Referral prohibited by N.Y. Public Health Law § 238-a(1).

**Claim Determinations.** Our claim determination procedure applies to all claims that do not relate to a Medical Necessity or experimental or investigational determination. For example, Our claim determination procedure applies to Referrals and contractual benefit denials. If You disagree with Our claim determination you may submit a Grievance pursuant to section IX of this Certificate.

For a description of the Utilization Review procedures and Appeal process for Medical Necessity or experimental or investigational determinations, see section IX of this Certificate.

A pre-service claim is a request that a service or treatment be approved before it has been received. A post-service claim is a request for a service or treatment that You have already received.

**Pre-service Claim Determinations.**

If We have all the information necessary to make a determination regarding a pre-

service claim (for example a Referral or a covered benefit determination), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

**Urgent Pre-service Reviews.** With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour time period. Written notice will follow within three calendar days of the decision.

**Post-service Claim Determinations.**

If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period.

## SECTION IX

### GRIEVANCE, UTILIZATION REVIEW & EXTERNAL APPEALS

**Grievances.** Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to providers.

**Filing a Grievance.** You can contact Us in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a Covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

**Grievance Determination.** Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You within the following timeframes:

**Expedited/Urgent Grievances:** By phone within the earlier of 48 hours of receipt of the necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.

**Pre-Service Grievances:** In writing, within 15 calendar days of receipt of Your Grievance.  
(A request for a service or treatment that has not yet been provided.)

**Post-Service Grievances:** In writing, within 30 calendar days of receipt of Your Grievance.  
(A claim for a service or a treatment that has already been provided.)

**All Other Grievances:** In writing, within 30 calendar days of receipt of Your Grievance  
(that are not in relation

to a claim or request for service.)

**Grievance Appeals.** If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal in writing. However, Urgent Appeals may be filed by phone. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

When We receive Your Appeal, We will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances: The earlier of 2 business days of receipt of the necessary information or 72 hours of receipt of Your Appeal.

Pre-Service Grievances: 15 calendar days of receipt of Your Appeal.  
(A request for a service or treatment that has not yet been provided.)

Post-Service Grievances: 30 calendar days of receipt of Your Appeal.  
(A claim for a service or an treatment that has already been provided.)

All Other Grievances: 30 calendar days of receipt of Your Appeal.  
that are not in relation to a claim or request for service.)

If You remain dissatisfied with Our Appeal determination or at any other time you are dissatisfied, you may:

**Call the New York State Department of Financial Services at  
1-800-342-3736 or write them at:**

New York State Department of Financial Services  
Consumer Assistance Unit  
One Commerce Plaza  
Albany, NY 12257  
[www.dfs.ny.gov](http://www.dfs.ny.gov)

If You need assistance filing a Grievance or Appeal You may also contact the state independent Consumer Assistance Program at:

Community Health Advocates  
105 East 22nd Street  
New York, NY. 10010  
Or call toll free: 1-888-614-5400  
Or e-mail [cha@cssny.org](mailto:cha@cssny.org)

### **Utilization Review**

We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review (UR). Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the number on Your ID card.

All determinations that services are not Medically Necessary will be made by licensed Physicians or by licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the health care Provider who typically manages Your medical condition or disease or provides the health care service under review. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not or were not Medically Necessary. We have developed guidelines and protocols to assist Us in this process. Specific guidelines and protocols are available for Your review upon request. For more information, You can contact Us.

### **Preauthorization Reviews**

If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three business days of receipt of the request.

If We need additional information, We will request it within 3 business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within

three business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45 day period.

**Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will follow within one calendar day of the decision. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You and Your Provider by telephone and in writing within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour time period.

After receiving a request for coverage of home care services following an inpatient Hospital admission, We will make a determination and provide notice to You (or Your designee), by telephone and in writing, within one business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, We will make a determination and provide notice to You (or Your designee) within 72 hours of receipt of the necessary information. When We receive a request for home care services and all necessary information prior to Your discharge from an inpatient hospital admission, We will not deny coverage for home care services while Our decision on the request is pending.

### **Concurrent Reviews**

Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee), by telephone and in writing, within one business day of receipt of all necessary information. If We need additional information, We will request it within one business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee), by telephone and in writing, within one business of Our receipt of the information or, if We do not receive the information, within 15 calendar days of the end of the 45-day time period.

**Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You by telephone within 24 hours of receipt of the request. Written notice will be provided within one business day of receipt of the request for coverage if all necessary information was included or three calendar days from the verbal notification if all necessary information was not included. If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment, the Urgent Preauthorization Review timeframes apply.

### **Retrospective Reviews**

If We have all information necessary to make a determination regarding a retrospective

claim, We will make a determination and notify You within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45 day period.

Once We have all the information to make a decision, Our failure to make a Utilization review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

### **Retrospective Review of Preauthorized Services**

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

### **Reconsideration**

If We did not attempt to consult with Your Provider before making an adverse determination, Your Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For Preauthorization and concurrent reviews, the reconsideration will take place within one business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

### **Utilization Review Internal Appeals**

You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will if necessary, inform You of any additional information needed before a decision can be made. A clinical peer reviewer who is a Physician or a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will

perform the Appeal.

### **Standard Appeal**

If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.

If Your Appeal relates to a retrospective claim, We will decide the Appeal within 60 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee) and where appropriate Your Provider within two business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

Expedited Appeals. Appeals of reviews of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, or any other urgent matter will be handled on an expedited basis. Expedited Appeals are not available for retrospective reviews. For expedited Appeals, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. Expedited Appeals will be determined within the lesser of 72 hours from receipt of the Appeal or two business days of receipt of the information necessary to conduct the Appeal.

If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal Appeal or an external Appeal.

