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THE NEW SCHOOL

Aetna Student Health

Plan Design and Benefits Summary
The New School

Policy Year: 2018 - 2019
Policy Number: 812804

www.aetnastudenthealth.com
(800) 878-1927

This is a brief description of the Student Health Plan. The Plan is available for New School students and their eligible dependents. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Certificate of Coverage and may be viewed online at **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Certificate, the Certificate of Coverage will govern and control the payment of benefits.

You may find additional information about The New School Health Insurance Plan by viewing the 2018-2019 Plan Guide at **www.aetnastudenthealth.com/schools/newschool** or by calling Customer Service Toll Free at **(800) 878-1927**.

The New School

Dear New School Student and Family,

In order to encourage an environment where students actively seek to engage in activities that promote health and well-being, The New School offers on-campus Student Health Services, a Wellness and Health Promotion Program, an Immunization Program, and a Student Health Insurance Plan.

Student Health Services

Student Health Services includes Medical Services, Counseling Services and Wellness and Health Promotion. Medical Services offers primary care to students who are ill, injured, or need routine care and preventive care services. Counseling Services offers short-term psychotherapy, psychiatric consultation, and referrals for specialized treatment needs. All services are offered by licensed professionals and are strictly confidential. Wellness and Health Promotion offers stress reduction and mindfulness services throughout the academic year.

Immunizations

New York State law requires certain categories of students to provide documentation of immunizations for measles, mumps, and rubella (MMR), as well as a response to receipt of information on Meningococcal Disease (Meningitis). Student Health Services schedules immunization clinics for students who have been unable to obtain MMR and Meningitis immunizations elsewhere. Meningitis information and the Immunization Form are available at Student Health Services or by accessing **www.newschool.edu/health**. Please contact Student Health Services at **SHS@newschool.edu** or call us at **(212) 229-1671**, option 5 for information on services and immunizations.

Student Health Insurance Plan

All degree, diploma, online only, visiting, mobility (study abroad), Maintenance of Status, Lang and Parsons consortium, graduate certificate program, ESL + Certificate program and both graduate and undergraduate degree program non-matriculating students are **automatically charged** a Student Health Services Fee and a Health Insurance Fee to cover the costs of the services indicated above.

The Student Health Services Fee (**$370** per semester) enables students to use Student Health Services. The New School Health Insurance Fee enables students to use services outside Student Health Services. Depending on course load and status, you may be eligible to decline these services by completing an Online Waiver Form by the posted Waiver Deadline Date. Students wishing to waive may do so online at **www.universityhealthplans.com**.

Please read this Plan Summary carefully. It describes services, insurance coverage and limitations, waiver process, and important deadlines. It is your responsibility to understand the nature and scope of benefits and limitations as well as abide by posted deadlines. A complete description of the benefits and full terms and conditions can be found in the Certificate of Coverage. If any discrepancy exists between this Plan Summary and the Policy, the Certificate of Coverage

will govern and control the payment of benefits. A copy of the Certificate of Coverage can be found at The New School Student Health Services and can be seen during regular business hours.

Health care is expensive. If you plan to waive participation in the Student Health Insurance Plan, be sure your plan covers care in New York City. We strongly encourage you to consider remaining enrolled in the Student Health Insurance Plan as it offers comprehensive coverage for students.

We wish you a healthy and successful year at The New School!

Sincerely,

Tracy Robin
Assistant Vice President for Student Health and Support Services

The New School Student Health Services

The Student Health Services staff consists of Licensed Nurses, Physicians, Physician Assistants, Psychologists, Psychiatrists, and Clinical Social Workers. This professional staff has experience and special interest in working with college students.

Student Health Services is open weekdays throughout the academic year, except for university holidays. Evening hours are available for counseling services. Appointments are made as follows:

- A student should call in advance to make an appointment. The student will be scheduled for the next available time slot. If the student has an acute problem, they will be connected to a clinician who can assess the problem and make an appropriate appointment. Non-urgent medical appointments can be scheduled through the online portal, **SHSportal.newschool.edu**. For urgent matters, Medical Services also offers daily walk in hours, which are posted on our website, newschool.edu/health.
- Call 24 hours ahead to cancel an appointment. A student who is very late to an appointment may not be able to be seen the same day.
- A student in crisis is encouraged to walk-in and see a counselor.
- A student who is acutely ill, injured, or distressed should try to call ahead so arrangements can be made to be seen by an appropriate clinician, or an appropriate referral can be made to the nearest hospital emergency room. (It should be noted that a referral is not needed for treatment of an **Emergency Medical Condition** as defined in this Plan Summary.)

In **emergency** situations, students should call **911** to be transported directly to the nearest emergency room.

