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

The Juilliard School

Policy Year: 2024 – 2025
Policy Number: 686195
https://www.aetnastudenthealth.com
(866) 746-6590

This is a brief description of the Student Health Plan. The plan is available for the Juilliard School students. 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.

JUILLIARD HEALTH AND COUNSELING SERVICES

Juilliard Health and Counseling Services is the school's on-campus health facility. For more information, call Health Services at (212) 799-5000 ext. 282. In the event of an emergency, call 911 or Juilliard Public Safety at (212) 496-4911 or (212) 799-5000 ext. 246.

Who is eligible?

All full-time and qualifying part-time undergraduate and graduate students, who are enrolled at The Juilliard School.

Coverage Dates and Rates

Coverage for all insured students 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.

	Annual	Fall	Spring/Summer
Coverage Start Date	**08/15/2024**	**08/15/2024**	**01/01/2025**
Coverage End Date	**08/14/2025**	**12/31/2024**	**08/14/2025**
Student insurance premium	$3,096.00	$1,179.00	$1,917.00

Enrollment

If you need information, please contact Gallagher Student Health Member Services at 888-272-4950.

Medicare Eligibility Notice

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

Termination of Coverage

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

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

The [date on; 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

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 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. If termination is a result of the student's action, coverage will terminate for the student.

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

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

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

Participating Providers

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

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

Preauthorization

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

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

You must contact Aetna to request preauthorization as follows:

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

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

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

Description of Benefits

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

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

COST-SHARING	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	
Medical Deductible				
• Individual	$50	$50	$100	
Out-of-Pocket Limit				
• Individual	$7,150	$7,150	$10,000 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	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Primary Care Office Visits (or Home Visits)	0% Coinsurance Not subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	See benefit for description
Specialist Office Visits (or Home Visits)	0% Coinsurance Not subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	See benefit for description
PREVENTIVE CARE	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Well Child Visits and Immunizations*	Covered in full	Covered in full	30% Coinsurance after Deductible	See benefit for description
Adult Annual Physical Examinations*	Covered in full	Covered in full	30% Coinsurance after Deductible	
Adult Immunizations*	Covered in full	Covered in full	30% Coinsurance after Deductible	
Routine Gynecological Services/Well Woman Exams*	Covered in full	Covered in full	30% Coinsurance after Deductible	
Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full	Covered in full	30% Coinsurance after Deductible	
Sterilization Procedures for Women *	Covered in full	Covered in full	30% Coinsurance after Deductible	
Vasectomy	Covered in full	Covered in full	30% Coinsurance after Deductible	
Bone Density Testing*	Covered in full	Covered in full	30% Coinsurance after Deductible	

PREVENTIVE CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
Screening for Prostate Cancer	Covered in full	Covered in full	30% Coinsurance after Deductible	
Screening for Colon Cancer	Covered in full	Covered in full	30% Coinsurance after Deductible	
All other preventive services required by USPSTF and HRSA.	Covered in full	Covered in full	30% Coinsurance after Deductible	
*When preventive services are not provided in accordance with the comprehensive guidelines supported by United States Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA).	Use Cost Sharing for Appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)			
EMERGENCY CARE	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	20% Coinsurance after Deductible	20% Coinsurance after Deductible	Paid the same as Participating Provider	See benefit for description
Non-Emergency Ambulance Services	20% Coinsurance after Deductible	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:
    - The point of pick-up is inaccessible by land vehicle; or
    - Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

EMERGENCY CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Emergency Department Copayment /Coinsurance waived if admitted to Hospital.	$250 Copayment then You pay 20% after the Deductible Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	$250 Copayment then You pay 20% after the Deductible Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	Paid the same as Participating Provider	See benefit for description
We do not Cover follow-up care or routine care provided in a Hospital emergency department.				
Urgent Care Center	20% Coinsurance after Deductible	20% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Advanced Imaging Services • Performed in a Specialist Office • Performed in a Freestanding Radiology Facility	20% Coinsurance after Deductible 20% Coinsurance after Deductible	$20 Copayment then You pay 20% after the Deductible $20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible $20 Copayment then You pay 40% after the Deductible	See benefit for description
Advanced Imaging Services • Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	
Allergy Testing & Treatment • Performed in a PCP Office • Performed in a Specialist Office	0% Coinsurance not Subject to Deductible 0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible $20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible $20 Copayment then You pay 40% after the Deductible	See benefit for description

