Aetna Student Health
Plan Design and Benefits Summary
Preferred Provider Organization (PPO)
Rochester Institute of Technology

Policy Year: 2023 - 2024
Policy Number: 812809
https://www.aetnastudenthealth.com
(866) 746-6590

This is a brief description of the Student Health Plan. The Plan is available for Rochester Institute of Technology 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.

Rochester Institute of Technology

RIT is concerned about the health, safety and general physical and mental well-being of its students. Students may encounter accidents and sickness while enrolled at RIT. The RIT Student Health Center, as a primary care facility, is available to all students when medical attention is needed. To supplement this, a direct enrollment student insurance program is available through the university**. RIT expects all students to have insurance coverage with local benefits through either their own personal insurance carrier or through this comprehensive Student Health Insurance Plan which is made available through the University.**

When choosing a student health plan, please consider the following:

- To what extent will my plan cover me in Rochester if I am from a different city or state? "Out-of-network" coverage can differ significantly from your local area coverage, even if your current coverage is a government-sponsored plan.
- Do I need a referral from my home doctor to see a health care provider in Rochester?
- Does your policy carry a high annual deductible or large co-pays? The Aetna plan can be used to supplement deductibles and co-pays of your existing primary coverage.

Domestic students may enroll themselves directly in the Student Health Plan. Enrollment must be completed by **September 30, 2023** (for students first registered in fall semester). International students should refer to the International Student Enrollment Process below.

For parents of entering students, we urge you to evaluate and consider purchasing the RIT Student Health Insurance Plan for your student, not only based upon the absence of insurance coverage, but as an important supplement to your existing coverage as well as enhanced ease of access to services which may be needed within the larger Rochester medical community.

The 2023-2024 Plan provides substantial benefits for **Covered Medical Expenses** at a reasonable cost. Coverage is also available for a student's spouse and/or **dependent** children at an additional charge.

Enrollment Process for Student Health Insurance Plan

RIT expects all students to have adequate medical insurance. If a student does not have coverage, this requirement may be satisfied by enrolling in the Aetna Student Health Plan **BEFORE THE ENROLLMENT DEADLINE DATE OF SEPTEMBER 30, 2023,** or later date if appropriate.

Students can enroll in this Plan by going online at **www.gallagherstudent.com/RIT.** Students have the option to either put the charge on their RIT student account or pay online with a credit card. Students first registering in spring semester must enroll by **February 29, 2024.**

Note: *Graduate and part-time students may also enroll voluntarily in the Aetna Student Health Plan.*

International Student Enrollment Process

All full and part-time international students (except those on H1b Visas) will be automatically enrolled in the policy each semester, based on registration status.

Insurance questions may be directed to Gallagher Student Health at **844-333-1464**.

Student Health Center

Access to the RIT Student Health Center (SHC) is available to all students and does not require (or accept) the use of insurance. The SHC Semester Health Services Fee is separate and independent from insurance premiums paid for the Student Health Plan. While the SHC does not bill or accept payment from any insurance company, staff will provide information and/or receipts as it is capable, to assist students in submitting claims for services rendered by other providers. **RIT expects all students to have insurance coverage through either their own personal insurance carrier or through this Student Health Plan which is made available through the University.**

Confidentiality

The Student Health Center is committed to the maintenance of confidentiality in the provider-patient relationship. The release of health care information to anyone, including parents, requires specific written authorization by the student, except as required by law or for insurance reimbursement.

What is the Student Health Center?

The Student Health Center (SHC) provides a full range of primary care, treatment and referral services, as well as related health education programs. The goal of all programs and services is to take care of students when they are ill and assist them in learning how **TO STAY WELL**. As a free-standing ambulatory care facility, the SHC is located in the August Center which is located between the residential and academic sides of campus.

How is the Student Health Center Staffed?

The SHC is staffed by Physicians, Physician Assistants, Nurse Practitioners, Registered Nurses, Dietitian, American Sign Language Interpreter, Administrative and Support Staff. The SHC providers are licensed/certified (as appropriate) in specialty areas that include Family Medicine and Psychiatry, as well as expertise in Women's Health, Health Education, and American Sign Language Interpreting for the Deaf. The Center also serves as a clinical practicum site for health profession students from area universities and colleges.

