



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

## **New York Medical College**

Policy Year: 2026 – 2027

Policy Number: 686207



**NEW YORK MEDICAL COLLEGE**  
A MEMBER OF THE Touro College and University System

<https://www.aetnastudenthealth.com>

(866) 381-1529



This is a brief description of the Student Health Plan available for New York Medical College. 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 <https://www.aetnastudenthealth.com/nymc> If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

### Who is eligible?

All students are required to enroll in the New York Medical College Sponsored Student Health Insurance Plan unless a waiver is submitted and approved. Enrollment and the insurance charge can be waived if proof of other health insurance is provided by submitting an online waiver.

### 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 will become effective at 12:01 AM on the Coverage Start Date and will terminate at 11:59 PM on the Coverage End Date indicated below.

	<b>Annual</b>
<b>Coverage Start Date</b>	<b>07/01/2026</b>
<b>Coverage End Date</b>	<b>06/30/2027</b>
Student Medical Premium	\$8,421
Spouse	\$8,421
One Child	\$8,421
2 or More Children	\$16,842

### Enrollment

The enrollment and waiver process is administered by **HSA Consulting, Inc. (HSAC)**, New York Medical College student insurance plan. To enroll in the New York Medical College student insurance plan, or if you have any questions regarding the enrollment or waiver process, contact **HSAC** at **1-888-978-8355**, or visit <https://app.hsac.com/nymc>.

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, less any claims paid. 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 Accident or Sickness.)

## Medicare Eligibility Notice

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

## Termination of Coverage

Coverage under the certificate will automatically be terminated on the first of the following to apply:

The student has failed to pay premiums within 30 days of when premiums are due. Coverage will terminate as of the last day for which premiums were paid.

The date on which the student ceases to meet the eligibility requirements as defined by the policyholder. We will provide written notice to the student at least 30 days prior to when the coverage will cease.

Upon the student's death, coverage will terminate unless the student has coverage for dependents. If the student has coverage for dependents, then coverage will terminate as of the last day of the month for which the premium has been paid.

For spouses in cases of divorce, the date of the divorce.

For children, until the end of the year in which the child turns 26 years of age.

For all other dependents, the end of the year in which the dependent ceases to be eligible.

The end of the month following the student provision of written notice to us requesting termination of coverage, or on such later date requested for such termination by the notice.

If a student or the student's dependent has performed an act that constitutes fraud or the student has made an intentional misrepresentation of material fact in writing on his or 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 student and/or the student's dependent, as applicable. If termination is a result of the student's action, coverage will terminate for the student and any dependents. If termination is a result of the dependent's action, coverage will terminate for the dependent.

The date that the policyholder's policy is terminated. If we decide to stop offering a particular class of policies, without regard to claims experience or health related status, to which the certificate belongs, we will provide the policyholder and students at least 90 days' prior written notice.

If we decide to stop offering all student accident and health insurance coverage in this state, we will provide written notice to the policyholder at least 180 days prior to when the coverage will cease. The policyholder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

For such other reasons that are acceptable to the superintendent and authorized by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act. No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

## 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 must 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.

## CVS Virtual Care®

From everyday illnesses and chronic conditions to mental health support, we've got your back. Once you tell us what you need, we'll connect you with trusted, in-network providers so you can schedule a virtual visit. Most mental health visits are available within two weeks. You can access 24/7 care through our virtual clinic. General Care: 100% coverage. Behavioral Health: See the schedule of benefits for more information. Go to [CVS.com/virtual-care](https://www.cvs.com/virtual-care) to register and schedule an appointment.

## 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 <https://www.aetnastudenthealth.com/nymc>.

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 <https://www.aetnastudenthealth.com/nymc> 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).

