Aetna Life Insurance Company

Student Health Insurance Policy

The student health insurance policy ("**student policy**") is by and between

Aetna Life Insurance Company
(**Aetna®**, we, us, or our)

and

Yeshiva University
(**Policyholder**, you, or your)

Student policy number:	186137
Date of issue:	09/19/24
Effective date:	08/15/24
Student policy delivered in:	New York

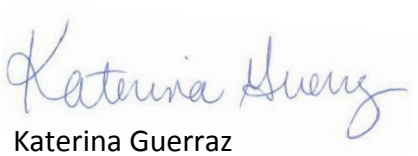
This **student policy** takes effect on the **effective date** if we have received your signed application and the initial **premium**.

Term of the student policy:	The initial term shall be the 12 consecutive month period beginning on the **effective date**. Subsequent terms shall be the 12 consecutive month period beginning with the **renewal date**.
Premium due dates:	Premium is due on the **premium due date** immediately following the date we invoice you.

Signed at **Aetna's®** Home Office, 151 Farmington Avenue Hartford, Connecticut 06156.

This **student policy** is non-participating.

This **student policy** is governed by applicable federal law and the laws of the State of New York.



Katerina Guerraz
Executive Vice President, Chief Operating Officer
Aetna Life Insurance Company
(A Stock Company)

New York Student Health Plan
This is Your

PREFERRED PROVIDER ORGANIZATION
CERTIFICATE OF COVERAGE

Issued by

Aetna Life Insurance Company

This Certificate of Coverage ("Certificate") explains the benefits available to You under a Policy between Aetna Life Insurance Company (hereinafter referred to as "We", "Us" or "Our") and the Policyholder. This Certificate is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

You have the right to return this Certificate. Examine it carefully. If You are not satisfied, You may return this Certificate to Us and ask Us to cancel it. Your request must be made in writing within ten (10) days from the date You receive this Certificate. We will refund any Premium paid including any Certificate fees or other charges.

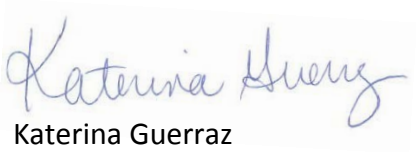
This Certificate offers You the option to receive Covered Services on two benefit levels:

1. **In-Network Benefits.** In-network benefits are the highest level of coverage available. In-network benefits apply when Your care is provided by Participating Providers in Our Network and Participating Pharmacies in Our Network. You should always consider receiving health care services first through the in-network benefits portion of this Certificate.

2. **Out-of-Network Benefits.** The out-of-network benefits portion of this Certificate provides coverage when You receive Covered Services from Non-Participating Providers. Your out-of-pocket expenses will be higher when You receive out-of-network benefits. In addition to Cost-Sharing, You will also be responsible for paying any difference between the Allowed Amount and the Non-Participating Provider's charge .

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE POLICY. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

This Certificate is governed by the laws of New York State.



Katerina Guerraz
Executive Vice President, Chief Operating Officer

If You need foreign language assistance to understand this Certificate, You may call Us at the number on Your ID card.

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SECTION I

Definitions

Defined terms will appear capitalized throughout this Certificate.

Acute: The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how the Allowed Amount is calculated. If your Non-Participating Provider charges more than the Allowed Amount, You will have to pay the difference between the Allowed Amount and the Provider's charge, in addition to any Cost-Sharing requirements.

Ambulatory Surgical Center: A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

Balance Billing: When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Certificate: This Certificate issued by Aetna Life Insurance Company, including the Schedule of Benefits and any attached riders.

Child, Children: The Student's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the Who is Covered section of this Certificate.

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged, or authorized for You by Us under the terms and conditions of this Certificate.

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

Dependents: The Student's Spouse and Children.

Durable Medical Equipment ("DME"): Durable Medical Equipment is equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Emergency Condition: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Emergency Department Care: Emergency Services You get in a Hospital emergency department.

Emergency Services: A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

Exclusions: Health care services that We do not pay for or Cover.

External Appeal Agent: An entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

Facility: A Hospital; Ambulatory Surgical Center; birthing center; dialysis center; rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under New York Public Health Law Article 36; a comprehensive care center for eating disorders pursuant to New York Mental Hygiene Law Article 30; and a Facility defined in New York Mental Hygiene Law Section 1.03, certified by the New York State Office of Addiction Services and Supports, or certified under New York Health Law Article 28 (or, in other states, a similarly licensed or certified Facility). If You receive treatment for substance use disorder outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program.

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitation Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Certificate.

Home Health Agency: An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

Hospice Care: Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to New York Public Health Law Article 40 or under a similar certification process required by the state in which the hospice organization is located.

Hospital: A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;
- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitory care.
- Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a Hospital that usually doesn't require an overnight stay.

In-Network Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the Covered Service that You are required to pay to a Participating Provider. The amount can vary by the type of Covered Service.

In-Network Copayment: A fixed amount You pay directly to a Participating Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

In-Network Cost-Sharing: Amounts You must pay to a Participating Provider for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

In-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Participating Providers. The In-Network Deductible applies before any Copayments or Coinsurance are applied. The In-Network Deductible may not apply to all Covered Services. You may also have an In-Network Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

In-Network Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services received from Participating Providers. This limit never includes Your Premium or services We do not Cover.

Medically Necessary: See the How Your Coverage Works section of this Certificate for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Student or a covered Dependent for whom required Premiums have been paid. Whenever a Member is required to provide a notice pursuant to a Grievance or emergency department visit or admission, "Member" also means the Member's designee.

Network: The Providers We have contracted with to provide health care services to You.

Non-Participating Provider: A Provider who doesn't have a contract with Us to provide services to You. You will pay more to see a Non-Participating Provider.

Out-of-Network Coinsurance: Your share of the costs of a Covered Service calculated as a percent of the Allowed Amount for the service that You are required to pay to a Non-Participating Provider. The amount can vary by the type of Covered Service.

Out-of-Network Copayment: A fixed amount You pay directly to a Non-Participating Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Out-of-Network Cost-Sharing: Amounts You must pay to a Non-Participating Provider for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Out-of-Network Deductible: The amount You owe before We begin to pay for Covered Services received from Non-Participating Providers. The Out-of-Network Deductible applies before any Copayments or Coinsurance are applied. The Out-of-Network Deductible may not apply to all Covered Services. You may also have an Out-of-Network Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

Out-of-Network Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services received from Non-Participating Providers. This limit never includes Your Premium, Balance Billing charges or services We do not Cover. You are also responsible for all differences, if any, between the Allowed Amount and the Non-Participating Provider's charge for out-of-network services regardless of whether the Out-of-Pocket Limit has been met.

Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of health care services We do not Cover.

Participating Provider: A Provider who has a contract with Us to provide health care services to You. A list of Participating Providers and their locations is available on Our website at https://www.aetnastudenthealth.com/ or upon Your request to Us. The list will be revised from time to time by Us.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan Year: The 12-month period beginning on the effective date of the Policy or any anniversary date thereafter, during which the Certificate is in effect.

Policy: The Policy issued by Aetna Life Insurance Company to the Policyholder

Policyholder: The institution of higher education that has entered in to an agreement with Us.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, procedure, treatment plan, device or Prescription Drug is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of this Certificate.

Premium: The amount that must be paid for Your health insurance coverage.

Prescription Drugs: A medication, product or device that has been approved by the Food and Drug Administration ("FDA") and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Primary Care Physician ("PCP"): A participating Physician who typically is an internal medicine, family practice or pediatric Physician and who directly provides or coordinates a range of health care services for You.

Provider: A Physician, Health Care Professional or Facility licensed, registered, certified or accredited as required by state law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, durable medical equipment, medical supplies, or any other equipment or supplies that are Covered under this Certificate that is licensed, registered, certified or accredited as required by state law.

Referral: An authorization given to one Participating Provider from Student Health Services in order to arrange for additional care for a Member.

Rehabilitation Services: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

Schedule of Benefits: The section of this Certificate that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, Preauthorization requirements, and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York, in which We provide coverage. Our Service Area consists of: all the counties in the state of New York.

Skilled Nursing Facility: An institution or a distinct part of an institution that is: currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by Us to meet the standards of any of these authorities.

Specialist: A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse: The person to whom the Student is legally married, including a same sex Spouse. Spouse also includes a domestic partner.

Student: The person to whom this Certificate is issued.

Student Health Services: Any organization, facility, or clinic, operated, maintained, or supported by the school which provides health care services to a Student and adult Dependents and has received accreditation by either the Accreditation Association of Ambulatory Health Care (AAAHC) or the Joint Commission for the ambulatory health care provided within their student health services.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Urgent Care: Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a Physician's office or Urgent Care Center.

Urgent Care Center: A licensed Facility (other than a Hospital) that provides Urgent Care.

Us, We, Our: Aetna Life Insurance Company and anyone to whom We legally delegate performance, on Our behalf, under this Certificate.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (i.e., treatment for a rare disease or a clinical trial).

You, Your: The Member.

SECTION II

How Your Coverage Works

A. Your Coverage Under this Certificate.

Your School (referred to as the "Policyholder") has purchased a Policy from Us. We will provide the benefits described in this Certificate to covered Members of Yeshiva University, that is, to a Student and his or her Covered Dependents. However, this Certificate is not a contract between You and Us. You should keep this Certificate with Your other important papers so that it is available for Your future reference.

B. Covered Services.

You will receive Covered Services under the terms and conditions of this Certificate only when the Covered Service is:

- Medically Necessary;
- Provided by a Participating Provider for in-network coverage;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Certificate; and
- Received while Your Certificate is in force.

C. Participating Providers.

To find out if a Provider is a Participating Provider:

- Check Our Provider directory, available at Your request;
- Call the number on Your ID card; or
- Visit Our website at https://www.aetnastudenthealth.com/.

The Provider directory will give You the following information about Our Participating Providers:

- Name, address, and telephone number;
- Specialty;
- Board certification (if applicable);
- Languages spoken; and
- Whether the Participating Provider is accepting new patients.

You are only responsible for any In-Network Cost-Sharing that would apply to the Covered Services if You receive Covered Services from a Provider who is not a Participating Provider in the following situations:

- The Provider is listed as a Participating Provider in Our online Provider directory;
- Our paper Provider directory listing the Provider as a Participating Provider is incorrect as of the date of publication;
- We give You written notice that the Provider is a Participating Provider in response to Your telephone request for network status information about the Provider; or
- We do not provide You with a written notice within one business day of Your telephone request for network status information.

In these situations, if a Provider bills You for more than Your In-Network Cost-Sharing and You pay the bill, You are entitled to a refund from the Provider, plus interest.

D. The Role of Primary Care Physicians.

This Certificate does not have a gatekeeper, usually known as a Primary Care Physician ("PCP").

E. 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 a Yeshiva University 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.

To contact Your Provider after normal business hours, call the Provider's office. You will be directed to Your provider, an answering machine with directions on how to obtain services, or another Provider. If You have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911.

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.

F. Out-of-Network Services.

We Cover the services of Non-Participating Providers. However, some services are only Covered when You go to a Participating Provider. See the Schedule of Benefits section of this Certificate for the Non-Participating Provider services that are Covered. In any case where benefits are limited to a certain number of days or visits, such limits apply in the aggregate to in-network and out-of-network services.

G. Services Subject to Preauthorization.

Our Preauthorization is required before You receive certain Covered Services. Student Health Services is responsible for requesting Preauthorization for in-network services and You are responsible for requesting Preauthorization for the out-of-network services listed in the Schedule of Benefits section of this Certificate.

H. Preauthorization Procedure.

If You seek coverage for out-of-network services that require Preauthorization, You must call Us at the number on Your ID card.

You must contact Us 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. If that is not possible, then as soon as reasonably possible during regular business hours prior to the surgery or procedure.

- 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.

After receiving a request for approval, We will review the reasons for Your planned treatment and determine if benefits are available. Criteria will be based on multiple sources which may include medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

I. Failure to Seek Preauthorization.

We will pay the amount specified above only if We determine the care was Medically Necessary even though You did not seek Our Preauthorization. If We determine that the services were not Medically Necessary, You will be responsible for paying the entire charge for the service.

J. Medical Management.

The benefits available to You under this Certificate are subject to pre-service, concurrent and retrospective reviews to determine when services should be covered by Us. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

K. Medical Necessity.

We Cover benefits described in this Certificate as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered, recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:

- Your medical records;
- Our medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care, or treatment;
- The opinion of Health Care Professionals in the generally recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis.

See the Utilization Review and External Appeal sections of this Certificate for Your right to an internal Appeal and external appeal of Our determination that a service is not Medically Necessary.

L. Protection from Surprise Bills.

1. **Surprise Bills.** A surprise bill is a bill You receive for Covered Services in the following circumstances:
   - For services performed by a non-participating Provider at a participating Hospital or Ambulatory Surgical Center, when:
     - A participating Provider is unavailable at the time the health care services are performed;
     - A non-participating Provider performs services without Your knowledge; or
     - Unforeseen medical issues or services arise at the time the health care services are performed.

   A surprise bill does not include a bill for health care services when a participating Provider is available and You elected to receive services from a non-participating Provider.

   - You were referred by a participating Physician to a Non-Participating Provider without Your explicit written consent acknowledging that the referral is to a Non-Participating Provider and it may result in costs not covered by Us. For a surprise bill, a referral to a Non-Participating Provider means:
     - Covered Services are performed by a Non-Participating Provider in the participating Physician's office or practice during the same visit;
     - The participating Physician sends a specimen taken from You in the participating Physician's office to a non-participating laboratory or pathologist; or
     - For any other Covered Services performed by a Non-Participating Provider at the participating Physician's request, when Referrals are required under Your Certificate.

   You will be held harmless for any Non-Participating Provider charges for the surprise bill that exceed Your In-Network Cost-Sharing. The Non-Participating Provider may only bill You for Your In-Network Cost-Sharing. You can sign a form to notify Us and the Non-Participating Provider that You received a surprise bill.

   The form for surprise bills is available at www.dfs.ny.gov or You can visit Our website at https://www.aetnastudenthealth.com/ for a copy of the form. You need to mail a copy of the form to Us at the address on Your ID card; for Surprise Bill Certification of Benefits form in the Important Telephone Numbers and Addresses paragraph below and to Your Provider.

2. **Independent Dispute Resolution Process.** Either We or a Provider may submit a dispute involving a surprise bill to an independent dispute resolution entity (IDRE) assigned by the state. The IDRE will determine whether Our payment or Provider's charge is reasonable within 30 days of receiving the dispute.

M. Delivery of Covered Services Using Telehealth.

If Your Participating Provider offers Covered Services using telehealth, We will not deny the Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Certificate that are at least as favorable as those requirements for the same service when not delivered using telehealth. "Telehealth" means the use of electronic information and communication technologies, including telephone or video using smart phones or other devices, by a Participating Provider to deliver Covered Services to You while Your location is different than Your Provider's location.

N. Case Management.

Case management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the case management program to help meet their health-related needs.

Our case management programs are confidential and voluntary. These programs are given at no extra cost to You and do not change Covered Services. If You meet program criteria and agree to take part, We will help You meet Your identified health care needs. This is reached through contact and team work with You and/or Your authorized representative, treating Physician(s), and other Providers. In addition, We may assist in coordinating care with existing community-based programs and services to meet Your needs, which may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care through Our case management program that is not listed as a Covered Service. We may also extend Covered Services beyond the benefit maximums of this Certificate. We will make Our decision on a case-by-case basis if We determine the alternate or extended benefit is in the best interest of You and Us.

Nothing in this provision shall prevent You from appealing Our decision. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to You or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate care. In such case, We will notify You or Your representative in writing.

O. Important Telephone Numbers and Addresses.

- CLAIMS
  Refer to the address on Your ID card

- COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
  Call the number on Your ID card

  Mail
  Aetna Customer Resolution Team
  P.O. Box 14462
  Lexington, KY 40512

- SURPRISE BILL CERTIFICATION Form
  Refer to the address on Your ID card
  (Submit surprise bill certification forms to this address.)

- MEMBER SERVICES
  Call the number on Your ID card
  (Member Services Representatives are available Monday - Friday, 8:00 a.m. – 5:00 p.m.)

- PREAUTHORIZATION
  Call the number on Your ID card

- BEHAVIORAL HEALTH SERVICES
  Call the number on Your ID card

- OUR WEBSITES
  www.aetna.com
  https://www.aetnastudenthealth.com/

  Aetna Provider Directory
  www.docfind.com

- Aetna Specialty Rx
  https://www.aetna.com/individuals-families/find-a-medication.html

SECTION III

Access to Care and Transitional Care

A. Referral to a Non-Participating Provider.

If We determine that We do not have a Participating Provider that has the appropriate training and experience to treat Your condition, We will approve a Referral to an appropriate Non-Participating Provider. Your Participating Provider or You must request prior approval of the Referral to a specific Non-Participating Provider. Approvals of Referrals to Non-Participating Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Non-Participating Provider You requested. If We approve the Referral, all services performed by the Non-Participating Provider are subject to a treatment plan approved by Us in consultation with Student Health Services, the Non-Participating Provider and You. Covered Services rendered by the Non-Participating Provider will be covered as if they were provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing. In the event a Referral is not approved, any services rendered by a Non-Participating Provider will be Covered as an out-of-network benefit if available.

B. When Your Provider Leaves the Network.

If You are in an ongoing course of treatment when Your Provider leaves Our network, then You may to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant, You may continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

The Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of Our relationship with the Provider. The Provider must also provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable In-Network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

C. New Members In a Course of Treatment.

If You are in an ongoing course of treatment with a Non-Participating Provider when Your coverage under this Certificate becomes effective, You may be able to receive Covered Services for the ongoing treatment from the Non-Participating Provider for up to 60 days from the effective date of Your coverage under this Certificate. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a Non-Participating Provider if You are in the second or third trimester of a pregnancy when Your coverage under this Certificate becomes effective. You may continue care through delivery and any post-partum services directly related to the delivery.

In order for You to continue to receive Covered Services for up to 60 days or through pregnancy, the Non-Participating Provider must agree to accept as payment Our fees for such services. The Provider must also agree to provide Us necessary medical information related to Your care and to adhere to Our policies and procedures including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

SECTION IV

Cost-Sharing Expenses and Allowed Amount

A. Deductible.

Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Certificate for Covered in-network and out-of-network Services during each Plan Year before We provide coverage. If You have other than individual coverage, the individual Deductible applies to each person covered under this Certificate.

You have a separate In-Network and Out-of-Network Deductible. Amounts You pay for out-of-network services do not apply toward Your In-Network Deductible. Copayments and Coinsurance for in-network services do not apply toward Your Out-of-Network Deductible. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Deductible.**

Prescription Drug Deductible.

Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Certificate for Covered Prescription Drugs during each Plan Year before We provide coverage. Copayments and Coinsurance for out-of-network services do not apply toward Your In-Network Deductible. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward the Prescription Drug Deductible.**

B. Copayments.

Except where stated otherwise, after You have satisfied the Deductible as described above, You must pay the Copayments, or fixed amounts, in the Schedule of Benefits section of this Certificate for Covered in-network and out-of-network Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

C. Coinsurance.

Except where stated otherwise, after You have satisfied the Deductible as described above, You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your in-network or out-of-network benefit as shown in the Schedule of Benefits section of this Certificate. **You must also pay any charges of a Non-Participating Provider that are in excess of the Allowed Amount.**

D. In-Network Out-of-Pocket Limit.

When You have met Your In-Network Out-of-Pocket Limit in payment of In-Network Cost-Sharing for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered In-Network Services for the remainder of that Plan Year. If You have other than individual coverage, once a person within a family meets the individual In-Network Out-of-Pocket Limit in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person. If other than individual coverage applies, when persons in the same family covered under this Certificate have collectively met the family In-Network Out-of-Pocket Limit in payment of In-Network Cost-Sharing for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for the entire family.