Our failure to render a determination of Your Appeal within 60 calendar days of receipt of the necessary information for a standard Appeal or within two business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

If you need Assistance filing an Appeal You may contact the state independent Consumer Assistance Program at:

Community Health Advocates  
105 East 22nd Street  
New York, NY. 10010  
Or call toll free: 1-888-614-5400  
Or e-mail [cha@cssny.org](mailto:cha@cssny.org)

## **EXTERNAL APPEALS**

### **I. YOUR RIGHT TO AN EXTERNAL APPEAL**

In some cases, You have a right to an external Appeal of a denial of coverage. Specifically, if We have denied coverage on the basis that a service does not meet Our requirements for Medical Necessity (including appropriateness, health care setting, level of care, or effectiveness of a covered benefit) or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these Appeals.

In order for You to be eligible for an external Appeal You must meet the following two requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under the Certificate and
- In general, You must have received a final adverse determination through of Our internal Appeal process. But, You can file an external Appeal even though You have not received a final adverse determination through Our internal Appeal process if:
  - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
  - You file an external Appeal at the same time as You apply for an expedited internal Appeal; or
  - We fail to adhere to Utilization review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

### **II. YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS NOT MEDICALLY NECESSARY**

If We have denied coverage on the basis that the service does not meet Our requirements for Medical Necessity, You may Appeal to an External Appeal Agent if You meet the requirements for an external Appeal in I above.

### **III. YOUR RIGHT TO APPEAL A DETERMINATION THAT A SERVICE IS EXPERIMENTAL OR INVESTIGATIONAL**

If We have denied coverage on the basis that the service is an experimental or investigational treatment, You must satisfy the two requirements for an external Appeal in I above and Your attending Physician must certify that: (1) Your condition or disease

is one for which standard health services are ineffective or medically inappropriate; **or** (2) one for which there does not exist a more beneficial standard service or procedure covered by Us; **or** (3) one for which there exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one of the following:

- A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
- A clinical trial for which You are eligible (only certain clinical trials can be considered); or
- A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

#### **IV. THE EXTERNAL APPEAL PROCESS**

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external Appeal. If You are filing an external Appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external Appeal.

We will provide an external Appeal application with the final adverse determination issued through Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external Appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external Appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external Appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited Appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external Appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received emergency services and have not been discharged from a facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external Appeal. In that case, the External Appeal Agent must make a decision within seventy-two (72) hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment We will provide coverage subject to the other terms and conditions of this Certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the costs of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be Covered under this Certificate for non-experimental or non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

## **V. YOUR RESPONSIBILITIES**

**It is Your RESPONSIBILITY to start the external Appeal process.** You may start the external Appeal process by filing a completed application with the New York

State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

**Under New York State law, Your completed request for external Appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.**

## SECTION X

### TERMINATION OF COVERAGE

#### TERMINATION OF INSURANCE

Benefits are payable under this Plan only for those Covered Expenses incurred while the policy is in effect as to the Member. No benefits are payable for expenses incurred after the date the insurance terminates, except as may be provided under the Extension of Benefits provision.

#### TERMINATION OF STUDENT COVERAGE

Insurance for a Student will end on the first of these to occur:

- a. The date this Plan terminates,
- b. The last day for which any required premium has been charged,
- c. The date on which the Student withdraws from the school because of entering the armed forces of any country. Premiums will be refunded on a pro-rata basis when application is made within **90 days** from withdrawal,
- d. The date the Student is no longer in an eligible class.

#### TERMINATION OF DEPENDENT COVERAGE

Insurance for a Student's Dependent will end when insurance for the Student ends.

Before then, coverage will end:

- a. For a Child, on the first premium due date following the Child's 26th birthday,
- b. For the Spouse, the date the marriage ends in divorce or annulment.
- c. The date Dependent coverage is deleted from this Plan.
- d. For a domestic partner, the earlier to occur of:
  1. The date this Plan no longer allows coverage for domestic partners, and
  2. The date of termination of the domestic partnership. In that event, a completed and signed declaration of Termination of Domestic Partnership must be provided to Us.
- e. The date the Dependent ceases to be in an eligible class.

#### Coverage May Also Be Terminated:

- Upon the Student's death, coverage will terminate unless You have coverage for Dependents. If You have coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium has been paid.
- If a Student has performed an act that constitutes fraud or made an intentional misrepresentation of material fact in writing on his/her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by US to the Subscriber. However, if a Student makes an intentional misrepresentation of material fact in writing on his/her enrollment application we will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission

means that the termination of Your coverage will have a retroactive effect of up to Your enrollment under the Certificate.

- If We elect to terminate or cease offering all hospital, surgical and medical expense coverage for Students and Covered Dependents, in this state, We will provide written notice to the Student at least 180 days prior to when the coverage will cease.

Termination will not prejudice any claim for a charge that is incurred prior to the date coverage ends. Coverage will not be terminated due to failure to pay the plan premium. The plan is offered for one year and is non-cancelable.

### **Refund Policy**

Except for medical withdrawal due to a Covered illness, if you withdraw from school within the first 31 days of a coverage period, you will not be Covered under the Policy and the full premium will be refunded. After 31 days, you will be Covered for the full period that you have paid the premium for, and **no refund will be allowed**. (This refund policy will not apply if you withdraw due to a Covered illness.)

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. In this case, a pro-rata refund of premium will be made for any such person and any Covered Dependents upon written request received by Us within 90 days of withdrawal from school.

**NOTE:** If claims from any provider have been submitted and paid for any period, no refund will be provided under any circumstances.

### **Early Termination Option**

A Student graduating mid-year may be eligible for a six-month plan. To be eligible your student record MUST indicate a "Completed as of Date". You may apply for the Early Termination Option by contacting the Cornell University Office of Student Health Insurance. You will be billed in August for the entire Plan Year, but will be credited for six months of the premium once the paperwork is completed and processed. All paperwork must be completed prior to January 31, 2015. No requests will be granted after this date.

## SECTION XI

### WHAT HAPPENS IF YOU LOSE COVERAGE

#### EXTENSION OF BENEFITS

If coverage for a Member ends while they are totally disabled, benefits will continue to be available for expenses incurred for that person only while the Member continues to be totally disabled.