Your health care is your business. Your right to privacy is protected by law and by the ethical standards of Student Health Services. Counseling and medical records are kept strictly confidential. No one other than the staff at Student Health Services may be given information without your prior written consent (except where required, by law, and/or in a life-threatening situation). Friends, relatives, parents, faculty, administration and outside agencies are not allowed to access your health records without permission. If you wish to release your medical or counseling records to another health care provider, you should submit a written request to Student Health Services. Release forms are available.

In addition to the Student Health Services Fee, there are nominal fees for vaccinations. These fees are billed directly to the student's university account.

Certain specimens obtained during your office visit must be analyzed by a commercial laboratory. In such instances, the lab submits its charges to your health insurance provider. The lab will bill you for the portion of the bill that is your responsibility.

Coverage Periods

Students: Coverage for all insured students enrolled in the Plan is for the following periods. Coverage will become effective at 12:01 AM on the Coverage Start Date indicated below, and will terminate at 11:59 PM on the Coverage End Date indicated.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	08/20/2018	08/19/2019	09/09/2018
Fall	08/20/2018	01/14/2019	09/09/2018
Spring	01/15/2019	08/19/2019	02/04/2019

Eligible Dependents: Coverage for dependents enrolled in the Plan is for the following periods. Coverage will become effective at 12:01 AM on the Coverage Start Date indicated below, and will terminate at 11:59 PM on the Coverage End Date indicated. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Certificate of Coverage.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	08/20/2018	08/19/2019	09/09/2018
Fall	08/20/2018	01/14/2019	09/09/2018
Spring	01/15/2019	08/19/2019	02/04/2019

Rates

Student Health Services Fee	Fall 8/20/18-1/14/19	Spring 1/15/19-8/19/19
	$370	**$370**

*The rates below DO NOT include the additional costs of $8 Annual and $5 Spring for the On Call Travel Assistance program or the New School Student Health Services Fee.

Student Health Insurance Plan	Annual Coverage 08/20/18 – 08/19/19	Spring Coverage 01/15/19 – 08/19/19
Student	**$3,015***	**$1,792***
Spouse/DP	**$3,015***	**$1,792***
Child	**$3,015***	**$1,792***
2+ Children	**$6,030***	**$3,584***

The New School University pro-rates on a monthly basis for qualifying life events and for school-defined short-term programs.

Student Coverage

Eligibility

Compulsory Students: All degree, diploma, online only, visiting, mobility (study abroad), Maintenance of Status, Lang and Parsons consortium, graduate certificate program, ESL + Certificate Program, and both graduate and undergraduate degree program non-matriculating students are **automatically charged** the Student Health Services Fee and the Student Health Insurance Fee. Undergraduate students who are registered for six (6) or more credits (except online only) and ESL + Certificate Program are required to pay the Student Health Services Fee regardless of their place of study (e.g., visiting). Any undergraduate student may waive participation in the Student Health Insurance Plan by demonstrating that they already have comparable health insurance.

Compulsory Students who have comparable coverage under other insurance may waive participation by waiving online and demonstrating that they already have comparable coverage. In order to have the Student Health Insurance Fee removed from your MyNewSchool online account, you must submit an Online Waiver Form each year by the posted Waiver Deadline Date.

Optional Students: Undergraduate students who are registered for five (5) or fewer credits, online only students, and all graduate students (except Parsons Paris) may waive participation in Student Health Services and/or the Student Health Insurance Plan by waiving online and demonstrating that they already have comparable coverage. In order to have the fee(s) waived from your MyNewSchool online account, you must submit an Online Waiver Form each year by the posted Waiver Deadline Date.

Late Enrollment: Under certain circumstances, coverage for late enrollees may be possible. For the Fall Semester, any enrollment occurring after 09/09/2018 is considered a late enrollment. For the Spring Semester, any enrollment occurring after 02/04/2019**,** is considered a late enrollment. Contact University Health Plans, Inc., at **(800) 437-6448** for late enrollment. If the student experiences a significant life change that directly affects their insurance coverage, **the deadline to enroll is 60 days after the significant life changing event**. A life changing event may include a loss of coverage from a prior plan, marriage, divorce, and other reasons beyond a person's control. Coverage for dependents will begin on 08/20/2018, if they are enrolled prior to the 09/09/2018 deadline.

If you withdraw from school before the waiver deadline, you will not be covered under the Policy and the full premium will be refunded, as long as no claim against the plan has been paid. After the waiver deadline, 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.)

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 they are 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

Students who meet the eligibility criteria, but do not want to remain enrolled in the student Plans, must submit an online waiver.

- Log on to **www.universityhealthplans.com/TNS**.
- Select "Waiver Form" from the left MENU.
- Simply follow the prompts on the screen by providing all information requested. You will receive a confirmation that your waiver form was successfully completed. A completed Online Waiver Form must be submitted by the posted Waiver Deadline Date.