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
<b>Medical Deductible</b> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul>	\$500 \$1,000	\$1,000 \$2,000	
<b>Out-of-Pocket Limit</b> <ul style="list-style-type: none"> <li>• Individual</li> <li>• Family</li> </ul>	\$6,350 \$12,700	\$6,350 \$12,700	
		<p>See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how We calculate the Allowed Amount.</p> <p>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.</p>	

<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 20% Coinsurance  Not subject to Deductible	40% Coinsurance after Deductible	See benefit for description
Specialist Office Visits (or Home Visits)	\$30 Copayment then You pay 20% Coinsurance  Not subject to Deductible	40% 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	
We do not Cover services related to the reversal of elective sterilizations.			
Bone Density Testing*	Covered in full	30% Coinsurance after Deductible	
Prostate Cancer Screening	Covered in full	30% Coinsurance after Deductible	
Screening for Colon Cancer	Covered in full	30% Coinsurance after Deductible	
All other preventive services required by USPSTF and HRSA.	Covered in full	30% Coinsurance after Deductible	
*When preventive services are not provided in accordance with the comprehensive guidelines supported by United States Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA).	Use Cost Sharing for Appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)		

EMERGENCY CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Emergency Ambulance Transportation (Pre-Hospital Emergency Medical Services and Emergency Transportation including Air Ambulance Services)	20% Coinsurance Not subject to Deductible	Paid the same as Participating Provider	See benefit for description
Non-Emergency Ambulance Services (Ground and Air Ambulance)	20% Coinsurance Not subject to Deductible	20% Coinsurance Not subject to Deductible	See benefit for description
<p><b>Limitations/Terms of Coverage:</b></p> <ul style="list-style-type: none"> <li>• We do not Cover travel or transportation expenses, unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician.</li> <li>• We do not Cover non-ambulance transportation such as ambulette, van or taxi cab.</li> <li>• Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; and Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met: <ul style="list-style-type: none"> <li>○ The point of pick-up is inaccessible by land vehicle; or</li> <li>○ Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.</li> </ul> </li> </ul>			
Emergency Department  Copayment /Coinsurance waived if admitted to Hospital.	\$150 Copayment then You pay 20% Coinsurance  Not subject to Deductible Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	Paid the same as Participating Provider	See benefit for description
We do not Cover follow-up care or routine care provided in a Hospital emergency department.			
Urgent Care Center	\$35 Copayment then You pay 20% Coinsurance  Not subject to Deductible	40% 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	20% Coinsurance after Deductible	40% 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	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% 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 20% Coinsurance Not Subject to Deductible \$30 Copayment then You pay 20% Coinsurance Not Subject to Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Ambulatory Surgical Center Facility Fee	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings)	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
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>	20% Coinsurance after Deductible 20% Coinsurance after Deductible Included as Part of Inpatient Hospital Service Cost-Sharing	40% Coinsurance after Deductible 40% Coinsurance after Deductible Included as Part of Inpatient Hospital Service Cost-Sharing	See benefits for description
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>	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description

<b>PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Chiropractic Services	\$30 Copayment then You pay 20% Coinsurance  Not subject to Deductible	40% Coinsurance after Deductible	See benefit for description
Clinical Trials	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description
We do not Cover: the costs of the investigational drugs or devices; the costs of non-health services required for You to receive the treatment; the costs of managing the research; or costs that would not be covered under this Certificate for non-investigational treatments provided in the clinical trial.			
Diagnostic Testing <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% Coinsurance after Deductible  20% Coinsurance after Deductible  20% Coinsurance after Deductible	40% Coinsurance after Deductible  40% Coinsurance after Deductible  40% Coinsurance after Deductible	See benefit for description
Dialysis <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>	20% Coinsurance after Deductible  20% Coinsurance after Deductible  20% Coinsurance after Deductible  20% Coinsurance after Deductible	40% Coinsurance after Deductible  40% Coinsurance after Deductible  40% Coinsurance after Deductible  40% Coinsurance after Deductible	See benefit for description
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 20% Not subject to Deductible  \$30 Copayment then You pay 20% Not subject to Deductible  \$30 Copayment then You pay 20% Not subject to Deductible	40% Coinsurance after Deductible  40% Coinsurance after Deductible  40% Coinsurance after Deductible	Unlimited visits per plan year

