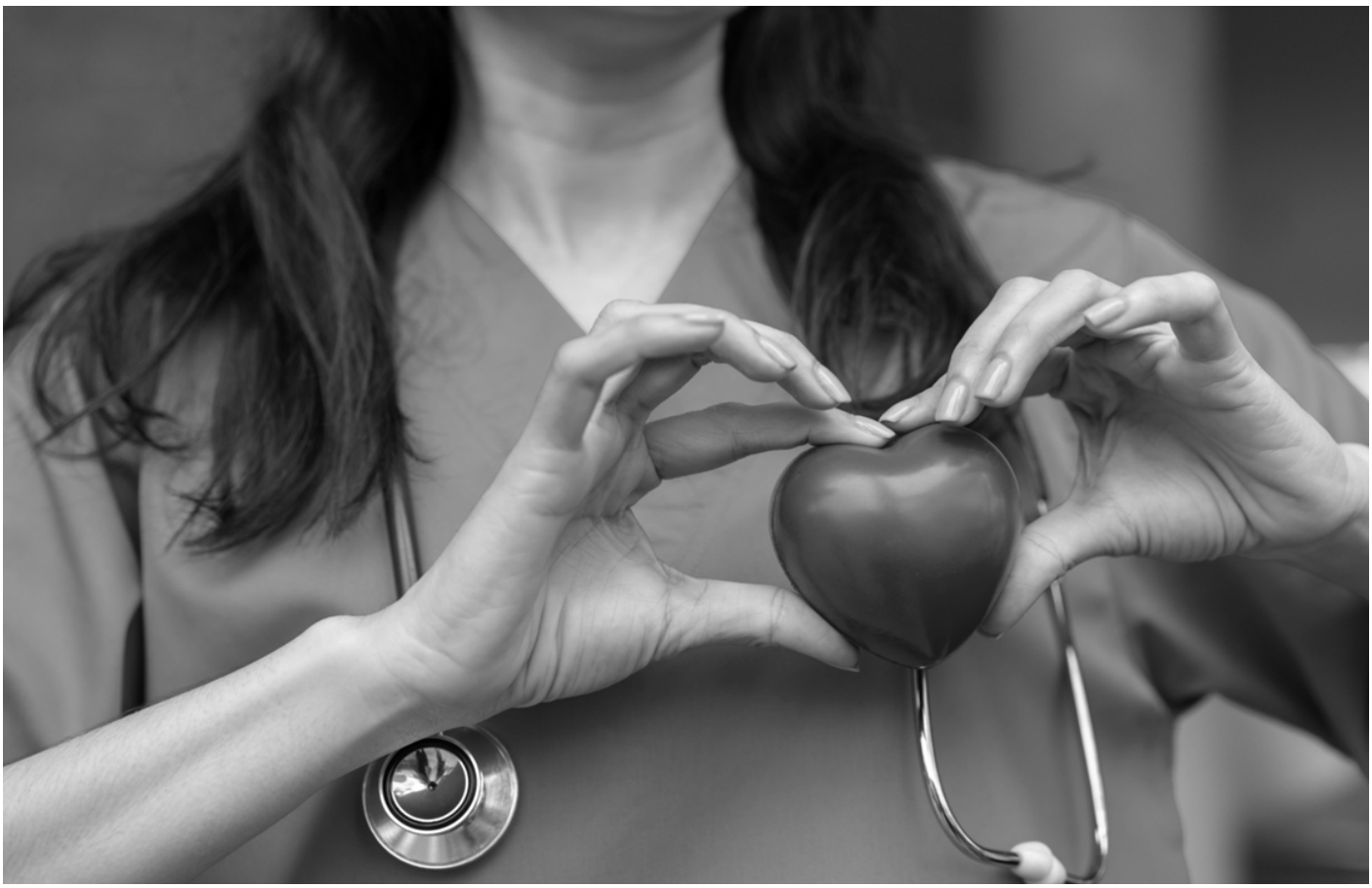
Aetna Student Health
Plan Design and Benefits Summary
Preferred Provider Organization (PPO)

Marist University

Policy Year: 2026 – 2027
Policy Number: 278766
https://www.aetnastudenthealth.com
(866) 381-1529



This is a brief description of the Student Health Plan. The plan is available for Marist 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 https://www.aetnastudenthealth.com**.** If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

MARIST HEALTH SERVICES

The Marist Health Services is the University's on-campus health facility. Staffed by authorized medical providers, it is open weekdays from 8:30 a.m. to 5:00 p.m.