Waiver Deadlines	
Fall Semester	09/09/2018
Spring Semester	02/04/2019

Take special note of the following:

- It is your responsibility to verify that the appropriate credit appears on your MyNewSchool online account. Any inappropriate charges must be reported before the semester Waiver Deadline.
- If you do not submit the Online Waiver Form by the semester Waiver Deadline, you will be required to pay the Student Health Insurance and Student Health Services Fees, even if you have health insurance coverage.
- Students who miss the Fall Semester Waiver Deadline and have paid the Fall Semester premium may elect to waive the remaining Spring Semester premium ONLY if the Plan is not used during the Fall Semester and proof of comparable personal insurance is provided. Because this is an annual Plan and partial coverage is not an option, if the student or any health care provider on behalf of the student submits a claim to Aetna Student Health, or Aetna Pharmacy Management, the student is obligated to continue participation in the Plan and will be charged the remaining premium.
- You must submit a new Online Waiver Form each Fall Semester. Those who do not register in the Fall Semester must submit an Online Waiver Form in the Spring Semester, and then again the following Fall Semester.
- If you submit an Online Waiver Form in the Fall Semester, you will be automatically waived for the Spring Semester.
- If you withdraw or take a leave of absence before the semester Waiver Deadline, the Student Health Insurance Fee paid by you will be refunded in full as long as no claim against the plan has been paid.
- If you are taking a leave of absence for health reasons before the semester Waiver Deadline, you may opt to remain covered in the Student Health Insurance Plan for the remainder of that semester only by notifying Student Health Services immediately at **(212) 229-1671**, option 3 or **shs@newschool.edu**.
- If you withdraw or take a leave of absence after the semester Waiver Deadline, you will remain covered in the Student Health Insurance Plan for the remainder of that semester only. Absolutely no refunds will be made for Student Health Insurance or Student Health Services Fees after the semester Waiver Deadline.
- Once you use the Student Health Services, the Health Services Fee cannot be waived. If you use the services in the fall semester, you will be required to pay the spring Health Services Fee as well if you are registered for the spring semester.

Under certain circumstances, students may appeal the Waiver Deadline. Students should contact University Health Plans, Inc., at **(800) 437-6448**. The deadline to submit a formal appeal is:

Waiver Appeal Deadlines	
Fall Semester	10/21/2018
Spring Semester	03/18/2019

Dependent Coverage

Eligibility

Covered students may also enroll their spouse, including same-sex marriage, domestic partner and dependent children up to the age of 29.

Enrollment

To enroll the dependent(s) of a covered student, please complete the Enrollment Application provided by University Health Plans at **www.universityhealthplans.com** or you may contact them directly at **(800) 437-6448**. The Fall enrollment deadline is 09/09/2018 and the Spring enrollment deadline for new spring students and their dependents is 02/04/2019. Dependent enrollment applications will not be accepted after these dates, unless there is a significant life change that directly affects their insurance coverage. If the student's dependent(s) experiences a significant life change that directly affects their insurance coverage, the deadline to enroll is **60** days after the significant life changing event. (An example of a significant life change would be loss of health coverage under another health plan.)

Special Enrollment Periods

You, your spouse or child can also enroll for coverage within 60 days of the loss of coverage in a health plan if coverage was terminated because You, your spouse or child are no longer eligible for coverage under the other health plan due to:

1. Termination of employment;
2. Termination of the other health plan;
3. Death of the spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions toward a health plan were terminated; or
7. A child no longer qualifies for coverage as a child under another health plan.

You, your spouse or child can also enroll within 60 days from exhaustion of your COBRA or continuation coverage. We must receive notice and premium payment within 60 days of the loss of coverage.

In addition, you, your spouse or child, can also enroll for coverage within 60 days of the following event:

- You, or your spouse or child lose[s] eligibility for Medicaid or a state child health plan.

We must receive notice and premium payment within 60 days of this event.

Participating Provider Network

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.

Pre-authorization

Some services have to be pre-authorized by Aetna beforehand if you want the Plan to cover them. Participating Providers are responsible for requesting pre-authorization for their services. You are responsible for requesting pre-authorization if you seek care from a Non-Participating Provider for any of the services listed in the Schedule of Benefits section of the Certificate. Pre-authorization 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 pre-authorization, you must call Aetna at the number on your ID card. After Aetna receives a request for pre-authorization, we will review the reasons for your planned treatment and determine if benefits are available.

You must contact Aetna to request pre-authorization 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 Design and Benefits Summary document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. To look at the full Plan description, which is contained in the Policy issued to you, go to **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Policy, the Master Policy will control.