When is the Student Health Center Open?

During the fall and spring semesters, the SHC is open Monday-Thursday, 8:30 a.m. - 6:30 p.m., Friday, 8:30 a.m. - 4:30 p.m. On Wednesdays, there is a scheduled weekly meeting between 11:00 a.m. and 12:00 p.m. Hours of operation during academic breaks and the summer semester are 8:30 a.m. - 4:30 p.m., Monday through Friday. The Center is closed during weekends and university holidays. When the SHC is closed, students can access medical information through a nurse advice line by calling **(585) 475-2255** and selecting the after-hours nurse triage option. Campus coverage is provided through the RIT Ambulance, which is dispatched by calling Public Safety. This New York State certified ambulance service is staffed by well-trained student volunteer emergency medical technicians who can assess medical conditions, treat and/or transport to a local hospital emergency department as the situation requires. If RIT Ambulance is not available, a local ambulance company will be dispatched to RIT. This may result in a fee charged to the student.

Who Can Use the Student Health Center?

The services and programs provided by the SHC are available to **all** students. Full-time undergraduate and graduate students are required to pay the semester health fee and are billed automatically. Part-time, and co-op students may choose to pay the semester health fee or use the SHC on a fee-for-service basis.

Student Health Fee Coverage and Financial Responsibility

Most of the clinical and health education services provided by the SHC are paid for by the semester health fee with no additional charge to the student user of the service. This includes office visits, some on-site laboratory testing, minor surgery, bed observation, psychiatric care and women's health services. Vaccinations, Tuberculosis screening tests and medications stocked by the SHC are the responsibility of the student to pay. Diagnostic imaging and an array of laboratory services are provided in cooperation with community-based providers, are NOT covered by the Student Health Fee and will be billed by the provider to the student's health insurance carrier. Consultations with community specialists, use of hospital emergency departments, urgent care and hospitalization, is the responsibility of the student or parent/guardian. For this reason, we strongly encourage students and their families to ensure adequate insurance coverage for the Rochester area.

Coverage Periods

Students: Coverage for all insured students enrolled for coverage in the Plan for the following Coverage Periods. Coverage will become effective at 12:01 AM on the Coverage Start Date of August 15, 2023 and will terminate at 11:59 PM on the Coverage End Date of August 14, 2024.

Eligible Dependents: Coverage for dependents eligible under the Plan for the following Coverage Periods. Coverage will, will become effective at 12:01 AM on the Coverage Start Date of August 15, 2023, and will terminate at 11:59 PM on the Coverage End Date of August 14, 2024. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Certificate of Coverage.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	08/15/2023	08/14/2024	09/30/2023
Fall (INT Students Only)	08/15/2023	12/31/2023	09/30/2023
Spring (New Students and Dependents of New Students)	01/01/2024	08/14/2024	02/29/2024

Rates

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

	Annual	Fall	Spring Semester
Student	$2,377	$903	$1,474
Spouse	$2,377	$903	$1,474
Child	$2,377	$903	$1,474
2+Children	$4,754	$1,806	$2,948

*The above rates reflect the insurance premium charged by Aetna to Rochester Institute of Technology.

*Rochester Institute of Technology pro-rates on a daily basis for qualifying life events and for school-defined short-term programs.

Termination and Refunds

Withdrawal from Classes – Other than Leave of Absence: If you withdraw from classes other than under a school-approved leave of absence within 31 days* after the start date of classes, you will be considered ineligible for coverage, your coverage will be terminated retroactively and any premiums collected will be refunded. If the withdrawal is more than 31 days after the start date of classes, your coverage will remain in force through the end of the period for which payment has been received and no premiums will be refunded. If you withdraw from classes to enter the armed forces of any country, coverage will terminate as of the effective date of such entry and a pro rata refund of premiums will be made if you submit a written request within 90 days of withdrawal from classes.