To schedule an appointment:

Call the office. Marist Health Services offers same-day appointments and students are encouraged to call our office early to schedule a visit.

NOTE: Services are available by appointment only. Walk-ins are not permitted for infection control purposes. Students that arrive without a scheduled visit will be advised to remain outside. They will be asked to call the office so staff may properly triage their health concerns.

Phone: 845-575-3270

Location: Murray Student Center: Room 352

Who is eligible?

All full-time undergraduate domestic students are automatically enrolled and charged for the Marist University Student Health Insurance Plan on their tuition bill. If you have comparable medical insurance, you will have the opportunity to remove the fee by completing an online waiver by the deadline at www.haylor.com/marist-university

All Graduate and Part-time students with at least 6 credit hours are eligible to purchase the SHIP on a voluntary basis. International students are automatically enrolled, without the option to waive. You may enroll at www.haylor.com/marist-university

Home study, correspondence, Internet classes, and television (TV) courses, do not fulfill the eligibility requirement that the student actively attend classes.

Dependent Coverage Eligibility

Students may enroll and pay for their dependents directly through Haylor, Freyer and Coon by visiting their website prior to the enrollment/waiver deadline. You may do so at: www.haylor.com/marist-university

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

Children covered under this Certificate include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which the Child turns 26 years of age. Coverage also includes Children for whom You are a legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order or Children for whom You are granted legal custody by court order, who are not Your natural children, legally adopted

Children, step Children, and Children for whom You are the proposed adoptive parent, if the Children are chiefly dependent upon You for support. Foster Children and Grandchildren are not covered.

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

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

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.

The rates below include premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna).

	Annual **08/01/26 - 07/31/27**	**Fall** **08/01/26 - 12/31/26**	**Spring** **01/01/27 - 07/31/27**
Student	$3,188	$1,336	$1,852
Spouse	$3,188	$1,336	$1,852
Child	$3,188	$1,336	$1,852
Child (2 or More)	$6,376	$2,672	$3,704

Enrollment waivers must be submitted by:
Annual, Fall: 08/31/2026
Spring: 02/05/2027

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 end of the month in 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 month in which the child turns 26 years of age.
For all other dependents, the end of the month 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 your out-of-pocket expenses will generally be lower 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.

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 **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**.**

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 Non-Participating Providers will be determined as follows:
  Facilities -For Facilities, the Allowed Amount will be 140% of an amount based on cost information from the Centers for Medicare and Medicaid Services.

- **For All Other Providers-**For all other Providers, the Allowed Amount will be 105% of an amount based on cost information from the Centers for Medicare and Medicaid Services.

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** for information on your financial responsibility when you receive services from a Non-Participating Provider.

Access to Providers and Changing Providers

Sometimes Providers in Our Provider directory are not available. You should call the Provider to make sure he or she is a Participating Provider and is accepting new patients.
To see a Provider, call his or her office and tell the Provider that You are an Aetna PPO Plan Member, and explain the reason for Your visit. Have Your ID card available. The Provider's office may ask You for Your Member ID number. When You go to the Provider's office, bring Your ID card with You.

If We do not have a Participating Provider for certain provider types in the county in which You live or in a bordering county that is within approved time and distance standards, We will approve a Referral to a specific Non-Participating Provider until You no longer need the care or We have a Participating Provider in Our Network that meets the time and distance standards and Your care has been transitioned to that Participating Provider. Covered Services rendered by the Non-Participating Provider will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

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	
Medical Deductible • Individual	$250	$500	
Out-of-Pocket Limit • Individual • Family	$7,900 $13,200	Unlimited Unlimited 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.	
OFFICE VISITS	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	$30 Copayment then You pay 20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Specialist Office Visits (or Home Visits)	$30 Copayment then You pay 20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description

PREVENTIVE CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
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	See benefit for description
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	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
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)	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 after Deductible	Paid the same as Participating Provider	See benefit for description
Non-Emergency Ambulance Services (Ground and Air Ambulance)	20% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Limitations/Terms of Coverage. • We do not Cover travel or transportation expenses, unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician. • We do not Cover non-ambulance transportation such as ambulette, van or taxi cab. • 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: o The point of pick-up is inaccessible by land vehicle; or o Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.			
Emergency Department Copayment /Coinsurance waived if admitted to Hospital.	$100 Copayment then You pay 20% After Deductible Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	Paid the same as Participating Provider Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	See benefit for description
We do not Cover follow-up care or routine care provided in a Hospital emergency department.			
Urgent Care Center	$50 Copayment then You pay 10% Coinsurance Not subject to Deductible	20% Coinsurance Not subject to Deductible	See benefit for description