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

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

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

Our Allowed Amount is not based on the "usual, customary and reasonable charge." If a Non-Participating Provider's actual charge is more than the Allowed Amount, you are responsible for the difference. Call us at the number on your ID card or visit **www.aetnastudenthealth.com** 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).

Metallic Level: Platinum, Tested at 90.14%.

COST-SHARING	Participating Provider – Member Responsibility for Cost-Sharing	Non-Participating Provider – Member Responsibility for Cost-Sharing
Medical Deductible*		
Individual	$100	$100
Family	$0	$0
Prescription Drug Deductible (user note- remove of not applicable to plan-will need		
Individual	$0	$0
Family	$0	$0
Out-of-Pocket Limit**		
Individual	$2,000	$0
Family	$5,000	$0
*Applicable to benefits unless indicated otherwise below. ** This limit never includes Your Premium, Balance Billing charges or the cost of health care services We do not Cover.		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.

Outpatient and Professional Services (for other than Mental Health and Substance Use)	Participating Provider – Member Responsibility for Cost-Sharing	Non-Participating Provider – Member Responsibility for Cost-Sharing
Office Visits - Primary Care (or home visits)	10% Coinsurance	$25 Copayment after Policy Year Deductible and then you pay 40% Coinsurance
Office Visits - Specialists (or home visits)	10% Coinsurance	$25 Copayment after Policy Year Deductible and then you pay 40% Coinsurance
PREVENTIVE CARE	**Participating Provider – Member Responsibility for Cost-Sharing**	**Non-Participating Provider – Member Responsibility for Cost-Sharing**
Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP").		
Well-Baby and Well-Child Care*	Covered in full	30% Coinsurance after Policy Year Deductible
Adult Annual Physical Examinations*	Covered in full	30% Coinsurance after Policy Year Deductible
Adult Immunizations*	Covered in full	30% Coinsurance after Policy Year Deductible
Routine Gynecological Services/Well-Woman Examinations *	Covered in full	30% Coinsurance after Policy Year Deductible
Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer*	Covered in full	30% Coinsurance after Policy Year Deductible
Sterilization Procedures for Women *	Covered in full	30% Coinsurance after Policy Year Deductible
Vasectomy We do not cover services related to the reversal of elective sterilizations.	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Bone Density Testing*	Covered in full	30% Coinsurance after Policy Year Deductible
Screening for Prostate Cancer	Covered in full	30% Coinsurance after Policy Year Deductible
All other preventive services required by USPSTF and HRSA	Covered in full	30% Coinsurance after Policy Year Deductible

PREVENTIVE CARE (continued)	Participating Provider – Member Responsibility for Cost-Sharing	Non-Participating Provider – Member Responsibility for Cost-Sharing
***When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA** You may contact Us at the number on Your ID card or visit Our website at www.aetnastudenthealth.com for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.	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**
Emergency Ambulance Transportation (Pre-Hospital Emergency Medical Services) 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.	10% Coinsurance after Policy Year Deductible	10% Coinsurance after Policy Year Deductible
Non-Emergency Ambulance Services	10% Coinsurance after Policy Year Deductible	10% Coinsurance after Policy Year Deductible
Emergency Department *Copayment /Coinsurance waived if Hospital admission. **Important Notice:** A separate hospital emergency room visit benefit deductible or copay applies for each visit to an emergency room for emergency care. If a covered person is admitted to a hospital as an inpatient immediately following a visit to an emergency room, the emergency room visit benefit deductible or copay is waived. Covered medical expenses that are applied to the emergency room visit benefit deductible or copay cannot be applied to any other benefit deductible or copay under the plan. Likewise, covered medical expenses that are applied to any of the plan's other benefit	10% Coinsurance after Policy Year Deductible	10% Coinsurance after Policy Year Deductible

EMERGENCY CARE (continued)	Participating Provider – Member Responsibility for Cost-Sharing	Non-Participating Provider – Member Responsibility for Cost-Sharing
Emergency Department (continued) deductibles or copays cannot be applied to the emergency room visit benefit deductible or copay. Separate benefit deductibles or copays may apply for certain services rendered in the emergency room that are not included in the hospital emergency room visit benefit. These benefit deductibles or copays may be different from the hospital emergency room visit benefit deductible or copay, and will be based on the specific service rendered. Similarly, services rendered in the emergency room that are not included in the hospital emergency room visit benefit may be subject to coinsurance rates that are different from the coinsurance rate applicable to the hospital emergency room visit benefit.	10% Coinsurance after Policy Year Deductible	10% Coinsurance after Policy Year Deductible
Urgent Care Center Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care.	10% Coinsurance after Policy Year Deductible	$25 Copayment subject to the Deductible then You pay 40%
Advanced Imaging Services (Performed in a Freestanding Radiology Facility or Specialist Office Setting)	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Advanced Imaging Services (Performed as Outpatient Hospital Services)	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Outpatient and Professional Services (for other than Mental Health and Substance Use)	**Participating Provider – Member Responsibility for Cost-Sharing**	**Non-Participating Provider – Member Responsibility for Cost-Sharing**
Allergy Testing and Treatment (Performed in a PCP Office)	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Allergy Testing and Treatment (Performed in a Specialist Office)	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Ambulatory Surgical Center Facility Fee	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Anesthesia Services (all settings)	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible

Outpatient and Professional Services (for other than Mental Health and Substance Use)	Participating Provider – Member Responsibility for Cost-Sharing	Non-Participating Provider – Member Responsibility for Cost-Sharing
Autologous Blood Banking Services	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Cardiac & Pulmonary Rehabilitation (Performed in a Specialist Office)	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Cardiac & Pulmonary Rehabilitation (Performed as Outpatient Hospital Services)	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Cardiac & Pulmonary Rehabilitation (Performed as Inpatient Hospital Services)	Included As Part of Inpatient Hospital Service Cost-Sharing	Included As Part of Inpatient Hospital Service Cost-Sharing
Chemotherapy (Performed in a PCP Office)	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Chemotherapy (Performed in a Specialist Office)	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Chemotherapy (Performed as Outpatient Hospital Services)	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Chiropractic Services	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Clinical Trials	Use Cost-Sharing for Appropriate Service	Use Cost-Sharing for Appropriate Service
Diagnostic Testing - Performed in a PCP Office We Cover x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Diagnostic Testing - Performed in a Specialists Office	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Diagnostic Testing - Performed as Outpatient Hospital Services	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Dialysis - Performed in a PCP Office	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Dialysis - Performed in a Freestanding Center	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Dialysis - Performed in a Specialists Office	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Dialysis - Performed as Outpatient Hospital Services	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Habilitation Services - Physical Therapy, Occupational Therapy, or Speech Therapy	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible

Outpatient and Professional Services (for other than Mental Health and Substance Use)	Participating Provider-Member Responsibility for Cost-Sharing	Non-Participating Provider - Member Responsibility for Cost-Sharing
Home Health Care Benefit limited to 40 Visits per Plan Year.	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Infertility Services We cover services for the diagnosis and treatment (surgical and medical) of infertility when such infertility is the result of malformation, disease or dysfunction. Such coverage is available as follows: **Basic Infertility Services.** Basic infertility services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York. However, Members must be between the ages of 21 and 44 (inclusive) in order to be considered a candidate for these services. **Services include:** Initial evaluation; Semen analysis; Laboratory evaluation; Evaluation of ovulatory function; Postcoital test; Endometrial biopsy; Pelvic ultra sound; Hysterosalpingogram; Sono-hystogram; Testis biopsy; Blood tests; and Medically appropriate treatment of ovulatory dysfunction. Additional tests may be covered if the tests are determined to be Medically Necessary. **Comprehensive Infertility Services**. If the basic infertility services do not result in increased fertility, we cover comprehensive infertility services. **Services include:** Ovulation induction and monitoring; Pelvic ultra sound; Artificial insemination; Hysteroscopy; Laparoscopy; and Laparotomy.	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)

Outpatient and Professional Services (for other than Mental Health and Substance Use)	Participating Provider-Member Responsibility for Cost-Sharing	Non-Participating Provider-Member Responsibility for Cost-Sharing
Infertility Services (continued) **Exclusions and Limitations**. We do not cover: In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers; Costs for an ovum donor or donor sperm; Sperm storage costs; 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. All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine.	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)
Infusion Therapy - Performed in a PCP Office We cover infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required you to be hospitalized. Drugs or nutrients administered directly into the veins are considered infusion therapy.	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Outpatient and Professional Services (for other than Mental Health and Substance Use)	**Participating Provider-Member Responsibility for Cost-Sharing**	**Non-Participating Provider-Member Responsibility for Cost-Sharing**
Infusion Therapy - Performed in a Specialists Office	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Infusion Therapy - Performed as Outpatient Hospital Services	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Infusion Therapy - Home Infusion Therapy Home Infusion counts towards Home Health Care Visit Limits.	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Interruption of Pregnancy - Medically Necessary Abortions	Covered in full not subject to Deductible	40% Coinsurance after Policy Year Deductible