Benefits will end thirty-one (31) days from the date coverage ends. Benefits will continue to be available for a Member who incurs medical expenses directly relating to a pregnancy that began before coverage under This Plan ceased. Such benefits will be covered only for the period of that pregnancy.

If a Member is confined to a hospital on the date his or her coverage terminates, charges incurred during the continuation of that hospital confinement or for that treatment of the covered condition shall also be included in the term "Allowed Amount", but only while they are incurred during the **90 day** period following such termination of insurance.

## **SECTION XII**

### **Temporary Suspension Rights for Armed Forces' Members**

If You, the Student, are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government; and
2. Your service ends during the plan year that this plan is active for.

You must make written request to Us to have Your coverage suspended during a period of active duty. Your unearned premiums will be refunded during the period of such suspension.

Upon completion of active duty, Your coverage may be resumed as long as You:

1. Make written application to Us; and
2. Remit the premium within 60 days of the termination or active duty.

The right of resumption extends to coverage for Your Dependents. For coverage that was suspended while on active duty, coverage will be retroactive to the date on which active duty terminated.

## SECTION XIII

### General Provisions

1. **Agreements between Us and Participating Providers.** Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Certificate does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any health benefits program.
2. **Assignment.** You cannot assign any benefits or monies due under this Certificate to any person, corporation, or other organization. Any assignment by You will be void. Assignment means the transfer to another person or to an organization of Your right to the services provided under this Certificate or your right to collect money from us for those services. However, You may request Us to make payment for services directly to Your Provider instead of You.
3. **Changes in This Certificate.** This Certificate specifically applies to this plan year. This Certificate may change from one plan year to the next.
4. **Choice of Law.** This Certificate shall be governed by the laws of the State of New York.
5. **Clerical Error.** Clerical error with respect to this Certificate or any other documentation issued by Us in connection with this Certificate or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.
6. **Continuation of Benefit Limitations.** Some of the benefits under this Certificate may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the Year. For example, if Your coverage status changes from Covered Dependent to Student, all benefits previously utilized when you were a covered family member will be applied toward your new status as a Student.
7. **Entire Agreement.** This Certificate including any endorsements, riders and the attached applications, if any, constitutes the entire Certificate
8. **Furnishing Information and Audit.** All Members under this Certificate will promptly furnish Us with all information and records that We may require from

time to time to perform Our obligations under this Certificate. You must provide Us with information over the telephone for reasons like the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care.

9. **Identification Cards.** Identification cards are issued by Us for identification only. Possession of any identification card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits Your Premiums must be paid in full at the time that the services are sought to be received.
10. **Incontestability.** No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be deemed representations and not warranties.
11. **Independent Contractors.** Participating Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Participating Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You, Your Covered Spouse or Children while receiving care from any Participating Provider or in any Participating Provider's facility.
12. **Material Accessibility.** We will give You, identification cards, Certificates, riders, and other necessary materials.
13. **More Information about Your Health Plan.** You can request additional information about Your coverage under this Certificate. Upon Your request, We will provide the following information.
  - A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
  - The information that We provide the State regarding Our consumer complaints.
  - A copy of Our procedures for maintaining confidentiality of Member information.
  - A copy of Our drug formulary. You may also inquire if a specific drug is

Covered under this Certificate.

- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- Provider affiliations with Participating Hospitals.
- A copy of Our clinical review criteria, and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or utilization review guidelines.

14. **Notice.** Any notice that We give to You under this Certificate will be mailed to Your address as it appears on our records or to the address of the Member. You agree to keep your address information updated on [studentcenter.cornell.edu](http://studentcenter.cornell.edu).

15. **Premium Refund.** We will give any refund of Premiums, if due, to You.

16. **Recovery of Overpayments.** On occasion a payment will be made to You when You are not covered, for a service that is not covered, or which is more than is proper. When this happens We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

17. **Right to Develop Guidelines and Administrative Rules.** We may develop or adopt standards that describe in more detail when We will make or will not make payments under this Certificate . Examples of the use of the standards are: to determine whether Hospital inpatient care was Medically Necessary; whether surgery was Medically Necessary to treat Your illness or injury; or whether certain services are skilled care. Those standards will not be contrary to the descriptions in this Certificate . If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Certificate.

18. **Right to Offset.** If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe to Us. Except as otherwise required by law, if We owe You a payment for other claims

received, We have the right to subtract any amount You owe Us from any payment We owe You.

19. **Severability.** The unenforceability or invalidity of any provision of the Certificate shall not affect the validity and enforceability of the remainder of the Certificate.

20. **Subrogation and Reimbursement.** These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for your injury, illness or other condition and We have provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to you under this Certificate. Subrogation means that We have the right, independently of you, to proceed directly against the other party to recover the benefits that We have provided.

Subject to applicable state law, unless preempted by federal law, We may have a right of reimbursement if you or anyone on your behalf receives payment from any responsible party (including Your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness, or condition for which We provided benefits. Under New York General Obligations Law 5-335, Our right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that You did not take any action against Our rights or violate any contract between You and us. The law presumes that the settlement between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

We request that You notify Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by You for which we have provided benefits. You must provide all information requested by Us or Our representatives including, but not limited to, completing and submitting any applications or other forms or statements as We may reasonably request.

21. **Time to Sue.** No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within 2 years from the date the claim was required to be filed.

- 22. Translation Services.** Translation services are available under this Certificate for non-English speaking Members. Gannett has a telephone translation service that can be requested when you make your appointment.
- 23. Venue for Legal Action.** If a dispute arises under this Certificate, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to these courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in those courts have been followed, the courts can order You to defend any action We bring against You.
- 24. Waiver.** The waiver by any party of any breach of any provision of the Certificate will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.
- 25. Who May Change This Certificate.** The Certificate may not be modified, amended, or changed, except in writing and signed by Our Chief Financial Officer (CFO) or a person designated by the CFO. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change the Certificate in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the CFO or person designated by the CFO.
- 26. Who Receives Payment under This Certificate.** Payments under this Certificate for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider regardless of whether an assignment has been made.
- 27. Workers' Compensation Not Affected.** The coverage provided under this Certificate is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.
- 28. Your Medical Records and Reports.** In order to provide Your coverage under this Certificate, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals, or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Certificate, You automatically give Us or our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and
- Permit copying of Your medical records by Us.

