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# **Aetna Student Health<sup>SM</sup>**

## **Plan Design and Benefits Summary**

### **Preferred Provider Organization (PPO)**

## **Hofstra University – International**

Policy Year: 2020 – 2021  
Policy Number: 686214  
[www.aetnastudenthealth.com](http://www.aetnastudenthealth.com)  
(866) 381-1529



This is a brief description of the Student Health Plan. The plan is available for Hofstra University students and their eligible dependents. The plan is insured by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Certificate issued to you and may be viewed online at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com). If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

### Hofstra Student Health Services

The Student Health Services is the University's on-campus health facility. It is open Monday – Thursday: 9 a.m. to 7 p.m., Friday: 9 a.m. to 6 p.m., Saturday & Sunday: 10 a.m. to 6 p.m. during the Fall and Spring semesters. You can call to make an appointment or make an appointment through your Hofstra portal. For more information, call the Health Services at 516-463-6745. In the event of an emergency, call 911 or public safety at 516-463-6789,

### Who is eligible?

All registered International students taking 1 or more credits are required to have health insurance coverage, either through this Student Health Plan or through another individual or family plan. Students will be automatically enrolled in and charged premium for the Student Health Plan unless proof of comparable coverage is provided by completing a waiver by the waiver deadline date.

### Dependent Coverage Eligibility

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

### Coverage Dates and Rates

Coverage for all insured students and eligible dependents will become effective at 12:01 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicated. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Certificate of Coverage.

### International Students & Dependents

	Fall	Spring
<b>Coverage Start Date</b>	<b>08/01/2020</b>	<b>01/01/2021</b>
<b>Coverage End Date</b>	<b>12/31/2020</b>	<b>07/31/2021</b>
Student	\$928	\$1,286
Spouse	\$928	\$1,286
Child	\$928	\$1,286
Two or More Children	\$1,856	\$2,572

***The rates above include charges for the Medical plan and for the Travel Assistance Program, as well as any applicable administrative fees and/or commissions. They are the total cost to students for the coverage periods listed.***

## Enrollment

International Students can contact the Hofstra International Office for information to waive the coverage.

If you need information or have general questions on dependent enrollment, call Member Services at 877-554-5523.

## Participating Providers

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

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

## Preauthorization

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

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

### You must contact Aetna to request preauthorization as follows:

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

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

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

## Description of Benefits

The Plan excludes coverage for certain services and has limitations on the amounts it will pay. While this Plan Summary document will tell you about some of the important features of the Plan, other features that may be important to you are defined in the Certificate. To look at the full Plan description, which is contained in the Certificate issued to you, go to [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).

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

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

- The Allowed Amount for Participating Providers is the amount we have negotiated with the Participating Provider.
- The Allowed Amount for Non-Participating Facilities is 140% of the Medicare rate.
- The Allowed Amount for all other providers is 105% of the Medicare rate.

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

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

<b>COST-SHARING</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	
<b>Medical Deductible</b> <ul style="list-style-type: none"><li>• Individual</li><li>• Family</li></ul>	\$250 \$500	\$750 \$1,500	
<b>Out-of-Pocket Limit</b> <ul style="list-style-type: none"><li>• Individual</li><li>• Family</li></ul>	\$7,350 \$14,700	None None	
		See the Cost-Sharing Expenses and Allowed Amount section of this 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 of the Non-Participating Provider’s charge that exceeds Our Allowed Amount.	