Cost-Sharing for out-of-network services, except for Emergency Services, and out-of-network services approved by Us as an in-network exception does not apply toward Your In-Network Out-of-Pocket Limit.

E. Out-of-Network Out-of-Pocket Limit.

This Certificate has a separate Out-of-Network Out-of-Pocket Limit in the Schedule of Benefits section of this Certificate for out-of-network benefits. When You have met Your Out-of-Network Out-of-Pocket Limit in payment of Out-of-Network Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered out-of-network Services for the remainder of that Plan Year. If You have other than individual coverage, once a person within a family meets the individual Out-of-Network Out-of-Pocket Limit in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered out-of-network Services for the rest of that Plan Year for that person.If other than individual coverage applies, when persons in the same family covered under this Certificate have collectively met the family Out-of-Network Out-of-Pocket Limit in payment of Out-of-Network Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered out-of-network Services for the rest of that Plan Year for the entire family. **Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply toward Your Out-of-Network Out-of-Pocket Limit.**

Cost-Sharing for in-network services does not apply toward Your Out-of-Network Out-of-Pocket Limit.

F. Your Additional Payments for Out-of-Network Benefits.

When You receive Covered Services from a Non-Participating Provider, in addition to the applicable Copayments, Deductibles and Coinsurance described in the Schedule of Benefits section of this Certificate, You must also pay the amount, if any, by which the Non-Participating Provider's actual charge exceeds Our Allowed Amount. This means that the total of Our coverage and any Cost-Sharing amounts You pay may be less than the Non-Participating Provider's actual charge.

When You receive Covered Services from a Non-Participating Provider, We will apply nationally-recognized payment rules to the claim submitted for those services. These rules evaluate the claim information and determine the accuracy of the procedure codes and diagnosis codes for the services You received. Sometimes, applying these rules will change the way that We pay for the services. This does not mean that the services were not Medically Necessary. It only means that the claim should have been submitted differently. For example, Your Provider may have billed using several procedure codes when there is a single code that includes all of the separate procedures. We will make one (1) inclusive payment in that case rather than a separate payment for each billed code. Another example of when We will apply the payment rules to a claim is when You have surgery that involves two (2) surgeons acting as "co-surgeons". Under the payment rules, the claim from each Provider should have a "modifier" on it that identifies it as coming from a co-surgeon. If We receive a claim that does not have the correct modifier, We will change it and make the appropriate payment.

G. Allowed Amount.

"Allowed Amount" means the maximum amount We will pay for the services or supplies Covered under this Certificate, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount for Participating Providers will be the amount We have negotiated with the Participating Provider.

The Allowed Amount for Non-Participating Providers will be determined as follows:

1. Facilities

For Facilities, the Allowed Amount will be 140% of
an amount based on cost information from the Centers for Medicare and Medicaid Services.

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

If there is no amount as described above, the Allowed Amount will be the average amounts paid by Us for comparable services to Participating Providers in the same county. If there are no Participating Providers in the same county, then the average amount paid by Us for comparable services to Participating Providers in the contiguous county or counties.

3. Physician-Administered Pharmaceuticals.
For Physician-administered pharmaceuticals, We use gap methodologies that are similar to the pricing methodology used by the Centers for Medicare and Medicaid Services, and produce fees based on published acquisition costs or average wholesale price for the pharmaceuticals. These methodologies are currently created by RJ Health Systems, Thomson Reuters (published in its Red Book), or Us based on an internally developed pharmaceutical pricing resource if the other methodologies have no pricing data available for a Physician-administered pharmaceutical or special circumstances support an upward adjustment to the other pricing methodology.

Our Allowed Amount is not based on UCR. The Non-Participating Provider's actual charge may exceed Our Allowed Amount. You must pay the difference between Our Allowed Amount and the Non-Participating Provider's charge. Contact Us at the number on Your ID card or visit Our website https://www.aetnastudenthealth.com/ for information on Your financial responsibility when You receive services from a Non-Participating Provider.

Medicare based rates referenced in and applied under this section shall be updated no less than annually.

See the Emergency Services and Urgent Care section of this Certificate for the Allowed Amount for Emergency Services rendered by Non-Participating Providers. See the Ambulance and Pre-Hospital Emergency Medical Services section of this Certificate for the Allowed Amount for Pre-Hospital Emergency Medical Services rendered by Non-Participating Providers.

SECTION V

Who is Covered

A. Who is Covered Under this Certificate.

You, the Student to whom this Certificate is issued, are covered under this Certificate. Members of Your family may also be covered depending on the type of coverage You selected.

B. Types of Coverage.

We offer the following types of coverage:

1. **Individual.** If You selected individual coverage, then You are covered.

2. **Family.** If You selected family coverage, then You and Your Spouse and Your Child or Children, as described below, are covered.

C. Children Covered Under this Certificate.

If You selected parent and child/children or family coverage, Children covered under this Certificate include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the year in which the Child turns 26 years of age. Coverage also includes Children for whom You are a legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order. Foster Children and Grandchildren are covered.

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

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

D. When Coverage Begins.

Coverage under this Certificate will begin as follows:

1. If You, the Student, elect coverage before becoming eligible, or within 30 days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your Policyholder. Your Policyholder cannot impose waiting periods that exceed 90 days.
2. If You, the Student, do not elect coverage upon becoming eligible or within 31 days of becoming eligible for other than a special enrollment period, You must wait until the Policyholder's next open enrollment period to enroll, except as provided below.

3. If You, the Student, marry while covered, and We receive notice of such marriage and any Premium payment within 30 days thereafter, coverage for Your Spouse and Child starts on the first day of the following month after We receive Your application. If We do not receive notice within 30 days of the marriage, You must wait until the Policyholder's next open enrollment period to add Your Spouse or Child.
4. If You, the Student, have a newborn or adopted newborn Child and We receive notice of such birth within 30 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise, coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 30 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, We will not provide Hospital benefits for the adopted newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay. If You have individual or individual and Spouse coverage, You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any additional Premium within 30 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which We receive notice, provided that You pay any additional Premium when due.

E. Special Enrollment Periods.

You, and Your Spouse or Child can also enroll for coverage within 30 days of the loss of coverage in another health plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other health plan due to:

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

You, and Your Spouse or Child can also enroll 30 days from exhaustion of Your COBRA or continuation coverage or if You gain a Dependent or become a Dependent through marriage, birth, adoption or placement for adoption.

We must receive notice and Premium payment within 30 days of one of these events. Your coverage will begin on the first day of the following month after We receive Your application. If You gain a Dependent or become a Dependent due to a birth, adoption, or placement for adoption, Your coverage will begin on the date of the birth, adoption or placement for adoption.

In addition, You, and Your Spouse or Child, can also enroll for coverage within 60 days of the occurrence of one of the following event:

1. You or Your Spouse or Child loses eligibility for Medicaid or Child Health Plus; or
2. You or Your Spouse or Child become eligible for Medicaid or Child Health Plus.

We must receive notice and Premium payment within 60 days of one of these events. Your coverage will begin on the first day of the following month after We receive Your application.

F. Domestic Partner Coverage.

This Certificate covers domestic partners of Students as Spouses. If You selected family coverage, Children covered under this Certificate also include the Children of Your domestic partner. Proof of the domestic partnership and financial interdependence must be submitted in the form of:

1. Registration as a domestic partnership indicating that neither individual has been registered as a member of another domestic partnership within the last six (6) months, where such registry exists; or
2. For partners residing where registration does not exist, by;
   a. An alternative affidavit of domestic partnership. The affidavit must be notarized and must contain the following:
      - The partners are both 18 years of age or older and are mentally competent to consent to contract;
      - The partners are not related by blood in a manner that would bar marriage under laws of the State of New York;
      - The partners have been living together on a continuous basis prior to the date of the application;
      - Neither individual has been registered as a member of another domestic partnership within the last six (6) months; and
   b. Proof of cohabitation (e.g., a driver's license, tax return or other sufficient proof); and
   c. Proof that the partners are financially interdependent. Two (2) or more of the following are collectively sufficient to establish financial interdependence:
      - A joint bank account;
      - A joint credit card or charge card;
      - Joint obligation on a loan;
      - Status as an authorized signatory on the partner's bank account, credit card or charge card;
      - Joint ownership of holdings or investments;
      - Joint ownership of residence;
      - Joint ownership of real estate other than residence;
      - Listing of both partners as tenants on the lease of the shared residence;
      - Shared rental payments of residence (need not be shared 50/50);
      - Listing of both partners as tenants on a lease, or shared rental payments, for property other than residence;
      - A common household and shared household expenses, e.g., grocery bills, utility bills, telephone bills, etc. (need not be shared 50/50);
      - Shared household budget for purposes of receiving government benefits;
      - Status of one (1) as representative payee for the other's government benefits;
      - Joint ownership of major items of personal property (e.g., appliances, furniture);
      - Joint ownership of a motor vehicle;
      - Joint responsibility for child care (e.g., school documents, guardianship);
      - Shared child-care expenses, e.g., babysitting, day care, school bills (need not be shared 50/50);
      - Execution of wills naming each other as executor and/or beneficiary;
      - Designation as beneficiary under the other's life insurance policy;
      - Designation as beneficiary under the other's retirement benefits account;
      - Mutual grant of durable power of attorney;
      - Mutual grant of authority to make health care decisions (e.g., health care power of attorney);
      - Affidavit by creditor or other individual able to testify to partners' financial interdependence;
      - Other item(s) of proof sufficient to establish economic interdependency under the circumstances of the particular case.

SECTION VI

Preventive Care

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Preventive Care.
We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at the number on Your ID card or visit Our website at https://www.aetnastudenthealth.com/ for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.

A. **Well-Baby and Well-Child Care.** We Cover well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. If the schedule of well-child visits referenced above permits one (1) well-child visit per Plan Year, We will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as recommended by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age 19 and is not subject to Cost-Sharing when provided by a Participating Provider.

B. **Adult Annual Physical Examinations.** We Cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

Examples of items or services with an "A" or "B" rating from USPSTF include, but are not limited to, blood pressure screening for adults, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening and diabetes screening. A complete list of the Covered preventive Services is available on Our website at https://www.aetnastudenthealth.com/, or will be mailed to You upon request.

You are eligible for a physical examination once every Plan Year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

This benefit is not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF and when provided by a Participating Provider.

C. **Adult Immunizations.** We Cover adult immunizations as recommended by ACIP. This benefit is not subject to Cost-Sharing when provided in accordance with the recommendations of ACIP and when provided by a Participating Provider.

D. **Well-Woman Examinations.** We Cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual screening for cervical cancer, including laboratory and diagnostic services in connection with evaluating cervical cancer screening tests. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF. A complete list of the Covered preventive Services is available on Our website at https://www.aetnastudenthealth.com/, or will be mailed to You upon request. This benefit is not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may be less frequent than described above, and when provided by a Participating Provider.

E. **Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer.** We Cover mammograms, which may be provided by breast tomosynthesis (i.e., 3D mammograms), for the screening of breast cancer as follows:

- One (1) baseline screening mammogram for Members age 35 through 39;
- Upon the recommendation of the Member's Provider, an annual screening mammogram for Members age 35 through 39 if Medically Necessary; and
- One (1) screening mammogram annually for Members age 40 and over.

If a Member of any age has a history of breast cancer or a first degree relative has a history of breast cancer, We Cover mammograms as recommended by the Member's Provider. However, in no event will more than one (1) preventive screening per Plan Year be Covered.

Mammograms for the screening of breast cancer are not subject to Cost-Sharing when provided by a Participating Provider.

We also Cover additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRI. Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs are not subject to Cost-Sharing when provided by a Participating Provider.

F. **Family Planning and Reproductive Health Services.** We Cover family planning services which consist of FDA-approved contraceptive methods prescribed by a Provider, not otherwise Covered under the Prescription Drug Coverage section of this Certificate, counseling on use of contraceptives and related topics, and sterilization procedures for women. Such services are not subject to Cost-Sharing when provided by a Participating Provider.

We also Cover vasectomies subject to Cost-Sharing.

We do not Cover services related to the reversal of elective sterilizations.

G. Bone Mineral Density Measurements or Testing. We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the Prescription Drug Coverage section of this Certificate. Bone mineral density measurements or tests, drugs or devices shall include those covered under the federal Medicare program and those in accordance with the criteria of the National Institutes of Health. You will also qualify for Coverage if You meet the criteria under the federal Medicare program or the criteria of the National Institutes of Health or if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

We also Cover osteoporosis screening as provided for in the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF.

This benefit is not subject to Cost-Sharing when provided by a Participating Provider and in accordance with the comprehensive guidelines supported by HRSA and items or services with an "A" or "B" rating from USPSTF, which may not include all of the above services such as drugs and devices.

H. Prostate Cancer Screening. We Cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. We also Cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

This benefit is not subject to Cost-Sharing, when provided by a Participating Provider.

I. Colon Cancer Screening. We Cover colon cancer screening for Members age 45 through 75, including all colon cancer examinations and laboratory tests in accordance with the USPSTF for average risk individuals. This benefit includes an initial colonoscopy or other medical test for colon cancer screening and a follow-up colonoscopy performed because of a positive result from a non-colonoscopy preventive screening test.

This benefit is not subject to Cost-Sharing when provided in accordance with the recommendations of the USPSTF and when provided by a Participating Provider.

SECTION VII

Ambulance and Pre-Hospital Emergency Medical Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits. Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

A. Emergency Ambulance Transportation.

1. **Pre-Hospital Emergency Medical Services.** We Cover Pre-Hospital Emergency Medical Services worldwide for the treatment of an Emergency Condition when such services are provided by an ambulance service.

   "Pre-Hospital Emergency Medical Services" means the prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the New York Public Health Law. We will, however, only Cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

   - Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
   - Serious impairment to such person's bodily functions;
   - Serious dysfunction of any bodily organ or part of such person; or
   - Serious disfigurement of such person.

   An ambulance service must hold You harmless and may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services except for the collection of any applicable Copayment, Deductible or Coinsurance.

   In the absence of negotiated rates, We will pay a Non-Participating Provider the usual and customary charge for Pre-Hospital Emergency Medical Services, which shall not be excessive or unreasonable. The usual and customary charge for Pre-Hospital Emergency Medical Services is the lesser of the FAIR Health rate at the 80th percentile calculated using the place of pickup.

2. **Emergency Ambulance Transportation.** In addition to Pre-Hospital Emergency Medical Services, We also Cover emergency ambulance transportation worldwide by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Services can be performed. This coverage includes emergency ambulance transportation to a Hospital when the originating Facility does not have the ability to treat Your Emergency Condition.

B. Non-Emergency Ambulance Transportation.

We Cover non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:

- From a non-participating Hospital to a participating Hospital;
- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective Acute care Facility; or
- From an Acute care Facility to a sub-Acute setting.

C. 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.

D. Payments for Air Ambulance Services. We will pay a Participating Provider the amount We have negotiated with the Participating Provider for the air ambulance service.

We will pay a Non-Participating Provider the amount We have negotiated with the Non-Participating Provider for the air ambulance service or an amount We have determined is reasonable for the air ambulance service or the Non-Participating Provider's charge for the air ambulance service. However, the negotiated amount or the amount We determine is reasonable will not exceed the Non-Participating Provider's charge.

If a dispute involving a payment for air ambulance services is submitted to an independent dispute resolution entity, We will pay the amount, if any, determined by the IDRE for the air ambulance services.

You are responsible for any In-Network Cost-Sharing for air ambulance services. The Non-Participating provider may only bill You for Your In-Network Cost-Sharing. If You receive a bill from a Non-Participating Provider that is more than Your In-Network Cost-Sharing, You should contact Us.

SECTION VIII

Emergency Services and Urgent Care

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Emergency Services.

We Cover Emergency Services for the treatment of an Emergency Condition in a Hospital.

We define an **"Emergency Condition"** to mean: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain
- Severe or multiple injuries
- Severe shortness of breath
- Sudden change in mental status (e.g., disorientation)
- Severe bleeding
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis
- Poisonings
- Convulsions

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. We will also Cover Emergency Services to treat Your Emergency Condition worldwide. However, We will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition in a Hospital.

Please follow the instructions listed below regardless of whether or not You are in Our Service Area at the time Your Emergency Condition occurs:

1. **Hospital Emergency Department Visits.** In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. However, **only Emergency Services for the treatment of an Emergency Condition are Covered in an emergency department**.

   We do not Cover follow-up care or routine care provided in a Hospital emergency department.

2. **Emergency Hospital Admissions.** In the event that You are **admitted** to the Hospital, You or someone on Your behalf must notify Us at the number listed in this Certificate and on Your ID card within 48 hours of Your admission, or as soon as is reasonably possible.

   We cover inpatient Hospital services following Emergency Department Care at a non-participating Hospital at the in-network Cost-Sharing.

3. **Payments Relating to Emergency Services.** We will pay a Participating Provider the amount We have negotiated with the Participating Provider for the Emergency Services.

   We will pay a Non-Participating Provider the amount We have negotiated with the Non-Participating Provider for the Emergency Service or an amount We have determined is reasonable for the Emergency Service. However, the negotiated amount or the amount We determine is reasonable will not exceed the Non-Participating Provider's charge.

   If a dispute involving a payment for physician or Hospital services is submitted to an independent dispute resolution entity ("IDRE"), We will pay the amount, if any, determined by the IDRE for physician or Hospital services.

   You are responsible for any In-Network Cost-Sharing. You will be held harmless for any Non-Participating Provider charges that exceed Your In-Network Cost-Sharing. The Non-Participating Provider may only bill You for Your In-Network Cost-Sharing. If You receive a bill from a Non-Participating Provider that is more than Your In-Network Cost-Sharing, You should contact Us.

B. Urgent Care.

Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care is typically available after normal business hours, including evenings and weekends. If You need care after normal business hours, including evenings, weekends or holidays, You have options. You can call Your Provider's office for instructions or visit an Urgent Care Center. If You have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. **Urgent Care is Covered in or out of Our Service Area**.

1. **In-Network.** We Cover Urgent Care from a participating Physician or a participating Urgent Care Center. You do not need to contact Us prior to or after Your visit.

2. **Out-of-Network.** We Cover Urgent Care from a non-participating Urgent Care Center or Physician.

If Urgent Care results in an emergency admission, please follow the instructions for Emergency Hospital Admissions described above.

SECTION IX

Outpatient and Professional Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Acupuncture.
We Cover acupuncture services rendered by a Health Care Professional licensed to provide such services.

B. Advanced Imaging Services.
We Cover PET scans, MRI, nuclear medicine, and CAT scans.

C. Allergy Testing and Treatment.
We Cover testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. We also Cover allergy treatment, including desensitization treatments, routine allergy injections and serums.

D. Ambulatory Surgical Center Services.
We Cover surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the center the day the surgery is performed.

E. Chemotherapy and Immunotherapy.
We Cover chemotherapy and immunotherapy in an outpatient Facility or in a Health Care Professional's office. Chemotherapy and immunotherapy may be administered by injection or infusion. Orally-administered anti-cancer drugs are Covered under the Prescription Drug Coverage section of this Certificate.

F. Chiropractic Services.
We Cover chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") or a Physician in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any laboratory tests will be Covered in accordance with the terms and conditions of this Certificate.

G. Clinical Trials.
We Cover the routine patient costs for Your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if You are:

- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and
- Referred by a Participating Provider who has concluded that Your participation in the approved clinical trial would be appropriate.

All other clinical trials, including when You do not have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and External Appeal sections of this Certificate.

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.

An “approved clinical trial” means a phase I, II III, or IV clinical trial that is:

- A federally funded or approved trial;
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

H. Dialysis.

We Cover dialysis treatments of an Acute or chronic kidney ailment.

I. Habilitation Services.

We Cover Habilitation Services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a Facility or in a Health Care Professional’s office for up to unlimited visits per Plan Year.