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Acupuncture	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Advanced Imaging Services • Performed in a Specialist Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Advanced Imaging Services • Performed in a Freestanding Radiology Facility	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Advanced Imaging Services • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Allergy Testing & Treatment • Performed in a PCP Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Allergy Testing & Treatment • Performed in a Specialist Office	20% 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	See benefit for description

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefits for description
Cardiac & Pulmonary Rehabilitation • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefits for description
Cardiac & Pulmonary Rehabilitation • Performed as Inpatient Hospital Services	Included as Part of Inpatient Hospital Service Cost-Sharing	Included as Part of Inpatient Hospital Service Cost-Sharing	See benefits for description
Chemotherapy and Immunotherapy • Performed in a PCP Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Chemotherapy and Immunotherapy • Performed in a Specialist Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Chemotherapy and Immunotherapy • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Chiropractic Services	20% Coinsurance after 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.			

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Diagnostic Testing • Performed in a PCP Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Diagnostic Testing • Performed in a Specialist Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Diagnostic Testing • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Dialysis • Performed in a PCP Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Dialysis • Performed in a Specialist Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Dialysis • Performed in a Freestanding Center	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Dialysis • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in a PCP Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in a Specialist Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in an Outpatient Facility	20% Coinsurance after Deductible	40% Coinsurance after Deductible	

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Home Health Care ADMIN Note: 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	Forty (40) – visits per Plan Year
Infertility Services	Use Cost Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See benefit for description
We do not Cover: • In vitro fertilization; • Gamete intrafallopian tube transfers or zygote intrafallopian tube transfers; • Costs associated with an ovum or sperm donor including the donor's medical expenses; • Cryopreservation and storage of sperm and ova except when performed as fertility preservation services; • Cryopreservation and storage of embryos; • Ovulation predictor kits; • Reversal of tubal ligations; • Reversal of vasectomies; • Costs for and services relating to surrogate motherhood that are not otherwise Covered Services under this Certificate; • Cloning; or • Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.			
Infusion Therapy • Performed in a PCP Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Infusion Therapy • Performed in Specialist Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Infusion Therapy • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Infusion Therapy • Home Infusion Therapy	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Home infusion counts towards home health care visit limits

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Medical Visits	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Interruption of Pregnancy • Abortion services	Covered in full	30% Coinsurance after Deductible	See benefit for description
Laboratory Procedures • Performed in a PCP Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefit for Description
Laboratory Procedures • Performed in a Specialist Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefit for Description
Laboratory Procedures • Performed in a Freestanding Laboratory Facility	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefit for Description
Laboratory Procedures • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See Benefit for Description
Maternity & Newborn Care • **Prenatal Care** • 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)	Covered in full	30% Coinsurance after Deductible	See Benefit for Description
Maternity & Newborn Care • 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)	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)	See Benefit for Description

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Maternity & Newborn Care • Inpatient Hospital Services and Birthing Center	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
Maternity & Newborn Care • Physician and Midwife Services for Delivery	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Maternity & Newborn Care • Breastfeeding Support, Counseling and Supplies including Breast Pumps	Covered in full	30% Coinsurance after Deductible	Covered for duration of breast feeding
Maternity & Newborn Care • Postnatal Care- Postnatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSAP	Covered in full	30% Coinsurance after Deductible	
Maternity & Newborn Care • Postnatal Care- Postnatal Care that is 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 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

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Prescription Drugs Administered in Office or Outpatient Facilities • Performed in a PCP Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities • Performed in Specialist Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities • Performed in Outpatient Facilities	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Diagnostic Radiology Services • Performed in a PCP Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Diagnostic Radiology Services • Performed in a Specialist Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Diagnostic Radiology Services • Performed in a Freestanding Radiology Facility	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Diagnostic Radiology Services • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Therapeutic Radiology Services • Performed in a Specialist Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Therapeutic Radiology Services • Performed in a Freestanding Radiology Facility	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Therapeutic Radiology Services • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in a PCP Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Speech and physical therapy are only Covered following a Hospital stay or surgery.
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in a Specialist Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in an Outpatient Facility	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Retail Health Clinic Care	20% Coinsurance after Deductible	40% Coinsurance after Deductible	