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

<b>EMERGENCY CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Pre-Hospital Emergency Medical Services (Ambulance Services)	20% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Non-Emergency Ambulance Services	20% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Emergency Department Copayment /Coinsurance waived if Hospital admission.	\$200 Copayment then You pay 20% Coinsurance after Deductible	\$200 Copayment then You pay 20% Coinsurance after Deductible	See benefit for description
Urgent Care Center	\$30 Copayment then You pay 0% Coinsurance after Deductible	\$30 Copayment then You pay 30% Coinsurance after Deductible	See benefit for description
<b>PROFESSIONAL SERVICES AND OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Acupuncture	\$30 Copayment then You pay 0% Coinsurance  Not subject to Deductible	30% Coinsurance after Deductible	
Advanced Imaging Services <ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> <li>Performed in a Freestanding Radiology Facility</li> <li>Performed as Outpatient Hospital Services</li> </ul>	20% Coinsurance after Deductible  20% Coinsurance after Deductible  20% Coinsurance after Deductible	50% Coinsurance after Deductible  50% Coinsurance after Deductible  50% Coinsurance after Deductible	See benefit for description
Allergy Testing & Treatment <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> </ul>	\$30 Copayment then You pay 0% Coinsurance Not Subject to Deductible  \$30 Copayment then You pay 0% Coinsurance Not Subject to Deductible	30% Coinsurance after Deductible  30% Coinsurance after Deductible	See benefit for description

<b>PROFESSIONAL SERVICES AND OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Ambulatory Surgical Center Facility Fee	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings)	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Autologous Blood Banking	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefits for description
Cardiac & Pulmonary Rehabilitation <ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> <li>Performed as Outpatient Hospital Services</li> <li>Performed as Inpatient Hospital Services</li> </ul>	\$30 Copayment then You pay 0% Coinsurance Not Subject to Deductible  \$30 Copayment then You pay 0% Coinsurance Not Subject to Deductible  Included as Part of Inpatient Hospital Service Cost-Sharing	30% Coinsurance after Deductible  30% Coinsurance after Deductible  Included as Part of Inpatient Hospital Service Cost-Sharing	See benefits for description
Chemotherapy <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>	\$30 Copayment then You pay 0% Coinsurance Not Subject to Deductible  \$30 Copayment then You pay 0% Coinsurance Not Subject to Deductible  \$30 Copayment then You pay 0% Coinsurance Not Subject to Deductible	30% Coinsurance after Deductible  30% Coinsurance after Deductible  30% Coinsurance after Deductible	See benefit for description
Chiropractic Services	\$30 Copayment then You pay 0% Coinsurance  Not Subject to Deductible	30% Coinsurance after Deductible	See benefit for description
Clinical Trials	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description

<b>PROFESSIONAL SERVICES AND OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Diagnostic Testing <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>	\$20 Copayment then You pay 0% Coinsurance Not Subject to Deductible	30% Coinsurance after Deductible	See benefit for description
Dialysis <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed in a Freestanding Center</li> <li>Performed as Outpatient Hospital Services</li> </ul>	\$30 Copayment then You pay 0% Coinsurance Not Subject to Deductible	30% Coinsurance after Deductible	See benefit for description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed in an Outpatient Facility</li> </ul>	\$30 Copayment then You pay 0% Coinsurance Not Subject to Deductible	30% Coinsurance after Deductible	60 visits per plan year



<b>PROFESSIONAL SERVICES AND OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Home Health Care	\$30 Copayment then You pay 0% Coinsurance Not Subject to Deductible	30% Coinsurance after Deductible	Unlimited visits per plan year
Infertility Services	Use Cost Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)		See benefit for description
Infusion Therapy <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>	\$30 Copayment then You pay 0% Coinsurance Not Subject to Deductible  \$30 Copayment then You pay 0% Coinsurance Not Subject to Deductible  \$30 Copayment then You pay 0% Coinsurance Not Subject to Deductible  \$30 Copayment then You pay 0% Coinsurance Not Subject to Deductible	30% Coinsurance after Deductible  30% Coinsurance after Deductible  30% Coinsurance after Deductible  30% Coinsurance after Deductible	See benefit for description
Inpatient Medical Visits	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Interruption of Pregnancy <ul style="list-style-type: none"> <li>Medically Necessary Abortions</li> <li>Elective Abortions</li> </ul>	Covered in full not subject to Deductible  0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible  30% Coinsurance after Deductible	Unlimited