We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, You automatically give Us permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Certificate, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

## RIDER TO EXTEND COVERAGE FOR YOUNG ADULTS THROUGH AGE 29

Issued by

Cornell University

This rider which has been selected by the Student extends the eligibility of Children for coverage under Your Certificate and any applicable rider(s) thereto. All of the terms, conditions and limitations of the Certificate to which this rider is attached also apply to this Rider, except where they are specifically changed by this rider.

1. **Young Adults Covered through Age 29.** If You selected Child Dependent coverage, Your young adult Child will be eligible for coverage through the age of 29 years when the young adult:
  - A. Is unmarried;
  - B. Is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured;
  - C. Lives, works or resides in New York State or Our Service Area.

The young adult need not live with or be financially dependent upon You or be a student in order to be covered under this rider.

The young adult's children are not eligible for coverage under this rider.

**SECTION XIV  
SCHEDULE OF BENEFITS**

**STUDENT HEALTH INSURANCE SCHEDULE OF BENEFITS  
CORNELL UNIVERSITY**

<b>COST-SHARING</b>	<b>In-Area Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Out-of-Area Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Deductible</b> <ul style="list-style-type: none"> <li>• Individual</li> </ul> <b>Out-of-Pocket Limit</b> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul>	None  \$3,000 \$4,000  There is one combined limit for both In-Area and Out-of-Area Participating Provider Cost-Sharing.	None  See "In-Area" See "In-Area"	\$150 per plan year  \$4,000 \$5,000  See section IV of the Certificate for a description of how We calculate the Allowed Amount. Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount by which the Non-Participating Provider's charge exceeds Our Allowed Amount.	
<b>OFFICE VISITS</b>	<b>In-Area Participating</b>	<b>Out-of-Area Participating</b>	<b>Non-Participating</b>	<b>Limits</b>

	<b>Provider Member Responsibility for Cost-Sharing</b>	<b>Provider Member Responsibility for Cost-Sharing</b>	<b>Provider Member Responsibility for Cost-Sharing</b>	
Primary Care Office Visits (or Home Visits)  <b>Referral Required if within Ithaca.</b>	\$25 Copayment and 0% Coinsurance	\$25 Copayment and 20% Coinsurance	\$25 Copayment per visit and 30% Coinsurance after \$150 plan year Deductible	See Benefit For Description
Specialist Office Visits (or Home Visits)  <b>Referral Required</b>	\$25 Copayment and 0% Coinsurance  <b>Referral Required</b>	\$25 Copayment and 20% Coinsurance	\$25 Copayment per visit and 30% Coinsurance after \$150 plan year Deductible	See Benefit For Description
<b>PREVENTIVE CARE</b>	<b>In-Area Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Out-of-Area Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<ul style="list-style-type: none"> <li>Well Child Visits and Immunizations</li> <li>Adult Annual Physical Examinations</li> <li>Adult Immunizations</li> </ul>	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p>	<p>Covered in full</p> <p>Covered in full</p> <p>Covered in full</p>	<p>\$25 Copayment per visit and 30% Coinsurance after \$150 plan year Deductible</p> <p>\$25 Copayment per visit and 30% Coinsurance</p> <p>30% Coinsurance after \$150 plan year Deductible</p>	

<ul style="list-style-type: none"> <li>• Routine Gynecological Services/Well Woman Exams</li> </ul>	Covered in full	Covered in full	30% Coinsurance after \$150 plan year Deductible
<ul style="list-style-type: none"> <li>• Mammography Screenings</li> </ul>	Covered in full	Covered in full	30% Coinsurance after \$150 plan year Deductible
<ul style="list-style-type: none"> <li>• Sterilization Procedures for Women</li> </ul>	Covered in full	Covered in full	30% Coinsurance after \$150 plan year Deductible
<ul style="list-style-type: none"> <li>• Vasectomy</li> </ul>	Covered in full	Covered in full	30% Coinsurance after \$150 plan year Deductible
<ul style="list-style-type: none"> <li>• Bone Density Testing</li> </ul>	Covered in full	Covered in full	30% Coinsurance after \$150 plan year Deductible
<ul style="list-style-type: none"> <li>• Screening for Prostate Cancer</li> </ul>	Covered in full	Covered in full	30% Coinsurance after \$150 plan year Deductible
<ul style="list-style-type: none"> <li>• All other preventive services required by USPSTF and HRSA.</li> </ul>	Covered in full	Covered in full	30% Coinsurance after \$150 plan year Deductible
<ul style="list-style-type: none"> <li>• When preventive services are not provided in accordance with the comprehensive</li> </ul>	Use Cost Sharing for Appropriate Service (Primary Care	Use Cost Sharing for Appropriate Service (Primary Care	Use Cost Sharing for Appropriate Service (Primary Care

guidelines supported by USPSTF and HRSA.	Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)  <b>Referral Required</b>	Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing) after \$150 plan year Deductible	
<b>EMERGENCY CARE</b>  Follow up care needs a referral.	<b>In-Area Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Out-of-Area Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Pre-Hospital Emergency Medical Services (Ambulance Services)	Covered in full	Covered in full	Covered in full	See Benefit For Description
Non-Emergency Ambulance Services	Covered in full	Covered in full	Covered in full	See Benefit For Description
Emergency Department  Copayment waived if Hospital admission.	\$75 Copayment and 0% Coinsurance	\$75 Copayment and 0% Coinsurance	\$75 Copayment and 0% Coinsurance, not subject to deductible	See Benefit For Description
Urgent Care Center	\$30 Copayment and 0% Coinsurance	\$30 Copayment and 20% Coinsurance	\$30 Copayment per visit and 30% Coinsurance after \$150 plan year Deductible	See Benefit For Description
<b>PROFESSIONAL SERVICES AND OUTPATIENT CARE</b>	<b>In-Area Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Out-of-Area Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Acupuncture	30% Coinsurance	30% Coinsurance	30% Coinsurance	
Advanced Imaging Services <ul style="list-style-type: none"> <li>Performed in a Freestanding</li> </ul>	0%	20%	30%	See Benefit For Description