Outpatient and Professional Services (for other than Mental Health and Substance Use)	Participating Provider-Member Responsibility for Cost-Sharing	Non-Participating Provider-Member Responsibility for Cost-Sharing
Laboratory Procedures - Performed in a PCP Office	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Laboratory Procedures - Performed in a Specialist Office	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Laboratory Procedures - Performed in a Performed in a Freestanding Laboratory Facility	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Laboratory Procedures - Performed as Outpatient Hospital Services	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Maternity and Newborn Care - Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered In Full	30% Coinsurance after Policy Year Deductible
Maternity and Newborn Care - Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)
Maternity and Newborn Care - Inpatient Hospital Services and Birthing Center One Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early.	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Maternity and Newborn Care - Physician and Midwife Services for Delivery	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Maternity and Newborn Care - Breastfeeding Support, Counseling and Supplies including Breast Pumps Breast Pumps We cover the cost of renting one breast pump per pregnancy for duration of breast feeding.	Covered in Full	30% Coinsurance after Policy Year Deductible
Maternity and Newborn Care - Postnatal Care	0% Coinsurance Not subject to Deductible	30% Coinsurance after Policy Year Deductible
Outpatient Hospital Surgery Facility Charge	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Preadmission Testing	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Prescription Drugs Administered in Office - Performed in a PCP Office	10% Coinsurance	$25 Copayment after Policy Year Deductible and then you pay 40% Coinsurance

Outpatient and Professional Services (for other than Mental Health and Substance Use)	Participating Provider-Member Responsibility for Cost-Sharing	Non-Participating Provider-Member Responsibility for Cost-Sharing
Prescription Drugs Administered in Office - Performed in a Specialist Office	10% Coinsurance	$25 Copayment after Policy Year Deductible and then you pay 40% Coinsurance
Prescription Drugs Administered in Office - Performed in an Outpatient Facilities	10% Coinsurance	$25 Copayment after Policy Year Deductible and then you pay 40% Coinsurance
Diagnostic Radiology Services - Performed in a PCP Office	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Diagnostic Radiology Services - Performed in a Specialist Office	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Diagnostic Radiology Services - Performed in a Freestanding Radiology Facility	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Diagnostic Radiology Services - Performed as Outpatient Hospital Services	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Therapeutic Radiology Services - Performed in a Specialist Office	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Therapeutic Radiology Services - Performed in a Freestanding Radiology Facility	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Therapeutic Radiology Services - Performed as Outpatient Hospital Services	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Rehabilitation Services - Physical Therapy, Occupational Therapy or Speech Therapy Speech and Physical Therapy are only Covered following a Hospital stay or surgery.	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Second Opinions on the Diagnosis of Cancer, Surgery & Other	10% Coinsurance	$25 Copayment after Policy Year Deductible and then you pay 40% Coinsurance Second Opinions on Diagnosis of Cancer are Covered at Participating Cost-Sharing for Non-Participating Specialist when a Referral is obtained.

Surgical Services (surgeon, assistant surgeon, anesthetist) - Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; and Transplants	Participating Provider-Member Responsibility for Cost-Sharing	Non-Participating Provider-Member Responsibility for Cost-Sharing
Surgical Services (surgeon, assistant surgeon, anesthetist) - Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; and Transplants - Inpatient Hospital Surgery	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Surgical Services (surgeon, assistant surgeon, anesthetist) - Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; and Transplants - Outpatient Hospital Surgery	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Surgical Services (surgeon, assistant surgeon, anesthetist) - Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; and Transplants - Surgery Performed at an Ambulatory Surgical Center	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Surgical Services (surgeon, assistant surgeon, anesthetist) - Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; and Transplants - Office Surgery	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Additional Benefits, Equipment and Devices	**Participating Provider-Member Responsibility for Cost-Sharing**	**Non-Participating Provider-Member Responsibility for Cost-Sharing**
Applied Behavioral Analysis Treatment for Autism Spectrum Disorder "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible

Additional Benefits, Equipment and Devices	Participating Provider-Member Responsibility for Cost-Sharing	Non-Participating Provider-Member Responsibility for Cost-Sharing
Assistive Communication Devices for Autism Spectrum Disorder We cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if You are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. We will only cover devices that generally are not useful to a person in the absence of communication impairment. We do not cover items, such as, but not limited to, laptops, desktop, or tablet computers. We cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device.	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Diabetic Equipment, Supplies and Insulin (30 day supply)	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Diabetic Education	10% Coinsurance	$25 Copayment after Policy Year Deductible and then you pay 40% Coinsurance
Durable Medical Equipment and Braces	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Hearing Aids - External Single Purchase Once Every Plan Year.	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Hearing Aids - Cochlear Implants One Per Ear Per Time Covered.	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Hospice Care – Inpatient Unlimited Days per Plan Year.	0% Coinsurance subject to Deductible Pre-authorization required	0% Coinsurance subject to Deductible Pre-authorization required
Hospice Care – Outpatient 5 Visits for Family Bereavement Counseling.	0% Coinsurance subject to Deductible	0% Coinsurance subject to Deductible