<b>PROFESSIONAL SERVICES AND OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<p>Laboratory Procedures</p> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed in a Freestanding Laboratory Facility</li> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$20 Copayment then You pay 0% Coinsurance Not Subject to Deductible</p> <p>\$20 Copayment then You pay 0% Coinsurance Not Subject to Deductible</p> <p>\$20 Copayment then You pay 0% Coinsurance Not Subject to Deductible</p> <p>\$20 Copayment then You pay 0% Coinsurance Not Subject to Deductible</p>	<p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p>	<p>See benefit for Description</p>
<p>Maternity &amp; Newborn Care</p> <ul style="list-style-type: none"> <li>Prenatal Care <ul style="list-style-type: none"> <li>Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> <li>Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> </ul> </li> </ul>	<p>Covered in Full</p> <p>Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)</p>	<p>30% Coinsurance after Deductible</p> <p>Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)</p>	<p>See benefit for Description</p> <p>One (1) Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early</p>

<b>PROFESSIONAL SERVICES AND OUTPATIENT CARE</b>	<b>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>Inpatient Hospital Services and Birthing Center</li> <li>Physician and Midwife Services for Delivery</li> <li>Breastfeeding Support, Counseling and Supplies including Breast Pumps, Nursing Bras</li> <li>Postnatal Care</li> </ul>	20% Coinsurance after Deductible  20% Coinsurance after Deductible  Covered in Full  Covered in Full	50% Coinsurance after Deductible  50% Coinsurance after Deductible  30% Coinsurance after Deductible  30% Coinsurance after Deductible	   Covered for duration of breast feeding
Outpatient Hospital Surgery Facility Charge	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Preadmission Testing	\$30 Copayment then You pay 0% Coinsurance Not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in Specialist Office</li> <li>Performed in Outpatient Facilities</li> </ul>	\$30 Copayment then You pay 0% Coinsurance Not subject to Deductible  \$30 Copayment then You pay 0% Coinsurance Not subject to Deductible  \$30 Copayment then You pay 0% Coinsurance Not subject to Deductible	30% Coinsurance after Deductible  30% Coinsurance after Deductible  30% Coinsurance after Deductible	See benefit for description

<b>PROFESSIONAL SERVICES AND OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<b>Diagnostic Radiology Services</b> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed in a Freestanding Radiology Facility</li> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>\$20 Copayment then You pay 0% Coinsurance Not subject to Deductible</p> <p>\$20 Copayment then You pay 0% Coinsurance Not subject to Deductible</p> <p>\$20 Copayment then You pay 0% Coinsurance Not subject to Deductible</p> <p>\$20 Copayment then You pay 0% Coinsurance Not subject to Deductible</p>	<p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p>	See benefit for description
<b>Therapeutic Radiology Services</b> <ul style="list-style-type: none"> <li>Performed in a Specialist Office</li> <li>Performed in a Freestanding Radiology Facility</li> <li>Performed as Outpatient Hospital Services</li> </ul>	<p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p>	<p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p>	See benefit for description
<b>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</b> <ul style="list-style-type: none"> <li>Performed in a PCP Office</li> <li>Performed in a Specialist Office</li> <li>Performed in an Outpatient Facility</li> </ul>	<p>\$30 Copayment then You pay 0% Coinsurance Not subject to Deductible</p> <p>\$30 Copayment then You pay 0% Coinsurance Not subject to Deductible</p> <p>\$30 Copayment then You pay 0% Coinsurance Not subject to Deductible</p>	<p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p>	60 visits per Plan Year