<p>Radiology Facility or Office Setting</p> <ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul> <p><b>Referral required in Ithaca area.</b></p>	<p>Coinsurance</p> <p>0% Coinsurance</p> <p><b>Referral Required</b></p>	<p>Coinsurance</p> <p>20% Coinsurance</p>	<p>Coinsurance after \$150 plan year Deductible</p> <p>30% Coinsurance after \$150 plan year Deductible</p>	
<p>Allergy Testing &amp; Treatment</p> <p><b>Referral required in Ithaca area.</b></p>	<p>Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory &amp; Diagnostic Procedures)</p> <p><b>Referral Required if not at Gannett Health Center</b></p>	<p>Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory &amp; Diagnostic Procedures)</p>	<p>Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Surgery; Laboratory &amp; Diagnostic Procedures)</p>	<p>See Benefit For Description</p>
<p>Ambulatory Surgical Center Facility Fee</p>	<p>\$150 Copayment and 0% Coinsurance</p> <p><b>Referral Required</b></p>	<p>\$150 Copayment and 20% Coinsurance</p>	<p>\$150 Copayment and 30% Coinsurance after \$150 plan year Deductible</p>	<p>See Benefit For Description</p>
<p>Anesthesia Services (all settings)</p>	<p>0% Coinsurance</p>	<p>20% Coinsurance</p>	<p>30% Coinsurance after \$150 plan year Deductible</p>	<p>See Benefit For Description</p>
<p>Autologous Blood Banking</p>	<p>0% Coinsurance</p>	<p>20% Coinsurance</p>	<p>30% Coinsurance after \$150 plan year Deductible</p>	<p>See Benefits For Description</p>
<p>Cardiac &amp; Pulmonary Rehabilitation</p> <ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> </ul>	<p>\$25 Copayment and 0% Coinsurance</p>	<p>\$25 Copayment and 20% Coinsurance</p>	<p>\$25 Copayment per visit and 30%</p>	<p>See Benefits For Description</p>

<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> <li>Performed as Inpatient Hospital Services</li> </ul>	<p><b>Referral Required</b></p> <p>0% Coinsurance</p> <p><b>Referral Required</b></p> <p>Included As Part of Inpatient Hospital Service Cost-Sharing</p> <p><b>Preauthorization Required</b></p>	<p>20% Coinsurance</p> <p>Included As Part of Inpatient Hospital Service Cost-Sharing</p>	<p>Coinsurance after \$150 plan year Deductible</p> <p>\$75 Copayment per visit and 30% Coinsurance after \$150 plan year Deductible</p> <p>Included As Part of Inpatient Hospital Service Cost-Sharing</p>	
<p>Chemotherapy</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul> <p><b>Referral is needed in Ithaca area for all service locations.</b></p>	<p>0% Coinsurance</p> <p>0% Coinsurance</p> <p>0% Coinsurance</p> <p><b>Referral Required</b></p>	<p>20% Coinsurance</p> <p>20% Coinsurance</p> <p>20% Coinsurance</p>	<p>30% Coinsurance after \$150 plan year Deductible</p> <p>30% Coinsurance after \$150 plan year Deductible</p> <p>30% Coinsurance after \$150 plan year Deductible</p>	<p>See Benefit For Description</p>
<p>Chiropractic Services</p>	<p>30% Coinsurance</p> <p><b>Referral Required</b></p>	<p>30% Coinsurance</p>	<p>30% Coinsurance after \$150 plan year Deductible</p>	<p>See Benefit For Description</p>
<p>Diagnostic Testing</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> </ul>	<p>0% Coinsurance</p>	<p>20% Coinsurance</p>	<p>30% Coinsurance</p>	<p>See Benefit For Description</p>

<ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul> <p><b>Referral is needed in Ithaca area for all service locations.</b></p>	<p>0% Coinsurance</p> <p>0% Coinsurance</p> <p><b>Referral Required</b></p>	<p>20% Coinsurance</p> <p>20% Coinsurance</p>	<p>after \$150 plan year Deductible</p> <p>30% Coinsurance after \$150 plan year Deductible</p> <p>30% Coinsurance after \$150 plan year Deductible</p>	
<p>Dialysis</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Freestanding Center or Specialist Office Setting</li> <li>Performed as Outpatient Hospital Services</li> </ul> <p><b>Referral is required within Ithaca area.</b></p>	<p>0% Coinsurance</p> <p>\$25 Copayment and 0% Coinsurance</p> <p>\$75 Copayment and 0% Coinsurance</p>	<p>20% Coinsurance</p> <p>\$25 Copayment and 20% Coinsurance</p> <p>20% Coinsurance</p>	<p>30% Coinsurance after \$150 plan year Deductible</p> <p>\$25 Copayment and 30% Coinsurance after \$150 plan year Deductible.</p> <p>30% Coinsurance after \$150 plan year Deductible.</p>	<p>See Benefit For Description</p>
<p>Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p>	<p>\$25 Copayment and 0% Coinsurance</p> <p><b>Referral Required</b></p>	<p>\$25 Copayment and 20% Coinsurance</p>	<p>\$25 Copayment and 30% Coinsurance after \$150 plan year Deductible</p>	<p>No limitations applied.</p>
<p>Home Health Care</p>	<p>0% Coinsurance</p>	<p>20% Coinsurance</p>	<p>30% Coinsurance,</p>	<p>40 visits per year.</p>