J. Home Health Care.

We Cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes:

- Part-time or intermittent nursing care by or under the supervision of a registered professional nurse;
- Part-time or intermittent services of a home health aide;
- Physical, occupational or speech therapy provided by the Home Health Agency; and
- Medical supplies, Prescription Drugs and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

Home Health Care is limited to unlimited visits per Plan Year. Each visit by a member of the Home Health Agency is considered one (1) visit. Each visit of up to four (4) hours by a home health aide is considered one (1) visit. Any Rehabilitation Services or Habilitation Services received under this benefit will not reduce the amount of services available under the Rehabilitation Services or Habilitation Services benefits.

K. Infertility Treatment.

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.

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 ultra sound;
   - Artificial insemination;
   - Hysteroscopy;
   - Laparoscopy; and
   - Laparotomy.

3. **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.

4. **Exclusions and Limitations.** We do not Cover:
   - In vitro fertilization;
   - Gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
   - Costs associated with an ovum or sperm donor including the donor's medical expenses;
   - Cryopreservation and storage of sperm and ova except when performed as fertility preservation services;
   - Cryopreservation and storage of embryos;
   - Ovulation predictor kits;
   - Reversal of tubal ligations;
   - Reversal of vasectomies;
   - Costs for and services relating to surrogate motherhood that are not otherwise Covered Services under this Certificate;
   - Cloning; or
   - Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.

   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.

L. Infusion Therapy.

We Cover infusion therapy which is the administration of drugs using specialized delivery systems. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an office or by an agency licensed or certified to provide infusion therapy. Any visits for home infusion therapy count toward Your home health care visit limit.

M. Interruption of Pregnancy.

We Cover abortion services. Coverage for abortion services includes any Prescription Drug prescribed for an abortion, including both Generic Drugs and Brand-Name Drugs, even if those Prescription Drugs have not been approved by the FDA for abortions, if the Prescription Drug is a recognized medication for abortions in one of the following reference compendia:

- The WHO Model Lists of Essential Medicines;
- The WHO Abortion Care Guidelines; or
- The National Academies of Science, Engineering and Medicine Consensus Study Report.

Abortion services are not subject to Cost-Sharing when provided by a Participating Provider.

N. Laboratory Procedures, Diagnostic Testing and Radiology Services.

We Cover x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

We Cover biomarker precision medical testing, including both single-analyte tests and multiplex panel tests, performed at a participating laboratory that is either CLIA certified or CLIA waived by the FDA, for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring to guide treatment decisions for Your disease or condition when one or more of the following recognizes the efficacy and appropriateness of such testing:

- Labeled indications for a test approved or cleared by the FDA or indicated tests for an FDA approved Prescription Drug;
- Centers for Medicare and Medicaid Services (“CMS”) national coverage determinations or Medicare administrative contractor local coverage determinations;
- Nationally recognized clinical practice guidelines; or
- Peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

O. Maternity and Newborn Care.

We Cover services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center. We Cover prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a midwife to be Covered, the midwife must be licensed pursuant to Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the New York Public Health Law. We will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section of this Certificate for Coverage of inpatient maternity care.

We Cover breastfeeding support, counseling and supplies, including the cost of renting one (1) breast pump per pregnancy for the duration of breast feeding from a Participating Provider or designated vendor.

P. Office Visits.
We Cover office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls.

Q. Outpatient Hospital Services.
We Cover Hospital services and supplies as described in the Inpatient Services section of this Certificate that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation.

R. Preadmission Testing.
We Cover preadmission testing ordered by Your Physician and performed in Hospital outpatient Facilities prior to a scheduled surgery in the same Hospital provided that:

- The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed;
- Reservations for a Hospital bed and operating room were made prior to the performance of the tests;
- Surgery takes place within seven (7) days of the tests; and
- The patient is physically present at the Hospital for the tests.

S. Prescription Drugs for Use in the Office and Outpatient Facilities.
We Cover Prescription Drugs (excluding self-injectable drugs) used by Your Provider in the Provider's office and Outpatient Facility for preventive and therapeutic purposes. This benefit applies when Your Provider orders the Prescription Drug and administers it to You. When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of this Certificate.

T. Rehabilitation Services.
We Cover Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a Facility or in a Health Care Professional's office for up to unlimited visits per Plan Year.
We Cover speech and physical therapy only when:

- Such therapy is related to the treatment or diagnosis of Your illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
- The therapy is ordered by a Physician; and
- You have been hospitalized or have undergone surgery for such illness or injury.

Covered Rehabilitation Services must begin within six (6) months of the later to occur:

- The date of the injury or illness that caused the need for the therapy;
- The date You are discharged from a Hospital where surgical treatment was rendered; or
- The date outpatient surgical care is rendered.

U. Second Opinions.

1. **Second Cancer Opinion.** We Cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a Non-Participating Provider on an in-network basis.

2. **Second Surgical Opinion.** We Cover a second surgical opinion by a qualified Physician on the need for surgery.

3. **Required Second Surgical Opinion.** We may require a second opinion before We preauthorize a surgical procedure. There is no cost to You when We request a second opinion.
    - The second opinion must be given by a board-certified Specialist who personally examines You.
    - If the first and second opinions do not agree, You may obtain a third opinion.

4. **Second Opinions in Other Cases.** There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that we designate another Provider to render a second opinion. If the first and second opinions do not agree, We will designate another Provider to render a third opinion. After completion of the second opinion process, We will preauthorize Covered Services supported by a majority of the Providers reviewing Your case.

V. Surgical Services.

We Cover Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure when rendered by the surgeon or the surgeon's assistant.

If Covered multiple surgical procedures are performed during the same operative session through the same or different incisions, We will pay:

- For the procedure with the highest Allowed Amount; and
- 50% of the amount We would otherwise pay for the other procedures.

W. Oral Surgery.

We Cover the following limited dental and oral surgical procedures:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when repair is not possible. Dental services must be obtained within 12 months of the injury.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not Covered.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

X. Reconstructive Breast Surgery.

We Cover breast or chest wall reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes all stages of reconstruction of the breast or chest wall on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast or chest wall to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate. Chest wall reconstruction surgery includes aesthetic flat closure as defined by the National Cancer Institute. We also Cover implanted breast prostheses following a mastectomy or partial mastectomy.

Y. Other Reconstructive and Corrective Surgery.

We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when it is:

- Performed to correct a congenital birth defect of a covered Child which has resulted in a functional defect;
- Incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or
- Otherwise Medically Necessary.

Z. Transplants.

We Cover only those transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, and heart/lung transplants; and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.

All transplants must be prescribed by Your Specialist(s). Additionally, all transplants must be performed at Hospitals that We have specifically approved and designated as Centers of Excellence to perform these procedures.

We Cover the Hospital and medical expenses, including donor search fees, of the Member-recipient. We Cover transplant services required by You when You serve as an organ donor only if the recipient is a Member. We do not Cover the medical expenses of a non-Member acting as a donor for You if the non-Member's expenses will be Covered under another health plan or program. If We Preauthorize the transplant at a Participating Provider because We determine there are no Preferred Providers available, You will be responsible for the Preferred Provider Cost-Sharing in the Schedule of Benefits section of this Certificate.

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.

SECTION X

Additional Benefits, Equipment and Devices

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Diabetic Equipment, Supplies and Self-Management Education.

We Cover diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under Title 8 of the New York Education Law as described below:

1. **Equipment and Supplies.**
   We Cover the following equipment and related supplies for the treatment of diabetes when prescribed by Your Physician or other Provider legally authorized to prescribe:
   - Acetone reagent strips
   - Acetone reagent tablets
   - Alcohol or peroxide by the pint
   - Alcohol wipes
   - All insulin preparations
   - Automatic blood lance kit
   - Cartridges for the visually impaired
   - Diabetes data management systems
   - Disposable insulin and pen cartridges
   - Drawing-up devices for the visually impaired
   - Equipment for use of the pump
   - Glucagon for injection to increase blood glucose concentration
   - Glucose acetone reagent strips
   - Glucose kit
   - Glucose monitor with or without special features for visually impaired, control solutions, and strips for home glucose monitor
   - Glucose reagent tape
   - Glucose test or reagent strips
   - Injection aides
   - Injector (Busher) Automatic
   - Insulin
   - Insulin cartridge delivery
   - Insulin infusion devices
   - Insulin pump
   - Lancets
   - Oral agents such as glucose tablets and gels
   - Oral anti-diabetic agents used to reduce blood sugar levels
   - Syringe with needle; sterile 1 cc box
   - Urine testing products for glucose and ketones
   - Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

2. Self-Management Education.

Diabetes self-management education is designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition, including information on proper diets. We Cover education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in Your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:

- By a Physician, other health care Provider authorized to prescribe under Title 8 of the New York Education Law, or their staff during an office visit;
- Upon the Referral of Your Physician or other health care Provider authorized to prescribe under Title 8 of the New York Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
- Education will also be provided in Your home when Medically Necessary.

3. 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.

Step Therapy for Diabetes Equipment and Supplies. Step therapy is a program that requires You to try one type of diabetic Prescription Drug, supply or equipment unless another Prescription Drug, supply or equipment is Medically Necessary. The diabetic Prescription Drugs, supplies and equipment that are subject to step therapy include:

- Diabetic glucose meters and test strips;
- Diabetic supplies (including but not limited to syringes, lancets, needles, pens);
- Insulin;
- Injectable anti-diabetic agents; and
- Oral anti-diabetic agents.

These items also require Preauthorization and will be reviewed for Medical Necessity. For diabetic Prescription Drugs, refer to the step therapy provisions in the Prescription Drug section and the Step Therapy Protocol Override Determination provisions in the Utilization Review section of this Certificate.

B. Durable Medical Equipment and Braces.

We Cover the rental or purchase of durable medical equipment and braces.

1. Durable Medical Equipment.

Durable Medical Equipment is equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Coverage is for standard equipment only. We Cover the cost of repair or replacement when made necessary by normal wear and tear. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You. We will determine whether to rent or purchase such equipment

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.

2. Braces.

We Cover braces, including orthotic braces, that are worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease or defect. Coverage is for standard equipment only. We Cover replacements when growth or a change in Your medical condition make replacement necessary. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You.

C. Hearing Aids.

1. External Hearing Aids.

We Cover hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Covered Services are available for a hearing aid that is purchased as a result of a written recommendation by a Physician and include the hearing aid and the charges for associated fitting and testing. We Cover a single purchase (including repair and/or replacement) of hearing aids for one (1) or both ears once every three (3) years.

2. Cochlear Implants.

We Cover bone anchored hearing aids (i.e. cochlear implants) when they are Medically Necessary to correct a hearing impairment. Examples of when bone anchored hearing aids are Medically Necessary include the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Coverage is provided for one (1) hearing aid per ear per Plan Year. We Cover repair and/or replacement of a bone anchored hearing aid only for malfunctions.

D. Hospice.

Hospice Care is available if Your primary attending Physician has certified that You have six (6) months or less to live. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. We also Cover five (5) visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We Cover Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the New York Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located. We do not Cover: funeral arrangements; pastoral, financial, or legal counseling; or homemaker, caretaker, or respite care.

E. Medical Supplies.

We Cover medical supplies that are required for the treatment of a disease or injury which is Covered under this Certificate. We also Cover maintenance supplies (e.g., ostomy supplies) for conditions Covered under this Certificate. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not Cover over-the-counter medical supplies. See the Diabetic Equipment, Supplies, and Self-Management Education section above for a description of diabetic supply Coverage.

F. Prosthetics.

1. External Prosthetic Devices.

We Cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). 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 shoe inserts.

We Cover external breast prostheses following a mastectomy, which are not subject to any lifetime limit.

Coverage is for standard equipment only.

We Cover the cost of one (1) prosthetic device per limb per Plan Year. We also Cover the cost of repair and replacement of the prosthetic device and its parts. 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.

2. Internal Prosthetic Devices.

We Cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate.

Coverage also includes repair and replacement due to normal growth or normal wear and tear.

Coverage is for standard equipment only.

SECTION XI

Inpatient Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Hospital Services.

We Cover inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for an illness, injury or disease of a severity that must be treated on an inpatient basis including:

- Semiprivate room and board;
- General, special and critical nursing care;
- Meals and special diets;
- The use of operating, recovery and cystoscopic rooms and equipment;
- The use of intensive care, special care or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

The Cost-Sharing requirements in the Schedule of Benefits section of this Certificate apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than 90 days for the same or related causes.

B. Observation Services.

We Cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge You. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

C. Inpatient Medical Services.

We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this Certificate.

D. Inpatient Stay for Maternity Care.

We Cover inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also Cover any additional days of such care that We determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage period, We will Cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or at the time of the mother's request, whichever is later. Our Coverage of this home care visit shall be in addition to home health care visits under this Certificate and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits section of this Certificate that apply to home care benefits.

We also Cover the inpatient use of pasteurized donor human milk, which may include fortifiers as Medically Necessary, for which a Health Care Professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breast feeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant must have a documented birth weight of less than one thousand five hundred grams, or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

E. Inpatient Stay for Mastectomy Care.

We Cover inpatient services for Members undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be medically appropriate by You and Your attending Physician.

F. Autologous Blood Banking Services.

We Cover autologous blood banking services only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury. In such instances, We Cover storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.

G. Habilitation Services.

We Cover inpatient Habilitation Services consisting of physical therapy, speech therapy and occupational therapy for unlimited days per Plan Year.

H. Rehabilitation Services.

We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy for unlimited days per Plan Year.

We Cover speech and physical therapy only when:

1. Such therapy is related to the treatment or diagnosis of Your illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
2. The therapy is ordered by a Physician; and
3. You have been hospitalized or have undergone surgery for such illness or injury.

Covered Rehabilitation Services must begin within six (6) months of the later to occur:

1. The date of the injury or illness that caused the need for the therapy;
2. The date You are discharged from a Hospital where surgical treatment was rendered; or
3. The date outpatient surgical care is rendered.

I. Skilled Nursing Facility.

We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent or domiciliary care is not Covered (see the Exclusions and Limitations section of this Certificate). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. We Cover up to 200 days per Plan Year for non-custodial care.

J. End of Life Care.

If You are diagnosed with advanced cancer and You have fewer than 60 days to live, We will Cover Acute care provided in a licensed Article 28 Facility or Acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the Facility. If We disagree with Your admission to the Facility, We have the right to initiate an expedited external appeal to an External Appeal Agent. We will Cover and reimburse the Facility for Your care, subject to any applicable limitations in this Certificate until the External Appeal Agent renders a decision in Our favor.

We will reimburse Non-Participating Providers for this end of life care as follows:

1. We will reimburse a rate that has been negotiated between Us and the Provider.
2. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare Acute care rate.
3. If it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare Acute care rate.

K. Centers of Excellence.

Centers of Excellence are Hospitals that We have approved and designated for certain services. We Cover the following Services only when performed at Centers of Excellence:
Transplants.

L. Limitations/Terms of Coverage.

1. When You are receiving inpatient care in a Facility, We will not Cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our Coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.
2. We do not Cover radio, telephone or television expenses, or beauty or barber services.

SECTION XII

Mental Health Care and Substance Use Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits which are no more restrictive than those that apply to medical and surgical benefits in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008.

A. Mental Health Care Services. We Cover the following mental health care services to treat a mental health condition. For purposes of this benefit, "mental health condition" means any mental health disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. **Inpatient Services.** We Cover inpatient mental health care services relating to the diagnosis and treatment of mental health conditions comparable to other similar Hospital, medical and surgical coverage provided under this Certificate. Coverage for inpatient services for mental health care is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:
    - A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
    - A state or local government run psychiatric inpatient Facility;
    - A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
    - A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health;

    and, in other states, to similarly licensed or certified Facilities. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.

    We also Cover inpatient mental health care services relating to the diagnosis and treatment of mental health conditions received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03 and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to New York Mental Hygiene Health Law Article 30; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment. In the absence of a similarly licensed or certified Facility that provides the same level of treatment, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.

2. **Outpatient Services.** We Cover outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental health conditions. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to the New York Mental Hygiene Law Article 31 or are operated by the New York State Office of Mental Health, and crisis stabilization centers licensed pursuant to New York Mental Hygiene Law section 36.01 and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker; a licensed nurse practitioner; a licensed mental health counselor; a licensed marriage and family therapist; a licensed psychoanalyst; or a professional corporation or a university faculty practice corporation thereof. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us. Outpatient services also include nutritional counseling to treat a mental health condition.

   Outpatient mental health care services also include outpatient care provided at a preschool, elementary, or secondary school by a school-based mental health clinic licensed pursuant to Mental Hygiene Law Article 31, regardless of whether the school-based mental health clinic is a Participating Provider. We will pay a Non-Participating Provider the amount We have negotiated with the Non-Participating Provider for the outpatient mental health care services. In the absence of a negotiated rate, We will pay an amount no less than the rate that would be paid under the Medicaid program. However, the negotiated amount or the amount paid under the Medicaid program will not exceed the Non-Participating Provider's charge. The school-based mental health clinic shall not seek reimbursement from You for outpatient services provided at a school-based mental health clinic except for Your In-Network Cost-Sharing.

3. **Autism Spectrum Disorder.** We Cover the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Us to be Medically Necessary for the screening, diagnosis, or treatment of autism spectrum disorder. For purposes of this benefit, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered.

   i. **Screening and Diagnosis.** We Cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.

   ii. **Assistive Communication Devices.** We Cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, We Cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if You are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. We will only Cover devices that generally are not useful to a person in the absence of a communication impairment. We do not Cover items, such as, but not limited to, laptop, desktop or tablet computers. We Cover software and/or applications that enable a laptop, desktop or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

We Cover repair, replacement fitting and adjustments of such devices when made necessary by normal wear and tear or significant change in Your physical condition. We do not Cover the cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft; however, We Cover one (1) repair or replacement per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to Your current functional level. We do not Cover delivery or service charges or routine maintenance.

iii. **Behavioral Health Treatment.** We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such Coverage when provided by a licensed Provider. We Cover applied behavior analysis when provided by a licensed or certified applied behavior analysis Health Care Professional. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

iv. **Psychiatric and Psychological Care.** We Cover direct or consultative services provided by a psychiatrist, psychologist or a licensed clinical social worker with the experience required by the New York Insurance Law, licensed in the state in which they are practicing.

v. **Therapeutic Care.** We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this Certificate. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Certificate.

vi. **Pharmacy Care.** We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a Provider legally authorized to prescribe under Title 8 of the New York Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug benefits under this Certificate.

vii. **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 New York Public Health Law Section 2545, an individualized education plan under New York Education Law Article 89, 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.

You are responsible for any applicable Cost-Sharing provisions under this Certificate for similar services. For example, any Cost-Sharing that applies to physical therapy visits will generally also apply to physical therapy services Covered under this benefit; and any Cost-Sharing for Prescription Drugs will generally also apply to Prescription Drugs Covered under this benefit. See the Schedule of Benefits section of this Certificate for the Cost-Sharing requirements that apply to applied behavior analysis services and assistive communication devices.

B. Substance Use Services. We Cover the following substance use services to treat a substance use disorder. For purposes of this benefit, "substance use disorder" means any substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. **Inpatient Services.** We Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorders. This includes Coverage for detoxification and rehabilitation services for substance use disorders. Inpatient substance use services are limited to Facilities in New York State which are licensed, certified or otherwise authorized by the Office of Addiction Services and Support ("OASAS"); and, in other states, to those Facilities that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs.

   We also Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorder received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities that are licensed, certified or otherwise authorized by OASAS; and, in other states, to those Facilities that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

2. **Outpatient Services.** We Cover outpatient substance use services relating to the diagnosis and treatment of substance use disorders, including but not limited to partial hospitalization program services, intensive outpatient program services, opioid treatment programs including peer support services, counseling and medication-assisted treatment. Such Coverage is limited to Facilities in New York State that are licensed, certified or otherwise authorized by OASAS to provide outpatient substance use disorder services and crisis stabilization centers licensed pursuant to New York Mental Hygiene Law section 36.01 and, in other states, to those that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs. Coverage in an OASAS-certified Facility includes services relating to the diagnosis and treatment of a substance use disorder provided by an OASAS credentialed Provider. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

   Additional Family Counseling. We also Cover 20 outpatient visits per Plan Year for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member: 1) identifies himself or herself as a family member of a person suffering from a substance use disorder; and 2) is covered under the same family Certificate that covers the person receiving, or in need of, treatment for a substance use disorder. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

SECTION XIII

Prescription Drug Coverage

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Covered Prescription Drugs.

