Aetna Student Health
Plan Design and Benefits Summary

Preferred Provider Organization (PPO)

Columbia University

This document has been updated.
Please refer to last page.

Policy Year: 2022 – 2023
Policy Number: 704502
www.aetnastudenthealth.com
(800) 859-8471

This is a brief description of the Student Health Plan. The plan is available for Columbia University students and their eligible dependents. The plan is insured by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Certificate issued to you and may be viewed online at **www.aetnastudenthealth.com.** If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

Columbia University Morningside Campus

Columbia Health offers a wide array of services provided by Medical Services, Counseling and Psychological Services, Disability Services, Sexual Violence Response, and Alice! Health Promotion. Detailed information including hours of operation, student insurance information, and department services can be found at **health.columbia.edu.**

For more information, please call Columbia Health at (212) 854-2284.

Columbia University Irving Medical Center Student Health on Haven

Columbia University Irving Medical Center CUIMC Student Health on Haven is CUIMC's on-campus health facility for all students registered at CUIMC. CUIMC Student Health on Haven offers a wide array of services provided by Medical Services, Counseling Services, and Well-Being and Health Promotion. Detailed information including hours of operation, student insurance information, and department services can be found at **studenthealth.cuimc.columbia.edu**.

For more information, call CUIMC Student Health on Haven at (212) 305-3400.

Teachers College, Jewish Theological Seminary, & Union Theological Seminary

Columbia Health offers a wide array of services to students from the three affiliate institutions. Detailed information including hours of operation and department services can be found at **health.columbia.edu**.

For more information, please call Columbia Health at (212) 854-2284.

Coverage Periods

Coverage will become effective at 12:00 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	08/15/2022	08/14/2023	09/30/2022
Fall (Only applies to students completing their degree program in December 2022)	08/15/2022	12/31/2022	09/30/2022
Spring/Summer (Only applies to students joining the university in the Spring term)	01/01/2023	08/14/2023	02/15/2023
Summer (Only applies to students joining the university in the Summer term)	05/15/2023	08/14/2023	06/30/2023

Annual Rates

Columbia University Student Health Insurance Plan

Morningside/CUIMC	Student	Spouse	Child	Children
Aetna Premium Rate	$4,243.00	$4,243.00	$4,243.00	$8,486.00
Columbia Subsidy	-$84.00	-$84.00	-$84.00	-$168.00
Dental Fee	$30.00	$30.00	Not Applicable	Not Applicable
Total Rate	$4,189.00	$4,189.00	$4,159.00	$8,318.00

Affiliate Campuses	Student	Spouse	Child	Children
Aetna Premium Rate	$5,282.00	$5,282.00	$5,282.00	$10,564.00
Columbia Subsidy	-$105.00	-$105.00	-$105.00	-$210.00
Dental Fee	$30.00	$30.00	Not Applicable	Not Applicable
Total Rate	$5,207.00	$5,207.00	$5,177.00	$10,354.00

Morningside & CUIMC Student Health on Haven Total Rates

The total rates below include both premiums for the student health plan underwritten by Aetna Life Insurance Company, as well as $30 per year (student) or $60 per year (student+spouse) for Columbia University fees for preventive dental services provided by the Columbia University College of Dental Medicine, less an $84 per year (Student, Spouse, Or Child) or $168 per year (Children) subsidy by Columbia University. Semester Rates, including the Subsidy and Dental Fee, are based on a pro-rata portion of the annual rate.

Columbia University Student Health Insurance Plan – available to Morningside and CUIMC Student Health on Haven Campus students

	Annual	Fall Semester	Spring/Summer Semester	Summer*
Morningside/ CUIMC Student	$4,189.00	$1,596.00	$2,593.00	$1,059.00
Morningside/CUIMC Student + Spouse	$8,378.00	$3,192.00	$5,186.00	$2,118.00
Morningside/CUIMC Student + Child	$8,348.00	$3,180.00	$5,168.00	$2,107.00
Morningside/CUIMC Student + Children	$12,507.00	$4,764.00	$7,743.00	$3,155.00
Morningside/CUIMC Student + Spouse + Child	$12,537.00	$4,776.00	$7,761.00	$3,166.00
Morningside/CUIMC Student + Spouse + Children	$16,696.00	$6,360.00	$10,336.00	$4,214.00

**Summer fees only apply to students enrolling for the first time in summer.*

Affiliate Campus Rates

The total rates below include both premiums for the student health plan underwritten by Aetna Life Insurance Company, as well as $30 per year (student) or $60 per year (student+spouse) for Columbia University fees for preventive dental services provided by the Columbia University College of Dental Medicine, less an $105 per year (Student, Spouse, Or Child) or $210 per year (Children) subsidy by Columbia University. Semester Rates, including the Subsidy and Dental Fee, are based on a pro-rata portion of the annual rate.

Columbia University Student Health Insurance Plan – available to TC, JTS, and UTS students

	Annual	Fall Semester	Spring/Summer Semester	Summer*
Affiliate Student	$5,207.00	$1,984.00	$3,223.00	$1,316.00
Affiliate Student + Spouse	$10,414.00	$3,968.00	$6,446.00	$2,632.00
Affiliate Student + Child	$10,384.00	$3,956.00	$6,428.00	$2,621.00
Affiliate Student + Children	$15,561.00	$5,928.00	$9,633.00	$3,926.00
Affiliate Student + Spouse + Child	$15,591.00	$5,940.00	$9,651.00	$3,937.00
Affiliate Student + Spouse + Children	$20,768.00	$7,912.00	$12,856.00	$5,242.00

**Summer fees only apply to students enrolling for the first time in summer.*

Student Coverage

Eligibility (Columbia Morningside)

Full-Time Domestic Students

All registered full-time domestic students at the Columbia University Morningside Campus are enrolled in the Columbia University Student Health Insurance Plan if no valid waiver request is submitted before the published deadline.

Full-time domestic students must confirm a specific insurance selection every year by actively enrolling in the Columbia University Student Health Insurance Plan through the Columbia Health Patient Portal by the published deadline, or request a waiver from enrollment in the Columbia University Student Health Insurance Plan and demonstrating coverage under another comparable policy. Enrollment in the Columbia University Student Health Insurance Plan, either by default enrollment or online selection, is effective only upon the student's registration for the term for which coverage will be active. Enrolling in the plan will also automatically initiate enrollment in and payment of the Full-Time Health and Related Service Fee, which is required. Please visit **health.columbia.edu** for more information about Preferred Member Responsibility for Cost-Sharing and the Health and Related Service Fee.