<b>PROFESSIONAL SERVICES AND OUTPATIENT CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Second Opinions on the Diagnosis of Cancer, Surgery & Other	\$30 Copayment then You pay 0% Coinsurance  Not Subject to Deductible	30% Coinsurance after Deductible	See benefit for description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery and Transplants <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>	20% Coinsurance after Deductible  20% Coinsurance after Deductible  20% Coinsurance after Deductible  20% Coinsurance after Deductible	50% Coinsurance after Deductible  50% Coinsurance after Deductible  50% Coinsurance after Deductible  50% Coinsurance after Deductible	See benefit for description  All transplants must be performed at Designated Facilities
<b>ADDITIONAL SERVICES, EQUIPMENT &amp; DEVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
ABA Treatment for Autism Spectrum Disorder	\$30 Copayment then You pay 0% Coinsurance Not subject to Deductible	30% Coinsurance after Deductible	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	\$30 Copayment then You pay 0% Coinsurance Not subject to Deductible	30% Coinsurance after Deductible	See benefit for description

<b>ADDITIONAL SERVICES, EQUIPMENT &amp; DEVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
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>	\$30 Copayment then You pay 0% Coinsurance Not subject to Deductible  \$30 Copayment then You pay 0% Coinsurance Not subject to Deductible	30% Coinsurance after Deductible   30% Coinsurance after Deductible	See benefit for description   See benefit for description
Durable Medical Equipment & Braces	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
External Hearing Aids	20% Coinsurance after Deductible	50% Coinsurance after Deductible	Single purchase once every three (3) years
Cochlear Implants	20% Coinsurance after Deductible	50% Coinsurance after Deductible	One (1) per ear per plan year
Hospice Care <ul style="list-style-type: none"> <li>• Inpatient</li> <li>• Outpatient</li> </ul>	20% Coinsurance after Deductible  \$30 Copayment then You pay 0% Coinsurance Not subject to Deductible	50% Coinsurance after Deductible  30% Coinsurance after Deductible	Unlimited days per Plan Year  Five (5) visits for family bereave-ment counseling
Medical Supplies	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Prosthetic Devices <ul style="list-style-type: none"> <li>• External</li> <li>• Internal</li> </ul>	20% Coinsurance after Deductible  20% Coinsurance after Deductible	50% Coinsurance after Deductible  50% Coinsurance after Deductible	One (1) prosthetic device, per limb, per Plan Year

<b>INPATIENT SERVICES &amp; FACILITIES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<p>Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac &amp; Pulmonary Rehabilitation, &amp; End of Life Care)</p> <p>Preauthorization Required. However, Preauthorization is not required for emergency admissions or services provided in a neonatal intensive care unit of a Hospital certified pursuant to Article 28 of the Public Health Law.</p>	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Observation Stay	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	20% Coinsurance after Deductible	50% Coinsurance after Deductible	200 days per plan year
Inpatient Habilitation Services (Physical Speech and Occupational Therapy)	20% Coinsurance after Deductible	50% Coinsurance after Deductible	60 days per plan year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	20% Coinsurance after Deductible	50% Coinsurance after Deductible	60 days per plan year

<b>MENTAL HEALTH &amp; SUBSTANCE USE DISORDER SERVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<p>Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment)</p> <p>Preauthorization Required. However, Preauthorization is not required for emergency admissions or for admissions at Participating OMH licensed Facilities for Members under 18.</p>	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
<p>Outpatient Mental Health Care (Including Partial Hospitalization &amp; Intensive Outpatient Program Services)</p> <ul style="list-style-type: none"> <li>Office Visits</li> <li>All Other Outpatient Services</li> </ul>	<p>\$30 Copayment then You pay 0% Coinsurance Not subject to Deductible</p> <p>20% Coinsurance after Deductible</p>	<p>30% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p>	See benefit for description
<p>Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)</p> <p>Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions or for Participating OASAS-certified Facilities</p>	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description



MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost- Sharing	Limits
<p>Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)</p> <ul style="list-style-type: none"> <li>Office Visits</li> <li>All Other Outpatient Services</li> </ul> <p>Preauthorization Required However, Preauthorization is not required for Participating OASAS-certified Facilities.</p>	<p>\$30 Copayment then You pay 0% Coinsurance Not subject to Deductible</p> <p>20% Coinsurance after Deductible</p>	<p>30% Coinsurance after Deductible</p> <p>50% Coinsurance after Deductible</p>	<p>Up to twenty (20) visits a plan year may be used for family counseling</p>