<b>PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)</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  The visit limit does not apply to Home Health Care for a mental health condition or substance use disorder.	20% Coinsurance after Deductible	40% Coinsurance after Deductible	60 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
<p>We do not Cover:</p> <ul style="list-style-type: none"> <li>• In vitro fertilization;</li> <li>• Gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;</li> <li>• Costs associated with an ovum or sperm donor including the donor's medical expenses;</li> <li>• Cryopreservation and storage of sperm and ova except when performed as fertility preservation services;</li> <li>• Cryopreservation and storage of embryos;</li> <li>• Ovulation predictor kits;</li> <li>• Reversal of tubal ligations;</li> <li>• Reversal of vasectomies;</li> <li>• Costs for and services relating to surrogate motherhood that are not otherwise Covered Services under this Certificate;</li> <li>• Cloning; or</li> <li>• Medical and surgical procedures that are experimental or investigational unless Our denial is overturned by an External Appeal Agent.</li> </ul>			
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>	20% Coinsurance after Deductible  20% Coinsurance after Deductible  20% Coinsurance after Deductible  20% Coinsurance after Deductible	40% Coinsurance after Deductible  40% Coinsurance after Deductible  40% Coinsurance after Deductible  40% Coinsurance after Deductible	See benefit for description    Home infusion counts towards home health care visit limits

<b>PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Inpatient Medical Visits	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Interruption of Pregnancy <ul style="list-style-type: none"> <li>Abortion services</li> </ul>	Covered in full	30% Coinsurance after Deductible	See benefit for description
Laboratory Procedures <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>	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for Description
Maternity & Newborn Care <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 United States Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA)</li> </ul> </li> </ul>	Covered in Full	30% Coinsurance after Deductible	See benefit for Description

PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<ul style="list-style-type: none"> <li>Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by United States Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA)</li> <li>Inpatient Hospital Services and Birthing Center</li> </ul>	<p>Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)</p> <p>\$500 Copayment then you pay 20% Coinsurance</p> <p>Not subject to 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>40% Coinsurance after Deductible</p>	
<ul style="list-style-type: none"> <li>Physician and Midwife Services for Delivery</li> </ul>	20% Coinsurance after Deductible	40% Coinsurance after Deductible	One (1) Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
<ul style="list-style-type: none"> <li>Breastfeeding Support, Counseling and Supplies including Breast Pumps, Nursing Bras</li> </ul>	Covered in Full	30% Coinsurance after Deductible	Covered for duration of breast feeding
<ul style="list-style-type: none"> <li>Postnatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSAP</li> </ul>	Covered in full	30% Coinsurance after Deductible	

PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<ul style="list-style-type: none"> <li>Postnatal Care Postnatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA</li> </ul>	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)	
Outpatient Donor Breast Milk	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Outpatient Hospital Surgery Facility Charge	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Preadmission Testing	20% Coinsurance after Deductible	40% 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>	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description
Diagnostic Radiology Services <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>	20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description

PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Therapeutic Radiology 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	40% Coinsurance after Deductible  40% Coinsurance after Deductible  40% Coinsurance after Deductible	See benefit for description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) <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 20% Not subject to Deductible  \$30 Copayment then You pay 20% Not subject to Deductible  \$30 Copayment then You pay 20% Not subject to Deductible	40% Coinsurance after Deductible  40% Coinsurance after Deductible  40% Coinsurance after Deductible	Unlimited visits per Plan Year  Speech and physical therapy are only Covered following a Hospital stay or surgery.
Second Opinions on the Diagnosis of Cancer, Surgery & Other	\$30 Copayment then You pay 20% Coinsurance  Not Subject to Deductible	40% Coinsurance after Deductible	See benefit for description

PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive &amp; Corrective Surgery and Transplants</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>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p> <p>20% Coinsurance after Deductible</p>	<p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p>	<p>See benefit for description</p> <p>All transplants must be performed at Designated Centers of Excellence Hospitals</p>
<p>We do not Cover: travel expenses, lodging, meals, or other accommodations for donors or guests; donor fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.</p>			

ADDITIONAL BENEFITS, EQUIPMENT & DEVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Diabetic Equipment, Supplies & Self-Management Education <ul style="list-style-type: none"> <li>• Diabetic Equipment and Supplies (30 Day Supply)</li> <li>• Diabetic Education</li> </ul>	\$15 Copayment then You pay 0% Coinsurance  Not Subject to Deductible  \$30 Copayment then You pay 20% Coinsurance  Not Subject to Deductible	\$15 Copayment then You pay 0% Coinsurance  Not Subject to Deductible  40% Coinsurance after Deductible	See benefit for description   See benefit for description
<ul style="list-style-type: none"> <li>• Diabetic Insulin (30 Day Supply)</li> <li>• Oral anti-diabetic agents and injectable anti-diabetic agents (30 day supply)</li> </ul>	Covered in full    Covered in full	\$15 Copayment then You pay 0% Coinsurance  Not Subject to Deductible  \$15 Copayment then You pay 0% Coinsurance  Not Subject to Deductible	See benefit for description   See benefit for description
<p><b>Limitations</b>            The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We Cover only basic models of blood glucose monitors unless You have special needs relating to poor vision or blindness or otherwise Medically Necessary.</p>			
Durable Medical Equipment & Braces	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
<p>We do not Cover: equipment designed for Your comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment), as it does not meet the definition of durable medical equipment.</p> <p><b>Braces.</b>            We do not Cover: the cost of repair or replacement that is the result of misuse or abuse by You.</p>			
External Hearing Aids <ul style="list-style-type: none"> <li>• Prescription Hearing Aids</li> </ul>	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Single purchase once every three (3) years
Cochlear Implants	20% Coinsurance after Deductible	40% Coinsurance after Deductible	One (1) per year per plan year