Once the student's insurance coverage decision has been determined for the Fall term, either by online selection, default enrollment, or waiver request, that decision will automatically be continued in the following Spring term as long as the student remains registered at the University. For students who do not register for the Spring 2023 Term, their insurance coverage will terminate on December 31, 2022.

Part-Time Domestic Students

During the open enrollment period part-time domestic students may choose to enroll in the Columbia University Student Health Insurance Plan. Enrolling in the plan will also automatically initiate enrollment in and required payment of the Full-Time Health and Related Service Fee, which is required. Please visit **health.columbia.edu** for more information about Preferred Member Responsibility for Cost-Sharing and the Health and Related Service Fee. Part-time students who have been insured under the plan in previous years and wish to enroll again must re-enroll by the published deadline in order to avoid a break in coverage.

International Students

All international students, regardless of the number of registered credits, are required to enroll in the Columbia University Student Health Insurance Plan. Students will be enrolled in the Columbia University Student Health Insurance Plan before the published enrollment deadline. International students are not eligible to waive enrollment in the Columbia University Student Health Insurance Plan, except in very limited circumstances. Please visit **health.columbia.edu/content/international-students** for more information. Enrolling in the plan will also automatically initiate enrollment in and payment of the Full-Time Health and Related Service Fee, which is required. Please visit **health.columbia.edu** for more information about Preferred Member Responsibility for Cost-Sharing and the Health and Related Service Fee.

Funded Graduate Students

Please contact your departmental administrator, Financial Aid Office, or Fellowship Office for information about whether your school provides funding to cover any portion of the Columbia University Student Health Insurance Plan premium.

Student-Veterans

Student-veterans may be eligible for health care benefits through the Veterans Administration (VA) for illnesses and injuries related to their service. Columbia Health recommends that Columbia student-veterans confirm their status with the VA and visit the Veterans Affairs website at **sfs.columbia.edu/departments/veterans-service**. All full-time students will be enrolled in the Columbia University Student Health Insurance Plan unless a waiver request is submitted and approved by the published deadline.

Students Studying Abroad

Students expecting to participate in any Study Abroad program are encouraged to consult with an Insurance Specialist at the Columbia University Student Health Insurance Office (Morningside) about the type of insurance coverage the student will rely on while traveling.

Eligibility (Columbia University Irving Medical Center Student Health on Haven)

Full-Time Domestic Students

All registered full-time domestic students at Columbia University Irving Medical Center are enrolled in the Columbia University Student Health Insurance Plan if no valid waiver request is submitted. Enrollment in the Columbia University Student Health Insurance Plan, either by default enrollment or online selection, is effective only upon the student's registration for the term for which coverage will be active. Enrolling in the plan will also automatically initiate enrollment in and payment of the CUIMC Student Health and Related Service Fee, which is required. Please visit **studenthealth.cuimc.columbia.edu** for more information about Preferred Member Responsibility for Cost-Sharing and the Health and Related Service Fee.

Waiver requests must be repeated annually and must demonstrate coverage under another comparable policy. Enrollment in the Columbia University Student Health Insurance Plan, either by default enrollment or online selection, is effective only upon the student's registration for the term for which coverage will be active.

Once the student's insurance coverage decision has been determined for the Fall term, either by online selection, default enrollment, or waiver request, that decision will automatically be continued in the following Spring term as long as the student remains registered at the University. For students who do not register for the Spring 2023 Term, their insurance coverage will terminate on December 31, 2022.

Part-Time Domestic Students

During the open enrollment period, part-time domestic students may choose to enroll in the Columbia University Student Health Insurance Plan. Enrolling in the plan will automatically initiate payment of the full CUIMC Student Health and Related Service Fee, which is required. Please visit **studenthealth.cuimc.columbia.edu** for more information about Preferred Member Responsibility for Cost-Sharing and the Health and Related Service Fee. Part-time students who have been insured under the plan in previous years and wish to enroll again must re-enroll by the published deadline in order to avoid a break in coverage.

International Students

All international students, regardless of the number of registered credits, are required to enroll in the Columbia University Student Health Insurance Plan. Students will be enrolled in the Columbia University Student Health Insurance Plan before the published enrollment deadline. International students are not eligible to waive enrollment in the Columbia University Student Health Insurance Plan, except in very limited circumstances. Please visit **https://www.studenthealth.cuimc.columbia.edu/insurance-and-administration/waiving-coverage** for more information. Enrolling in the plan will also automatically initiate enrollment in and payment of the CUIMC Student Health and Related Service Fee, which is required. Please visit **studenthealth.cuimc.columbia.edu** for more information about Preferred Member Responsibility for Cost-Sharing and the Health and Related Service Fee.

Funded Graduate Students

Please contact your departmental administrator, Financial Aid Office, or Fellowship Office for information about whether your school provides funding to cover any portion of the Columbia University Student Health Insurance Plan premium.

Student-Veterans

Student-veterans may be eligible for health care benefits through the Veterans Administration (VA) for illnesses and injuries related to their service. CUIMC Student Health on Haven recommends that Columbia University student-veterans confirm their status with the VA and, if necessary, complete the VA paperwork needed to receive benefits in the New York City area. All students will be enrolled in the Columbia University Student Health Insurance Plan unless a waiver request is submitted and approved by the waiver request deadline.

Eligibility (Teachers College)

Full-time (9 billable credits or more) and residential domestic students are enrolled in the Columbia University Student Health Insurance Plan or request a waiver from the Columbia University Student Health Insurance Plan before the published deadline. Part-time (5-8 billable credits or more) domestic students enrolled in degree-granting programs may elect enrollment in the Columbia University Student Health Insurance Plan, which also initiates payment of the Health and Related Service Fee.

International Students

All international students, regardless of the number of registered credits, are required to enroll in the Columbia University Student Health Insurance Plan. Students will be enrolled in the Columbia University Student Health Insurance Plan before the published enrollment deadline. International students are not eligible to waive enrollment in the Columbia University Student Health Insurance Plan, except in very limited circumstances. Please visit **tc.columbia.edu/health** for more information.

Eligibility (Jewish Theological Seminary)

Full-time and residential domestic students are enrolled in Columbia University Student Health Insurance Plan if no valid waiver request is submitted by the enrollment/waiver deadlines. Part-time and exempt status domestic students may elect enrollment in the Columbia University Student Health Insurance Plan, which also initiates payment of the Health and Related Service Fee.

International Students

All international students, regardless of the number of registered credits, are required to enroll in the Columbia University Student Health Insurance Plan. Students will be enrolled in the Columbia University Student Health Insurance Plan before the published enrollment deadline. International students are not eligible to waive enrollment in the Columbia University Student Health Insurance Plan, except in very limited circumstances. Please visit **jtsa.edu/health-services** for more information. Enrolling in the plan will also automatically initiate enrollment in and payment of the Health and Related Service Fee, which is required. Please visit **health.columbia.edu** for more information about Preferred Member Responsibility for Cost-Sharing and the Health and Related Service Fee.