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Ambulatory Surgical Center Facility Fee	20% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Anesthesia Services (all settings)	20% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Cardiac & Pulmonary Rehabilitation				See benefits for description
• Performed in a Specialist Office	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	
• Performed as Outpatient Hospital Services	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	
• Performed as Inpatient Hospital Services	Included as Part of Inpatient Hospital Service Cost-Sharing	Included as Part of Inpatient Hospital Service Cost-Sharing	Included as Part of Inpatient Hospital Service Cost-Sharing	
Chemotherapy and Immunotherapy				See benefit for description
• Performed in a PCP Office	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	
• Performed in a Specialist Office	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	
• Performed as Outpatient Hospital Services	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	
Chiropractic Services	0% Coinsurance not Subject to Deductible	20% Coinsurance after Deductible	$5 Copayment then You pay 40% after the Deductible	See benefit for description
Clinical Trials	Use Cost-Sharing for appropriate service	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	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Diagnostic Testing • Performed in a PCP Office	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	See benefit for description
• Performed in a Specialist Office	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	
• Performed as Outpatient Hospital Services	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	
Dialysis • Performed in a PCP Office	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	See benefit for description
• Performed in a Specialist Office	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	
• Performed in a Freestanding Center	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	
• Performed as Outpatient Hospital Services	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)				Unlimited visits per plan year
• Performed in a PCP Office	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	
• Performed in a Specialist Office	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	
• Performed in an Outpatient Facility	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	
Home Health Care	20% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Unlimited visits per plan year
Infertility Services	Use Cost Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)			See benefit for description

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 relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);
- Cloning; or
- Medical and surgical procedures that are experimental or investigational unless Our denial is overturned by an External Appeal Agent.

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Infusion Therapy • Performed in a PCP Office	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	See benefit for description
• Performed in Specialist Office	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	
• Performed as Outpatient Hospital Services	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	
• Home Infusion Therapy	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	Home infusion counts towards home health care visit limits
Inpatient Medical Visits	20% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Interruption of Pregnancy • Abortion services	Covered in full	Covered in full	30% Coinsurance after Deductible	See benefit for description
Laboratory Procedures • Performed in a PCP Office	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% Not subject to Deductible	$20 Copayment then You pay 40% after the Deductible	See Benefit for Description
• Performed in a Specialist Office	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% Not subject to Deductible	$20 Copayment then You pay 40% after the Deductible	

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
• Performed in a Freestanding Laboratory Facility	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% not subject to Deductible	$20 Copayment then You pay 40% after the Deductible	
• Performed as Outpatient Hospital Services	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% not subject to Deductible	$20 Copayment then You pay 40% after the Deductible	
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	Covered in Full	30% Coinsurance after Deductible	See Benefit for Description
• 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)	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)	

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
• Inpatient Hospital Services and Birthing Center	20% Coinsurance after Deductible	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
• Physician and Midwife Services for Delivery	20% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Breastfeeding Support, Counseling and Supplies including Breast Pumps, Nursing Bras	Covered in Full	Covered in Full	30% Coinsurance after Deductible	Covered for duration of breast feeding
• Postnatal Care	Covered in Full	Covered in Full	30% Coinsurance after Deductible	
Outpatient Hospital Surgery Facility Charge	20% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Preadmission Testing	0% Coinsurance not Subject to Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities				See benefit for description
• Performed in a PCP Office	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	
• Performed in Specialist Office	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	
• Performed in Outpatient Facilities	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment after the Deductible then You pay 40%	

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Diagnostic Radiology Services • Performed in a PCP Office	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% not subject to Deductible	$20 Copayment then You pay 40% after the Deductible	See benefit for description
Diagnostic Radiology Services				
• Performed in a Specialist Office	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% not subject to Deductible	$20 Copayment then You pay 40% after the Deductible	
• Performed in a Freestanding Radiology Facility	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% not subject to Deductible	$20 Copayment then You pay 40% after the Deductible	
• Performed as Outpatient Hospital Services	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% not subject to Deductible	$20 Copayment then You pay 40% after the Deductible	
Therapeutic Radiology Services				See benefit for description
• Performed in a Specialist Office	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% not subject to Deductible	$20 Copayment then You pay 40% after the Deductible	
• Performed in a Freestanding Radiology Facility	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% not subject to Deductible	$20 Copayment then You pay 40% after the Deductible	
• Performed as Outpatient Hospital Services	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% not subject to Deductible	$20 Copayment then You pay 40% after the Deductible	