Exception: A **Covered Person** entering the armed forces of any country will not be covered under the Policy as of the date of such entry. In this case, a pro-rata refund of premium will be made for any such person and any covered **dependents** upon written request received by Aetna Student Health within 90 days of withdrawal from school.

Student Coverage

Eligibility

Enrollment is voluntary for all domestic registered students. International Students (except those on H1b Visas) will be automatically enrolled in the Aetna Student Health Plan policy each semester, based on registration status, and billed by Student Financial Services.

All lawful spouse and **dependent** children: Subject to the terms of this Plan, benefits are available for an eligible student and his or her eligible **dependents** only for the coverages listed below. The coverage sections of this Plan contain a complete description of the benefits available. No person may be covered as both a **covered student** and as a **dependent**; and no person may be covered as a **dependent** of more than one **covered student**.

Home study, correspondence, Internet classes, and television (TV) courses, do not fulfill the eligibility requirement that the student actively attend classes. If it is discovered that this eligibility requirement has not been met, our only obligation is to refund premium, less any claims paid.

Enrollment

Eligible international students will be automatically enrolled in this Plan, unless the completed waiver application has been received by the Rochester Institute of Technology by the specified enrollment deadline dates listed in the previous section of this Plan Design and Benefits Summary. Eligible domestic students can obtain an enrollment application for voluntary coverage at **www.gallagherstudent.com/RIT.**

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.)

POLICY: Rochester Institute of Technology allows eligible students who are on an approved medical leave of absence to continue enrollment under the RIT Student Health Insurance Plan, for a maximum of one year.

ELIGIBILITY REQUIREMENTS:
• Student must have been previously enrolled in the University's Student Health Insurance Plan for the semester immediately preceding the requested enrollment extension.
• Student must provide a copy of the Leave of Absence verification letter signed by the Registrar's Office.
• Student intends to return to the University and remain a degree-seeking candidate.

A person who is eligible for Medicare at the time of enrollment under this plan is not eligible for medical expense coverage and prescribed medicines expense coverage. If a covered person becomes eligible for Medicare after he or she is enrolled in this plan, such Medicare eligibility will not result in the termination of medical expense coverage and prescribed medicines expense coverage under this plan. As used within this provision, persons are "eligible for Medicare" if they are entitled to benefits under Part A (receiving free Part A) or enrolled in Part B or Premium Part A.

Waiver Process/Procedure

For International Students only:

If you are eligible to waive the RIT Student Health Plan, please go to **www.gallagherstudent.com/RIT**. You can click on Help Center, click on Live Chat, or call **1-844-333-1464** if you have any questions.

Dependent Coverage

Eligibility

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

Enrollment

An Insured may add a dependent by submitting an enrollment form and payment to Gallagher Student Health until the deadline of **September 30, 2023**.

If an Insured adds a new **dependent** after the effective date of coverage, coverage will become effective on the date of their qualifying event. If the **dependent** is a newborn child and no other children are covered under the plan, notification of the birth along with the appropriate premium must be submitted within 60 days of such birth. (Addition of a spouse must be within 60 days of marital status change.)

Premium need not be submitted if the newly added **dependent** is a child and the Insured already has two or more covered children. However, written notice of the new child must be submitted within the 60-day period.

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.

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.

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 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 maxiitmum 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.