Eligibility (Union Theological Seminary)

Full-time and residential domestic students are enrolled in the Columbia University Student Health Insurance Plan. Part- time domestic students may elect enrollment in the Columbia University Student Health Insurance Plan, which also initiates payment of the Health and Related Service Fee.

International Students

All international students, regardless of the number of registered credits, are required to enroll in the Columbia University Student Health Insurance Plan. Students will be enrolled in the Columbia University Student Health Insurance Plan before the published enrollment deadline. International students are not eligible to waive enrollment in the Columbia University Student Health Insurance Plan, except in very limited circumstances. Please visit **utsnyc.edu/life/student-affairs/health/insurance** for more information. Enrolling in the plan will also automatically initiate enrollment in and payment of the Health and Related Service Fee, which is required. Please visit **health.columbia.edu** for more information about Preferred Member Responsibility for Cost-Sharing and the Health and Related Service Fee.

How to Enroll

Morningside Campus

Eligible students will be enrolled in the Columbia University Student Health Insurance Plan unless the completed waiver application has been received and approved by Columbia University by the published enrollment deadline. To confirm enrollment in the Columbia University Student Health Insurance Plan (full-time students) or to request enrollment in the Columbia University Student Health Insurance Plan (part-time students), a student must enter the confirmation or request by indicating their choice through the **Columbia Health Patient Portal.**

International students are not eligible to waive enrollment in the Columbia University Student Health Insurance Plan, except in very limited circumstances.

CUIMC Student Health on Haven Campus

Eligible students will be enrolled in the Columbia University Student Health Insurance Plan unless the student completes a waiver application that has been received and approved by Columbia University by the published enrollment deadline. All students interested in requesting a waiver may do so by indicating their choice through the **CUIMC Student Health Portal**.

International students are not eligible to waive enrollment in the Columbia University Student Health Insurance Plan, except in very limited circumstances.

Teachers College

Eligible students will be enrolled in the Columbia University Student Health Insurance Plan unless the completed waiver application has been received and approved by Columbia University by the published enrollment deadline. To confirm enrollment in the Columbia University Student Health Insurance Plan (full-time students) or to request enrollment in the Columbia University Student Health Insurance Plan (part-time students), a student must enter the confirmation or request by indicating their choice through the **Columbia Health Patient Portal.**

International students are not eligible to waive enrollment in the Columbia University Student Health Insurance Plan, except in very limited circumstances.

Jewish Theological Seminary

Enrollment for JTS students is coordinated by the JTS Office of Human Resources. Please note that student health insurance for Double Degree Barnard College students is administered through Barnard. For questions about Columbia Health and the Columbia Student Health Insurance Plan, refer to the JTS Office of Human Resources' Student Health Insurance website at **jtsa.edu/Campus_Life/Student_Services/Student_Health_Insurance.xml.**

International students are not eligible to waive enrollment in the Columbia University Student Health Insurance Plan, except in very limited circumstances.

Union Theological Seminary

Enrollment is coordinated by the UTS Office of Student Life. For questions about enrollment, please refer to the UTS Office of Student Life. For questions about Columbia Health and the Columbia University Student Health Insurance Plan, please contact the UTS Office of Student Life.

International students are not eligible to waive enrollment in the Columbia University Student Health Insurance Plan, except in very limited circumstances.

Morningside Campus Dependent Coverage

Eligibility

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

Enrollment

To enroll the dependent(s) of a covered student, please complete the downloadable Dependent Enrollment Form via the **Patient Portal** at **https://secure.health.columbia.edu**.

The form, along with supporting documentation, must be uploaded through the **Patient Portal** at **https://secure.health.columbia.edu** for processing before the published deadline.

Dependent enrollment applications will not be accepted after the enrollment deadline unless there is a qualifying life change that directly affects their insurance coverage. An example of a qualifying life change would be loss of health coverage under another health plan.

Please contact the Columbia University Health Insurance Office at **studentinsurance@columbia.edu** or **212-854-3286** for more information or with any questions.

CUIMC Student Health on Haven Dependent Coverage

Eligibility

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

Enrollment

To enroll the dependent(s) of a covered student, please complete the Enrollment Form on the CUIMC Student Health on Haven website. The form, along with supporting documentation, should be submitted, via email to **shsinsurance@cumc.columbia.edu** before the published deadline.

Dependent enrollment applications will not be accepted after the enrollment deadline unless there is a qualifying life change that directly affects their insurance coverage. An example of a qualifying life change would be loss of health coverage under another health plan.

Please contact the CUIMC Student Health on Haven Insurance Office at **shsinsurance@cumc.columbia.edu** or **(212) 305-3400** for more information or with any questions.

Teachers College Dependent Coverage

Eligibility

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

Enrollment

To enroll the dependent(s) of a covered student, please complete the downloadable Dependent Enrollment Form via the **Patient Portal** at **https://secure.health.columbia.edu**.

The form, along with supporting documentation, must be uploaded through the **Patient Portal** at **https://secure.health.columbia.edu** for processing before the published deadline.

Dependent enrollment applications will not be accepted after the enrollment deadline unless there is a qualifying life change that directly affects their insurance coverage. An example of a qualifying life change would be loss of health coverage under another health plan.

Please contact the Columbia University Health Insurance Office at **studentinsurance@columbia.edu** or **212-854-3286** for more information or with any questions.

Jewish Theological Seminary Dependent Coverage

Eligibility

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

Enrollment

To enroll the dependent(s) of a covered student, please complete the Enrollment Form on the JTS website. The form, along with supporting documentation, should be submitted to JTS Office of Human Resources, 3080 Broadway. Please bring both the form and supporting documentation at the same time to ensure timely enrollment.

Dependent enrollment applications will not be accepted after the enrollment deadline unless there is a qualifying life change that directly affects their insurance coverage. An example of a qualifying life change would be loss of health coverage under another health plan.

Please contact the JTS Office of Human Resources at **212-678-8014** or **hrdept@jtsa.edu** for more information or with any questions.

Union Theological Seminary Dependent Coverage

Eligibility

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

Enrollment

To enroll the dependent(s) of a covered student, please complete the Enrollment Form on the UTS website. The form, along with supporting documentation, should be submitted to UTS Office of Student Life, 3041 Broadway, Room 108. Please bring both the form and supporting documentation at the same time to ensure timely enrollment.