We Cover Medically Necessary Prescription Drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

- Required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription";
- FDA approved;
- Ordered by a Provider authorized to prescribe and within the Provider's scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines; and
- Dispensed by a licensed pharmacy.

Covered Prescription Drugs include, but are not limited to:

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA, or generic equivalents as approved substitutes, for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Prescription or non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders include but are not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies. Multiple food allergies include but are not limited to: immunoglobulin E and non immunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.
- Modified solid food products that are low in protein, contain modified protein, or are amino based to treat certain inherited diseases of amino acid and organic acid metabolism and severe protein allergic conditions.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the infertility treatment benefit in the Outpatient and Professional Services section of this Certificate.
- Off-label cancer drugs, so long as the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one (1) of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.

- Smoking cessation drugs, including over-the-counter drugs for which there is a written order and Prescription Drugs prescribed by a Provider.
- Preventive Prescription Drugs, including over-the-counter drugs for which there is a written order, provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") or that have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF").
- Prescription drugs for pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP) to prevent HIV infection.
- Prescription Drugs for the treatment of mental health and substance use disorders, including drugs for detoxification and maintenance treatment, all buprenorphine products, methadone, and long-acting injectable naltrexone, and opioid overdose reversal medication, including when dispensed over-the-counter.
- Contraceptive drugs, devices and other products, including over-the-counter contraceptive drugs, devices and other products, approved by the FDA and as prescribed or otherwise authorized under State or Federal law. "Over-the-counter contraceptive products" means those products provided for in comprehensive guidelines supported by HRSA. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over-the-counter. You may request coverage for an alternative version of a contraceptive drug, device and other product if the Covered contraceptive drug, device and other product is not available or is deemed medically inadvisable, as determined by Your attending Health Care Provider. You may request an exception by having Your attending Health Care Provider complete the Contraception Exception Form and sending it to Us. Visit Our website www.aetna.com or call the number on Your ID card get a copy of the form or to find out more about this exception process.

B. Refills.

We Cover Refills of Prescription Drugs only when dispensed at a retail or mail order pharmacy as ordered by an authorized Provider and only after ¾ of the original Prescription Drug has been used. Benefits for Refills will not be provided beyond one (1) year from the original prescription date. For prescription eye drop medication, We allow for the limited refilling of the prescription prior to the last day of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. To the extent practicable, the quantity of eye drops in the early Refill will be limited to the amount remaining on the dosage that was initially dispensed. Your Cost-Sharing for the limited Refill is the amount that applies to each prescription or Refill as set forth in the Schedule of Benefits section of this Certificate.

C. Benefit and Payment Information.

1. **Cost-Sharing Expenses.** You are responsible for paying the costs outlined in the Schedule of Benefits section of this Certificate when Covered Prescription Drugs are obtained from a retail or mail order pharmacy.

   You have a three (3) tier plan design, which means that Your out-of-pocket expenses will generally be lowest for Prescription Drugs on tier 1 and highest for Prescription Drugs on tier 3. Your out-of-pocket expense for Prescription Drugs on tier 2 will generally be more than for tier 1 but less than tier 3.

For most Prescription Drugs, You pay only the Cost-Sharing in the Schedule of Benefits. An additional charge, called an "ancillary charge" may apply to some Prescription Drugs when a Prescription Drug on a higher tier is dispensed at Your or Your Provider's request and Our formulary includes a chemically equivalent Prescription Drug on a lower tier. You will pay the difference between the full cost of the Prescription Drug on the higher tier and the cost of the Prescription Drug on the lower tier. The cost difference is not Covered and must be paid by You in addition to the lower tier Cost-Sharing. If Your Provider thinks that a chemically equivalent Prescription Drug on a lower tier is not clinically appropriate, You, Your designee or Your Provider may request that We approve coverage at the higher tier Cost-Sharing. If approved, You will pay the higher tier Cost-Sharing only. If We do not approve coverage at the higher tier Cost-Sharing, You are entitled to an Appeal as outlined in the Utilization Review and External Appeal sections of this Certificate. The request for an approval should include a statement from Your Provider that the Prescription Drug at the lower tier is not clinically appropriate (e.g., it will be or has been ineffective or would have adverse effects.) We may also request clinical documentation to support this statement. If We do not approve coverage for the Prescription Drug on the higher tier, the ancillary charge will not apply toward Your Out-of-Pocket Limit.

You are responsible for paying the full cost (the amount the pharmacy charges You) for any non-Covered Prescription Drug, and Our contracted rates (Our Prescription Drug Cost) will not be available to You.

Coupons and Other Financial Assistance. We will apply any third-party payments, financial assistance, discounts, or other coupons that help You pay Your Cost-Sharing towards Your Deductible and Out-of-Pocket Limit.

This provision only applies to: 1) a Brand-Name Drug without an AB-rated generic equivalent, as determined by the FDA; 2) a Brand-Name Drug with an AB-rated generic equivalent, as determined by the FDA, and You have accessed the Brand-Name Drug through Preauthorization or an Appeal, including step-therapy protocol; and 3) all Generic Drugs.

2. **Participating Pharmacies.** For Prescription Drugs purchased at a retail or mail order Participating Pharmacy, You are responsible for paying the lower of:
   - The applicable Cost-Sharing; or
   - The Prescription Drug Cost for that Prescription Drug.

   (Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

   In the event that Our Participating Pharmacies are unable to provide the Covered Prescription Drug, and cannot order the Prescription Drug within a reasonable time, You may, with Our prior approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required in-network Cost-Sharing upon receipt of a complete Prescription Drug claim form. Contact Us at the number on Your ID card or visit Our website at www.aetna.com to request approval.

3. **Non-Participating Pharmacies**. If You purchase a Prescription Drug from a Non-Participating Pharmacy, You must pay for the Prescription Drug at the time it is dispensed and then file a claim for reimbursement with Us. We will not reimburse You for the difference between what You pay the Non-Participating Pharmacy and Our price for the Prescription Drug. In most cases, You will pay more if You purchase Prescription Drugs from a Non-Participating Pharmacy.

4. **Mail Order.** Certain Prescription Drugs may be ordered through Our mail order pharmacy after an initial 30 day supply, with the exception of contraceptive drugs or devices which are available for an initial three month supply. You are responsible for paying the lower of:
   - The applicable Cost-Sharing; or
   - The Prescription Drug Cost for that Prescription Drug.

   (Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

   To maximize Your benefit, ask Your Provider to write Your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with three (3) Refills). You will be charged the mail order Cost-Sharing for any Prescription Orders or Refills sent to the mail order pharmacy regardless of the number of days supply written on the Prescription Order or Refill.

   Prescription Drugs purchased through mail order will be delivered directly to Your home or office.

   We will provide benefits that apply to drugs dispensed by a mail order pharmacy to drugs that are purchased from a retail pharmacy when that retail pharmacy is a Participating Pharmacy and agrees to the same reimbursement amount as a participating mail order pharmacy.

   You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting Our website at www.aetna.com or by calling the number on Your ID card.

5. **Formulary Changes.** We will not add utilization management restrictions (e.g., step therapy or Preauthorization requirements) to a Prescription Drug on Our Formulary during a Plan Year unless the requirements are added pursuant to FDA safety concerns.

6. **Tier Status.** A Prescription Drug will not be moved to a tier with a higher Cost-Sharing during the Plan Year, except a Brand-Name Drug may be moved to a tier with higher Cost-Sharing if an AB-rated generic equivalent or interchangeable biological product for that Prescription Drug is added to the Formulary at the same time. Additionally, a Prescription Drug may be moved to a tier with a higher Copayment during the Plan Year, although the change will not apply to You if You are already taking the Prescription Drug or You have been diagnosed or presented with a condition on or prior to the start of the Plan Year which is treated by such Prescription Drug or for which the Prescription Drug is or would be part of Your treatment regimen.

   Before We move a Prescription Drug to a different tier, We will provide at least 90 days' notice prior to the start of the Plan Year. We will also post such notice on Our website www.aetna.com. If a Prescription Drug is moved to a different tier during the Plan Year for one of reasons described above, We will provide at least 30 days' notice before the change is effective. You will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned. You may access the most up to date tier status on Our website www.aetna.com or by calling the number on Your ID card.

7. **Supply Limits.** Except for contraceptive drugs, devices, or products, We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy. You are responsible for one (1) Cost-Sharing amount for up to a 30-day supply.

   You may have the entire supply (of up to 12 months) of the contraceptive drug, device or product dispensed at the same time. Contraceptive drugs, devices, or products are not subject to Cost-Sharing when provided by a Participating Pharmacy.

Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing Our website at www.aetna.com or by calling the number on Your ID card. If We deny a request to Cover an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to the Utilization Review and External Appeal sections of this Certificate.

8. **Initial Limited Supply of Prescription Opioid Drugs.** If you receive an initial limited prescription for a seven (7) day supply or less of any schedule II, III, or IV opioid prescribed for Acute pain, and You have a Copayment, Your Copayment will be the same Copayment that would apply to a 30-day supply of the Prescription Drug. If You receive an additional supply of the Prescription Drug within the same 30-day period in which You received the seven (7) day supply, You will not be responsible for an additional Copayment for the remaining 30-day supply of that Prescription Drug.

9. **Cost-Sharing for Orally-Administered Anti-Cancer Drugs.** Your Cost-Sharing for orally-administered anti-cancer drugs is at least as favorable to You as the Cost-Sharing amount, if any, that applies to intravenous or injected anticancer medications Covered under the Outpatient and Professional Services section of this Certificate.

10. **Emergency Refill During a State Disaster Emergency.** If a state disaster emergency is declared, You, Your designee, or Your Health Care Provider on Your behalf, may immediately get a 30-day Refill of a Prescription Drug You are currently taking. You will pay the Cost-Sharing that applies to a 30-day Refill. Certain Prescription Drugs, as determined by the New York Commissioner of Health, are not eligible for this emergency Refill, including schedule II and III controlled substances.

D. Medical Management.

This Certificate includes certain features to determine when Prescription Drugs should be Covered, which are described below. As part of these features, Your prescribing Provider may be asked to give more details before We can decide if the Prescription Drug is Medically Necessary.

1. **Preauthorization.** Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. When appropriate, Your Provider will be responsible for obtaining Preauthorization for the Prescription Drug. Should You choose to purchase the Prescription Drug without obtaining Preauthorization, You must pay for the cost of the entire Prescription Drug and submit a claim to Us for reimbursement. Preauthorization is not required for Covered medications to treat substance use disorder, including opioid overdose reversal medications prescribed or dispensed to You.

   For a list of Prescription Drugs that need Preauthorization, please visit Our website at www.aetna.com or call the number on Your ID card. The list will be reviewed and updated from time to time. We also reserve the right to require Preauthorization for any new Prescription Drug on the market. However, We will not add Preauthorization requirements to a Prescription Drug on Our Formulary during a plan Year unless the requirements are added pursuant to FDA safety concerns. Your Provider may check with Us to find out which Prescription Drugs are Covered.

2. **Step Therapy.** Step therapy is a process in which You may need to use one (1) or more types of Prescription Drugs before We will Cover another as Medically Necessary. A "step therapy protocol" means Our policy, protocol or program that establishes the sequence in which We approve Prescription Drugs for Your medical condition. When establishing a step therapy protocol, We will use recognized evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost-effective Prescription Drugs. The Prescription Drugs that require Preauthorization under the step therapy program are also included on the Preauthorization drug list. If a step therapy protocol is applicable to Your request for coverage of a Prescription Drug, You, Your designee, or Your Health Care Professional can request a step therapy override determination as outlined in the Utilization Review section of this Certificate. We will not add step therapy requirements to a Prescription Drug on Our Formulary during a Plan Year unless the requirements are added pursuant to FDA safety concerns.

3. **Therapeutic Substitution.** Therapeutic substitution is an optional program that tells You and Your Providers about alternatives to certain prescribed drugs. We may contact You and Your Provider to make You aware of these choices. Only You and Your Provider can determine if the therapeutic substitute is right for You. We have a therapeutic drug substitutes list, which We review and update from time to time. For questions or issues about therapeutic drug substitutes, visit Our website at www.aetna.com or call the number on Your ID card.

E. 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.

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.

2. 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.

3. 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.

4. 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.

5. 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.

6. 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.

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

8. 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.

9. 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.

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

F. General Conditions.

1. You must show Your ID card to a retail pharmacy at the time You obtain Your Prescription Drug or You must provide the pharmacy with identifying information that can be verified by Us during regular business hours.

2. **Drug Utilization, Cost Management and Rebates.** We conduct various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, You benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the Premiums for Your coverage.

We may also, from time to time, enter into agreements that result in Us receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others. Any rebates are based upon utilization of Prescription Drugs across all of Our business and not solely on any one Member's utilization of Prescription Drugs. Any rebates received by Us may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of Our Prescription Drug premiums. Instead, any such rebates may be retained by Us, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities and increasing reserves for the protection of Members. Rebates may change or reduce the amount of any Copayment or Coinsurance applicable under Our Prescription Drug coverage.

G. Definitions.

Terms used in this section are defined as follows. (Other defined terms can be found in the Definitions section of this Certificate).

1. **Brand-Name Drug:** A Prescription Drug that: 1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or 2) We identify as a Brand-Name Prescription Drug, based on available data resources. All Prescription Drugs identified as "brand name" by the manufacturer, pharmacy, or Your Physician may not be classified as a Brand-Name Drug by Us.

2. **Designated Pharmacy:** A pharmacy that has entered into an agreement with Us or with an organization contracting on Our behalf, to provide specific Prescription Drugs, including but not limited to, specialty Prescription Drugs. The fact that a pharmacy is a Participating Pharmacy does not mean that it is a Designated Pharmacy.

3. **Formulary:** The list that identifies those Prescription Drugs for which coverage may be available under this Certificate. To determine which tier a particular Prescription Drug has been assigned visit Our website at https://www.aetna.com/individuals-families/find-a-medication.html or call the number on Your ID card.

4. **Generic Drug:** A Prescription Drug that: 1) is chemically equivalent to a Brand-Name Drug; or 2) We identify as a Generic Prescription Drug based on available data resources. All Prescription Drugs identified as "generic" by the manufacturer, pharmacy or Your Physician may not be classified as a Generic Drug by Us.

5. **Maintenance Drug:** A Prescription Drug used to treat a condition that is considered chronic or long-term and which usually requires daily use of Prescription Drugs.

6. **Non-Participating Pharmacy:** A pharmacy that has not entered into an agreement with Us to provide Prescription Drugs to Members.

7. **Participating Pharmacy:** A pharmacy that has:
   - Entered into an agreement with Us or Our designee to provide Prescription Drugs to Members;
   - Agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
   - Been designated by Us as a Participating Pharmacy.

   A Participating Pharmacy can be either a retail or mail-order pharmacy.

8. **Prescription Drug:** A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

9. **Prescription Drug Cost:** The amount, including a dispensing fee and any sales tax, We have agreed to pay Our Participating Pharmacies for a Covered Prescription Drug dispensed at a Participating Pharmacy. If Your Certificate includes coverage at Non-Participating Pharmacies, the Prescription Drug Cost for a Prescription Drug dispensed at a Non-Participating Pharmacy is calculated using the Prescription Drug Cost that applies for that particular Prescription Drug at most Participating Pharmacies.

10. **Prescription Order or Refill:** The directive to dispense a Prescription Drug issued by a duly licensed Health Care Professional who is acting within the scope of his or her practice.

11. **Usual and Customary Charge:** The usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties as required by New York Education Law Section 6826-a.

SECTION XIV

Wellness Benefits

A. Exercise Facility Reimbursement.

We will partially reimburse the Student and the Student's covered Spouse; each covered Dependent for certain exercise facility fees or membership fees but only if such fees are paid to exercise facilities which maintain equipment and programs that promote cardiovascular wellness.

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.

In order to obtain reimbursement, at the end of the six (6)-month period, You must submit:

- A copy of Your current facility bill which shows the fee paid for Your membership.

Once We receive the bill, You will be reimbursed the lesser of $200 for the Student and $100 for the Student's covered Spouse or the actual cost of the membership per six (6)-month period.

B. Discount Arrangements

Aetna arranges for members to get discounts on a wide variety of products and services for your health, wellness and life, such as:

1. At-home health care products - blood pressure monitors, pedometers and activity trackers, and other over-the-counter products
2. Hearing - Hearing exams, hearing aids, batteries, repairs and other hearing aid services
3. Vision - eye exams, frames, lenses, contact lenses and solutions, sunglasses, and LASIK eye surgery
4. Health and fitness - gym memberships, fitness gear, weight loss programs and products, diet and meal plans, books and magazine subscriptions
5. Dental – electronic toothbrushes and a variety of oral health care products
6. Natural products and services - Acupuncture, chiropractic, massage, and nutrition

Generally, other companies provide these discounted goods and services. These companies may pay us so that they can offer you their services.

These discount arrangements are not insurance. You are responsible for paying for the discounted goods or services. We don't pay the companies for them.

Check your Schedule of Benefits for any insurance plan benefits you might have before using these discount offers, as those benefits may give you lower costs than these discounts.

To see what discounts are available and how to use them, log in to your member website at **AetnaStudentHealth.com** once you're an Aetna member.

SECTION XV

Pediatric Vision Care

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits and any Preauthorization or Referral requirements that apply to these benefits.

A. Pediatric Vision Care.
We Cover emergency, preventive and routine vision care for Members through the end of the month in which the Member turns 19 years of age.

B. Pediatric Vision Examinations.
We Cover vision examinations for the purpose of determining the need for corrective lenses, and if needed, to provide a prescription for corrective lenses. We Cover a vision examination one (1) time in any 12 month period, unless more frequent examinations are Medically Necessary as evidenced by appropriate documentation. The vision examination may include, but is not limited to:

- Case history;
- External examination of the eye or internal examination of the eye;
- Ophthalmoscopic exam;
- Determination of refractive status;
- Binocular distance;
- Tonometry tests for glaucoma;
- Gross visual fields and color vision testing; and
- Summary findings and recommendation for corrective lenses.

C. Pediatric Prescribed Lenses and Frames.
We Cover standard prescription lenses or contact lenses one (1) time in any 12 month period, unless it is Medically Necessary for You to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic.

We also Cover standard frames for Members adequate to hold lenses one (1) time in any 12 month period, unless it is Medically Necessary for You to have new frames more frequently, as evidenced by appropriate documentation.

SECTION XVI

Pediatric Dental Care

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

We Cover the following dental care services for Members through the end of the month in which the Member turns 19 years of age:

A. Emergency Dental Care. We Cover emergency dental care, which includes emergency dental treatment required to alleviate pain and suffering caused by dental disease or trauma. Emergency dental care is not subject to Our Preauthorization.

B. Preventive Dental Care. We Cover preventive dental care that includes procedures which help to prevent oral disease from occurring, including:

- Prophylaxis (scaling and polishing the teeth) at six (6) month intervals;
- Topical fluoride application at six (6) month intervals where the local water supply is not fluoridated;
- Sealants on unrestored permanent molar teeth; and
- Unilateral or bilateral space maintainers for placement in a restored deciduous and/or mixed dentition to maintain space for normally developing permanent teeth.