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	$0	$0	
• Family	$0	$0	
Out-of-Pocket Limit			
• Individual	$6,350	$10,000	
• Family	$12,700	$30,000	
		See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how We calculate the 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)	10% Coinsurance	30% Coinsurance	See benefit for description
Specialist Office Visits (or Home Visits)	10% Coinsurance	30% Coinsurance	See benefit for description
PREVENTIVE CARE			
Well Child Visits and Immunizations*	Covered in full	30% Coinsurance	See benefit for description
Adult Annual Physical Examinations*	Covered in full	30% Coinsurance	
Adult Immunizations*	Covered in full	30% Coinsurance	
Routine Gynecological Services/Well Woman Exams*	Covered in full	30% Coinsurance	
Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full	30% Coinsurance	
Sterilization Procedures for Women *	Covered in full	30% Coinsurance	
Vasectomy	10% Coinsurance	30% Coinsurance	
We do not Cover services related to the reversal of elective sterilizations.			
Bone Density Testing*	Covered in full	30% Coinsurance	
Screening for Prostate Cancer	Covered in full	30% Coinsurance	
All other preventive services required by USPSTF and HRSA.	Covered in full	30% Coinsurance	
*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
Pre-Hospital Emergency Medical Services (Ambulance Services)	10% Coinsurance	10% Coinsurance	See benefit for description
Non-Emergency Ambulance Services	10% Coinsurance	10% Coinsurance	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	10% Coinsurance	10% Coinsurance	See benefit for description
We do not Cover follow-up care or routine care provided in a Hospital emergency department.			
Urgent Care Center	10% Coinsurance	30% Coinsurance	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**
Advanced Imaging Services			See benefit for description
• Performed in a Specialist Office	10% Coinsurance	30% Coinsurance	
• Performed in a Freestanding Radiology Facility	10% Coinsurance	30% Coinsurance	
• Performed as Outpatient Hospital Services	10% Coinsurance	30% Coinsurance	

PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Allergy Testing & Treatment • Performed in a PCP Office • Performed in a Specialist Office	 10% Coinsurance 10% Coinsurance	 30% Coinsurance 30% Coinsurance	See benefit for description
Ambulatory Surgical Center Facility Fee	10% Coinsurance	30% Coinsurance	See benefit for description
Anesthesia Services (all settings)	10% Coinsurance	30% Coinsurance	See benefit for description
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services	 10% Coinsurance 10% Coinsurance Included as Part of Inpatient Hospital Service Cost-Sharing	 30% Coinsurance 30% Coinsurance Included as Part of Inpatient Hospital Service Cost-Sharing	See benefits for description
Chemotherapy • Performed in a PCP Office • Performed in a Specialist Office • Performed as Outpatient Hospital Services	 10% Coinsurance 10% Coinsurance 10% Coinsurance	 30% Coinsurance 30% Coinsurance 30% Coinsurance	See benefit for description
Chiropractic Services	10% Coinsurance	30% Coinsurance	See benefit for description
Clinical Trials	Use Cost-Sharing for appropriate service Non-Participating Provider services are not covered and You pay the full cost	Use Cost-Sharing for appropriate service Non-Participating Provider services are not covered and You pay the full cost	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 (continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Diagnostic Testing			See benefit for description
• Performed in a PCP Office	10% Coinsurance	30% Coinsurance	
• Performed in a Specialist Office	10% Coinsurance	30% Coinsurance	
• Performed as Outpatient Hospital Services	10% Coinsurance	30% Coinsurance	
Dialysis			See benefit for description
• Performed in a PCP Office	10% Coinsurance	30% Coinsurance	
• Performed in a Specialist Office	10% Coinsurance	30% Coinsurance	
• Performed in a Freestanding Center	10% Coinsurance	30% Coinsurance	
• Performed as Outpatient Hospital Service	10% Coinsurance	30% Coinsurance	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)			
• Performed in a PCP Office	10% Coinsurance	30% Coinsurance	unlimited
• Performed in a Specialist Office	10% Coinsurance	30% Coinsurance	
• Performed in an Outpatient Facility	10% Coinsurance	30% Coinsurance	

PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Home Health Care	10% Coinsurance	30% Coinsurance	unlimited
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			See benefit for description
• Performed in a PCP Office	10% Coinsurance	30% Coinsurance	
• Performed in Specialist Office	10% Coinsurance	30% Coinsurance	
• Performed as Outpatient Hospital Services	10% Coinsurance	30% Coinsurance	
• Home Infusion Therapy	10% Coinsurance	30% Coinsurance	Home infusion counts towards home health care visit limits
Inpatient Medical Visits	10% Coinsurance	30% Coinsurance	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
Interruption of Pregnancy • Medically Necessary Abortions	Covered in full	30% Coinsurance	Unlimited
• Elective Abortions	Covered in full	30% Coinsurance	
Laboratory Procedures • Performed in a PCP Office	10% Coinsurance	30% Coinsurance	See Benefit for Description
• Performed in a Specialist Office	10% Coinsurance	30% Coinsurance	
• Performed in a Freestanding Laboratory Facility	10% Coinsurance	30% Coinsurance	
• Performed as Outpatient Hospital Services	10% Coinsurance	30% Coinsurance	
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	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
Maternity & Newborn Care (continued) • 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)	
• Inpatient Hospital Services and Birthing Center	10% Coinsurance	30% Coinsurance	One (1) Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
• Physician and Midwife Services for Delivery	10% Coinsurance	30% Coinsurance	
• Breastfeeding Support, Counseling and Supplies including Breast Pumps, Nursing Bras	Covered in Full	30% Coinsurance	Covered for duration of breast feeding
• Postnatal Care	Covered in Full	30% Coinsurance	
Outpatient Hospital Surgery Facility Charge	10% Coinsurance	30% Coinsurance	See benefit for description
Preadmission Testing	10% Coinsurance	30% Coinsurance	

PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Prescription Drugs Administered in Office or Outpatient Facilities			See benefit for description
• Performed in a PCP Office	10% Coinsurance	30% Coinsurance	
• Performed in Specialist Office	10% Coinsurance	30% Coinsurance	
• Performed in Outpatient Facilities	10% Coinsurance	30% Coinsurance	
Diagnostic Radiology Services			See benefit for description
• Performed in a PCP Office	10% Coinsurance	30% Coinsurance	
• Performed in a Specialist Office	10% Coinsurance	30% Coinsurance	
• Performed in a Freestanding Radiology Facility	10% Coinsurance	30% Coinsurance	
• Performed as Outpatient Hospital Services	10% Coinsurance	30% Coinsurance	
Therapeutic Radiology Services			See benefit for description
• Performed in a Specialist Office	10% Coinsurance	30% Coinsurance	
• Performed in a Freestanding Radiology Facility	10% Coinsurance	30% Coinsurance	
• Performed as Outpatient Hospital Services	10% Coinsurance	30% Coinsurance	

PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in a PCP Office	10% Coinsurance	30% Coinsurance	Unlimited Speech and physical therapy are only Covered following a Hospital stay or surgery.
• Performed in a Specialist Office	10% Coinsurance	30% Coinsurance	
• Performed in an Outpatient Facility	10% Coinsurance	30% Coinsurance	
Second Opinions on the Diagnosis of Cancer, Surgery & Other	10% Coinsurance	30% Coinsurance	See benefit for description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery and Transplants • Inpatient Hospital Surgery	10% Coinsurance	30% Coinsurance	All transplants must be performed at Designated Facilities
• Outpatient Hospital Surgery	10% Coinsurance	30% Coinsurance	
• Surgery Performed at an Ambulatory Surgical Center	10% Coinsurance	30% Coinsurance	
• Office Surgery	10% Coinsurance	30% Coinsurance	
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.			
Telemedicine Program	10% Coinsurance	30% Coinsurance	

ADDITIONAL SERVICES, EQUIPMENT & DEVICES	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies, and Insulin (30-Day Supply) • Diabetic Education	10% Coinsurance but not more than $100 in Cost-Sharing for a 30-day supply for an insulin drug. 10% Coinsurance	30% Coinsurance but not more than $100 in Cost-Sharing for a 30-day supply for an insulin drug. 30% Coinsurance	See benefit for description
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	10% Coinsurance	30% Coinsurance	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	10% Coinsurance	30% Coinsurance	We Cover a single purchase (including repair and/or replacement) of hearing aids for one (1) or both ears once every three (3) years.
Cochlear Implants	10% Coinsurance	30% Coinsurance	One (1) per ear per plan year
Hospice Care • Inpatient • Outpatient	10% Coinsurance 10% Coinsurance	30% Coinsurance 30% Coinsurance	unlimited Five (5) visits for family bereavement counseling
We do not Cover funeral arrangements; pastoral, financial, or legal counseling; or homemaker, caretaker, or respite care.			