Dependent enrollment applications will not be accepted after the enrollment deadline unless there is a qualifying life change that directly affects their insurance coverage. An example of a qualifying life change would be loss of health coverage under another health plan.

Please contact the UTS Office of Student Life at **212-280-1341** for more information or with any questions.

On-Campus Services at Columbia Health/ CUIMC Student Health on Haven

Columbia Health (Morningside/Affiliate students) or CUIMC Student Health on Haven (CUIMC students) are considered your Primary Care provider. You receive the highest level of coverage for the lowest out-of-pocket cost when you receive care through your on-campus services. Columbia Health / CUIMC Student Health on Haven can also refer you to other providers for care.

Preferred Providers

Some Participating Providers are also Preferred Providers. Certain services may be obtained from Preferred Providers. If You receive Covered Services from Preferred Providers, Your Cost-Sharing may be lower than if You received the services from Participating Providers. See the Schedule of Benefits section of this Certificate for coverage of Preferred Provider services.

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.

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 **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 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).

The Role of Primary Care Physicians

This plan does not have a gatekeeper, usually known as a Primary Care Physician ("PCP"). This plan requires that Student Health Services act as a Primary Care Physician ("PCP). You need a Referral from Student Health Services before receiving Specialist care from a Participating Provider.

REFERRAL REQUIREMENT

Columbia Health (for Morningside and Affiliate students and any enrolled spouse/partner) and the CUIMC Student Health on Haven (for CUIMC Student Health on Haven students and any enrolled spouse/partner) are considered your Preferred Primary Care provider. They will either provide the care you need or will give you a referral to another provider. **Any care received outside of Columbia Health or CUIMC Student Health on Haven requires a referral, some exceptions to this rule are listed below. If you do not have a referral, then benefits will be paid at the Non-Participating Provider level even if the provider is a Participating Provider. The Non-Participating Provider deductible may also apply for services received without a referral.**

You do not need a Referral from Columbia Health or CUIMC Student Health on Haven to a Participating Provider for the following services:

- Preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, treatment of acute gynecologic conditions, or for any care related to a pregnancy from a qualified Participating Provider of such services;
- Maternal depression screenings;
- Emergency Services;
- Pre-Hospital Emergency Medical Services and emergency ambulance transportation;
- Elective termination of pregnancy;
- Medical or mental health care received more than 50 miles from Columbia University;
- Continuing treatment for a mental health condition when you were covered by the Columbia plan and a referral was issued in a previous policy year.
- Spouse/Partner do not need referrals for mental health & substance use disorder services
- Dependent children do not need a referral.

NOTE: Follow up visits for the services above may require a referral from Columbia Health or CUIMC Student Health on Haven.

If you fail to obtain a referral from Columbia Health (Medical Services or Counseling and Psychological Services) or CUIMC Student Health on Haven for the services below, benefits will be paid at the Non-Participating Provider level of benefits even if the provider is a Participating Provider.

- Specialists Office Visits;
- Allergy Testing & Treatment – specialist office visit;
- Inpatient Care;
- Surgical;
- Laboratory;
- Radiology;
- Imaging;
- Physical Therapy;
- Chiropractic;
- Mental Health;
- Substance Abuse Treatment.

Access to Providers and Changing Providers. Sometimes Providers in Our Provider directory are not available. You should call the Provider to make sure he or she is a Participating Provider and is accepting new patients.

To see a Provider, call his or her office and tell the Provider that You are an Aetna Student Health PPO Member, and explain the reason for Your visit. Have Your ID card available. The Provider's office may ask You for Your Member ID number. When You go to the Provider's office, bring Your ID card with You.

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

COST-SHARING	**Student Health Services Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**
Medical Deductible			
• Individual	**$0**	**$0**	**$600**
Out-of-Pocket Limit			
• Individual	**$0**	**$3,000**	**$6,000**
• Family	**$0**	**$12,700**	**Unlimited**
			See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how We calculate the Allowed Amount. Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount of the Non-Participating Provider's charge that exceeds Our Allowed Amount.

OFFICE VISITS	**Student Health Services – 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)	Covered in full	**$30** Copayment **with Referral** **30% Coinsurance after deductible without referral**	**30%** Coinsurance after deductible	See benefit for description
NOTE: Columbia Health (for Morningside and Affiliate students and any enrolled spouse/partner) and the CUIMC Student Health on Haven (for CUIMC Student Health on Haven students and any enrolled spouse/partner) are considered your **Preferred Provider for Primary Care** provider. They will either provide the care you need or will give you a referral to another provider.				
Specialist Office Visits (or Home Visits)	Not Applicable	**$30** Copayment **with Referral** **30% Coinsurance after deductible without referral**	**30%** Coinsurance after deductible	
PREVENTIVE CARE	**Student Health Services – 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*	Not Applicable	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	Not Applicable	Covered in full	**30%** Coinsurance after deductible	
Sterilization Procedures for Women *	Not Applicable	Covered in full	**30%** Coinsurance after deductible	

PREVENTIVE CARE (continued)	**Student Health Services – Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Vasectomy	Not Applicable	**10%** Coinsurance	**40%** Coinsurance after deductible	
We do not Cover services related to the reversal of elective sterilizations.				
Bone Density Testing*	Not Applicable	Covered in full	**30%** Coinsurance after deductible	
Screening for Prostate Cancer	Not Applicable	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 USPSTF and HRSA.	Use Cost Sharing for Appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)			
EMERGENCY CARE	**Student Health Services – 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)	Not Applicable	**$100** Copayment then You pay **0%**	**$100** Copayment then You pay **0%** Not subject to Deductible	See benefit for description
Non-Emergency Ambulance Services	Not Applicable	**$100** Copayment then You pay **0%**	**$100** Copayment then You pay **0%** Not subject to 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 (continued)	**Student Health Services – 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.	Not Applicable	**$150** Copayment Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	**$150** Copayment Not subject to Deductible Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	See benefit for description
Urgent Care Center	Covered in full	**$60** Copayment	**30%** Coinsurance after deductible	See benefit for description
PROFESSIONAL SERVICES AND OUTPATIENT CARE	**Student Health Services – Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Acupuncture	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	
Advanced Imaging Services (PET scans, MRI, nuclear medicine, and CAT scans.) **Pre-authorization Required** • Performed in a Specialist Office	Not Applicable	**10%** Coinsurance **with referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	See benefit for description

PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued) Advanced Imaging Services (PET scans, MRI, nuclear medicine, and CAT scans.) **Pre-authorization Required**	**Student Health Services – Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
• Performed in a Freestanding Radiology Facility	Not Applicable	**10%** Coinsurance **with referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	
• Performed as Outpatient Hospital Services	Not Applicable	**10%** Coinsurance **with referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	
Allergy Testing & Treatment • Performed in a PCP Office	**0%** Coinsurance not subject to Deductible	**10%** Coinsurance **with referral** **40%** coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	See benefit for description
• Performed in a Specialist Office	Not Applicable	**10%** Coinsurance **with referral** **40%** coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	
Ambulatory Surgical Center Facility Fee	Not Applicable	**10%** Coinsurance **with referral** **40%** coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	See benefit for description

PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)	**Student Health Services – Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Anesthesia Services (all settings)	Not Applicable	**10%** Coinsurance **with referral** **40%** coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	See benefit for description
Cardiac & Pulmonary Rehabilitation • Performed in a Specialist Office	Not Applicable	**$30** Copayment **with Referral** **30% Coinsurance after deductible without referral**	**30%** Coinsurance after deductible	See benefits for description
• Performed as Outpatient Hospital Services	Not Applicable	**$30** Copayment **with Referral** **30% Coinsurance after deductible without referral**	**30%** Coinsurance after deductible	
• Performed as Inpatient Hospital Services	Not Applicable	Included as Part of Inpatient Hospital Service Cost-Sharing	Included as Part of Inpatient Hospital Service Cost-Sharing	
Chemotherapy and Immunotherapy • Performed in a PCP Office	Not Applicable	**$30** Copayment **with Referral** **30% Coinsurance** after deductible **without referral**	**30%** Coinsurance after deductible	See benefit for description
• Performed in a Specialist Office	Not Applicable	**$30** Copayment **with Referral** **30% Coinsurance after deductible without referral**	**30%** Coinsurance after deductible	

PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)	**Student Health Services – Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Chemotherapy and Immunotherapy				See benefit for description
• Performed as Outpatient Hospital Services	Not Applicable	**$30** Copayment **with Referral** **30% Coinsurance after deductible without referral**	**30%** Coinsurance after deductible	
• Performed at Home	Not Applicable	**$30** Copayment **with Referral** **30% Coinsurance after deductible without referral**	**30%** Coinsurance after deductible	
Chiropractic Services	Not Applicable	**$30** Copayment **with Referral** **30% Coinsurance after deductible without referral**	**30%** Coinsurance after deductible	See benefit for description
Clinical Trials	Not Applicable	Use Cost-Sharing for appropriate service		See benefit for description
We do not Cover: the costs of the investigational drugs or devices; the costs of non-health services required for You to receive the treatment; the costs of managing the research; or costs that would not be covered under this Certificate for non-investigational treatments provided in the clinical trial.				
Diagnostic Testing • Performed in a PCP Office	**0%** Coinsurance not subject to Deductible	**$30** Copayment **with Referral** **30% Coinsurance after deductible without referral**	**30%** Coinsurance after deductible	See benefit for description
• Performed in a Specialist Office	**0%** Coinsurance not subject to Deductible	**$30** Copayment **with Referral** **30% Coinsurance after deductible without referral**	**30%** Coinsurance after deductible	

PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)	**Student Health Services – 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 as Outpatient Hospital Services	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	See benefit for description
Dialysis • Performed in a PCP Office	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	See benefit for description
• Performed in a Specialist Office	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	
• Performed in a Freestanding Center	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	
• Performed as Outpatient Hospital Services	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	

PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)	**Student Health Services – 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) • Performed in a PCP Office	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	See benefit for description
• Performed in a Specialist Office	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	
• Performed in an Outpatient Facility	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	
Home Health Care	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	See benefit for description

PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)	Student Health Services – Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Infertility Services	Not Applicable	Use Cost Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)		See benefit for description

We Cover services for the diagnosis and treatment (surgical and medical) of infertility. "Infertility" is a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six (6) months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female 35 years of age or older. Earlier evaluation and treatment may be warranted based on a Member's medical history or physical findings.

Such Coverage is available as follows:

1. 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.

Basic infertility 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.

(continued on next page)

Infertility Services (continued)

Such Coverage is available as follows:
2. Comprehensive Infertility Services. If the basic infertility services do not result in increased fertility, We Cover comprehensive infertility services.

Comprehensive infertility services include:
- Ovulation induction and monitoring;
- Pelvic ultrasound;
- Artificial insemination;
- Hysteroscopy;
- Laparoscopy; and
- Laparotomy.

3. Advanced Infertility Services. We Cover the following advanced infertility services:
- Three (3) cycles per lifetime of in vitro fertilization;
- Gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
- Costs for an ovum donor or donor sperm;
- Sperm storage costs in connection with in vitro fertilization; and
- Cryopreservation and storage of embryos in connection with in vitro fertilization.

A "cycle" is all treatment that starts when: preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing in vitro fertilization using a fresh embryo transfer, or medications are administered for endometrial preparation with the intent of undergoing in vitro fertilization using a frozen embryo transfer.

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. We will not discriminate based on Your expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions, or based on personal characteristics including age, sex, sexual orientation, marital status or gender identity, when determining coverage under this benefit.

4. Fertility Preservation Services. We Cover standard fertility preservation services when a medical treatment will directly or indirectly lead to iatrogenic infertility. Standard fertility preservation services include the collecting, preserving, and storing of ova and sperm. "Iatrogenic infertility" means an impairment of Your fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.

We do not Cover:
- Ovulation predictor kits;
- Reversal of tubal ligations;
- Reversal of vasectomies;
- Costs for and services relating to surrogate motherhood that are not otherwise Covered Services under this Certificate;
- Cloning; or
- Medical and surgical procedures that are experimental or investigational unless Our denial is overturned by an External Appeal Agent.

PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)	**Student Health Services – 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	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	See benefit for description
• Performed in Specialist Office	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	
• Performed as Outpatient Hospital Services	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	
• Home Infusion Therapy	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	
Inpatient Medical Visits	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral** **Preauthorization Required**	**40%** Coinsurance after deductible **Preauthorization Required**	See benefit for description

PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)	**Student Health Services – Preferred Provider Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Interruption of Pregnancy • Medically Necessary Abortions	Not Applicable	Covered in full	**30%** Coinsurance after deductible	See benefit for description
• Elective Abortions	Not Applicable	Covered in full	**30%** Coinsurance after deductible	
Laboratory Procedures • Performed in a PCP Office	**0%** Coinsurance not subject to Deductible	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	See Benefit for Description
• Performed in a Specialist Office	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	
• Performed in a Freestanding Laboratory Facility	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	
• Performed as Outpatient Hospital Services	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	

PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)	Student Health Services – Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Maternity & Newborn Care • Prenatal Care - Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and 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 USPSTF and HRSA	Not Applicable	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)	One (1) Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
• Inpatient Hospital Services and Birthing Center	Not Applicable	**10%** Coinsurance	**40%** Coinsurance after deductible	
• Physician and Midwife Services for delivery	Not Applicable	**10%** Coinsurance	**40%** Coinsurance after deductible	
• Breastfeeding Support, Counseling and Supplies including Breast Pumps, Nursing Bras	Not Applicable	Covered in Full	**30%** Coinsurance after deductible	Covered for duration of breast feeding
• Postnatal Care	Not Applicable	Covered in Full	**30%** Coinsurance after deductible	
Outpatient Hospital Surgery Facility Charge	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	See benefit for description

PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)	**Student Health Services Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Preadmission Testing	**0%** Coinsurance not subject to Deductible	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities • Performed in a PCP Office	**0%** Coinsurance not subject to Deductible	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	See benefit for description
• Performed in Specialist Office	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	
• Performed in Outpatient Facilities	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	

PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)	Student Health Services Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Diagnostic Radiology Services (diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, ultrasounds)				See benefit for description
• Performed in a PCP Office	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	
• Performed in a Specialist Office	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	
• Performed in a Freestanding Radiology Facility	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	
• Performed as Outpatient Hospital Services	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	

PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)	Student Health Services Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Therapeutic Radiology Services (x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, ultrasounds) • Performed in a Specialist Office	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	See benefit for description
• Performed in a Freestanding Radiology Facility	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	
• Performed as Outpatient Hospital Services	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) • Performed in a PCP Office	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	Unlimited visits per Plan Year
• Performed in a Specialist Office	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	

PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)	**Student Health Services 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 an Outpatient Facility	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	
Second Opinions on the Diagnosis of Cancer, Surgery & Other	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	See benefit for description
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery and Transplants • Inpatient Hospital Surgery **Pre-authorization Required** *(continued on next page)*	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	See benefit for description All transplants must be performed at Designated Facilities

PROFESSIONAL SERVICES AND OUTPATIENT CARE (continued)	Student Health Services 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 (continued) • Outpatient Hospital Surgery	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	
• Surgery Performed at an Ambulatory Surgical Center	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	
• Office Surgery	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**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	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	See benefit for description

ADDITIONAL SERVICES, EQUIPMENT & DEVICES	Student Health Services Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	Not Applicable	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance 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				
Diabetic Equipment, Supplies & Self-Management Education • Diabetic Equipment, Supplies, and Insulin (30-Day Supply)	Not Applicable	**10%** Coinsurance but not more than $100 in Cost-Sharing for a 30-day supply for an insulin drug **with referral** **40%** Coinsurance after deductible but not more than $100 in Cost-Sharing for a 30-day supply for an insulin drug **without referral**	**40%** Coinsurance after deductible but not more than $100 in Cost-Sharing for a 30-day supply for an insulin drug.	See benefit for description
• Diabetic Education ***(refer to next page for limitations)***	Covered in full	**$30** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	

Diabetic Equipment, Supplies & Self-Management Education (continued)
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.

ADDITIONAL SERVICES, EQUIPMENT & DEVICES (continued)	**Student Health Services Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Durable Medical Equipment & Braces	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	See benefit for description
We do not Cover equipment designed for Your comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment), as it does not meet the definition of durable medical equipment. **Braces.** We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You.				
External Hearing Aids	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	Single purchase once every three (3) years
Cochlear Implants	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	One (1) per ear per plan year
Hospice Care • Inpatient **Preauthorization Required**	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	Unlimited days per Plan Year
• Outpatient	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	Five (5) visits for family bereavement counseling
We do not Cover: funeral arrangements; pastoral, financial, or legal counseling; or homemaker, caretaker, or respite care.				

ADDITIONAL SERVICES, EQUIPMENT & DEVICES (continued)	Student Health Services Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Medical Supplies	Covered in full	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	See benefit for description
We do not Cover over-the-counter medical supplies.				
Prosthetic Devices • External	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	See benefit for description
• Internal	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	
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	Student Health Services Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Autologous Blood Banking	Not Applicable	**10%** Coinsurance **With Referral** **40%** Coinsurance after deductible **without referral**	**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.	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	See benefit for description

INPATIENT SERVICES & FACILITIES (continued)	Student Health Services Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Observation Stay	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	See benefit for description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) **Preauthorization Required**	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	See benefit for description
Inpatient Habilitation Services (Physical Speech and Occupational Therapy) **Preauthorization Required**	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	See benefit for description
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) **Preauthorization Required**	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	See benefit for description

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES	Student Health Center 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.	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	See benefit for description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services) • Office Visits	Covered in full	**$20** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	See benefit for description
• All Other Outpatient Services	Covered in full	Covered in full **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	

MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES (continued)	**Student Health Center 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	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	See benefit for description
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)				Unlimited visits a plan year may be used for family counseling
• Office Visits	Covered in full	**$20** Copayment **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	
• All Other Outpatient Services **Preauthorization Required** However, Preauthorization is not required for Participating OASAS-certified Facilities.	Covered in full	Covered in full **with Referral** **30%** Coinsurance after deductible **without referral**	**30%** Coinsurance after deductible	

Gender affirming treatment	Student Health Services Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Medically necessary surgical, hormone replacement therapy, and counseling treatment Visit **https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html** for detailed information about this benefit, including eligibility and medical necessity requirements. You can also call the toll-free number on your ID card.	Not Applicable	Use Cost Sharing for Appropriate service	Use Cost Sharing for Appropriate service	None
Gender affirming treatment - Cosmetic Services	**Student Health Services Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
In addition to the medically necessary services related to gender affirming treatment covered under your certificate of coverage, we also Cover the following additional services in connection with gender dysphoria.				
Tracheal shave **Preauthorization Required**	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	None
Nipple reconstruction **Preauthorization Required**	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	None

Gender affirming treatment (continued)	**Student Health Services Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Electrolysis **Preauthorization Required**	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	$2,400 per Plan Year
Voice and Communication Therapy and voice lessons **Preauthorization Required**	Not Applicable	**$30 Copayment** With Referral **30%** Coinsurance after deductible without referral	**30%** Coinsurance after deductible	None
Chest Binder **Preauthorization Required**	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	$200 per Plan Year
Blepharoplasty (surgery of the eyelid and eye region) and brow lift **Preauthorization Required**	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	
Cheek implants Chin implants Facial bone reduction or augmentation Forehead lift Lip enhancement or reduction **Preauthorization Required**	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	