C. Routine Dental Care. We Cover routine dental care provided in the office of a dentist, including:

- Dental examinations, visits and consultations once within a six (6) month consecutive period (when primary teeth erupt);
- X-rays, full mouth x-rays or panoramic x-rays at 36 month intervals, bitewing x-rays at six (6) month intervals, and other x-rays if Medically Necessary (once primary teeth erupt);
- Procedures for simple extractions and other routine dental surgery not requiring Hospitalization, including preoperative care and postoperative care;
- In-office conscious sedation;
- Amalgam, composite restorations and stainless steel crowns; and
- Other restorative materials appropriate for children.

D. Endodontics. We Cover routine endodontic services, including procedures for treatment of diseased pulp chambers and pulp canals, where Hospitalization is not required.

E. Periodontics. We Cover limited periodontic services. We Cover non-surgical periodontic services. We Cover periodontic surgical services necessary for treatment related to hormonal disturbances, drug therapy, or congenital defects. We also Cover periodontic services in anticipation of, or leading to orthodontics that are otherwise Covered under this Certificate.

F. Prosthodontics. We Cover prosthodontic services as follows:

- Removable complete or partial dentures for Members 15 years of age and above, including six (6) months follow-up care;
- Additional services including insertion of identification slips, repairs, relines and rebases and treatment of cleft palate; and
- Interim prosthesis for Members five (5) to 15 years of age.

We do not Cover implants or implant related services.

Fixed bridges are not Covered unless they are required:

- For replacement of a single upper anterior (central/lateral incisor or cuspid) in a patient with an otherwise full complement of natural, functional and/or restored teeth;
- For cleft palate stabilization; or
- Due to the presence of any neurologic or physiologic condition that would preclude the placement of a removable prosthesis, as demonstrated by medical documentation.

G. Oral Surgery. We Cover non-routine oral surgery, such as partial and complete bony extractions, tooth re-implantation, tooth transplantation, surgical access of an unerupted tooth, mobilization of erupted or malpositioned tooth to aid eruption, and placement of device to facilitate eruption of an impacted tooth. We also Cover oral surgery in anticipation of or leading to orthodontics that are otherwise Covered under this Certificate.

H. Orthodontics. We Cover orthodontics used to help restore oral structures to health and function and to treat serious medical conditions such as: cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism; severe asymmetry (craniofacial anomalies); ankylosis of the temporomandibular joint; and other significant skeletal dysplasia.

Procedures include but are not limited to:

- Rapid Palatal Expansion (RPE);
- Placement of component parts (e.g. brackets, bands);
- Interceptive orthodontic treatment;
- Comprehensive orthodontic treatment (during which orthodontic appliances are placed for active treatment and periodically adjusted);
- Removable appliance therapy; and
- Orthodontic retention (removal of appliances, construction and placement of retainers).

SECTION XVII

Exclusions and Limitations

No coverage is available under this Certificate for the following:

A. 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.

B. 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.

C. 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.

D. 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.

E. Coverage Outside of the United States, Canada or Mexico.
We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

F. 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.

G. 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.

H. 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).

I. 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.

J. 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.

K. 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.

L. 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.

M. Military Service.

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

N. 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.

O. Services Not Listed.
We do not Cover services that are not listed in this Certificate as being Covered.

P. 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.

Q. Services Separately Billed by Hospital Employees.
We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

R. Services With No Charge.
We do not Cover services for which no charge is normally made.

S. 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 of this Certificate.

T. War.
We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

U. 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.

SECTION XVIII

Claim Determinations

A. Claims.

A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us.

B. Notice of Claim.

Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on Your ID card or visiting Our website at https://www.aetnastudenthealth.com/. Completed claim forms should be sent to the address in the How Your Coverage Works section of this Certificate or on Your ID card. You may also submit a claim to Us electronically by visiting Our website www.aetna.com.

C. Timeframe for Filing Claims.

Claims for services must be submitted to Us for payment within 120 days after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 120-day period, You must submit it as soon as reasonably possible.

D. Claims for Prohibited Referrals.

We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by New York Public Health Law Section 238-a(1).

E. Claim Determinations.

Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our claim determination procedure applies to contractual benefit denials. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance Procedures section of this Certificate.

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Certificate.

F. Pre-Service Claim Determinations.

1. A pre-service Claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

   If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45-day period.

2. **Urgent Pre-Service Reviews.** With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period. Written notice will follow within three (3) calendar days of the decision.

G. Post-Service Claim Determinations.

A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim if We deny the claim in whole or in part. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period if We deny the claim in whole or in part.

H. Payment of Claims.

Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within 15 days of Our determination that payment is due but no later than 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.

SECTION XIX

Grievance Procedures

A. Grievances.

Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to Providers.

B. Filing a Grievance.

You can contact Us by phone at the number on Your ID card, in person, or in writing to file a Grievance. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

You may ask that We send You electronic notification of a Grievance determination instead of notice in writing or by telephone. You must tell Us in advance if You want to receive electronic notifications. To opt into electronic notifications, call the number on Your ID card or visit Our website https://www.aetnastudenthealth.com/. You can opt out of electronic notifications at any time.

C. Grievance Determination.

Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:	By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.
Pre-Service Grievances: (A request for a service or treatment that has not yet been provided.)	In writing, within 15 calendar days of receipt of Your Grievance.
Post-Service Grievances: (A claim for a service or treatment that has already been provided.)	In writing, within 30 calendar days of receipt of Your Grievance
All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)	In writing, within 30 calendar days of receipt of Your Grievance

D. Assistance.
If You remain dissatisfied with Our Grievance determination, or at any other time You are dissatisfied, You may:

Call the New York State Department of Financial Services at 1-800-342-3736 or write them at:
New York State Department of Financial Services
Consumer Assistance Unit
One Commerce Plaza
Albany, NY 12257
Website: www.dfs.ny.gov

If You need assistance filing a Grievance, You may also contact the state independent Consumer Assistance Program at:
Community Health Advocates
633 Third Avenue 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION XX

Utilization Review

A. Utilization Review.

We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the number on Your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

Initial determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) for mental health or substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment. Appeal determinations that services are not Medically Necessary will be made by: 1) licensed Physicians who are board certified or board eligible in the same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) for mental health or substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary.

We have developed guidelines and protocols to assist Us in this process. We will use evidence-based and peer reviewed clinical review criteria that are appropriate to the age of the patient and designated by OASAS for substance use disorder treatment or approved for use by OMH for mental health treatment. Specific guidelines and protocols are available for Your review upon request. For more information, call the number on Your ID card or visit Our website at https://www.aetnastudenthealth.com/.

You may ask that We send You electronic notification of a Utilization Review determination instead of notice in writing or by telephone. You must tell Us in advance if You want to receive electronic notifications. To opt into electronic notifications, call the number on Your ID card or visit Our website at https://www.aetnastudenthealth.com/. You can opt out of electronic notifications at any time.

B. Preauthorization Reviews.

1. **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

   If We need additional information, We will request it within three (3) business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the earlier of the receipt of part of the requested information or the end of the 45-day period.

2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48 hour period. Written notification will be provided within the earlier of three (3) business days of Our receipt of the information or three (3) calendar days after the verbal notification.

3. **Court Ordered Treatment.** With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if You (or Your designee) certify, in a format prescribed by the Superintendent of Financial Services, that You will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three (3) business days of Our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

4. **Inpatient Rehabilitation Services Review.** After receiving a Preauthorization request for coverage of inpatient rehabilitation services following an inpatient Hospital admission provided by a Hospital or skilled nursing facility, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of the necessary information.

5. **Preauthorization for Rabies Treatment**. Post-exposure rabies treatment authorized by a county health authority is sufficient to be considered Preauthorized by Us.

6. **Crisis Stabilization Centers.** Coverage for services provided at participating crisis stabilization centers licensed under New York Mental Hygiene Law section 36.01 is not subject to Preauthorization. We may review the treatment provided at crisis stabilization centers retrospectively to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS or approved by OMH. If any treatment at a participating crisis stabilization center is denied as not Medically Necessary, You are only responsible for the In-Network Cost-Sharing that would otherwise apply to Your treatment.

C. Concurrent Reviews.

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within the earlier of 15 calendar days of the receipt of part of the requested information or 15 calendar days of the end of the 45-day period.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

   If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of 72 hours or one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour period.

3. **Home Health Care Reviews.** After receiving a request for coverage of home care services following an inpatient Hospital admission, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, We will make a determination and provide notice to You (or Your designee) and Your Provider within 72 hours of receipt of the necessary information. When We receive a request for home care services and all necessary information prior to Your discharge from an inpatient hospital admission, We will not deny coverage for home care services while Our decision on the request is pending.

4. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted to Us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within 24 hours of receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.

5. **Inpatient Mental Health Treatment for Members under 18 at Participating Hospitals Licensed by the Office of Mental Health (OMH).** Coverage for inpatient mental health treatment at a participating OMH-licensed Hospital is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 14 days of the inpatient admission if the OMH-licensed Hospital notifies Us of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 14 days of the inpatient admission, We may review the entire stay to determine whether it is Medically Necessary, and We will use clinical review tools approved by OMH. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the In-Network Cost-Sharing that would otherwise apply to Your inpatient admission.

6. **Inpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for inpatient substance use disorder treatment at a Participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 28 days of the inpatient admission if the OASAS-certified Facility notifies Us of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 28 days of the inpatient admission, We may review the entire stay to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your inpatient admission.

7. **Outpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment at a participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first four (4) weeks of continuous treatment, not to exceed 28 visits, if the OASAS-certified Facility notifies Us of both the start of treatment and the initial treatment plan within two (2) business days. After the first four (4) weeks of continuous treatment, not to exceed 28 visits, We may review the entire outpatient treatment to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS. If any portion of the outpatient treatment is denied as not Medically Necessary, You are only responsible for the In-Network Cost-Sharing that would otherwise apply to Your outpatient treatment.

D. Retrospective Reviews.

If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of all or part of the requested information or the end of the 45-day period.

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

E. Retrospective Review of Preauthorized Services.

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

F. Step Therapy Override Determinations

You, Your designee or Your Health Care Professional may request a step therapy protocol override determination for Coverage of a Prescription Drug selected by Your Health Care Professional. When conducting Utilization Review for a step therapy protocol override determination, We will use recognized evidence-based and peer reviewed clinical review criteria that is appropriate for You and Your medical condition.

1. **Supporting Rationale and Documentation.** A step therapy protocol override determination request must include supporting rationale and documentation from a Health Care Professional, demonstrating that:
    - The required Prescription Drug(s) is contraindicated or will likely cause an adverse reaction or physical or mental harm to You:
    - The required Prescription Drug(s) is expected to be ineffective based on Your known clinical history, condition, and Prescription Drug regimen;
    - You have tried the required Prescription Drug(s) while covered by Us or under Your previous health insurance coverage or another Prescription Drug in the same pharmacologic class or with the same mechanism of action, and that Prescription Drug(s) was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
    - You are stable on a Prescription Drug(s) selected by Your Health Care Professional for Your medical condition, provided this does not prevent Us from requiring You to try an AB-rated generic equivalent; or
    - The Required Prescription Drug(s) is not in Your best interest because it will likely cause a significant barrier to Your adherence to or compliance with Your plan of care, will likely worsen a comorbid condition, or will likely decrease Your ability to achieve or maintain reasonable functional ability in performing daily activities.

2. **Standard Review.** We will make a step therapy protocol override determination and provide notification to You or Your designee and, where appropriate, Your Health Care Professional, within 72 hours of receipt of the supporting rationale and documentation.

3. **Expedited Review.** If You have a medical condition that places Your health in serious jeopardy without the Prescription Drug prescribed by Your Health Care Professional, We will make a step therapy protocol override determination and provide notification to You or Your designee and Your Health Care Professional within 24 hours of receipt of the supporting rationale and documentation.

If the required supporting rationale and documentation are not submitted with a step therapy protocol override determination request. We will request the information within 72 hours for Preauthorization and retrospective reviews, the lesser of 72 hours or one (1) business day for concurrent reviews, and 24 hours for expedited reviews. You (or Your designee) and Your Health Care Professional will have 45 calendar days to submit the information for Preauthorization, concurrent and retrospective reviews, and 48 hours for expedited reviews. For Preauthorization reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 72 hours of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For concurrent reviews, We will make a determination and provide notification to You or Your designee and Your Health Care Professional within the earlier of 72 hours or one (1) business day of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For retrospective reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 72 hours of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For expedited reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 24 hours of Our receipt of the information or 48 hours of the end of the 48-hour period if the information is not received.

If We do not make a determination within 72 hours (or 24 hours for expedited reviews) of receipt of the supporting rationale and documentation, the step therapy protocol override request will be approved.

If We determine that the step therapy protocol should be overridden, We will authorize immediate coverage for the Prescription Drug prescribed by Your treating Health Care Professional. An adverse step therapy override determination is eligible for an Appeal.

G. Reconsideration.

If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

H. Utilization Review Internal Appeals.

You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling Your Appeal and, if necessary, inform You of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is (1) a Physician or (2) a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

1. **Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, You or Your designee must submit:
    - A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
    - Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-Network Referral Denial.** You also have the right to Appeal the denial of a request for a Referral to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network Referral denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:
   - That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and
   - Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

I. Standard Appeal.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.

2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within the earlier of 30 calendar days of receipt of the information necessary to conduct the Appeal or 60 days of receipt of the Appeal. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 60 calendar days after receipt of the Appeal request.

3. **Expedited Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal. Written notice of the determination will be provided to You (or Your designee) within 24 hours after the determination is made, but no later than 72 hours after receipt of the Appeal request.

   Our failure to render a determination of Your Appeal within 30 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

4. **Substance Use Appeal.** If We deny a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and You or Your Provider file an expedited internal Appeal of Our adverse determination, We will decide the Appeal within 24 hours of receipt of the Appeal request. If You or Your Provider file the expedited internal Appeal and an expedited external appeal within 24 hours of receipt of Our adverse determination, We will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external appeal is pending.

J. Full and Fair Review of an Appeal.

We will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by Us or any new or additional rationale in connection with Your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

K. Appeal Assistance.

If You need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION XXI

External Appeal

A. Your Right to an External Appeal.

In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is an out-of-network treatment, or is an emergency service or a surprise bill (including whether the correct Cost-Sharing was applied), You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two (2) requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under this Certificate; and
- In general, You must have received a final adverse determination through Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through Our internal Appeal process if:
    - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
    - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
    - We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

B. Your Right to Appeal a Determination that a Service is Not Medically Necessary.

If We have denied coverage on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph "A" above.

C. Your Right to Appeal a Determination that a Service is Experimental or Investigational.

If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph "A" above and Your attending Physician must certify that Your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; **or**
2. There does not exist a more beneficial standard service or procedure Covered by Us; **or**
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one (1) of the following:

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network **or** that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

D. Your Right to Appeal a Determination that a Service is Out-of-Network.

If We have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above, and You have requested Preauthorization for the out-of-network treatment.

In addition, Your attending Physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

E. Your Right to Appeal an Out-of-Network Referral Denial to a Non-Participating Provider.

If We have denied coverage of a request for a Referral to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above.

In addition, Your attending Physician must: 1) certify that the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs; and 2) recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

F. The External Appeal Process.

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited external appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received Emergency Services and have not been discharged from a Facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, We will provide coverage subject to the other terms and conditions of this Certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the cost of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, 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.

The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

We will charge You a fee of $25 for each external appeal, not to exceed $75 in a single Plan Year. The external appeal application will explain how to submit the fee. We will waive the fee if We determine that paying the fee would be a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to You.

G. Your Responsibilities.

It is Your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

SECTION XXII

Termination of Coverage

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

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

2. The date on which the Student ceases to meet the eligibility requirements as defined by the Policyholder. We will provide written notice to the Student at least 30 days prior to when the coverage will cease.

3. Upon the Student's death, coverage will terminate unless the Student has coverage for Dependents. If the Student has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium has been paid.

4. For Spouses in cases of divorce, the date of the divorce.

5. For Children, until the end of the year in which the Child turns 26 years of age.

6. For all other Dependents, the end of the year in which the Dependent ceases to be eligible.

7. The end of the month following the Student provision of written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.

8. If a Student or the Student's Dependent has performed an act that constitutes fraud or the Student has made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Student and/or the Student's Dependent, as applicable. If termination is a result of the Student's action, coverage will terminate for the Student and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.

9. The date that the Policyholder's Policy is terminated. If We decide to stop offering a particular class of policies, without regard to claims experience or health related status, to which this Certificate belongs, We will provide the Policyholder and Students at least 90 days' prior written notice.

10. If We decide to stop offering all student accident and health insurance coverage in this state, We will provide written notice to the Policyholder at least 180 days prior to when the coverage will cease.

11. The Policyholder has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.

12. For such other reasons that are acceptable to the superintendent and authorized by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, and any later amendments or successor provisions, or by any federal regulations or rules that implement the provisions of the Act.

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

SECTION XXIII

Extension of Benefits

When Your coverage under this Certificate ends, benefits stop. But if You are totally disabled on the date Your coverage under this Certificate terminates, continued benefits may be available for the treatment of the injury or sickness that is the cause of the total disability. If you are pregnant on the date Your coverage under this Certificate terminates, continued benefits may be available for Your maternity care.

A. When You May Continue Benefit.

1. If You are totally disabled on the date Your coverage under this Certificate terminates, We will continue to pay for Your care under this Certificate during an uninterrupted period of total disability until the first of the following:
    - The date You are no longer totally disabled; or
    - 90 days from the date extended benefits began (if Your benefits are extended based on termination of Student status
2. If You are pregnant on the date Your coverage under this Certificate terminates, We will continue to pay for Your maternity care under this Certificate through delivery and any post-partum services directly related to the delivery.

B. Limits on Extended Benefits.

We will not pay extended benefits:

- For any Member who is not totally disabled or pregnant on the date coverage under this Certificate ends; or
- Beyond the extent to which We would have paid benefits under this Certificate if coverage had not ended.

SECTION XXIV

Temporary Suspension Rights for Armed Forces' Members

If You, the Student, are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government; and
2. Your service ends during the Plan Year for which this Certificate is effective.

You must make written request to Us to have Your coverage suspended during a period of active duty. Your unearned Premiums will be refunded during the period of such suspension.

Upon completion of active duty, Your coverage may be resumed as long as You:

1. Make written application to Us; and
2. Remit the Premium within 60 days of the termination of active duty.

The right of resumption extends to coverage for Your Dependents. For coverage that was suspended while on active duty, coverage will be retroactive to the date on which active duty terminated.

SECTION XXV

General Provisions

1. Agreements Between Us and Participating Providers.
Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Certificate does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any health benefits program.

2. Assignment.
You cannot assign any benefits under this Certificate to any person, corporation or other organization and any such assignment will be void and unenforceable. You cannot assign any monies due under this Certificate to any person, corporation or other organization.

Assignment means the transfer to another person, corporation or other organization of Your right to the services provided under this Certificate or Your right to collect money from Us for those services.

3. Choice of Law.
This Certificate shall be governed by the laws of the State of New York.

4. Clerical Error.
Clerical error, whether by the Policyholder or Us, with respect to this Certificate, or any other documentation issued by Us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

5. Conformity with Law.
Any term of this Certificate which is in conflict with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

6. Continuation of Benefit Limitations.
Some of the benefits in this Certificate may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, if Your coverage status changes from covered family member to Student, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Student.

7. Entire Agreement.
This Certificate including any endorsements, riders and the attached applications, if any, constitutes the entire Certificate.

8. Furnishing Information and Audit.
All persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with information over the telephone for reasons such as the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care. The Policyholder will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to enrollment at the Policyholder's New York office.

9. Identification Cards.
Identification ("ID") cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits, Your Premiums must be paid in full at the time the services are sought to be received.

10. Incontestability.
No statement made by the Student in an application for coverage under this Policy shall avoid the Policy or be used in any legal proceeding unless the application or an exact copy is attached to this Policy.

11. Independent Contractors.
Participating Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Participating Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You, or Your covered Spouse or Children while receiving care from any Participating Provider or in any Participating Provider's Facility.