ADDITIONAL BENEFITS, EQUIPMENT & DEVICES (continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Hospice Care <ul style="list-style-type: none"> <li>• Inpatient</li> <li>• Outpatient</li> </ul>	20% Coinsurance after Deductible  20% Coinsurance after Deductible	40% Coinsurance after Deductible  40% Coinsurance after Deductible	Unlimited days per Plan Year  Five (5) visits for family bereavement counseling
We do not Cover funeral arrangements; pastoral, financial, or legal counseling; or homemaker, caretaker, or respite care.			
Medical Supplies	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
We do not Cover over-the-counter medical supplies.			
Prosthetic Devices <ul style="list-style-type: none"> <li>• External</li> <li>• Internal</li> </ul>	20% Coinsurance after Deductible  20% Coinsurance after Deductible	40% Coinsurance after Deductible  40% Coinsurance after Deductible	One (1) prosthetic device, per limb, per Plan Year  Unlimited
<p>We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials.</p> <p>We do not Cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.</p> <p>Eyeglasses and contact lenses are not Covered under this section of the Certificate and are only Covered under the Pediatric Vision Care section of this Certificate.</p> <p>We do not Cover the cost of repair or replacement covered under warranty or if the repair or replacement is the result of misuse or abuse by You.</p> <p>We do not Cover shoe inserts.</p>			

<b>INPATIENT SERVICES</b>	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
Autologous Blood Banking	20% Coinsurance after the Deductible	40% Coinsurance after the Deductible	See benefit for description
<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>	<p>\$500 Copayment then you pay 20% Coinsurance</p> <p>Not subject to Deductible</p>	40% Coinsurance after Deductible	See benefit for description
Observation Stay	<p>\$500 Copayment then you pay 20% Coinsurance</p> <p>Not subject to Deductible</p>	40% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	<p>\$500 Copayment then you pay 20% Coinsurance</p> <p>Not subject to Deductible</p>	40% Coinsurance after Deductible	Unlimited days per plan year
Inpatient Habilitation Services (Physical Speech and Occupational Therapy)	<p>20% Coinsurance</p> <p>Not subject to Deductible</p>	40% Coinsurance after Deductible	Unlimited
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	<p>20% Coinsurance</p> <p>Not subject to Deductible</p>	40% Coinsurance after Deductible	<p>Unlimited Speech and physical therapy are only Covered following a Hospital stay or surgery</p>

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment)  Preauthorization Required. However, Preauthorization is not required for emergency admissions or for admissions at Participating Hospitals or crisis residence facilities licensed or operated by OMH	\$500 Copayment then you pay 20% Coinsurance  Not subject to Deductible	40% Coinsurance after Deductible	See benefit for description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)  <ul style="list-style-type: none"> <li>Office Visits</li> </ul>	\$30 Copayment then you pay 20% Coinsurance Not subject to Deductible	40% Coinsurance after Deductible	See benefit for description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services) (continued)  <ul style="list-style-type: none"> <li>All Other Outpatient Services</li> </ul>	20% Coinsurance Not subject to Deductible	40% Coinsurance after Deductible	
ABA Treatment for Autism Spectrum Disorder	20% Coinsurance  Not Subject to Deductible	40% Coinsurance after Deductible	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	20% Coinsurance  Not subject to Deductible	40% Coinsurance after Deductible	See benefit for description
<p><b>Limitations.</b> We do not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the New York Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the New York Public Health Law, an individualized education plan under Article 89 of the New York Education Law, or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities shall not affect coverage under this Certificate for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist</p>			