PRESCRIPTION DRUGS	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
*Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an “A” or “B” rating from the USPSTF and obtained at a participating pharmacy			
<b>Note:</b> If You have an Emergency Condition, Preauthorization is not required for a five (5) day emergency supply of a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.			
<b>Retail Pharmacy</b>			
30-day supply			See benefit for description
Tier 1 (generic)	\$15 Copayment per supply  Not subject to Deductible	\$15 Copayment per supply  Not subject to Deductible	
Tier 2 (formulary brand)	\$40 Copayment per supply  Not subject to Deductible	\$40 Copayment per supply  Not subject to Deductible	
Tier 3 (non-formulary brand)	\$40 Copayment per supply  Not subject to Deductible	\$40 Copayment per supply  Not subject to Deductible	

<b>PRESCRIPTION DRUGS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
<b>Mail Order Pharmacy</b>			
Up to a 90-day supply			See benefit for description
Tier 1 (generic)	\$37.50 Copayment not subject to the Deductible then You pay 0% Coinsurance	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 2 (formulary brand)	\$100 Copayment not subject to the Deductible then You pay 0% Coinsurance	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
Tier 3 (non-formulary brand)	\$100 Copayment not subject to the Deductible then You pay 0% Coinsurance	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	
<b>PRESCRIPTION DRUGS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Enteral Formulas			See benefit for description
Tier 1 (generic)	\$15 Copayment per supply Not subject to Deductible	\$15 Copayment per supply Not subject to Deductible	
Tier 2 (formulary brand)	\$40 Copayment per supply Not subject to Deductible	\$40 Copayment per supply Not subject to Deductible	
Tier 3 (non-formulary brand)	\$40 Copayment per supply Not subject to Deductible	\$40 Copayment per supply Not subject to Deductible	

<b>WELLNESS BENEFITS</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Exercise Facility Reimbursement	Up to \$200 per six (6) month period		
<b>PEDIATRIC DENTAL &amp; VISION CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Pediatric Dental Care <ul style="list-style-type: none"> <li>Preventive</li> <li>Routine Dental Care</li> <li>Major Dental Care (Oral Surgery, Endodontics, Periodontics &amp; Prosthodontics)</li> <li>Orthodontics</li> </ul>	0% Coinsurance after Deductible  0% Coinsurance after Deductible  50% Coinsurance after Deductible  50% Coinsurance after Deductible	30% Coinsurance after Deductible  30% Coinsurance after Deductible  50% Coinsurance after Deductible  50% Coinsurance after Deductible	One (1) dental exam & cleaning per six (6)-month period  Full mouth x-rays or panoramic x-rays at thirty-six (36) month intervals and bitewing x-rays at six (6) month intervals

<b>PEDIATRIC DENTAL &amp; VISION CARE</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Pediatric Vision Care <ul style="list-style-type: none"> <li>Exams</li> <li>Lenses &amp; Frames</li> <li>Contact Lenses</li> </ul>	\$30 Copayment then You pay 0% Coinsurance Not subject to Deductible	30% Coinsurance after Deductible	One (1) exam per twelve (12)-month period
	20% Coinsurance after Deductible	50% Coinsurance after Deductible	One (1) prescribed lenses & frames per twelve (12)-month period
	20% Coinsurance after Deductible	50% Coinsurance after Deductible	

All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not covered under the Certificate, you will be responsible for the full cost of the services.

### Exclusions

No coverage is available under the certificate for the following:

**Aviation.**

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

**Convalescent and Custodial Care.**

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

**Conversion Therapy.**

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

**Cosmetic Services.**

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

**Dental Services.**

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

**Experimental or Investigational Treatment.**

We do not Cover any health care service, procedure, treatment, device or Prescription Drug that is experimental or investigational. However, we will Cover experimental or investigational treatments, including treatment for Your

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

**Felony Participation.**

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

**Foot Care.**

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

**Government Facility.**

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

**Medically Necessary.**

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

**Medicare or Other Governmental Program.**

We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid). When You are eligible for Medicare, we will reduce Our benefits by the amount Medicare would have paid for the Covered Services. Except as otherwise required by law, this reduction is made even if You fail to enroll in Medicare or You do not pay Your Medicare premium. Benefits for Covered Services will not be reduced if We are required by federal law to pay first or if You are not eligible for premium-free Medicare Part A.