Additional Benefits, Equipment and Devices	Participating Provider-Member Responsibility for Cost-Sharing	Non-Participating Provider-Member Responsibility for Cost-Sharing
Medical Supplies We cover medical supplies that are required for the treatment of a disease or injury which is covered under the certificate. We also cover maintenance supplies (e.g., ostomy supplies) for conditions covered under the certificate. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not cover over-the-counter medical supplies.	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Prosthetics – External 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. We do not cover orthotics (e.g., shoe inserts). One (1) prosthetic device, per limb, per Plan Year	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Prosthetics - Internal	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Inpatient Services (for other than Mental Health and Substance Use)	**Participating Provider-Member Responsibility for Cost-Sharing**	**Non-Participating Provider-Member Responsibility for Cost-Sharing**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	10% Coinsurance after Policy Year Deductible Pre-authorization required	40% Coinsurance after Policy Year Deductible Pre-authorization required
Observation Stay	10% Coinsurance after Policy Year Deductible	40% Coinsurance after Policy Year Deductible
Inpatient Medical Visits Services	10% Coinsurance after Policy Year Deductible Pre-authorization required	40% Coinsurance after Policy Year Deductible Pre-authorization required
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation)	10% Coinsurance after Policy Year Deductible Pre-authorization required	40% Coinsurance after Policy Year Deductible Pre-authorization required
Inpatient Rehabilitation Services - Physical Therapy, Occupational Therapy or Speech Therapy	10% Coinsurance after Policy Year Deductible Pre-authorization required	40% Coinsurance after Policy Year Deductible Pre-authorization required

Mental Health Care and Substance Use Services	Participating Provider-Member Responsibility for Cost-Sharing	Non-Participating Provider-Member Responsibility for Cost-Sharing
Inpatient Mental Health Care including Residential Treatment (for a continuous confinement when in a Hospital) Pre-authorization is Not Required for Emergency Admissions.	10% Coinsurance after Policy Year Deductible Pre-authorization required	40% Coinsurance after Policy Year Deductible Pre-authorization required
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)	10% Coinsurance	$25 Copayment after Policy Year Deductible and then you pay 40% Coinsurance
Inpatient Substance Use Services including Residential Treatment (for a continuous confinement when in a Hospital) Pre-authorization is Not Required for Emergency Admissions.	10% Coinsurance after Policy Year Deductible Pre-authorization required	40% Coinsurance after Policy Year Deductible Pre-authorization required
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment) Up to 20 Visits a Plan Year May Be Used For Family Counseling.	10% Coinsurance	$25 Copayment after Policy Year Deductible and then you pay 40% Coinsurance
Prescription Drug Coverage ***Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF and obtained at a participating pharmacy** **If You have an Emergency Condition, Preauthorization is not required for a five (5) day emergency supply of a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.**	**Participating Provider-Member Responsibility for Cost-Sharing**	**Non-Participating Provider-Member Responsibility for Cost-Sharing**

Prescription Drug Coverage (continued)	Participating Provider-Member Responsibility for Cost-Sharing	Non-Participating Provider-Member Responsibility for Cost-Sharing
Retail Pharmacy (30 day supply) - Tier 1 (generic) Supply Limits: Except for contraceptive drugs or devices We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy or Designated Pharmacy. You are responsible for one (1) Cost-Sharing amount for up to a 30-day supply. However, for Maintenance Drugs We will pay for up to a 90-day supply of a drug purchased at a retail pharmacy. You are responsible for up to three (3) Cost-Sharing amounts for a 90-day supply at a retail pharmacy. You may have an initial three-month supply of a contraceptive drug or device dispensed to You. For subsequent dispensing of the same contraceptive drug or device, You may have the entire prescribed supply (of up to 12 months) of the contraceptive drug or device dispensed at the same time. Contraceptive drugs and devices are not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Pharmacy. For other contraceptive drugs and devices, for an initial three-month supply, You are responsible for up to three (3) Cost-Sharing amounts and You are responsible for up to nine (9) Cost-Sharing Amounts for the remaining supply of a 12 month prescription. For a subsequent 12 month dispensing of the same contraceptive drug or device, You are responsible for up to twelve (12) Cost-Sharing amounts.	$25 Copayment per supply	Copayment per supply of 30% of the Allowed Amount.
Retail Pharmacy (30 day supply) - Tier 2 (formulary brand)	$40 Copayment per supply	Copayment per supply of 30% of the Allowed Amount.
Retail Pharmacy (30 day supply) - Tier 3 (non-formulary brand)	$50 Copayment per supply	Copayment per supply of 30% of the Allowed Amount.
Mail Order Pharmacy (30 day supply) - Tier 1 (generic)	Not Covered	Not Covered
Mail Order Pharmacy (30 day supply) - Tier 2 (formulary brand)	Not Covered	Not Covered