<b>MENTAL HEALTH &amp; SUBSTANCE USE DISORDER SERVICES (continued)</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 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 Facilities licensed, certified or otherwise authorized by OASAS.</p>	<p>\$500 Copayment then you pay 20% Coinsurance</p> <p>Not subject to Deductible</p>	<p>40% Coinsurance after Deductible</p>	<p>See benefit for description</p>
<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>• Opioid Treatment Programs</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 20% Coinsurance Not subject to Deductible</p> <p>Covered in full</p> <p>20% Coinsurance Not subject to Deductible</p>	<p>40% Coinsurance after Deductible</p> <p>30% Coinsurance after Deductible</p> <p>40% Coinsurance after Deductible</p>	<p>Up to twenty (20) visits a plan year may be used for family counseling</p>

<b>PRESCRIPTION DRUGS</b> Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by Health Resources and Services Administration (HRSA) or if the item or service has an “A” or “B” rating from the United States Preventive Services Task Force (USPSTF) and obtained at a participating pharmacy	<b>Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Provider Member Responsibility for Cost-Sharing</b>	<b>Limits</b>
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**Cost-Sharing Expenses.** You are responsible for paying the costs outlined in the Schedule of Benefits section of this Certificate when Covered Prescription Drugs are obtained from a retail or mail order pharmacy.

You have a one three (3) tier plan design, which means that Your out-of-pocket expenses will generally be lowest for Prescription Drugs on tier 1 and highest for Prescription Drugs on tier 3. Your out-of-pocket expense for Prescription Drugs on tier 2 will generally be more than for tier 1 but less than tier 3.

Preauthorization is not required for Covered antiretroviral Prescription Drugs for the treatment or prevention of HIV or AIDS and Prescription Drugs 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  Tier 1 Preferred Generic drugs          Tier 2 Preferred Brand drugs          Tier 3 Non-Preferred Generic and Brand drugs	\$15 Copayment Not subject to Deductible          \$50 Copayment Not subject to Deductible          \$75 Copayment Not subject to Deductible	\$15 Copayment Not subject to Deductible          \$50 Copayment Not subject to Deductible          \$75 Copayment Not subject to Deductible	See benefit for description

PRESCRIPTION DRUGS (continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost- Sharing	Limits
<b>Mail Order Pharmacy</b>			
Up to a 90-day supply  Tier 1 Preferred Generic drugs   Tier 2 Preferred Brand drugs   Tier 3 Non-Preferred Generic and Brand drugs	\$37.50 Copayment then You pay 0% Not subject to Deductible  \$125 Copayment then You pay 0% Not subject to Deductible  \$187.50 Copayment then You pay 0% Not subject to Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Non-Participating Provider Services Are Not Covered and You Pay the Full Cost  Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See benefit for description
Enteral Formulas  Tier 1 Preferred Generic drugs   Tier 2 Preferred Brand drugs   Tier 3 Non-Preferred Generic and Brand drugs	\$15 Copayment Not subject to Deductible  \$50 Copayment Not subject to Deductible  \$75 Copayment Not subject to Deductible	\$15 Copayment Not subject to Deductible  \$50 Copayment Not subject to Deductible  \$75 Copayment Not subject to Deductible	See benefit for description

## Limitations/Terms of Coverage.

1. We reserve the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.
2. If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies and prescribing Providers may be limited. If this happens, We may require You to select a single Participating Pharmacy and a single Provider that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. Benefits will be paid only if Your Prescription Order or Refills are written by the selected Provider or a Provider authorized by Your selected provider. If You do not make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy and/or prescribing Provider for You.
3. Compounded Prescription Drugs will be Covered only when they contain at least one (1) ingredient that is a Covered legend Prescription Drug, they are not essentially the same as a Prescription Drug from a manufacturer and are obtained from a pharmacy that is approved for compounding.
4. Various specific and/or generalized "use management" protocols will be used from time to time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our Members with a quality-focused Prescription Drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.
5. Injectable drugs (other than self-administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies and equipment are not Covered under this section but are Covered under other sections of this Certificate.
6. We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician's office are Covered under the Outpatient and Professional Services section of this Certificate.
7. We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs for which there is a written order, over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an "A" or "B" rating from USPSTF for which there is a written order, or as otherwise provided in this Certificate. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as Covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts. We do not Cover repackaged products such as therapeutic kits or convenience packs that contain a Covered Prescription Drug unless the Prescription Drug is only available as part of a therapeutic kit or convenience pack. Therapeutic kits or convenience packs contain one or more Prescription Drug(s) and may be packaged with over-the-counter items, such as glove, finger cots, hygienic wipes or topical emollients.
8. We do not Cover Prescription Drugs to replace those that may have been lost or stolen.
9. We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.
10. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in the Utilization Review and External Appeal sections of this Certificate.
11. A pharmacy need not dispense a Prescription Order that, in the pharmacist's professional judgment, should not be filled.