<b>Referral is required in Ithaca area.</b>			after \$150 plan year Deductible	
Infertility Services	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)  <b>Referral Required</b>	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See Benefit For Description
<p>Infusion Therapy</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> <li>Home Infusion Therapy</li> </ul>	<p>0% Coinsurance</p> <p>0% Coinsurance</p> <p>\$75 Copayment and 0% Coinsurance</p> <p>0% Coinsurance</p> <p><b>Referral Required</b></p>	<p>20% Coinsurance</p> <p>20% Coinsurance</p> <p>\$75 Copayment and 20% Coinsurance</p> <p>20% Coinsurance</p>	<p>30% Coinsurance after \$150 plan year Deductible</p> <p>30% Coinsurance after \$150 plan year Deductible</p> <p>\$75 Copayment and 30% Coinsurance after \$150 plan year Deductible</p> <p>30% Coinsurance after \$150 plan year Deductible</p>	<p>See Benefit For Description</p> <p>Home Infusion counts towards Home Health Care Visit Limits</p>
Inpatient Medical Visits	0% Coinsurance	20% Coinsurance	\$250 Deductible  30% Coinsurance based off of the	See Benefit For Description

	<b>Preauthorizati on Required</b>	<b>Preauthorizati on Required</b>	semi-private room rate  <b>Preauthorizati on Required</b>	
Laboratory Procedures <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Freestanding Laboratory Facility or Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul> <b>Referral required in Ithaca area.</b>	0% Coinsurance          \$75 Copayment and 0% Coinsurance	20% Coinsurance          \$75 Copayment and 20% Coinsurance	30% Coinsurance after \$150 plan year Deductible          \$75 Copayment and 30% Coinsurance after \$150 plan year Deductible	See Benefit For Description
Maternity & Newborn Care <ul style="list-style-type: none"> <li>Prenatal Care</li> <li>Inpatient Hospital Services and Birthing Center</li> </ul>	Covered in full          Birthing Center: \$100 Copayment, and 0% Coinsurance per admission          Inpatient: \$250 Copayment and 0% Coinsurance per admission	Covered in full          Birthing Center: \$100 Copayment, and 20% Coinsurance per admission;          Inpatient: \$250 Copayment and 20% Coinsurance per admission;	\$25 Copay and 30% Coinsurance after \$150 plan year Deductible          Birthing Center: \$100 Copayment, and 30% Coinsurance per admission; after \$150 Deductible          Inpatient: \$250 Copayment and 30% Coinsurance	See Benefit For Description          Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early

<ul style="list-style-type: none"> <li>Physician and Nurse Midwife Services for Delivery</li> <li>Breast Pump</li> </ul> <p><b>Preauthorization is required, after the 48 hours for vaginal delivery, or after 96 hours for cesarean</b></p>	<p>\$150 Copayment and 0% Coinsurance per admission</p> <p>Covered in Full</p> <p><b>Preauthorization is required, after the 48 hours for vaginal delivery, or after 96 hours for cesarean</b></p>	<p>\$150 Copayment and 20% Coinsurance per admission</p> <p>Covered in Full</p> <p><b>Preauthorization is required, after the 48 hours for vaginal delivery, or after 96 hours for cesarean</b></p>	<p>per admission; after \$150 Deductible</p> <p>\$150 Copayment and 30% Coinsurance; after \$150 Deductible</p> <p>30% Coinsurance; after \$150 plan year Deductible</p> <p><b>Preauthorization is required, after the 48 hours for vaginal delivery, or after 96 hours for cesarean</b></p>	<p>Covered for duration of breast feeding</p>
<p>Outpatient Hospital Surgery Facility Charge</p> <p><b>Referral required in Ithaca area.</b></p>	<p>0% Coinsurance</p>	<p>20% Coinsurance</p>	<p>30% Coinsurance; after \$150 plan year Deductible</p>	<p>See Benefit For Description</p>
<p>Preadmission Testing</p>	<p>0% Coinsurance</p>	<p>20% Coinsurance</p>	<p>30% Coinsurance; after \$150 Deductible</p>	<p>See Benefit For Description</p>
<p>Diagnostic Radiology Services</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Freestanding Radiology Facility or Specialist Office</li> </ul>	<p>\$25 Copayment per visit and 0% Coinsurance</p> <p>\$25 Copayment per visit and 0% Coinsurance</p>	<p>\$25 Copayment per visit and 20% Coinsurance</p> <p>\$25 Copayment and 20% Coinsurance</p>	<p>\$25 Copayment per visit and 30% Coinsurance after \$150 plan year</p> <p>\$25 Copayment and 30% Coinsurance after \$150 plan year Deductible</p>	<p>See Benefit For Description</p>

<ul style="list-style-type: none"> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$25 Copayment per visit and 0% Coinsurance</p> <p><b>Referral Required</b></p>	<p>\$25 Copayment and 20% Coinsurance</p>	<p>\$25 Copayment and 30% Coinsurance after \$150 plan year Deductible</p>	
<p>Therapeutic Radiology Services</p> <ul style="list-style-type: none"> <li>Performed in a Freestanding Radiology Facility or Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$25 Copayment per visit and 0% Coinsurance</p> <p>0% Coinsurance</p> <p><b>Referral Required</b></p>	<p>\$25 Copayment per visit and 20% Coinsurance</p> <p>20% Coinsurance</p>	<p>\$25 Copayment per visit and 30% Coinsurance after \$150 plan year Deductible</p> <p>30% Coinsurance after \$150 plan year Deductible</p>	<p>See Benefit For Description</p>
<p>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p>	<p>\$25 Copayment and 0% Coinsurance</p> <p><b>Referral Required</b></p>	<p>\$25 Copayment and 20% Coinsurance</p>	<p>\$25 Copayment and 30% Coinsurance after \$150 plan year Deductible</p>	<p>See Benefit For Description</p> <p>No limitations applied.</p>
<p>Second Opinions on the Diagnosis of Cancer, Surgery &amp; Other</p>	<p>\$25 Copayment, and 0% Coinsurance</p> <p><b>Referral Required</b></p>	<p>\$25 Copayment, and 20% Coinsurance</p>	<p>\$25 Copayment, and 30% Coinsurance, \$150 plan year Deductible</p> <p>Second Opinions on Diagnosis of Cancer are Covered at Participating Cost-Sharing for Non-Participating Specialist when a Referral is obtained</p>	<p>See Benefit For Description</p>
<p>Surgical Services</p>				<p>See</p>