12. Material Accessibility.
We will give the Policyholder and the Policyholder will give You: ID cards, Certificates, riders and other necessary materials.

13. More Information about Your Health Plan.
You can request additional information about Your coverage under this Certificate. Upon Your request, We will provide the following information:

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.
- A copy of Our drug formulary. You may also inquire if a specific drug is Covered under this Certificate.
- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- Provider affiliations with participating Hospitals.
- A copy of Our clinical review criteria (e.g. Medical Necessity criteria), and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines including clinical review criteria relating to a step therapy protocol override determination.
- Written application procedures and minimum qualification requirements for Providers.
- Documents that contain the processes, strategies evidentiary standards, and other factors used to apply a treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the Certificate.

14. Notice.
Any notice that We give You under this Certificate will be mailed to Your address as it appears in Our records. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. mail, first class, postage prepaid to: the address on Your ID card.

15. Premium Refund.
We will give any refund of Premiums which are paid by You, if due, to You.

16. Recovery of Overpayments.
On occasion, a payment will be made to You when You are not covered, for a service that is not Covered, or which is more than is proper. When this happens, We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

17. Reinstatement after Default.
If the Student defaults in making any payment this Policy, the subsequent acceptance of payment by Us or by one of Our authorized agents or brokers shall reinstate the Policy.

18. Right to Develop Guidelines and Administrative Rules.
We may develop or adopt standards that describe in more detail when We will or will not make payments under this Certificate. Examples of the use of the standards are to determine whether: Hospital inpatient care was Medically Necessary; surgery was Medically Necessary to treat Your illness or injury; or certain services are skilled care. Those standards will not be contrary to the descriptions in this Certificate. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters. We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Certificate.

We review and evaluate new technology according to technology evaluation criteria developed by Our medical directors and reviewed by a designated committee, which consists of Health Care Professionals from various medical specialties. Conclusions of the committee are incorporated into Our medical policies to establish decision protocols for determining whether a service is Medically Necessary, experimental or investigational, or included as a covered benefit.

19. Right to Offset.
If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

20. Severability.
The unenforceability or invalidity of any provision of this Certificate shall not affect the validity and enforceability of the remainder of this Certificate.

21. Significant Change in Circumstances.
If We are unable to arrange for Covered Services as provided under this Certificate as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel, or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

22. Subrogation and Reimbursement.
These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for Your injury, illness or other condition and We have provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to You under this Certificate. Subrogation means that We have the right, independently of You, to proceed directly against the other party to recover the benefits that We have provided.

Subject to applicable state law, unless preempted by federal law, We may have a right of reimbursement if You or anyone on Your behalf receives payment from any responsible party (including Your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness, or condition for which We provided benefits. Under Section 5-335 of the New York General Obligations Law, Our right of recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that You did not take any action against Our rights or violate any contract between You and Us. The law presumes that the settlement between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

We request that You notify Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by You for which We have provided benefits. You must provide all information requested by Us or Our representatives including, but not limited to, completing and submitting any applications or other forms or statements as We may reasonably request.

23. Third Party Beneficiaries.
No third party beneficiaries are intended to be created by this Certificate and nothing in this Certificate shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Certificate. No other party can enforce this Certificate's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Certificate, or to bring an action or pursuit for the breach of any terms of this Certificate.

24. Time to Sue.
No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within three (3) years from the date the claim was required to be filed.

25. Translation Services.
Translation services are available under this Certificate for non-English speaking Members. Please contact Us at the number on Your ID card to access these services.

26. Waiver.
The waiver by any party of any breach of any provision of this Certificate will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

27. Who May Change this Certificate.
This Certificate may not be modified, amended, or changed, except in writing and signed by Our Chief Executive Officer ("CEO") or a person designated by the CEO. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Certificate in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the CEO or person designated by the CEO.

28. Who Receives Payment under this Certificate.
Payments under this Certificate for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider. However, We will directly pay a Provider instead of You for Emergency Services, including inpatient services following Emergency Department Care, pre-hospital emergency medical services, air ambulance services, and surprise bills.

29. Workers' Compensation Not Affected.

The coverage provided under this Certificate is not in lieu of and does not affect any requirements for coverage by workers' compensation insurance or law.

30. Your Medical Records and Reports.

In order to provide Your coverage under this Certificate, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Certificate, except as prohibited by state or federal law, You automatically give Us or Our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and
- Permit copying of Your medical records by Us.

We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, to the extent permitted under state or federal law, You automatically give Us permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Certificate, so long as they also agree to maintain the information in accordance with state and federal confidentiality requirements.

SECTION XXVI

Other Covered Services

1. Medical Evacuation, Assistance and Repatriation Benefits

Definitions

The following definitions apply to the Medical Evacuation, Assistance and Repatriation benefits described further below.

- "Emergency Medical Event" means an event wherein a Member's medical condition and circumstances are such that, in the opinion of Our authorized vendor and the Member's treating physician, the Member has an Emergency Condition and adequate medical treatment is not available at the Member's initial medical facility.

- "Home Country" means, with respect to a Member, the country or territory as shown on the Member's passport or, if different, the country or territory of which the Member is a permanent resident.

- "Host Country" means, with respect to a Member, the country or territory the Member is visiting or in which the Member is living, which is not the Member's Home Country.

- "Physician Advisors" mean physicians retained by Our authorized vendor for provision of consultative and advisory services to Our authorized vendor, including the review and analysis of the medical care received by Members.

Eligibility
A Member under this student Policy is eligible for Medical Evacuation, Assistance and Repatriation benefits in addition to the underlying plan coverage. The requirements to receive these benefits are as follows:

- An international Student (whose Home Country is not the United States), and their Spouse and child(ren) are eligible to receive Medical Evacuation, Assistance and Repatriation Benefits worldwide, except in their Home Country.
- A domestic Student (whose Home Country is the United States), and their Spouse and child(ren) are eligible for Medical Evacuation, Assistance and Repatriation Benefits when 100 miles or more away from their primary residence or while participating in a study abroad program.

2. Covered Services

A Member should notify Our authorized vendor to obtain benefits for Medical Evacuation, Assistance and Repatriation, unless a Member is incapacitated and unable to contact Our authorized vendor during an Emergency Medical Event.

If the Member doesn't notify Our authorized vendor, benefits will be limited to the amount that would have been paid if advance notice had been provided.

Call 1-866-525-1956 for Medical Evacuation, Assistance and Repatriation Benefits 24 hours a day, 7 days a week, 365 days a year. If the condition is an Emergency Condition, the Member should go immediately to the nearest physician or hospital without delay and then call the number on the Member's ID card.

Services are covered if needed due to a Member's illness or injury. These services are subject to the Limits shown on the Schedule of Benefits.

- *Emergency Medical Evacuation*: If a Member experiences an Emergency Medical Event and adequate medical facilities are not available locally in the opinion of the Physician Advisors of Our authorized vendor, Our authorized vendor will provide an emergency medical evacuation (under medical supervision if necessary) from a land-based treatment location to the nearest facility capable of providing adequate care by whatever means is necessary. We will pay costs for arranging and providing for Medically Necessary transportation and related medical services (including the cost of a medical escort) and medical supplies incurred in connection with the emergency medical evacuation.

- *Medical Repatriation*: After a Member receives initial treatment and stabilization for an Emergency Medical Event in a land-based treatment facility, if the attending physician and the Physician Advisors of Our authorized vendor determine that it is Medically Necessary, Our authorized vendor will transport a Member back to the Member's campus or permanent place of residence for further medical treatment or to recover. We will pay costs for arranging and providing for transportation and related medical services (including the cost of a medical escort if necessary) and medical supplies necessarily incurred in connection with the repatriation.

- *Transportation to Join a Hospitalized Member*: If a Member who is travelling alone is or will be hospitalized for more than three (3) days due to a sickness or injury, Our authorized vendor will coordinate round-trip airfare for a person of the Member's choice to join the Member. We will pay costs for economy class round-trip airfare for a person to join the Member.

- *Return of Minor Children*: If a Member's minor child(ren) age 18 or under are present but left unattended as a result of the Member's injury or sickness, Our authorized vendor will coordinate airfare to send them back to the Member's Home Country. Our authorized vendor will also arrange for the services, transportation expenses, and accommodations of a non-medical escort, if required as determined by Our authorized vendor. We will pay costs for economy class one-way airfare for the minor children (or upgraded transportation to match the Member's originally booked travel arrangement) and, if required, the cost of the services, transportation expenses, and accommodations of a non-medical escort to accompany the minor children back to the Member's Home Country.

- *Repatriation of Mortal Remains*: In the event of a Member's death, Our authorized vendor will assist in obtaining the necessary clearances for the Member's cremation or the return of the Member's mortal remains. Our authorized vendor will coordinate the preparation and transportation of the Member's mortal remains from a land-based location to the Member's Home Country or place of primary residence, as it obtains the number of certified death certificates required by the Host Country and Home Country to release and receive the remains. We will pay costs for the certified death certificates required by the Home Country or Host Country to release the remains and expenses of the preparation and transportation of the Member's mortal remains to the Member's Home Country or place of primary residence.

3. Conditions and Limitations

- Covered Services shall only be provided to a Member after Our authorized vendor receives the request (in writing or via phone) from the Member or an authorized representative of the Member of the need for the requested Covered Services. Unless a Member is incapacitated and unable to contact Our authorized vendor during an Emergency Medical Event, for Covered Services to be available, the requested Covered Services and payments must be arranged, authorized, verified and approved in advance by Our authorized vendor to be covered. If a Member is incapacitated and unable to immediately contact Our authorized vendor due to an Emergency Medical Event, the Member should notify Our authorized vendor within 48 hours or as soon as reasonably possible.

- With respect to any evacuation requested by a Member, Our authorized vendor reserves the right to determine the need for and the feasibility of an evacuation and the means, method, timing, and destination of such evacuation, and may consult with relevant third-parties, including as applicable, Physician advisors and treating Physicians as needed to make its determination.

- If a Member is incapacitated or deceased, his/her designated or legal representative shall have the right to act for and on behalf of the Member.

SECTION XXVII

Accidental Death and Dismemberment Benefits

If an Accidental injury results in any one of the following specific losses to a Member, We will pay the applicable amount below in addition to payments made for Covered Services.

Exclusions that apply to these benefits can be found in the Exclusions and Limitations section of this Certificate.

Loss of Life
The death must occur within 364 days of the Accidental injury.

Loss of Limb or Sight
The Loss must occur within 364 days of the Accidental Injury. If multiple losses occur as a result of the same Accidental injury, only the benefit with the largest benefit amount is payable.

Claims for benefits under this Section should be submitted to:

On Call International Claims Department
11 Manor Parkway
Salem, NH 03079
Ph: 855-878-9590
Fax: 603-898-9172
Aetnastudentclaims@oncallinternational.com

The definitions below apply to this Section of the Certificate only. See the Definitions section for other defined terms.

Accident means a sudden, unexpected event that occurs abruptly and by chance at an identifiable time and place, the cause of which is beyond the control of the Member.

Accidental injury means an injury to a Member that is directly caused by an Accident and is the direct cause of an injury or loss sustained on or after the Member's effective date of coverage and while this policy is in force, which is independent of sickness and not excluded under this Certificate.

Loss of a Hand(s) means complete severance, as determined by a Physician, of at least four (4) fingers at or above the metacarpal phalangeal joint on the same hand or at least three (3) fingers and the thumb on the same hand. We will consider such severance a Loss of a Hand even if the hand, fingers or thumb are later reattached. If the reattachment fails and amputation becomes necessary, then We will not pay an additional benefit amount for such amputation.

Loss of a Foot/Feet means complete Severance through or above the ankle joint. We will consider such Severance a Loss of a Foot even if the foot is later reattached. If the reattachment fails and amputation becomes necessary, then We will not pay an additional benefit amount for such amputation.

Loss of Sight means permanent loss of vision. Any remaining vision must be no better than 20/200 using a corrective aid or device, as determined by a Physician.

Loss of Speech means total and permanent loss of audible communication which is irrecoverable by natural, surgical or artificial means.

Loss of Hearing means permanent, irrecoverable and total deafness, as determined by a Physician, with an auditory threshold of more than ninety (90) decibels in each ear. The deafness cannot be corrected by any aid or device, as determined by a Physician.

Loss of Thumb and Index Finger on the Same Hand means complete Severance, through the metacarpal phalangeal joints, of the thumb and index finger of the same hand, as determined by a Physician. We will consider such severance a Loss of Thumb and Index Finger even if a thumb, an index finger or both are later reattached. If the reattachment fails and amputation becomes necessary, then We will not pay an additional benefit amount for such amputation.

Loss of all Four Fingers on the Same Hand means complete Severance, through the metacarpal phalangeal joints, of the index fingers of the same hand, as determined by a Physician. We will consider such Severance a Loss of all Four Fingers on the Same Hand even if one or more index fingers are later reattached. If the reattachment fails and amputation becomes necessary, then We will not pay an additional benefit amount for such amputation.

Loss of Toes means complete Severance through the metatarsophalangeal joint (the joint between the toes and the foot).

Loss of Thumb means complete Severance through or above the metacarpal phalangeal joint (the joint between the thumb and the hand).

Severance means complete separation and dismemberment of the part from the body.

SECTION XXVIII

New York Student Health Plan SCHEDULE OF BENEFITS

Gold 79.93%

Yeshiva University

COST-SHARING	**Participating Provider Member Responsibility for Cost-Sharing**	**Non-Participating Provider Member Responsibility for Cost-Sharing**	**Limit**
Medical Deductible • Individual • Family	$600 None	$2,000 None	
Prescription Drug Deductible • Individual	$100		
Out-of-Pocket Limit • Individual • Family	$9,100 $18,200	Unlimited Unlimited See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how We calculate the Allowed Amount. Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount of the Non-Participating Provider's charge that exceeds Our Allowed Amount.	
OFFICE VISITS			
Primary Care Office Visits (or Home Visits)	$50 Copayment then You pay 0% not subject to Deductible	$50 Copayment then You pay 30% not subject to Deductible	See benefit for description
Specialist Office Visits (or Home Visits)	$50 Copayment then You pay 0% not subject to Deductible	$50 Copayment then You pay 30% not subject to Deductible	See benefit for description

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
PREVENTIVE CARE			
Well Child Visits and Immunizations*	Covered in full	30% Coinsurance not subject to Deductible	See benefit for description
Adult Annual Physical Examinations*	Covered in full	30% Coinsurance not subject to Deductible	See benefit for description
Adult Immunizations*	Covered in full	30% Coinsurance not subject to Deductible	See benefit for description
Routine Gynecological Services/Well Woman Exams*	Covered in full	30% Coinsurance not subject to Deductible	See benefit for description
Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full	30% Coinsurance not subject to Deductible	See benefit for description
Sterilization Procedures for Women*	Covered in full	30% Coinsurance not subject to Deductible	
Vasectomy	20% Coinsurance after Deductible	30% Coinsurance after Deductible	See benefit for description
Bone Density Testing*	Covered in full	30% Coinsurance not subject to Deductible	See benefit for description
Screening for Prostate Cancer	Covered in full	30% Coinsurance not subject to Deductible	
Screening for Colon Cancer	Covered in full	30% Coinsurance not subject to Deductible	
All other preventive services required by USPSTF and HRSA.	Covered in full	30% Coinsurance not subject to Deductible	See benefit for description
*When preventive services are not provided in accordance with the comprehensive guidelines supported by United States Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA).	Use Cost Sharing for Appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Use Cost Sharing for Appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
EMERGENCY CARE			
Pre-Hospital Emergency Medical Services (Ambulance Services)	20% Coinsurance after Deductible	Paid the same as Participating Provider	See benefit for description
Non-Emergency Ambulance Services **Preauthorization Required**	20% Coinsurance after Deductible	20% Coinsurance after Deductible	See benefit for description
Emergency Department Copayment /Coinsurance waived if Hospital admission.	$200 Copayment then You pay 20% after Deductible Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	Paid the same as Participating Provider Health care forensic examinations performed under Public Health Law § 2805-I are not subject to Cost-Sharing	See benefit for description
Urgent Care Center	$50 Copayment then You pay 0% not subject to Deductible	$50 Copayment then You pay 30% not subject to Deductible	See benefit for description
PROFESSIONAL SERVICES AND OUTPATIENT CARE			
Acupuncture	$50 Copayment then You pay 0% not subject to Deductible	$50 Copayment then You pay 30% not subject to Deductible	
Advanced Imaging Services			
• Performed in a Specialist Office **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
• Performed in a Freestanding Radiology Facility **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
• Performed as Outpatient Hospital Services **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
Allergy Testing & Treatment			
• Performed in a PCP Office	$50 Copayment then You pay 0% not subject to Deductible	$50 Copayment then You pay 30% not subject to Deductible	See benefit for description
• Performed in a Specialist Office	$50 Copayment then You pay 0% not subject to Deductible	$50 Copayment then You pay 30% not subject to Deductible	See benefit for description
Ambulatory Surgical Center			
Ambulatory Surgical Center Facility Fee **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Anesthesia Services			
Anesthesia Services (all settings)	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Cardiac & Pulmonary Rehabilitation			
• Performed in a Specialist Office	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefits for description
• Performed as Outpatient Hospital Services **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefits for description
• Performed as Inpatient Hospital Services **Preauthorization Required**	Included As Part of Inpatient Hospital Service Cost-Sharing	Included As Part of Inpatient Hospital Service Cost-Sharing	See benefits for description
Chemotherapy and Immunotherapy			
• Performed in a PCP Office	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefits for description
• Performed in a Specialist Office	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefits for description

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
• Performed as Outpatient Hospital Services **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefits for description
Chiropractic Services			
• Chiropractic Services	$50 Copayment then You pay 0% not subject to Deductible	$50 Copayment then You pay 30% not subject to Deductible	See benefits for description
Clinical Trials			
• Clinical Trials **Preauthorization Required**	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description
Diagnostic Testing			
• Performed in a PCP Office	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefits for description
• Performed in a Specialist Office	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefits for description
• Performed as Outpatient Hospital Services **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefits for description
Dialysis			
• Performed in a PCP Office **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	
• Performed in a Freestanding Center **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
• Performed as Outpatient Hospital Services **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)			
• Performed in a PCP Office	20% Coinsurance after Deductible	50% Coinsurance after Deductible	Unlimited visits per Plan Year
• Performed in a Specialist Office	20% Coinsurance after Deductible	50% Coinsurance after Deductible	
• Performed in an Outpatient Facility **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	
Home Health Care			
Home Health Care **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	Unlimited visits per Plan Year
Infertility Services			
Infertility Services **Preauthorization Required**	Use Cost Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	See benefit for description
Infusion Therapy			
• Performed in a PCP Office	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
• Performed in Specialist Office	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
• Performed as Outpatient Hospital Services **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
• Home Infusion Therapy **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	Home infusion counts towards home health care visit limits
Inpatient Medical Visits			
Inpatient Medical Visits **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Interruption of Pregnancy			
Interruption of Pregnancy • Abortion Services	Covered in full	30% Coinsurance not subject to Deductible	See benefit for description
Laboratory Procedures			
• Performed in a PCP Office	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
• Performed in a Freestanding Laboratory Facility	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
• Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
Maternity & Newborn Care			
• Prenatal Care • Prenatal Care provided in accordance with the comprehensive guidelines supported by United States Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA)	Covered In Full	30% Coinsurance after Deductible	See Benefit For Description
• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by United States Preventive Services Task Force (USPSTF) and Health Resources and Services Administration (HRSA)	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit, Specialist Office Visit, Diagnostic Radiology Services, Laboratory Procedures and Diagnostic Testing)	See Benefit For Description
• Inpatient Hospital Services and Birthing Center **Preauthorization Required for Inpatient Services**	20% Coinsurance per admission after Deductible	50% Coinsurance per admission after Deductible	One (1) Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early
• Physician and Midwife Services for Delivery	20% Coinsurance per admission after Deductible	50% Coinsurance per admission after Deductible	
• Breastfeeding Support, Counseling and Supplies including Breast Pumps	Covered in Full	30% Coinsurance after Deductible	Covered for duration of breast feeding
• Postnatal Care	$50 Copayment then You pay 0% not subject to Deductible	$50 Copayment then You pay 30% not subject to Deductible	