Gender affirming treatment (continued)	**Student Health Services Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Hair transplantation **Preauthorization Required**	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	
Rhinoplasty or nose implants **Preauthorization Required**	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	
Rhytidectomy (face lift, facial liposuction, neck tightening) **Preauthorization Required**	Not Applicable	**10%** Coinsurance **with Referral** **40%** Coinsurance after deductible **without referral**	**40%** Coinsurance after deductible	

PRESCRIPTION DRUGS	Student Health Services Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
*****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.				
Note: If You have an Emergency Condition, Preauthorization is not required for a five (5) day emergency supply of a Covered Prescription Drug used to treat a substance sue disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.				
Retail Pharmacy				
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.				
30-day supply Tier 1 (generic)	Not Applicable	**$15** Copayment	Coinsurance per supply of **30%** Not Subject to Deductible	See benefit for description
Tier 2 (formulary brand)	Not Applicable	**$50** Copayment	Coinsurance per supply of **30%** Not Subject to Deductible	
Tier 3 (non-formulary brand) 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. *(continued on next page, including **limitations/terms of coverage**)*	Not Applicable	**$75** Copayment	Coinsurance per supply of **30%** Not Subject to Deductible	

PRESCRIPTION DRUGS (continued)	Student Health Services 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)	Not Applicable	Coinsurance per supply of **10%**	Coinsurance is **40%** per supply after deductible	
Tier 2 (formulary brand)	Not Applicable	Coinsurance per supply of **10%**	Coinsurance is **40%** per supply after deductible	
Tier 3 (non-formulary brand)	Not Applicable	Coinsurance per supply of **10%**	Coinsurance is **40%** per supply after deductible	

Limitations/Terms of Coverage.

1. We reserve the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.

2. If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies and prescribing Providers may be limited. If this happens, We may require You to select a single Participating Pharmacy and a single Provider that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. Benefits will be paid only if Your Prescription Order or Refills are written by the selected Provider or a Provider authorized by Your selected provider. If You do not make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy and/or prescribing Provider for You.

3. Compounded Prescription Drugs will be Covered only when they contain at least one (1) ingredient that is a Covered legend Prescription Drug, they are not essentially the same as a Prescription Drug from a manufacturer and are obtained from a pharmacy that is approved for compounding.

4. Various specific and/or generalized "use management" protocols will be used from time to time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our Members with a quality-focused Prescription Drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.

5. Injectable drugs (other than self-administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies and equipment are not Covered under this section but are Covered under other sections of this Certificate.

6. We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician's office are Covered under the Outpatient and Professional Services section of this Certificate.

(continued on next page)

Prescription Drugs - Limitations/Terms of Coverage (continued)

7. We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs, over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an "A" or "B" rating from USPSTF, or as otherwise provided in this Certificate. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as Covered in the drug Formulary. Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts. We do not Cover repackaged products such as therapeutic kits or convenience packs that contain a Covered Prescription Drug unless the Prescription Drug is only available as part of a therapeutic kit or convenience pack. Therapeutic kits or convenience packs contain one or more Prescription Drug(s) and may be packaged with over-the-counter items, such as glove, finger cots, hygienic wipes or topical emollients.

8. We do not Cover Prescription Drugs to replace those that may have been lost or stolen.

9. We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.

10. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in the Utilization Review and External Appeal sections of this Certificate.

A pharmacy need not dispense a Prescription Order that, in the pharmacist's professional judgment, should not be filled.

WELLNESS BENEFITS	**Student Health Services Member Responsibility for Cost-Sharing**	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limits**
Exercise Facility Reimbursement	Not Applicable	Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for Spouse		

Reimbursement is limited to actual workout visits. We do not reimburse:
- Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities;
- Lifetime memberships;
- Equipment, clothing, vitamins or other services that may be offered by the facility (e.g., massages, etc.); or
- Services that are amenities, such as a gym, that are included in Your rent or homeowners association fees.

In order to be eligible for reimbursement, You must:
- Be an active member of the exercise facility, and
- Complete 50 visits in a six (6)-month period.

PEDIATRIC DENTAL & VISION CARE	Student Health Services Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pediatric Dental Care • Preventive	Not Applicable	**0%** Coinsurance	**30%** Coinsurance after deductible	One (1) dental exam & cleaning per six (6)-month period. Full mouth x-rays or panoramic x-rays at thirty-six (36) month intervals and bitewing x-rays at six (6) month intervals
• Routine Dental Care	Not Applicable	**0%** Coinsurance	**30%** Coinsurance after deductible	
• Major Dental Care (Oral Surgery, Endodontics, Periodontics & Prosthodontics) • Orthodontics	Not Applicable Not Applicable	**30%** Coinsurance **50%** Coinsurance	**50%** Coinsurance after deductible **50%** Coinsurance after deductible	
Pediatric Vision Care • Exams	Not Applicable	**0%** Coinsurance	**30%** Coinsurance Not subject to Deductible	One (1) exam per twelve (12)-month period
• Lenses & Frames	Not Applicable	**0%** Coinsurance	**30%** Coinsurance Not subject to Deductible	One (1) prescribed lenses & frames per twelve (12)-month period
• Contact Lenses	Not Applicable	**0%** Coinsurance	**30%** Coinsurance Not subject to Deductible	

Eligibility: Students enrolled in one of the school's clinical programs and insured under this Student Health Plan. This rider is provided to the individual student only. Family members of the student are not eligible. Employees of the school are not eligible.

Blood Borne Pathogen Exposure Benefit We pay 100% of covered benefits up to the first $10,000 of covered expenses for blood borne pathogen exposure without any Member responsibility for cost-sharing. After we have paid the first $10,000 of covered expenses for blood borne pathogen exposure, Your cost-sharing is the same as for other services under the plan.			
	Student Health Services Member Responsibility for Cost-Sharing	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**
Before the plan has paid $10,000 of covered expenses for blood borne pathogen exposure	Copayment: $0 Coinsurance: 0%	Copayment: $0 Coinsurance: 0%	Deductible: not subject to deductible Copayment: $0 Coinsurance: $0%
After the plan has paid $10,000 in covered expenses for blood borne pathogen exposure	Copayment: Per Your Schedule of Benefits Coinsurance: Per Your Schedule of Benefits	Copayment: Per Your Schedule of Benefits Coinsurance: Per Your Schedule of Benefits	Deductible: Per Your Schedule of Benefits Copayment: Per Your Schedule of Benefits Coinsurance: Per Your Schedule of Benefits

Preauthorization for coverage provided under this rider is not required.

All other terms and conditions of the student policy, booklet-certificate and schedule of benefits apply.