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Preferred Provider Member Responsibility for Cost-Sharing	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 • Performed in a Specialist Office • Performed in an Outpatient Facility	 0% Coinsurance not Subject to Deductible 0% Coinsurance not Subject to Deductible 0% Coinsurance not Subject to Deductible	 $20 Copayment then You pay 20% after the Deductible $20 Copayment then You pay 20% after the Deductible $20 Copayment then You pay 20% after the Deductible	 $20 Copayment then You pay 40% after the Deductible $20 Copayment then You pay 40% after the Deductible $20 Copayment then You pay 40% after the Deductible	Unlimited visits per Plan Year
Second Opinions on the Diagnosis of Cancer, Surgery & Other	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the 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 • Outpatient Hospital Surgery	 20% Coinsurance after Deductible 0% Coinsurance not Subject to Deductible	 20% Coinsurance after Deductible 20% Coinsurance after Deductible	 40% Coinsurance after Deductible 40% Coinsurance after Deductible	See benefit for description All transplants must be performed at Designated Facilities

PROFESSIONAL SERVICES AND OUTPATIENT CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery and Transplants				
• Surgery Performed at an Ambulatory Surgical Center	0% Coinsurance not Subject to Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
• Office Surgery	0% Coinsurance not Subject to Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible	
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	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible Coinsurance	$20 Copayment then You pay 40% after the Deductible Coinsurance	
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Diabetic Equipment, Supplies & Self-Management Education				See benefit for description
• Diabetic Equipment and Supplies	0% Coinsurance not Subject to Deductible	$20 Copayment then you pay 0% after the Deductible	$20 Copayment then you pay 0% after the Deductible	
• Diabetic Education	0% Coinsurance not Subject to Deductible	$20 Copayment then you pay 0% after the Deductible	$20 Copayment then you pay 0% after the Deductible	See benefit for description
• Diabetic Insulin (30 Day Supply)	0% Coinsurance not Subject to Deductible but not more than $100 in Cost-Sharing for a 30-day supply for an insulin drug.	$20 Copayment then you pay 0% after the Deductible but not more than $100 in Cost-Sharing for a 30-day supply for an insulin drug.	$20 Copayment then you pay 0% after the Deductible but not more than $100 in Cost-Sharing for a 30-day supply for an insulin drug.	

• Oral anti-diabetic agents and injectable anti-diabetic agents (30 day supply)	0% Coinsurance not Subject to Deductible	$20 Copayment then you pay 0% after the Deductible	$20 Copayment then you pay 0% after the 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 not Subject to Deductible	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.				
ADDITIONAL SERVICES, EQUIPMENT & DEVICES	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
External Hearing Aids • Prescription Hearing Aids	20% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Single purchase once every three (3) years
Cochlear Implants	20% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible	One (1) per ear per plan year
Hospice Care • Inpatient • Outpatient	20% Coinsurance after Deductible 20% Coinsurance after Deductible	20% Coinsurance after Deductible 20% Coinsurance after Deductible	40% Coinsurance after Deductible 40% Coinsurance after Deductible	Unlimited days per Plan Year Five (5) visits for family bereavement counseling
We do not Cover: funeral arrangements; pastoral, financial, or legal counseling; or homemaker, caretaker, or respite care.				
Medical Supplies	20% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
We do not Cover over-the-counter medical supplies.				

ADDITIONAL SERVICES, EQUIPMENT & DEVICES	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Prosthetic Devices • External	20% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible	One (1) prosthetic device, per limb, per Plan Year
• Internal	20% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Unlimited See benefit for description
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	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Autologous Blood Banking	20% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible	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.	20% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Observation Stay	20% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	20% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Unlimited days per plan year