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
Outpatient Hospital Surgery Facility Charge			
• Outpatient Hospital Surgery Facility Charge **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Preadmission Testing			
Preadmission Testing	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities			
• Performed in a PCP Office **Preauthorization Required**	$50 Copayment then You pay 0% not subject to Deductible	$50 Copayment then You pay 30% not subject to Deductible	See benefit for description
• Performed in Specialist Office **Preauthorization Required**	$50 Copayment then You pay 0% not subject to Deductible	$50 Copayment then You pay 30% not subject to Deductible	See benefit for description
• Performed in Outpatient Facilities **Preauthorization Required**	$50 Copayment then You pay 0% not subject to Deductible	$50 Copayment then You pay 30% not subject to Deductible	See benefit for description
Diagnostic Radiology Services			
• Performed in a PCP Office	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
• Performed in a Specialist Office	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
• Performed in a Freestanding Radiology Facility	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
• Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
Therapeutic Radiology Services			
• Performed in a Specialist Office	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
• Performed in a Freestanding Radiology Facility **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
• Performed as Outpatient Hospital Services **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)			
• Performed in a PCP Office	20% Coinsurance after Deductible	50% Coinsurance after Deductible	Unlimited visits per Plan Year Speech and physical therapy are only Covered following a Hospital stay or surgery.
• Performed in a Specialist Office	20% Coinsurance after Deductible	50% Coinsurance after Deductible	
• Performed in an Outpatient Facility **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	
Second Opinions on the Diagnosis of Cancer, Surgery & Other			
• Second Opinions on the Diagnosis of Cancer, Surgery & Other	$50 Copayment then You pay 0% not subject to Deductible	$50 Copayment then You pay 30% not subject to Deductible Second Opinions on Diagnosis of Cancer are Covered at participating Cost-Sharing for non-participating Specialist	See benefit for description

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
Surgical Services (Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery and Transplants			
• Inpatient Hospital Surgery **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description **All transplants must be performed at Designated Facilities**
• Outpatient Hospital Surgery **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	
• Surgery Performed at an Ambulatory Surgical Center **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	
• Office Surgery	20% Coinsurance after Deductible	50% Coinsurance after Deductible	
ADDITIONAL SERVICES, EQUIPMENT & DEVICES			
Diabetic Equipment, Supplies & Self-Management Education			
• Diabetic Equipment and Supplies, and Insulin (30-Day Supply)	$25 Copayment then You pay 0% not subject to Deductible but not more than $100 in Cost-Sharing for a 30-day supply for an insulin drug.	$25 Copayment then You pay 0% not subject to Deductible but not more than $100 in Cost-Sharing for a 30-day supply for an insulin drug.	See benefit for description
• Diabetic Insulin (30 Day Supply	$25 Copayment then You pay 0% not subject to Deductible but not more than $100 in Cost-Sharing for a 30-day supply for an insulin drug.	$25 Copayment then You pay 0% not subject to Deductible but not more than $100 in Cost-Sharing for a 30-day supply for an insulin drug.	See benefit for description
• Oral anti-diabetic agents and injectable anti-diabetic agents (30 day supply)	$25 Copayment then You pay 0% not subject to Deductible	$25 Copayment then You pay 0% not subject to Deductible	See benefit for description

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
• Diabetic Education	$50 Copayment then You pay 0% not subject to Deductible	$50 Copayment then You pay 30% not subject to Deductible	See benefit for description
Durable Medical Equipment & Braces			
Durable Medical Equipment & Braces	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
External Hearing Aids			
External Hearing Aids • **Prescription Hearing Aids**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	Single purchase once every three (3) years
Cochlear Implants			
Cochlear Implants	20% Coinsurance after Deductible	50% Coinsurance after Deductible	One (1) per ear per Plan Year
Hospice Care			
Hospice Care • Inpatient **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	Unlimited days per Plan Year
• Outpatient **Preauthorization Required**	20% Coinsurance after Deductible	50% Coinsurance after Deductible	Five (5) visits for family bereavement counseling
Medical Supplies			
Medical Supplies	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description
Prosthetic Devices			
• External	20% Coinsurance after Deductible	50% Coinsurance after Deductible	One (1) prosthetic device, per limb, per Plan Year
• Internal	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefit for description

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
INPATIENT SERVICES & FACILITIES			
Autologous Blood Banking	20% Coinsurance after Deductible	50% Coinsurance after Deductible	See benefits for description
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care) **Preauthorization Required. However, Preauthorization is not required for emergency admissions or services provided in a neonatal intensive care unit of a Hospital certified pursuant to Article 28 of the Public Health Law.**	20% Coinsurance per admission after Deductible	50% Coinsurance per admission after Deductible	See benefit for description
Observation Stay **Preauthorization Required**	20% Coinsurance per admission after Deductible	50% Coinsurance per admission after Deductible	See benefit for description
Skilled Nursing Facility (Includes Cardiac & Pulmonary Rehabilitation) **Preauthorization Required**	20% Coinsurance per admission after Deductible	50% Coinsurance per admission after Deductible	Two hundred (200) days per Plan Year
Inpatient Habilitation Services (Physical Speech and Occupational Therapy) **Preauthorization Required**	20% Coinsurance per admission after Deductible	50% Coinsurance per admission after Deductible	Unlimited visits per Plan Year

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
Inpatient Rehabilitation Services (Physical, Speech & Occupational therapy) **Preauthorization Required**	20% Coinsurance per admission after Deductible	50% Coinsurance per admission after Deductible	Unlimited visits per Plan Year Speech and physical therapy are only Covered following a Hospital stay or surgery
MENTAL HEALTH & SUBSTANCE USE DISORDER SERVICES			
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment) **Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions or for admissions at Participating OMH licensed Facilities for Members under 18.**	20% Coinsurance per admission after Deductible	50% Coinsurance per admission after Deductible	See benefit for description
Outpatient Mental Health Care (Including Partial Hospitalization & Intensive Outpatient Program Services)			
• Office Visits	$50 Copayment then You pay 0% not subject to Deductible	$50 Copayment then You pay 30% not subject to Deductible	See benefit for description
• All Other Outpatient Services	0% Coinsurance not subject to Deductible	0% Coinsurance not subject to Deductible	See benefit for description
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment) **Preauthorization Required. However, Preauthorization is Not Required for Emergency Admissions or for Participating OASAS-certified Facilities**	20% Coinsurance per admission after Deductible	50% Coinsurance per admission after Deductible	See benefit for description

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
ABA Treatment for Autism Spectrum Disorder **Preauthorization Required**	0% Coinsurance not subject to Deductible	0% Coinsurance not subject to Deductible	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder	0% Coinsurance not subject to Deductible	0% Coinsurance not subject to Deductible	See benefit for description
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)			
• Office Visits	$50 Copayment then You pay 0% not subject to Deductible	$50 Copayment then You pay 30% not subject to Deductible	Up to twenty (20) visits a plan year may be used for family counseling
• All Other Outpatient Services • Opioid Treatment Programs	Covered in full	30% Coinsurance not subject to Deductible	
• All Other Outpatient Services	0% Coinsurance not subject to Deductible	0% Coinsurance not subject to Deductible	

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
PRESCRIPTION DRUGS *****Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by Health Resources and Services Administration (HRSA) or if the item or service has an "A" or "B" rating from the United States Preventive Services Task Force (USPSTF) and obtained at a participating pharmacy			
Retail Pharmacy			
30-day supply			
Tier 1 (generic) **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.**	$25 Copayment after Deductible	$25 Copayment after Deductible	See benefit for description
Tier 2 (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.**	20% Coinsurance after Deductible	20% Coinsurance after 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.**	30% Coinsurance after Deductible	30% Coinsurance after Deductible	

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
The Deductible does not apply to certain Prescription Drugs. Visit Our website at Aetna.com to review Our formulary or call the number on Your ID card to learn more.			
Mail Order Pharmacy			
Up to a 90-day supply			
Tier 1 (generic)	$62.50 Copayment then You pay 0% after Deductible	$62.50 Copayment then You pay 0% after Deductible	See benefit for description
Tier 2 (formulary brand)	$0 Copayment then You pay 20% after Deductible	$0 Copayment then You pay 20% after Deductible	See benefit for description
Tier 3 (non-formulary brand)	$0 Copayment then You pay 30% after Deductible	$0 Copayment then You pay 30% after Deductible	See benefit for description
Enteral Formulas			
Tier 1 (generic)	$25 Copayment after Deductible	$25 Copayment after Deductible	See benefit for description
Tier 2 (formulary brand)	20% Coinsurance after Deductible	20% Coinsurance after Deductible	
Tier 3 (non-formulary brand)	30% Coinsurance after Deductible	30% Coinsurance after Deductible	
WELLNESS BENEFITS			
Exercise Facility Reimbursement	Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for Spouse.		
PEDIATRIC DENTAL & VISION CARE			
Pediatric Dental Care			
• Preventive Dental Care	$35 Copayment then You pay 0% not subject to Deductible	$35 Copayment then You pay 0% not subject to 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	$100 Copayment then You pay 0% not subject to Deductible	$100 Copayment then You pay 0% not subject to Deductible	

COST-SHARING	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limit
• Major Dental Care (Oral Surgery, Endodontics, Periodontics & Prosthodontics)	$250 Copayment then You pay 0% not subject to Deductible	$250 Copayment then You pay 0% not subject to Deductible	
• Orthodontics	50% Coinsurance not subject to Deductible	50% Coinsurance not subject to Deductible	
Pediatric Vision Care			
• Exams	$20 Copayment then You pay 0% not subject to Deductible	30% Coinsurance not subject to Deductible	One (1) exam per twelve (12)-month period
• Lenses & Frames	$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance not subject to Deductible	One (1) prescribed lenses & frames per twelve (12)-month period
• Contact Lenses	$40 Copayment then You pay 0% not subject to Deductible	30% Coinsurance not subject to Deductible	
OTHER COVERED SERVICES			
Emergency Medical Evacuation	0% Coinsurance of actual cost not subject to Deductible		
Medical Repatriation	0% Coinsurance of actual cost not subject to Deductible		
Transportation to Join a Hospitalized Member	0% Coinsurance of actual cost not subject to Deductible		
Return of Minor Children	0% Coinsurance of actual cost not subject to Deductible		
Repatriation of Mortal Remains	0% Coinsurance of actual cost not subject to Deductible		

Accidental Death and Dismemberment Benefits

Loss	Benefit Amount
Life	$10,000
Loss of Two or More Hands or Feet	$10,000
Loss of Use of Two or More Hands or Feet	$10,000
Loss of Sight in Both Eyes	$10,000
Loss of Speech and Hearing (in Both Ears)	$5,000
Loss of one Hand or Foot and Sight in One Eye	$10,000
Loss of One Hand or Foot	$5,000
Loss of Sight in One Eye	$5,000
Loss of Speech	$2,500
Loss of Hearing (in Both Ears)	$2,500
Loss of Thumb and Index Finger on the Same Hand	$2,500
Loss of all Four Fingers on the Same Hand	$2,500
Loss of all Toes on the Same Foot	$2,500
Loss of Thumb	$2,500

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.

Aetna Life Insurance Company Rider

Reimbursement for Travel and Lodging Expenses

Rider effective date: 08/15/2024

A. General.

This rider amends the benefits of Your Certificate as follows:

1. Travel and Lodging Expenses

- We will reimburse certain travel and lodging expenses for You to travel at least 100 miles from Your location to another State to access Covered Services when access to Covered Services is not available to You due to a law or regulation in the State where You are located unless such reimbursement is prohibited by law. We will also reimburse travel and lodging expenses for a companion to accompany You, if the companion is a Member covered under this Certificate and the companion's presence is necessary for You to receive Covered Services. We will reimburse You up to $3,000 per Plan Year for Your and Your companion's travel and lodging expenses not to exceed amounts permitted by Internal Revenue Service guidelines. Lodging expenses are limited to $50 per night for You, or $100 per night if You are traveling with a companion.

- To get reimbursed by Us, You must submit Your travel and lodging receipts to Us. For more information, call the number on Your ID card or visit Our website at https://www.aetnastudenthealth.com.

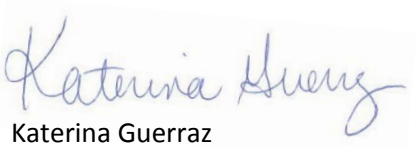
2. Access to Covered Services

- If You are traveling to another State to access Covered Services from a Participating Provider, You will be responsible for Your In-Network Cost-Sharing for the Covered Services.

- If You are traveling to another State to access Covered Services from a Non-Participating Provider, You must contact Us at the number on Your ID card for an authorization before receiving services. If an authorization is not approved, any services rendered by a Non-Participating Provider will be Covered as out-of-network and You will be responsible for Your Out-of-Network Cost-Sharing and the difference between the Provider's charge and Our Allowed Amount.

B. Controlling Certificate.

All of the terms, conditions, limitations, and exclusions of Your Certificate to which this rider is attached shall also apply to this rider except where specifically changed by this rider.



Katerina Guerraz
Executive Vice President, Chief Operating Officer
Aetna Life Insurance Company
(A Stock Company)

Important disclosure information about New York group and Student Health plans

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

Table of contents

Here is important disclosure information about our plans. It's followed by required content that varies by state.

We offer quality health plans

By following health plan accreditation standards of the National Committee for Quality Assurance (NCQA), we offer you quality health plans. Visit **Aetna.com/ individuals-families-health-insurance/document-library/documents/2019Disclosures/NCQA-MED-Disclosures-FI-SI.pdf** to learn more about how we meet the NCQA accreditation and standards. You can also call us at the number on your member ID card to ask for a printed copy.

This document details how to:

Understand your health plan

- Benefits and services included in, and excluded from, your coverage
- Prescription drug benefit
- Mental health and addiction benefits
- Care after office hours, urgent care, and emergency care

Get plan information online and by phone

- How you can reach us
- Help for those who speak another language and for the hearing impaired
- Get information about how to file a claim
- Search our network for doctors, hospitals and other health care providers
- Accountable care organizations (ACOs)
- Our quality management programs, including goals and outcomes

Know the costs and rules for using your plan

- What you pay
- Your costs when you go outside the network
- Precertification: getting approvals for services
- We study the latest medical technology
- How we make coverage decisions
- Complaints, appeals and external reviews

Understand your rights and responsibilities

- Member rights and responsibilities
- Notice of Privacy Practices

Features of a group plan

If you're a member, not all of the information in this document applies to your specific plan. Most information applies to all plans, but some does not. For example, not all plans have prescription drug or behavioral health benefits. There's also information that may only apply to a handful of states and plans. To be sure about which plan features apply to you, check your Summary of Benefits and Coverage plan documents. Can't find them? Ask your benefits administrator or call Member Services to have a copy of your plan documents mailed to you.

How some plans pay

Providers set the rates to charge you. It may be higher (sometimes, much higher) than what your Aetna® plan allows. For some plans, your doctor may bill you for the dollar amount that the plan doesn't allow and no dollar amount above the allowed charge will count toward your deductible or out-of-pocket limits. This means you're fully responsible for paying everything above the amount the plan allows for a service or procedure. However, emergency care is always covered by your plan, and you don't have to get prior approval.

Plans pay for your health care depending on the plan that you, or your employer, chooses. Some plans pay for services by looking at what Medicare would pay and adjusting that amount up or down. Plans range from paying 90% of Medicare (that is 10% less than Medicare would pay) up to 300% of Medicare (the Medicare rate multiplied by three). Some plans pay for services based on what is called the "usual and customary" charge.
These plans use information from FAIR Health, Inc., a not-for-profit company that reports how much providers charge for services in any ZIP code. You can call Member Services at the number on your member ID card to find out the method your plan uses to pay providers.

Not yet a member?

For help understanding how a certain medical plan works, review the plan's Summary of Benefits and Coverage document.

aetna®

Avoid unexpected bills

To avoid a surprise bill, make sure you check your plan documents to see what's covered before you get health care. Also, make sure you get care from a provider who is part of your plan's network. This just makes sense because:

- We have negotiated lower rates for you
- Network doctors and hospitals won't bill you above our negotiated rates for covered services
- You have access to quality care from our national network

To find a network provider, sign in to **Aetna.com** and select "Find Care" from the top menu bar to start your search. To learn more about how we pay out-of-network benefits when a plan allows them, visit **Aetna.com** and type "how Aetna pays" into the search box.

Get a free printed directory

To get a free printed list of doctors and hospitals, call the toll-free number on your member ID card. If you're not yet a member, call **1-888-982-3862 (TTY: 711)**.

No coverage based on U.S. trade sanctions

If U.S. trade sanctions consider you a "blocked person," the plan can't provide benefits or coverage to you. If you travel to a country sanctioned by the United States, the plan, in most cases, can't provide benefits or coverage to you. Also, if your health care provider is a blocked person or is in a sanctioned country, we can't pay for services from that provider. For example, if you receive care while traveling in another country and the health care provider is a blocked person or is in a sanctioned country, the plan can't pay for those services. For more information, visit **Treasury.gov/resource-center/sanctions/pages/ default.aspx** to read about U.S. trade sanctions.

Coverage for transplants and other complex conditions

Our National Medical Excellence Program® (NME) is for members who need a transplant or have a condition that can only be treated at a certain hospital. You may need to visit an Aetna Institutes of ExcellenceTM hospital to get coverage for the treatment. Some plans won't cover the service if you don't. We choose hospitals for the NME program based on their expertise and experience with these services. We also follow any state rules when choosing these hospitals.

Clinical policy bulletins

We write a report about a product or service when we decide if it's medically necessary. We call the report a clinical policy bulletin (CPB). CPBs guide us in deciding whether to approve a coverage request. Your plan may not cover everything our CPBs say is medically necessary. Each plan is different, so check your plan documents. CPBs are not meant to advise you or your doctor on your care. Only your doctor can give you advice and treatment. Talk to your doctor about any CPB related to your coverage or condition.

You and your doctor can visit **Aetna.com/health-care-professionals/clinical-policy-bulletins.html** to read CPBs. No internet? Call the number on your Aetna member ID card and ask for a copy of a CPB for any product or service.

Member rights and responsibilities

We don't consider race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age or national origin when giving you access to care. Federal law requires network providers to do the same.

Nondiscrimination policy for genetic testing

We don't use the results of genetic testing to discriminate, in any way, against applicants or enrollees. Also, you choose if you want to tell us your race or ethnicity and preferred language. We'll keep that information private.
We use it to help us improve your access to health care and to serve you better.

Your rights under the Employee Retirement Income Security Act of 1974 (ERISA)

If you're a participant in an employer-funded group health plan, you're entitled to certain rights and protections under ERISA. Some of those rights are listed below. Your rights are outlined in more detail in your plan documents. Below are some of your rights.

- Receive, free of charge, information about your plan and benefits.
- Upon written request to your plan administrator, examine copies of documents governing the operation of the plan, contracts, collective bargaining agreements, annual reports and more. The administrator may charge you a reasonable copy fee.
- Receive a copy of procedures used to determine a qualified domestic relation or medical child support order.
- Continue group health coverage for you, your spouse or dependents if there is a loss of coverage as the result of a qualifying event.
- Know why a claim was denied.
- Exercise your rights and take steps to enforce your rights, without discrimination or retribution.
- Get answers to your questions about the plan. Contact your plan administrator with questions about your plan.

If they don't provide the information you asked for, you can get help from the nearest office of the Employee Benefits Security Administration, which is part of the U.S. Department of Labor. Look them up online or in your local telephone directory.