ADDITIONAL SERVICES, EQUIPMENT & DEVICES (Continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Medical Supplies	10% Coinsurance	30% Coinsurance	
We do not Cover over-the-counter medical supplies.			
Prosthetic Devices • External • Internal	 10% Coinsurance 10% Coinsurance	 30% Coinsurance 30% Coinsurance	One (1) prosthetic device, per limb, per Plan Year Unlimited
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.			
INPATIENT SERVICES & FACILITIES	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Autologous Blood Banking	10% Coinsurance	30% Coinsurance	See benefit for description
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) 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.	10% Coinsurance 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.	30% Coinsurance 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.	See benefit for description
Observation Stay	10% Coinsurance	30% Coinsurance	See benefit for description

INPATIENT SERVICES & FACILITIES (continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) Preauthorization Required.	10% Coinsurance Preauthorization Required.	30% Coinsurance Preauthorization Required.	unlimited
Inpatient Habilitation Services (Physical Speech and Occupational Therapy)	10% Coinsurance	30% Coinsurance	unlimited
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	10% Coinsurance	30% Coinsurance	unlimited
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.	10% Coinsurance Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.	30% Coinsurance Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.	See benefit for description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services) • Office Visits • All Other Outpatient Services	 10% Coinsurance 10% Coinsurance	 30% Coinsurance 30% Coinsurance	See benefit for description
ABA Treatment for Autism Spectrum Disorder	10% Coinsurance	30% Coinsurance	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	10% Coinsurance	30% Coinsurance	See benefit for description
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			

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES (continued)	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment) Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions or for Participating OASAS-certified Facilities	10% Coinsurance Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.	30% Coinsurance Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions.	See benefit for description
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) • Office Visits • All Other Outpatient Services	 10% Coinsurance 10% Coinsurance	 30% Coinsurance 30% Coinsurance	unlimited

PRESCRIPTION DRUGS *Certain 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	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
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 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.			
Preauthorization is not required for a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.			
Retail Pharmacy	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
30-day supply			See benefit for description
Tier 1 (generic)	$15 Copayment per supply	$15 Copayment per supply	
Tier 2 (formulary brand)	$45 Copayment per supply	$45 Copayment per supply	
Tier 3 (non-formulary brand)	$70 Copayment per supply	$70 Copayment per supply	

Retail Pharmacy	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Enteral Formulas			See benefit for description
Tier 1 (generic)	Coinsurance per supply of 10% not subject to the Deductible	Coinsurance per supply of 30% not subject to the Deductible	
Tier 2 (formulary brand)	Coinsurance per supply of 10% not subject to the Deductible	Coinsurance per supply of 30% not subject to the Deductible	
Tier 3 (non-formulary brand)	Coinsurance per supply of 10% not subject to the Deductible	Coinsurance per supply of 30% not subject to the Deductible	

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 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 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, 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, 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 6-month period.	Up to an additional $100 per 6-month period for Spouse.	

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.

In order to be eligible for reimbursement, You must:

- Be an active member of the exercise facility, and
- Complete 50 visits in a six (6)-month period.

PEDIATRIC DENTAL & PEDIATRIC VISION CARE through the end of the month in which the Member turns 19 years of age	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Dental Care • Preventive • Routine Dental Care • Major Dental Care (Oral Surgery, Endodontics, • Orthodontics	Covered in Full Covered in Full 30% Coinsurance 50% Coinsurance	Covered in full Covered in full 50% Coinsurance 50% Coinsurance	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 & PEDIATRIC VISION CARE through the end of the month in which the Member turns 19 years of age	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pediatric Vision Care • Exams • Lenses & Frames • Contact Lenses	Covered in Full Covered in Full Covered in Full	30% Coinsurance 30% Coinsurance 30% Coinsurance	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.

Travel Assistance Services

Complete benefit information is found in the Certificate of Coverage.

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 eligible for Medicare, we will reduce Our benefits by the amount Medicare would have paid for the Covered Services. Except as otherwise required by law, this reduction is made even if You fail to enroll in Medicare or You do not pay Your Medicare premium. Benefits for Covered Services will not be reduced if We are required by federal law to pay first or if You are not eligible for premium-free Medicare Part A.

Military Service.

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

No-Fault Automobile Insurance.