OTHER COVERED SERVICES	Student Health Services Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing
Emergency Medical Evacuation	0% of actual cost, not subject to Deductible		
Medical Repatriation	0% of actual cost, not subject to Deductible		
Transportation to Join a Hospitalized Member	0% of actual cost, not subject to Deductible		
Return of Minor Children	0% of actual cost, not subject to Deductible		
Repatriation of Mortal Remains	0% 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

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.

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.

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.

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 Columbia University Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health[SM] 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 1-800-859-8471.

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 1-800-859-8471.

If you have questions about our nondiscrimination policy or have a discrimination-related concern that you would like to discuss, please call us at 1-800-859-8471.

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 **1-800-859-8471** (TTY: **711**).

Español/Spanish

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-859-8471** (TTY: **711**).

አማርኛ/Amharic

ልብ ይበሉ: አማርኛ ቋንቋ የሚናገሩ ከሆነ፥ የትርጉም ድጋፍ ሰጪ ድርጅቶች፣ ያለምንም ክፍያ እርስዎን ለማገልገል ተዘጋጅተዋል። የሚከተለው ቁጥር ላይ ይደውሉ **1-800-859-8471** (መስማት ለተሳናቸው: **711**).

العربية/Arabic

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-800-859-8471** (رقم الهاتف النصي: **711**).

Ɓàsɔ̀ɔ̀ Wùɖù/Bassa

Dè dɛ nìà kɛ dyɛ́ɖɛ́ gbo: Ɔ jǔ kɛ́ m̀ dyi Ɓàsɔ́ɔ̀-wùɖù-po-nyɔ̀ jǔ nɨ́, nɨ̀ì à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ m̀ gbo kpáa. Ɖá **1-800-859-8471** (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 **1-800-859-8471** (TTY: **711**)。

فارسی/Farsi

توجه: اگر به زبان فارسی صحبت می کنید، خدمات زبانی رایگان به شما ارایه میگردد، با شماره **1-800-859-8471** (TTY: **711**) تماس بگیرید.

Français/French

Attention : Si vous parlez français, vous pouvez disposer d’une assistance gratuite dans votre langue en composant le **1-800-859-8471** (TTY: **711**).

ગુજરાતી/Gujarati

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો ભાષાકીય સહાયતા સેવા તમને નિ:શુલ્ક ઉપલબ્ધ છે. કૉલ કરો **1-800-859-8471** (TTY: **711**).

Kreyòl Ayisyen/Haitian Creole

Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-800-859-8471** (TTY: **711**).

Igbo

Nrụbama: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n’efu, dịịrị gị. Kpọọ **1-800-859-8471** (TTY: **711**).

한국어/Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스가 무료로 제공됩니다. **1-800-859-8471** (TTY: **711**)번으로 전화해 주십시오.

Português/Portuguese

Atenção: a ajuda está disponível em português por meio do número **1-800-859-8471** (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 **1-800-859-8471** (TTY: **711**).

Tagalog

Paunawa: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-859-8471** (TTY: **711**).

اردو/Urdu

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت دستیاب ہیں ۔ (TTY: **711**) **1-800-859-8471** 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 **1-800-859-8471** (TTY: **711**).

Yorùbá/Yoruba

Àkíyèsí: Bí o bá nsọ èdè Yorùbá, ìrànlọ́wọ́ lórí èdè, lófẹ̀ẹ́, wà fún ọ. Pe **1-800-859-8471** (TTY: **711**).

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

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2022/2023 Plan Design & Benefits Summary Update

The following changes have been made to the original plan design and benefits summary describing your plan.
Unless otherwise indicated, all changes listed below are retroactive to your plan's effective date.

Issue Date of this Update: 3/21/2023
State: New York

1. Revising the "Referral Requirement" section as follows:

REFERRAL REQUIREMENT

Columbia Health (for Morningside and Affiliate students and any enrolled spouse/partner) and the CUIMC Student Health on Haven (for CUIMC Student Health on Haven students and any enrolled spouse/partner) are considered your Preferred Primary Care provider. They will either provide the care you need or will give you a referral to another provider. **Any care received outside of Columbia Health or CUIMC Student Health on Haven requires a referral, some exceptions to this rule are listed below. If you do not have a referral, then benefits will be paid at the Non-Participating Provider level even if the provider is a Participating Provider. The Non-Participating Provider deductible may also apply for services received without a referral.**

You do not need a Referral from Columbia Health or CUIMC Student Health on Haven to a Participating Provider for the following services:

- Preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, treatment of acute gynecologic conditions, or for any care related to a pregnancy from a qualified Participating Provider of such services;
- Maternal depression screenings;
- Emergency Services;
- Pre-Hospital Emergency Medical Services and emergency ambulance transportation;
- Elective termination of pregnancy;
- Medical or mental health care received more than 50 miles from Columbia University;
- Continuing treatment for a mental health condition when you were covered by the Columbia plan and a referral was issued in a previous policy year.
- Spouse/Partner do not need referrals for mental health & substance use disorder services
- Dependent children do not need a referral.

NOTE: Follow up visits for the services above may require a referral from Columbia Health or CUIMC Student Health on Haven.

If you fail to obtain a referral from Columbia Health (Medical Services or Counseling and Psychological Services) or CUIMC Student Health on Haven for the services below, benefits

will be paid at the Non-Participating Provider level of benefits even if the provider is a Participating Provider.

- Specialists Office Visits;
- Allergy Testing & Treatment – specialist office visit;
- Inpatient Care;
- Surgical;
- Laboratory;
- Radiology;
- Imaging;
- Physical Therapy;
- Chiropractic;
- Mental Health;
- Substance Abuse Treatment.

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 the number on your ID card.

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).

TTY: 711

For language assistance in your language call the number listed on your ID card at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación. (Spanish)

欲取得繁體中文語言協助，請撥打您 ID 卡上所列的號碼，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an. (German)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني المذكور في بطاقتك التعريفية. (Arabic)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo a yo endike nan kat idantifikasyon ou gratis. (French Creole)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente il numero riportato sulla Sua scheda identificativa. (Italian)

日本語で援助をご希望の方は、IDカードに記載されている番号まで無料でお電話ください。(Japanese)

한국어로 언어 지원을 받고 싶으시면 보험 ID 카드에 수록된 무료 통화번호로 전화해 주십시오. (Korean)

برای راهنمایی به زبان فارسی، بدون هیچ هزینه ای با شماره ای که بر روی کارت شناسایی شما آمده است تماس بگیرید. (Persian) انگلیسی

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer podany na karcie ID. (Polish)

Para obter assistência linguística em português ligue para o número grátis listado no seu cartão de identificação. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру, указанному в вашей ID-карте удостоверения личности. (Russian)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số được ghi trên thẻ ID của quý vị. (Vietnamese)