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Second Opinions on the Diagnosis of Cancer, Surgery & Other	$30 Copayment then You pay 20% Coinsurance after Deductible	40% Coinsurance after Deductible Second Opinions on Diagnosis of Cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained.	See benefit for description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery and Transplants • Inpatient Hospital Surgery	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description All transplants must be performed at Designated Centers of Excellence Hospitals
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.			
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery and Transplants • Outpatient Hospital Surgery	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery and Transplants • Surgery Performed at an Ambulatory Surgical Center	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery and Transplants • Office Surgery	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description

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 • Retail Diabetic Equipment and Supplies (30-Day Supply)	$15 Copayment then You pay 0% after Deductible	$15 Copayment then You pay 0% after Deductible	See benefit for description
• Diabetic Insulin (30 Day Supply)	Covered in full	30% Coinsurance after Deductible	
• Oral anti-diabetic agents and injectable anti-diabetic agents (30 day supply)	$15 Copayment then You pay 0% after Deductible	$15 Copayment then You pay 0% after Deductible	
• Diabetic Education	$30 Copayment then You pay 20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Limitations The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We Cover only basic models of blood glucose monitors unless You have special needs relating to poor vision or blindness or otherwise Medically Necessary.			
Durable Medical Equipment & Braces	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
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. **Braces.** We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You.			
External Hearing Aids • **Prescription Hearing Aids**	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	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Hospice Care • Inpatient	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Two hundred ten (210) – days per Plan Year
Hospice Care • Outpatient	20% Coinsurance after Deductible	40% Coinsurance after Deductible	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 • External	20% Coinsurance after Deductible	40% Coinsurance after Deductible	One (1) prosthetic device, per limb, per Plan Year
We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials. 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. 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. 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. We do not Cover shoe inserts.			
Prosthetic Devices • Internal	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description

INPATIENT SERVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Autologous Blood Banking	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefits for description
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	See benefit for description
Observation Stay	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) The visit limit does not apply to Skilled Nursing Facility for a mental health condition or substance use disorder.	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	Two hundred (200)-days per Plan Year
Inpatient Habilitation Services (Physical Speech and Occupational Therapy)	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	Speech and physical therapy are only Covered following a Hospital stay or surgery

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 or Residential Facility	20% Coinsurance per admission after Deductible	40% Coinsurance per admission after Deductible	See benefit for description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services) • Office Visits	$30 Copayment then You pay 20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services) • All Other Outpatient Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
ABA Treatment for Autism Spectrum Disorder	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)	20% Coinsurance per admission after Deductible	40% Coinsurance per admission 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
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) • Office Visits	$30 Copayment then You pay 20% Coinsurance after Deductible	40% Coinsurance after Deductible	Up to twenty (20) –visits a plan year may be used for family counseling
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) • All Other Outpatient Services- Opioid Treatment Programs	Covered in full	30% Coinsurance after Deductible	
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) • All Other Outpatient Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
Limitations. 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			

PRESCRIPTION DRUGS	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
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]			

Note:
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 sue disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.

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 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.

PRESCRIPTION DRUGS	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Retail Pharmacy			
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.			
Retail Pharmacy 30-day supply Tier 1 Preferred Generic drugs	$15 Copayment not subject to the Deductible	$15 Copayment not subject to the Deductible	See benefit for description
Retail Pharmacy 30-day supply Tier 2 Preferred Brand drugs	$30 Copayment not subject to the Deductible	$30 Copayment not subject to the Deductible	See benefit for description
Retail Pharmacy 30-day supply Tier 3 Non-Preferred Generic and Brand drugs	$45 Copayment not subject to the Deductible	$45 Copayment not subject to the Deductible	See benefit for description

PRESCRIPTION DRUGS	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Mail Order Pharmacy			
Mail Order Pharmacy Up to a 90-day supply Tier 1 Preferred Generic drugs	$45 Copayment not subject to the Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See benefit for description
Mail Order Pharmacy Up to a 90-day supply Tier 2 Preferred Brand drugs	$90 Copayment not subject to the Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See benefit for description
Mail Order Pharmacy Up to a 90-day supply Tier 3 Non-Preferred Generic and Brand drugs	$135 Copayment not subject to the Deductible	Non-Participating Provider Services Are Not Covered and You Pay the Full Cost	See benefit for description
Enteral Formulas Tier 1 Preferred Generic drugs	$15 Copayment not subject to the Deductible	$15 Copayment not subject to the Deductible	See benefit for description
Enteral Formulas Tier 2 Preferred Brand drugs	$30 Copayment not subject to the Deductible	$30 Copayment not subject to the Deductible	See benefit for description
Enteral Formulas Tier 3 Non-Preferred Generic and Brand drugs	$45 Copayment not subject to the Deductible	$45 Copayment not subject to the 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 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. If You do not make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy 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
Exercise Facility Reimbursement	Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for Covered Dependent	
Reimbursement is limited to actual workout visits. We do not reimburse: • Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities; • Lifetime memberships; • Equipment, clothing, vitamins or other services that may be offered by the facility (e.g., massages, etc.); or • Services that are amenities, such as a gym, that are included in Your rent or homeowners association fees.		