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

Services Not Listed.

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

Services Provided by a Family Member.

We do not Cover services performed by a 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 Pediatri 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 Rochester Institute of Technology 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.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-877-480-4161.

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 is committed to being an inclusive health care company. Aetna does not discriminate on the basis of ancestry, race, ethnicity, color, religion, sex/gender (including pregnancy), national origin, sexual orientation, gender identity or expression, physical or mental disability, medical condition, age, veteran status, military status, marital status, genetic information, citizenship status, unemployment status, political affiliation, or on any other basis or characteristic prohibited by applicable federal, state or local law.

Aetna provides free aids and services to people with disabilities and free language services to people whose primary language is not English.

These aids and services include:

- Qualified language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Qualified interpreters
- Information written in other languages

If you need these services, contact the number on your ID card. Not an Aetna member? Call us at 1-877-480-4161.

If you have questions about our nondiscrimination policy or have a discrimination-related concern that you would like to discuss, please call us at 1-877-480-4161.

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.

Language accessibility statement

Interpreter services are available for free.

Attention: If you speak English, language assistance service, free of charge, are available to you. Call **1-877-480-4161** (TTY: **711**).

Español/Spanish

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-480-4161** (TTY: **711**).

አማርኛ**/Amharic**

ልብ ይበሉ: አማርኛ ቋንቋ የሚናገሩ ከሆነ፥ የትርጉም ድጋፍ ሰጪ ድርጅቶች፣ ያለምንም ክፍያ እርስዎን ለማገልገል ተዘጋጅተዋል። የሚከተለው ቁጥር ላይ ይደውሉ **1-877-480-4161** (መስማት ለተሳናቸው: **711**).

العربية**/Arabic**

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-480-4161** (رقم الهاتف النصي: **711**).

Ɓàsɔ̀ɔ̀ Wùɖù/Bassa

Dè dɛ nìà kɛ dyɛ́dɛ́ gbo: Ɔ jǔ kɛ́ m̀ dyi Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ nɨ̀, nɨ̀ì à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ m̀ gbo kpáa.
Ɖá **1-877-480-4161** (TTY: **711**).

中文/Chinese

注意：如果您说中文，我们可为您提供免费的语言协助服务。请致电 **1-877-480-4161** (TTY: **711**)。

فارسی**/Farsi**

توجه: اگر به زبان فارسی صحبت می کنید، خدمات زبانی رایگان به شما ارایه میگردد، با شماره **1-877-480-4161** (TTY: **711**) تماس بگیرید.

Français/French

Attention : Si vous parlez français, vous pouvez disposer d'une assistance gratuite dans votre langue en composant le **1-877-480-4161** (TTY: **711**).

ગુજરાતી**/Gujarati**

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો ભાષાકીય સહાયતા સેવા તમને નિ:શુલ્ક ઉપલબ્ધ છે.
કૉલ કરો **1-877-480-4161** (TTY: **711**).

Kreyòl Ayisyen/Haitian Creole

Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-877-480-4161** (TTY: **711**).

Igbo

Nrụbama: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-877-480-4161** (TTY: **711**).

한국어/Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스가 무료로 제공됩니다. **1-877-480-4161**(TTY: **711**)번으로 전화해 주십시오.

Português/Portuguese

Atenção: a ajuda está disponível em português por meio do número **1-877-480-4161** (TTY: **711**). Estes serviços são oferecidos gratuitamente.

Русский/Russian

Внимание: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Звоните по телефону **1-877-480-4161** (TTY: **711**).

Tagalog

Paunawa: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-480-4161** (TTY: **711**).

/Urduاردو

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت دستیاب ہیں ۔ (TTY: **711**) **1-877-480-4161** پر کال کریں.

Tiếng Việt/Vietnamese

Lưu ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị.
Gọi số **1-877-480-4161** (TTY: **711**).

Yorùbá/Yoruba

Àkíyèsí: Bí o bá nsọ èdè Yorùbá, ìrànlọ́wọ́ lórí èdè, lófẹ̀ẹ́, wà fún ọ. Pe **1-877-480-4161** (TTY: **711**).

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