INPATIENT SERVICES & FACILITIES	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Habilitation Services (Physical Speech and Occupational Therapy)	20% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Unlimited days per plan year
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy)	20% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible	Unlimited days per plan year
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment) Preauthorization Required. However, Preauthorization is not required for emergency admissions or for admissions at Participating OMH licensed Facilities for Members under 18.	20% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services) • Office Visits • All Other Outpatient Services	 0% Coinsurance not Subject to Deductible 0% Coinsurance not Subject to Deductible	 $20 Copayment then You pay 20% after the Deductible 0% Coinsurance not Subject to Deductible	 $20 Copayment then You pay 40% after the Deductible 30% after Deductible	See benefit for description
ABA Treatment for Autism Spectrum Disorder	0% Coinsurance Not subject to Deductible	0% Coinsurance Not subject to Deductible	30% after Deductible	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	0% Coinsurance Not subject to Deductible	0% Coinsurance Not subject to Deductible	30% after Deductible	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	**Preferred Provider Member Responsibility for Cost-Sharing**	**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	20% Coinsurance after Deductible	20% Coinsurance after Deductible	40% Coinsurance after Deductible	See benefit for description
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)				Up to twenty (20) visits a plan year may be used for family counseling
• Office Visits	0% Coinsurance not Subject to Deductible	$20 Copayment then You pay 20% after the Deductible	$20 Copayment then You pay 40% after the Deductible	
• Opioid Treatment programs	Covered in full	Covered in full	30% Coinsurance after Deductible	
• All Other Outpatient Services	0% Coinsurance not Subject to Deductible	0% Coinsurance not Subject to Deductible	30% after Deductible	
Preauthorization Required However, Preauthorization is not required for Participating OASAS-certified Facilities.				

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	**Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
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.				
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				
30-day supply Tier 1 (generic)	N/A	$20 Copayment Not subject to Deductible	$20 Copayment Not subject to Deductible	See benefit for description
Tier 2 (formulary brand)	N/A	$45 Copayment Not subject to Deductible	$45 Copayment Not subject to Deductible	

PRESCRIPTION DRUGS	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Tier 3 (non-formulary brand)	N/A	$70 Copayment Not subject to Deductible	$70 Copayment Not subject to Deductible	
Mail Order Pharmacy				
Up to a 90-day supply Tier 1 (generic)	N/A	$50 Copayment Not subject to Deductible	$50 Copayment Not subject to Deductible	See benefit for description
Tier 2 (formulary brand)	N/A	$112.50 Copayment Not subject to Deductible	$112.50 Copayment Not subject to Deductible	
Tier 3 (non-formulary brand)	N/A	$175 Copayment Not subject to Deductible	$175 Copayment Not subject to Deductible	

PRESCRIPTION DRUGS	Preferred Provider Member Responsibility for Cost-Sharing	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)	N/A	$20 Copayment Not subject to Deductible	$20 Copayment Not subject to Deductible	
Tier 2 (formulary brand)	N/A	$45 Copayment Not subject to Deductible	$45 Copayment Not subject to Deductible	
Tier 3 (non-formulary brand)	N/A	$70 Copayment Not subject to Deductible	$70 Copayment Not subject to Deductible	

WELLNESS BENEFITS	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Exercise Facility Reimbursement	Up to $200 per six (6) month period			

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 home-owners 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 & VISION CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care				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
• Preventive	20% Coinsurance after Deductible	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Routine Dental Care	20% Coinsurance after Deductible	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Major Dental Care (Oral Surgery, Endodontics, Periodontics & Prosthodontics)	20% Coinsurance after Deductible	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Orthodontics **Orthodontia & Major Dental Require Preauthorization**	20% Coinsurance after Deductible	20% Coinsurance after Deductible	20% Coinsurance after Deductible	

PEDIATRIC DENTAL & VISION CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Vision Care				One (1) exam per twelve (12)-month period
• Exams	20% Coinsurance after Deductible	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
• Lenses & Frames	20% Coinsurance after Deductible	20% Coinsurance after Deductible	20% Coinsurance after Deductible	One (1) prescribed lenses & frames per twelve (12)-month period
• Contact Lenses	20% Coinsurance after Deductible	20% Coinsurance after Deductible	20% 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.

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 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 Juilliard School 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**).

Bàsɔ̀ɔ̀ Wùɖù/Bassa

Dè dɛ nìà kɛ dyeɖeˈ gbo: ɔ juˇ keˈ m̀ dyi Bàsɔ̀ɔ̀-wùɖù-po-nyɔ̀ juˇ niˈ, nìiˈ à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ m̀ gbo kpaˈa. Ɓaˈ **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, dịrị 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**).

Urdu/اردو

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

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