PEDIATRIC DENTAL & VISION CARE	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care • Preventive Dental care	20% Coinsurance after Deductible	20% 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
Pediatric Dental Care • Routine Dental Care	20% Coinsurance after Deductible	20% Coinsurance after Deductible	

Pediatric Dental Care • Major Dental Care (Oral Surgery, Endodontics, Periodontics & Prosthodontics) Orthodontics & Major Dental Require Preauthorization	50% Coinsurance after Deductible	50% Coinsurance after Deductible	
Pediatric Dental Care • Orthodontics Orthodontics & Major Dental Require Preauthorization	50% Coinsurance after Deductible	50% Coinsurance after Deductible	
Pediatric Vision Care			
Pediatric Vision Care • Exams	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	One (1) exam per twelve (12)-month period
Pediatric Vision Care • Lenses & Frames	0% Coinsurance not subject to Deductible	30% Coinsurance after Deductible	One (1) prescribed lenses & frames per twelve (12)-month period
Pediatric Vision Care • Contact Lenses	0% Coinsurance not subject to Deductible	30% 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.

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.

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

Accidental Death and Dismemberment Benefits

Loss	Benefit Amount
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 Marist University Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health℠ 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.

Discrimination is Against the Law

Aetna Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with 45 CFR § 92.101(a)(2)). Aetna Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Aetna Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include:
    - Qualified interpreters
    - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 1-877-480-4161 (TTY: 711) or the number on the back of your ID card.

If you believe that Aetna Inc. 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

Attn: 1557 Coordinator
CVS Pharmacy, Inc.
1 CVS Drive, MC 2332,
Woonsocket, RI 02895

Phone: 1-800-648-7817, TTY: 711
Email: CRCoordinator@aetna.com

You can file a grievance in person, by mail, or email. If you need help filing a grievance, the 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.
This notice is available at Aetna Inc.'s website: https://www.aetnastudenthealth.com

Please note, Aetna covers health services in compliance with applicable federal and state laws. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations, and conditions of coverage.

TTY: **711**

English	**To access language services at no cost to you, call the number on your ID card.**
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ።
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով ավվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէրախոսահամարով հէրախոսահամարով
Carolinian (Kapasal Falawasch)	Ngir mëna am sarwis lakk yi te doo fay, woo nimero bi am ci sa kàrt.
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf, lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Greek	Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισής σας.
Gujarati	તમારે કોઇ પણ જાતના ખર્ચ વિના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇડી કાર્ડ પર રહેલ નંબર પર કૉલ કરવો.
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.
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	လၢတၢကမ္ၢၢကိုၢ်တၢမၤစၢၤအတၢဖံးတၢမၤတဖၣ လၢတအိၣ်ဒီးအပ្ၤလၢနကဘၣဟ့ၣ်အီၤအဂ့ၢ်ကီးဘၣလီတဲစိနီၣ်ဂံၢ်လၢအအိၣ်လၢနခိၣ်ဂီၤ ဗ (ၡိ) အလိၤ္ၣတက့ၢ်ၡ
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Laotian	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈໍາຕົວຂອງທ່ານ.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T'áá ni nizaad k'ehjí bee níká a'doowoł doo bááh ílínígóó naaltsoos bee atah nílįįgo nanitinígíí bee nééhoʼdólzinígíí béésh bee haneʼí bikáʼígíí áajįʼ hólneʼ.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian-Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Samoan	Mō le mauaina o 'au'aunaga tau gagana e aunoa ma se totogi, vala'au le numera i luga o lau pepa ID.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Syriac-Assyrian	ܒܥܝ ܚܫܚܬܐ ܬܠܘܢ ܥܠ ܝܠܦܢܘܬܐ ܕܡܫܪܬܐ ܕܠܫܢܐ ܡܓܢܐܝܬ، ܩܪܘܢ ܡܢܝܢܐ ܥܠ ܦܬܩܐ ܕܡܫܘܕܥܘܬܐ ܕܝܠܟܘܢ.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน
Ukrainian	Щоб безкоштовнј отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.