<p>(Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive &amp; Corrective Surgery; Transplants; &amp; Interruption of Pregnancy)</p> <ul style="list-style-type: none"> <li>Inpatient Hospital Surgery</li> <li>Outpatient Hospital Surgery</li> <li>Surgery Performed at an Ambulatory Surgical Center</li> <li>Office Surgery</li> </ul> <p><b>Referral Required in Ithaca Area.</b></p>	<p>\$150 Copayment and 0% Coinsurance</p> <p>\$150 Copayment and 0% Coinsurance</p> <p>0% Coinsurance</p> <p>\$150 Copayment and 0% Coinsurance</p> <p><b>Referral Required</b></p>	<p>\$150 Copayment and 20% Coinsurance</p> <p>\$150 Copayment and 20% Coinsurance</p> <p>20% Coinsurance</p> <p>\$150 Copayment and 20% Coinsurance</p>	<p>\$150 Deductible and 30% Coinsurance after \$150 plan year Deductible</p> <p>\$150 Copayment and 30% Coinsurance after \$150 plan year Deductible</p> <p>30% Coinsurance after \$150 plan year Deductible</p> <p>\$150 Copayment and 20% Coinsurance after \$150 plan year Deductible</p>	<p>Benefit For Description</p> <p><b>All Transplants Must be Performed at Designated Facilities</b></p>
<p>All surgical expenses related to Non-Medically Necessary gender reassignment</p> <p><b>Referral Required in Ithaca Area.</b></p>	<p>\$150 Copayment and 0% Coinsurance</p>	<p>\$150 Copayment and 20% Coinsurance</p>	<p>\$150 Deductible and 30% Coinsurance after \$150 plan year Deductible</p>	<p>Limited to \$300,000 per plan year</p>
<p><b>ADDITIONAL SERVICES, EQUIPMENT &amp; DEVICES</b></p>	<p><b>In-Area Participating Provider Member Responsibility for Cost-</b></p>	<p><b>Out-of-Area Participating Provider Member Responsibility for Cost-</b></p>	<p><b>Non-Participating Provider Member Responsibility for Cost-</b></p>	<p><b>Limits</b></p>

	<b>Sharing</b>	<b>Sharing</b>	<b>Sharing</b>	
ABA Treatment for Autism Spectrum Disorder	\$25 copayment for office visits and 0% Coinsurance  <b>Referral Required</b>	\$25 copayment for office visits and 20% Coinsurance	\$25 copayment for office visits and 30% Coinsurance; after \$150 Deductible	
Assistive Communication Devices for Autism Spectrum Disorder	0% Coinsurance  <b>Referral Required</b>	20% Coinsurance	30% Coinsurance; after \$150 Deductible	See Benefit For Description
Diabetic Equipment, Supplies & Self-Management Education  <ul style="list-style-type: none"> <li>Diabetic Equipment, Supplies and Insulin (30-Day Supply)</li> <li>Diabetic Education</li> </ul> <b>Referral Required in Ithaca area.</b>	\$20 Prescription Copayment and 0% Coinsurance  0% Coinsurance	\$20 Prescription Copayment and 20% Coinsurance  20% Coinsurance	\$20 Prescription Copayment and 30% Coinsurance; after \$150 plan year Deductible  30% Coinsurance; after \$150 plan year Deductible	See Benefit For Description  See Prescription Drug Benefit for cost sharing
Durable Medical Equipment & Braces  <b>Referral Required in Ithaca area.</b>	0% Coinsurance	20% Coinsurance	30% Coinsurance; after \$150 plan year Deductible	See Benefit For Description
External Hearing Aids  <b>Referral Required in Ithaca area.</b>	0% Coinsurance	20% Coinsurance	30% Coinsurance; after \$150 plan year Deductible	Single purchase (including repair and/or replacement)
Cochlear Implants  <b>Referral Required in Ithaca area.</b>	0% Coinsurance	20% Coinsurance	30% Coinsurance; after \$150 plan year Deductible	

Hospice Care <ul style="list-style-type: none"> <li>Inpatient</li> <li>Outpatient</li> </ul> <b>Referral Required in Ithaca area.</b>	0% Coinsurance	20% Coinsurance	25% of Medicare rate after \$150 plan year Deductible	210 Maximum visits per plan year.
Medical Supplies  <b>Referral Required in Ithaca area.</b>	0% Coinsurance	20% Coinsurance	30% Coinsurance; after \$150 plan year Deductible	See Benefit For Description
Prosthetic Devices <ul style="list-style-type: none"> <li>External and Internal</li> </ul> <b>Referral Required in Ithaca area.</b>	0% Coinsurance	20% Coinsurance	30% Coinsurance; after \$150 plan year Deductible	No limitations for either external or internal devices.  See Benefit For Description
<b>INPATIENT SERVICES &amp; FACILITIES</b>	<b>In-Area Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Out-of-Area Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	\$250 Copayment and 0% Coinsurance per admission  <b>Preauthorization; Referral Required</b>	\$250 Copayment and 20% Coinsurance per admission  <b>Preauthorization required</b>	\$250 Copayment and 30% Coinsurance per admission; after \$150 Deductible  <b>Preauthorization required</b>	See Benefit For Description
Observation Stay	\$250 Copayment and 0%	\$250 Copayment and 20%	\$250 Copayment and 30%	See Benefit For Description