**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 covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

**Services Separately Billed by Hospital Employees.**

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

**Services with No Charge.**

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

**Vision Services.**

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

**War.**

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

**Workers' Compensation.**

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

**Fully Insured Disclaimer**

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

**Sanctioned Countries**

If coverage provided by this policy violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or



a country under sanction by the United States, unless permitted under a written Office of Foreign Asset Control (OFAC) license. For more information, visit <http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

### **Assistive Technology**

Persons using assistive technology may not be able to fully access the following information. For assistance, please call the number listed on your ID card at no cost.

### **Smartphone or Tablet**

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

### **Non-Discrimination**

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, [CRCoordinator@aetna.com](mailto:CRCoordinator@aetna.com). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

**Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.**





Hawaiian	No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i ka helu kelepona ma kāu kāleka ID. Kāki 'ole 'ia kēia kōkua nei.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Igbo	Inweta enyemaka asụsụ na akwughi ụgwọ obula, kpọọ nomba nọ na kaadi njirimara gi
Ilocano	Tapno maakses dagiti serbisio ti pagsasao nga awanan ti bayadna, awagan ti numero nga adda ayan ti ID kardmo.
Indonesian	Untuk mengakses layanan bahasa tanpa dikenakan biaya, silakan hubungi nomor telepon di kartu asuransi Anda.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Karen	လၢတၢ်ကမၤန့ၣ်ကိၣ်တၢ်မၤစၢၤအတၢ်ဖဲတၢ်မၤတဖၣ် လၢတၢ်အိၣ်ဒီးအပူၤလၢနကတၢ်ဟ့ၣ်အီၤအဂီၢ်,ကိးဘၣ်လီၤတဲစီၣ်နီၣ်ဂံၢ်လၢအအိၣ်လၢနခိၣ်ဂီၤ (ID) အလီၤန့ၣ်တက့ၢ်.
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Kru-Bassa	I nyuu kosna mahola ni language services ngui nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matibla
Kurdish	بۆ دەستگیر ئەگەشتن بە خزمەتگوزاری زمان بەبێ تێچوون بۆ تۆ، پەیوەندی بکە بە ژمارەی سەر ئای دی (ID) کارتی خۆت.
Lao	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໃບຫາເບີໂທລະສັບໃນບັດປະຈຳຕົວຂອງທ່ານ.
Marathi	आपल्याला कोणत्याही शुल्काशिवाय भाषा सेवांपर्यंत पोहोचण्यासाठी, आपल्या ID कार्डवरील क्रमांकावर फोन करा.
Marshallese	Ñan bōk jipañ kōn kajin ilo an ejjelok wōñean ñan kwe, kwōn kallok nōm̄ba eo ilo kaat in ID eo am̄.
Micronesian-Ponapean	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាភាសាដែលគេគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T'áá ni nizaad k'éhjí bee níká a'doowoł doo b'ááq'í ílínígóó naaltsoos bee atah nílíggo nanitinígíí bee n'éého'dólzínígíí béésh bee hane'í biká'ígíí áají' hólne'.
Nepali	भाषासम्बन्धी सेवाहरूमाथि निःशुल्क पहुँच राख्न आफ्नो कार्डमा रहेको नम्बरमा कल गर्नुहोस्।
Nilotic-Dinka	Të koor yin ran de wëër de thokic ke c'in wëu kor keek tënɔŋ yin. Ke yin col ran ye koc kuony në namba de abac tö në ID kard duön de tiit de nyin de panakim kōu.
Norwegian	For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt.