WELLNESS BENEFITS	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Exercise Facility Reimbursement	Up to \$200 per six (6) month period		
<p>Reimbursement is limited to actual workout visits. We do not reimburse:</p> <ul style="list-style-type: none"> <li>• Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities;</li> <li>• Lifetime memberships;</li> <li>• Equipment, clothing, vitamins or other services that may be offered by the facility (e.g., massages, etc.); or</li> <li>• Services that are amenities, such as a gym, that are included in Your rent or homeowners association fees.</li> </ul>			
PEDIATRIC DENTAL & VISION CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
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>	<ul style="list-style-type: none"> <li>• Preventive \$35 Copayment then You pay 0% Coinsurance Not Subject to Deductible</li> <li>• Routine Dental Care \$100 Copayment then You pay 0% Coinsurance Not Subject to Deductible</li> <li>• Major Dental Care (Oral Surgery, Endodontics, Periodontics &amp; Prosthodontics) \$250 Copayment then You pay 0% Coinsurance Not Subject to Deductible</li> <li>• Orthodontics 50% Coinsurance Not Subject to Deductible</li> </ul>	<ul style="list-style-type: none"> <li>• Preventive \$35 Copayment then You pay 0% Coinsurance Not Subject to Deductible</li> <li>• Routine Dental Care \$100 Copayment then You pay 0% Coinsurance Not Subject to Deductible</li> <li>• Major Dental Care (Oral Surgery, Endodontics, Periodontics &amp; Prosthodontics) \$250 Copayment then You pay 0% Coinsurance Not Subject to Deductible</li> <li>• Orthodontics 50% Coinsurance Not Subject to Deductible</li> </ul>	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

PEDIATRIC DENTAL & VISION CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Vision Care <ul style="list-style-type: none"> <li data-bbox="82 380 201 407">• Exams</li> <li data-bbox="82 583 331 611">• Lenses &amp; Frames</li> <li data-bbox="82 772 306 800">• Contact Lenses</li> </ul>	\$20 Copayment then You pay 0% Coinsurance Not Subject to Deductible  \$40 Copayment then You pay 0% Coinsurance Not Subject to Deductible  \$40 Copayment then You pay 0% Coinsurance Not Subject to Deductible	30% Coinsurance  Not subject to Deductible  30% Coinsurance  Not subject to Deductible  30% Coinsurance  Not subject to Deductible	One (1) exam per twelve (12)-month period  One (1) prescribed lenses & frames per twelve (12)-month period

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.

Contact Us at the number on Your ID card for information on Your financial responsibility when You receive Covered Services with a primary diagnosis of mental health or substance use disorder.

Travel Assistance Services

Complete benefit information is found in the Certificate of Coverage.

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

**Accidental Death and Dismemberment Benefits**

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

## **Exclusions**

No coverage is available under the certificate for the following:

### **Aviation.**

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

### **Convalescent and Custodial Care.**

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

### **Conversion Therapy.**

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

### **Cosmetic Services.**

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

### **Coverage Outside of the United States, Canada or Mexico.**

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

**Dental Services.**

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

**Experimental or Investigational Treatment.**

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

**Felony Participation.**

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

**Foot Care.**

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

**Government Facility.**

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

**Medically Necessary.**

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

**Medicare or Other Governmental Program.**

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

**Military Service.**

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

**No-Fault Automobile Insurance.**

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

**Services Not Listed.**

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

**Services Provided by a Family Member.**

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

**Services Separately Billed by Hospital Employees.**

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

**Services with No Charge.**

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

**Vision Services.**

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

**War.**

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

**Workers' Compensation.**

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



The New York Medical College 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>.