	Coinsurance per admission  <b>Preauthorization; Referral Required</b>	Coinsurance per admission  <b>Preauthorization; Required</b>	Coinsurance per admission; after \$150 Deductible  <b>Preauthorization; Required</b>	
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)  <b>Preauthorization Required</b>	\$250 Copayment and 0% Coinsurance per admission  <b>Preauthorization; Referral Required</b>	\$250 Copayment and 20% Coinsurance per admission  <b>Preauthorization Required</b>	\$250 Copayment and 30% Coinsurance per admission; after \$150 Deductible  <b>Preauthorization Required</b>	
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	\$250 Copayment and 0% Coinsurance per admission  <b>Preauthorization; Referral Required</b>	\$250 Copayment and 20% Coinsurance per admission  <b>Preauthorization Required</b>	\$250 Copayment and 30% Coinsurance per admission; after \$150 Deductible  <b>Preauthorization Required</b>	
<b>MENTAL HEALTH &amp; SUBSTANCE USE DISORDER SERVICES</b>	<b>In-Area Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Out-of-Area Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Inpatient Mental Health Care (for a continuous confinement when in a Hospital)  <b>Preauthorization; Referral Required. However, Preauthorization is Not Required for Emergency Admissions</b>	\$250 Copayment and 0% Coinsurance per admission;  <b>Preauthorization; Referral Required</b>	\$250 Copayment and 20% Coinsurance per admission;  <b>Preauthorization Required</b>	\$250 Copayment and 30% Coinsurance per admission; after \$150 Deductible  <b>Preauthorization Required</b>	See Benefit For Description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive	\$10 Copayment and 0% Coinsurance	\$10 Copayment and 20% Coinsurance n	\$10 Copayment and 30% Coinsurance	See Benefit For Description

Outpatient Program Services) <b>Referral Required</b>	<b>Referral Required</b>		per admission after \$150 plan year Deductible	
Inpatient Substance Use Services (for a continuous confinement when in a Hospital)  <b>Preauthorization; Referral Required. However, Preauthorization is Not Required for Emergency Admissions</b>	\$250 Copayment and 0% Coinsurance  <b>Preauthorization Required</b>	\$250 Copayment and 20% Coinsurance  <b>Preauthorization Required</b>	\$250 Copayment and 30% Coinsurance after \$150 Deductible  <b>Preauthorization Required</b>	See Benefit For Description
Outpatient Substance Use Services  <b>Referral Required</b>	0% Coinsurance  <b>Referral Required</b>	20% Coinsurance	30% Coinsurance after \$150 Deductible	Up to 20 visits a plan year may be used for Family Counseling
<b>PRESCRIPTION DRUGS</b>	<b>In-Area Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Out-of-Area Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<b>Retail Pharmacy</b>				
30 Day Supply Per Prescription  Generic  Preferred Brand Name  Non-Preferred Brand Name	\$12 Copayment  \$30 Copayment  \$40 Copayment	\$12 Copayment  \$30 Copayment  \$40 Copayment	\$12 Copayment and 30% Coinsurance  \$30 Copayment and 30% Coinsurance  \$40 Copayment and 30%	See Benefit For Description

Up to a 90 Day Supply For Maintenance Drugs			Coinsurance	
Generic	\$36 Copayment and 0% Coinsurance	\$36 Copayment	\$36 Copayment and 30% Coinsurance	
Preferred Brand Name	\$90 Copayment and 0% Coinsurance	\$90 Copayment	\$90 Copayment and 30% Coinsurance	
Non-Preferred Brand Name	\$120 Copayment and 0% Coinsurance	\$120 Copayment	\$120 Copayment and 30% Coinsurance	
<b>WELLNESS BENEFITS</b>	<b>In-Area Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Out-of-Area Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	
Gym Reimbursement				
<ul style="list-style-type: none"> <li>Students taking classes on the Ithaca campus and their spouses</li> </ul>	Half of the Cornell Fitness Center Fee for a Year Membership per 6 month period.	Half of the Cornell Fitness Center Fee for a Year Membership per 6 month period.	Half of the Cornell Fitness Center Fee for a Year Membership per 6 month period	
<ul style="list-style-type: none"> <li>Students taking classes not on the Ithaca Campus</li> </ul>	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse	Up to \$200 per 6 month period; up to an additional \$100 per 6 month period for Spouse	
<b>PEDIATRIC DENTAL &amp; VISION CARE</b>	<b>In-Area Participating Provider Member</b>	<b>Out-of-Area Participating Provider Member</b>	<b>Non-Participating Provider Member</b>	<b>Limits</b>

	<b>Responsibility for Cost-Sharing</b>	<b>Responsibility for Cost-Sharing</b>	<b>Responsibility for Cost-Sharing</b>	
<b>Pediatric Dental Care</b> <ul style="list-style-type: none"> <li>• Preventive/Routine Dental Care</li> <li>• Major Dental (Endodontics &amp; Prosthodontics)</li> <li>• Orthodontia</li> </ul>	\$25 Copayment and 20% Coinsurance           50% Coinsurance           \$500 Copayment and 50% Coinsurance	\$25 Copayment and 30% Coinsurance           50% Coinsurance           \$500 Copayment and 50% Coinsurance	\$25 Copayment per visit and 50% Coinsurance after \$150 plan year Deductible           50% Coinsurance           \$500 Copayment and 50% Coinsurance	One Dental Exam & Cleaning Per 6-Month Period
<b>Pediatric Vision Care</b> <ul style="list-style-type: none"> <li>• Exams</li> <li>• Lenses &amp; Frames</li> <li>• Contact Lenses</li> </ul> <b>Referral Required.</b>	\$25 Copayment. and 20% Coinsurance           50% Coinsurance           50% Coinsurance	\$25 Copayment. and 30% Coinsurance           50% Coinsurance           50% Coinsurance	\$25 Copayment. and 50% Coinsurance; after \$150 Deductible           50% Coinsurance; after \$150 Deductible           50% Coinsurance; after \$150 Deductible	One Exam Per 12-Month Period for under 6; One Exam Per 12-Month Period for Children over 6; One Prescribed Lenses & Frames in a 12-Month Period