Prescription Drug Coverage (continued)	Participating Provider-Member Responsibility for Cost-Sharing	Non-Participating Provider-Member Responsibility for Cost-Sharing
Mail Order Pharmacy (30 day supply) - Tier 3 (non-formulary brand)	Not Covered	Not Covered
Mail Order More than 30-day supply Up to a 90-day supply - Tier 1 (generic)	Not Covered	Not Covered
Mail Order More than 30-day supply Up to a 90-day supply - Tier 2 (formulary brand)	Not Covered	Not Covered
Mail Order More than 30-day supply Up to a 90-day supply - Tier 3 (non-formulary brand)	Not Covered	Not Covered
Enteral Formulas - Tier 1 (Generic)	Copayment per supply of 10% of the Allowed Amount.	Copayment per supply of 40% of the Allowed Amount.
Enteral Formulas - Tier 2 (formulary brand)	Copayment per supply of 10% of the Allowed Amount.	Copayment per supply of 40% of the Allowed Amount.
Enteral Formulas - Tier 3 (non-formulary brand)	Copayment per supply of 10% of the Allowed Amount.	Copayment per supply of 40% of the Allowed Amount.
WELLNESS BENEFITS	**Participating Provider-Member Responsibility for Cost-Sharing**	**Non-Participating Provider-Member Responsibility for Cost-Sharing**
Exercise Facility Reimbursement Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited to actual workout visits. We will not provide reimbursement for equipment, clothing, vitamins or other services that may be offered by the facility (e.g., massages, etc.).	Up to $200 per 6 month period	
Pediatric Vision Care We Cover emergency, preventive and routine vision care for Members through the end of the month in which the Member turns nineteen (19) years of age.	**Participating Provider-Member Responsibility for Cost-Sharing**	**Non-Participating Provider-Member Responsibility for Cost-Sharing**
Vision Examinations One Exam per 12-Month Period.	0% Coinsurance Not subject to Deductible	30% Coinsurance Not subject to Deductible

Pediatric Vision Care (continued)	Participating Provider-Member Responsibility for Cost-Sharing	Non-Participating Provider-Member Responsibility for Cost-Sharing
Prescribed Lenses and Frames We cover standard prescription lenses or contact lenses, one (1) time in any twelve (12) month period, unless it is Medically Necessary for You to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic. We also cover standard frames adequate to hold lenses one (1) time in any twelve (12) month period, unless it is Medically Necessary for you to have new frames more frequently, as evidenced by appropriate documentation.	0% Coinsurance Not subject to Deductible	30% Coinsurance Not subject to Deductible
Contact Lenses	0% Coinsurance Not subject to Deductible	30% Coinsurance Not subject to Deductible
Pediatric Dental Care We Cover the following dental care services for Members up through the end of the month in which the Member turns nineteen (19) years of age.	**Participating Provider-Member Responsibility for Cost-Sharing**	**Non-Participating Provider-Member Responsibility for Cost-Sharing**
Preventive/Routine Dental Care One Dental Exam & Cleaning Per 6-Month Period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6-month intervals.	Covered in Full	30% Coinsurance
Major Dental - Endodontics, Periodontics and Prosthodontics	30% Coinsurance Not subject to Deductible	50% Coinsurance
Orthodontia	50% Coinsurance Not subject to Deductible	50% Coinsurance

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.

Cosmetic Services

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

Dental Services

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

Experimental or Investigational Treatment

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

Felony Participation

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

Foot Care

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

Government Facility

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

Medically Necessary

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

Medicare or Other Governmental Program

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

Military Service

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

Services Not Listed

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

Services Provided by a Family Member

We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

Services 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.

Workers' Compensation

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

Fully Insured Disclaimer

The New 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).

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call (800)878-1927.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

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).

TTY: 711

To access language services at no cost to you, call (800) 878-1927.

Para acceder a los servicios de idiomas sin costo, llame al (800) 878-1927. (Spanish)

如欲使用免費語言服務，請致電(800) 878-1927. (Chinese)

Afin d'accéder aux services langagiers sans frais, composez le (800) 878-1927. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa (800) 878-1927. (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie an(800) 878-1927. (German)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero(800) 878-1927. (Italian)

言語サービスを無料でご利用いただくには、 までお電話ください(800) 878-1927. (Japanese)

무료 언어 서비스를 이용하려면 번으로 전화해 주십시오(800) 878-1927. (Korean)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć (800) 878-1927. (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para (800) 878-1927. (Portuguese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону (800) 878-1927. (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số (800) 878-1927. (Vietnamese)

(800) 878-1927. (Arabic) على الاتصال الرجاء تكلفة، أي دون اللغوية الخدمات على للحصول الرقمي
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(800) 878-1927Persian Farsi) - برای تماس.) شماره با ارایگان، طور به زبان خدمات به دسترسی