Women's Health and Cancer Rights Act of 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

Benefits will be provided to a person who has already undergone a mastectomy as a result of breast cancer while covered under a different health plan. Coverage is provided according to your plan design and is subject to plan limitations, copays, deductibles, coinsurance and referral requirements, if any, as outlined in your plan documents.

For more information:

- Call the number on your member ID card
- Visit the U.S. Department of Labor at **DOL.gov/sites/ dolgov/files/ebsa/about-ebsa/our-activities/ resource-center/publications/your-rights-after-a-mastectomy.pdf**

Your right to enroll later

You might choose not to enroll now because you already have health insurance. You may be able to enroll later if you lose that other coverage or if your employer stops contributing to the cost. This includes enrolling your spouse or children and other dependents. If that happens, you must apply within 31 days after your coverage ends (or after the employer stops contributing to the other coverage).

When you have a new dependent

Getting married? Having a baby? If you chose not to enroll during the normal open enrollment period, you may enroll within 31 days after a life event. Examples of life events are marriage, divorce, birth, adoption, and placement for adoption. Talk to your benefits administrator for more information or to request special enrollment.

Important information for New York plans

Using your NY plan

You may have more time to enroll

If you've lost your Medicaid insurance, you may have more time to enroll in an Aetna plan.

You can choose any primary care provider (PCP) who participates in the Aetna network and who is accepting new patients.

A PCP may be a general practitioner, family physician, internist or a pediatrician. Each covered family member may select his or her own PCP. Your PCP provides routine preventive care and will treat you for illness or injury. Your PCP may refer you to other network doctors and hospitals for covered services and supplies. The PCP can also order lab tests and X-rays, prescribe medicines or therapies and arrange hospitalization.

The online provider directory indicates whether a provider is accepting new patients. You can also ask the provider's office to confirm when scheduling an appointment.

Tell us who you chose to be your PCP

Each member of the family may chose a different PCP from the Aetna network. Enter the ID number of the PCP you choose on your enrollment form.

You can change your PCP or specialist at any time. Log in at **Aetna.com** or call the Member Services toll-free number on your Aetna ID card. The change will become effective when we receive and approve the request.

Making your specialist your PCP

If you have a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, you may request a referral to a specialist with expertise in treating the life-threatening or degenerative and disabling disease or condition, who will be responsible for and capable of providing and coordinating your primary and specialty care. This referral will be issued based on a treatment plan that is approved by Aetna, in consultation with the primary care provider if appropriate, the specialist, and you or your authorized representative. Please call Member Services at the toll-free number in your ID card or call **1-888-982-3862 (TTY: 711)** to request these services.

Colorectal Cancer Screenings

Your plan covers colorectal cancer screenings in accordance with the standards set forth by the American Cancer Society and the American Gastroenterological Association. For more information:

- Visit the American Cancer Society at: **https://standuptocancer.org/news/american-cancer-society-updates-colorectal-cancer-screening-guideline/?gclid=EAIaIQobChMIncf7ju-V_QIVB8zlCh06pgmiEAAYASAAEgLn1fD_BwE**
- Visit the American Gastroenterological Association at: **https://gastro.org/clinical-guidance/reducing- the-burden-of-colorectal-cancer-crc/**

Direct Access Ob/Gyn program

This program allows female members direct access to primary and preventive obstetric and gynecologic services, including annual examinations, care resulting from such examinations, and treatment of acute gynecologic conditions, including care for pregnancy- related services, from a qualified participating provider of the member's choice.

Direct specialist care for life threatening conditions If you have a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, you may request access to a specialty care center or to a specialist responsible for providing or coordinating your medical care. To request these services, please call Member Services at the toll-free number on your ID card or call **1-888-982-3862 (TTY: 711)**.

Not all plans require referrals: Your PCP will refer you to a specialist when needed

You never need to get a referral if you have an Aetna Open Access® Managed Choice, Aetna Open Access® Elect Choice or Open Choice® plan. With the Managed Choice plan, you will receive the highest level of benefits under the plan when you get a referral from your PCP before you see a network specialist.

A referral is a written request for you to see another doctor. Some doctors can send the referral right to your specialist for you. There's no paper involved. Talk to your doctor to understand why you need to see a specialist. And remember to always get the referral before you receive the care.

Getting a referral from your PCP is not the same as getting approval (called precertification) from the plan. Some health care services require both. For more information, read the "Precertification: getting approvals for services" section of this booklet.

Remember these points about referrals:

- You do not need a referral for emergency care or urgent care.
- If you do not get a referral when required, the plan will pay for the service as an out-of-network benefit, if available.
- Your specialist might recommend treatment or tests that were not on the original referral. In that case, you may need to get another referral from your PCP for those services.
- Women can go to an Ob/Gyn without a referral. See "Direct Access Ob/Gyn program."
- Referrals are valid for one year as long as you are still a member of the plan. Your first visit must be within 90 days of the referral issue date.
- Certain services, such as inpatient stays, outpatient surgery and certain other medical procedures and tests, require both a PCP referral and precertification. See the "Precertification: getting approvals for services" section for details.

Referrals within physician groups

Some PCPs are part of a larger group of doctors. These PCPs will usually refer you to another doctor within that same group. If this group cannot meet your medical needs, you can ask us for a coverage exception to go outside this group. You may also need to precertify these services. And you may need permission from the physician group as well.

Out-of-network referrals

If a covered service you need isn't available from a network provider or facility with the training or expertise needed for your condition, or if a participating provider is not geographically accessible, your PCP may refer you to an out-of-network provider. Your PCP or other network provider must get preapproval from Aetna and issue a special nonparticipating referral for services from out-of-network providers to be covered.

Standing referrals

If you have a condition that requires ongoing care from a specialist, you may request a standing referral from your PCP or Aetna to such a specialist.

You don't need a PCP referral for:

- Emergency care — see the "Emergency care" section to learn more
- Urgent care — see the "Emergency care" section to learn more
  - Direct access services — certain routine and preventive services do not require a referral under the plan when accessed in accordance with the age and frequency limitations outlined in the "What the Plan Covers" and the "Summary of Benefits" sections of your plan documents. You can directly access these network specialists for:
  - Routine gynecologist visits
  - Routine eye exams in accordance with the schedule
  - An annual screening mammogram for age-eligible women
  - Routine prenatal care (precertification may be required)

Precertification: getting approvals for services

Sometimes we will pay for care only if we have given an approval before you get it. We call that precertification or preauthorization. We usually only need to precertify more serious care like surgery or being admitted to a hospital. Your PCP or Aetna network doctor will get this approval for you. If the request is to go outside the network, you may have to get this approval yourself. To do so, call the precertification number on your Aetna ID card,
1-877-204-9186 (TTY: 711), or send your request to:

Aetna
1425 Union Meeting Road Blue
Bell, PA 19422

You must get the precertification before you receive the care.

Your plan documents list all the services that require you to get precertification. If you don't have a service precertified when required, you may incur a penalty. Please see your plan documents for more information.

Member Cost of Care tool for New York members

If a service or procedure is not listed in the member Cost of Care tool on your member website, you can obtain an estimated cost by completing the appropriate Member Request for Estimate form on our website.

Please visit the state information section at **Aetna.com/individuals-families/member-rights-resources/rights/state-specific-information.html** for the form or to link to an online price estimator tool.

An "out of network" doctor is one with whom we do not have a contract for discounted rates. We don't know exactly what an out-of-network doctor will charge you.
If you choose a doctor who is out of network, your Aetna health plan may pay some of that doctor's bill. Most of the time, you will pay more money out of your own pocket if you choose to see an out-of-network doctor.

Your out-of-network doctor or hospital sets the rate to charge you. It may be higher — sometimes much higher — than what your Aetna plan recognizes, or allows. Your doctor may bill you for the dollar amount the plan doesn't recognize. You'll also pay higher copayments, coinsurance and deductibles under your plan. No dollar amount above the recognized charge counts toward your deductible or out-of-pocket limits.

This means you are fully responsible for paying everything above the amount the plan allows for a service or procedure.

When you choose to see an out-of-network doctor, we pay for your health care depending on the plan you or your employer chooses. Some of our plans pay for out-of-network services by looking at what Medicare would pay and adjusting that amount up or down. Our plans range from paying 90% of Medicare (that is, 10% less than Medicare would pay) to 300% of Medicare (the Medicare rate multiplied by three). Some plans pay for out-of-network services based on what is called the usual and customary charge or reasonable amount rate. These plans use information from FAIR Health, Inc. (**Fairhealth.org**), which is a not-for-profit company that reports how much providers charge for services in any ZIP code.

When you choose to enroll in a plan with out-of-network coverage, you should consider how plans based on Medicare rates compare to plans based on "usual and customary" charges. Roughly speaking, in New York for all services combined, 325-350% of Medicare rates are the same as the usual and customary charges.

You can call Member Services at the toll-free number on your Aetna ID card to find out the method your plan uses to reimburse out-of-network doctors. You can also ask for an estimate of your share of the cost for out-of-network services you are planning. The way of paying out-of network doctors and hospitals applies when you choose to get care out of network.

Emergency care

If you need emergency care, you are covered 24 hours a day, 7 days a week, anywhere in the world.

Emergency condition

A medical or behavioral condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person

Treatment for an emergency medical condition is not subject to prior approval. However, whether you are in or out of an Aetna service area, we simply ask that you follow the guidelines below when you believe you need emergency care.

Call the local emergency hotline (ex. 911) or go to the nearest emergency facility. If a delay would not be detrimental to your health, call your PCP. Notify your PCP as soon as possible after receiving treatment.

If you are admitted to an inpatient facility, you or a family member or friend acting on your behalf should notify your PCP or Aetna as soon as possible.

Covered expenses for emergency medical conditions are payable in accordance with your plan. Please refer to your summary of benefits for the applicable copay, deductible and coinsurance amounts that apply.

Urgent care

Care for certain conditions (such as severe vomiting, earaches, sore throats or fever) is considered "urgent care." You can get urgent care from your PCP or an urgent care facility. If you're traveling outside your Aetna service area or if you are a student who is away at school, you are covered for any urgently needed care rendered by any licensed physician or facility.

Claims for emergency care

We'll review the information when the claim comes in. If we think the situation was not an emergency, we might ask you for more information and may send you a form to fill out. Please complete the form, or call Member Services to give us the information over the phone.
Emergency care expenses that are not related to an emergency medical condition are excluded and are your financial responsibility.

Follow-up care for plans that require a PCP

Your PCP should coordinate any follow-up care after your emergency. For example, you'll need a doctor to remove stitches or a cast or take another set of X-rays to see if you've healed. You will need a referral for follow-up care that is not performed by your PCP. You may also need to get approval if you go outside the network.

After-hours care

You may call your doctor's office 24 hours a day, 7 days a week if you have medical questions or concerns. You may also consider visiting participating urgent care facilities.

We check if it's medically necessary

We cover benefits described in your certificate as long as the health care service, procedure, treatment, test, device, prescription drug or supply (collectively, "service") is medically necessary. The fact that a provider has furnished, prescribed, ordered, recommended, or approved the service does not make it medically necessary or mean that we have to cover it.

We may base our decision on a review of:

- Your medical records
- Our medical policies and clinical guidelines
- Medical opinions of a professional society, peer review committee or other groups of physicians
- Reports in peer-reviewed medical literature
- Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data
- Professional standards of safety and effectiveness, which are generally recognized in the United States for diagnosis, care, or treatment
- The opinion of health care professionals in the generally recognized health specialty involved
- The opinion of the attending providers, which have credence but do not overrule contrary opinions

Services will be deemed medically necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and are considered effective for your illness, injury, or disease
- They are required for the direct care and treatment or management of that condition
- Your condition would be adversely affected if the services were not provided
- They are provided in accordance with generally accepted standards of medical practice
- They are not primarily for the convenience of you, your family, or your provider
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results

When setting or place of service is part of the review, services that can be safely provided to you in a lower cost setting will not be medically necessary if they are performed in a higher cost setting. For example, we will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a hospital if the drug could be provided in a physician's office or the home setting.

See the Utilization Review and External Appeal sections of this document or in your certificate of coverage for your right to an internal appeal and external appeal of our determination that a service is not medically necessary.

We do not reward Aetna employees for denying coverage. Sometimes a physician's group will determine medical necessity. Those groups might use different resources than we do.

If we deny coverage, we'll send you and your doctor a letter. The letter will explain how to appeal the denial. You have the same right to appeal if a physician's group denied coverage. You can call Member Services to ask for a free copy of the materials we use to make coverage decisions. Or visit **Aetna.com/about/cov_ det_policies.html** to read our policies. Doctors can write or call our Patient Management department with questions. Contact Member Services either online or at the phone number on your Aetna ID card.

We study the latest medical technology

We look at scientific evidence published in medical journals to help us decide what is medically necessary. This is the same information doctors use. We also make sure the product or service is in line with how doctors, who usually treat the illness or injury, use it. Our doctors may use nationally recognized resources like MCG (formerly Milliman Care Guidelines).

We also review the latest medical technology, including drugs, equipment and mental health treatments. Plus, we look at new ways to use old technologies.

To make decisions, we may:

- Read medical journals to see the research. We want to know how safe and effective any treatments and technologies are.
- See what other medical and government groups say about treatments and technologies. That includes the federal Agency for Healthcare Research and Quality.
- Ask experts.
- Check how often and how successfully treatments and technologies have been used.

We publish our decisions in our Clinical Policy Bulletins.

How to file a claim

For most services, network doctors will file your claims for you. If you go outside the network, you may need to file claims yourself. Your health care professional may file a claim within 120 days from the date of service. You may also file a claim yourself.

We accept claims by mail, fax and electronically. If you need to file a claim with us, please call Member Services at the number on your Aetna ID card. The representative will give you the mailing address, email address or fax number for our claims office. You can also log in to your member website at **Aetna.com** to download a claim form (which includes the mailing address) or to send the claim electronically. To send the claim electronically, log in to **Aetna.com** and click "Contact" in upper right corner.

You can submit a claim form as an attachment.

Our plans comply with mental health laws

We want you to know that our plans comply with all federal and NY state requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA). This includes the non-quantitative treatment limitation (NQTL) requirements applied to behavioral health and substance use disorder benefits. We use the same processes and standards to determine these requirements as those we use to determine requirements for medical and surgical treatments. In other words, we apply the same medical management requirements, such as precertification, to all plan benefits, including:

- Behavioral health
- Substance use disorder
- Medical and surgical treatments

If you'd like to see how we arrive at the NQTL requirements, we'd be happy to show you our analysis. Just call Member Services at the number on your ID card to request a copy.

How we determine cost share

To ensure that we comply with federal and state mental health laws regarding members' cost share, we apply certain test measures laid out in the federal law. These are called the "substantially all" and "predominant level" tests. If you'd like to see how we arrive at members' cost share, we'd be happy to show you our analysis. Just call Member Services at the number on your ID card to request a copy.

What to do if you disagree with us

A. Grievances

Our grievance procedure applies to any issue not relating to a medical necessity or experimental or investigational determination by us. For example, it applies to contractual benefit denials or issues or concerns you have regarding our administrative policies or access to providers.

B. Filing a grievance

You can contact us by phone at the number on your ID card, in person, or in writing to file a grievance. You may submit an oral grievance in connection with a denial of a referral or a covered benefit determination. We may require that you sign a written acknowledgement of your oral grievance, prepared by us. You or your designee has up to 180 calendar days from when you received the decision you are asking us to review to file the grievance.

When we receive your grievance, we will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling your grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and we will take no discriminatory action because of your issue. We have a process for both standard and expedited grievances, depending on the nature of your inquiry.

You may ask that we send you electronic notification of a grievance or grievance appeal determination instead of notice in writing or by telephone. You must tell us in advance if you want to receive electronic notifications. To opt into electronic notifications, call the number on your ID card or visit our website **Aetna.com**. You can opt out of electronic notifications at any time.

C. Grievance determination

Qualified personnel will review your grievance, or if it is a clinical matter, a licensed, certified or registered health care professional will look into it. We will decide the grievance and notify you within the following time frames.

Time frames for determining a grievance

Type of grievance	Level 1 appeals
Expedited/urgent grievance	By phone within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of the grievance. We will provide written notice within 72 hours of receipt of your grievance.
Preservice grievance (a request for a service or treatment that has not yet been provided)	In writing, within 15 calendar days of receipt of your grievance
Postservice grievance (a claim for a service or a treatment that has already been provided)	In writing, within 30 calendar days of receipt of your grievance
All other grievances (those that are not in relation to a claim or request for service)	In writing within 30 calendar days of receipt of your grievance

Grievance appeals
(Does not apply to Student Health plans.)

If you are not satisfied with the resolution of your grievance, you or your designee may file an appeal by phone, in person or in writing. You may file an urgent appeal by phone. You have up to 60 business days from receipt of our decision to file an appeal.

When we receive your appeal, we will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address and telephone number of the person handling your appeal. If necessary, it will also inform you of any additional information we may need to make a decision. One or more qualified personnel at a higher level than the person who rendered the complaint decision will review the appeal. If it is a clinical matter, a clinical peer reviewer will look into it.

Time frames for determining your appeal of a grievance determination:
(Does not apply to Student Health plans.)

Type of grievance	Level 1 appeals
Expedited/urgent grievance	By phone within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of the grievance. We will provide written notice within 72 hours of receipt of your grievance.
Preservice grievance (a request for a service or treatment that has not yet been provided)	In writing, within 15 calendar days of receipt of your grievance.
Postservice grievance (a claim for a service or a treatment that has already been provided)	30 calendar days of receipt of your appeal
All other grievances (those that are not in relation to a claim or request for service)	In writing, within 30 calendar days of receipt of your grievance.

If you are not satisfied or if you need help
If you remain dissatisfied with our appeal determination, or at any other time you are dissatisfied, you may:

- Call the New York State Department of Financial Services at **1-800-342-3736**
- Write them at:
  New York State Department of Financial Services Consumer Assistance Unit
  One Commerce Plaza Albany,
  NY 12257
- Visit their website: **www.dfs.ny.gov**

If you need assistance filing a grievance, you may also contact the state independent Consumer Assistance Program:

- Write them at:
  Community Health Advocates 633
  Third Avenue, 10th Floor New York,
  NY 10017
- Call toll free: **1-888-614-5400**
- Email: **cha@cssny.org**
- Visit their website:
  www.communityhealthadvocates.org

Appointing a designee
You have the right to appoint a designee to handle your grievance, appeal or utilization review request.

Utilization review

We review health services to determine whether the services are or were medically necessary or experimental or investigational ("medically necessary"). This process is called utilization review. Utilization review includes all review activities, whether they take place prior to the service being performed (preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If you have any questions about the utilization review process for services including mental health and substance use services, please call the number on your ID card. The toll- free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not medically necessary will be made by:

- Licensed physicians; or
- Licensed, certified, registered or credentialed health care professionals who are in the same profession and same or similar specialty as the provider who typically manages your medical condition or disease or provides the health care service under review; or
- With respect to mental health or substance use disorder treatment, licensed physicians or licensed, certified, registered or credentialed health care professionals who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment. We do not compensate or provide financial incentives to our employees or reviewers for determining that services are not medically necessary. We have developed guidelines and protocols to assist us in this process. We will use evidence-based and peer-reviewed clinical review criteria that are appropriate to the age of the patient and designated by Office of Addiction Services and Supports (OASAS) for substance use disorder treatment or approved for use by Office of Mental Health (OMH) for mental health treatment. Specific guidelines and protocols are available for your review upon request. For more information, call the number on your ID card or visit our website at **Aetna.com**.

You may ask that we send you electronic notification of a utilization review determination instead of notice in writing or by telephone. You must tell us in advance if you want to receive electronic notifications. To opt into electronic notifications, call the number on your ID card or visit our website **Aetna.com**. You can opt out of electronic notifications at any time.

A. Preauthorization reviews

1. Non-urgent preauthorization reviews. If we have all the information necessary to make a determination regarding a preauthorization review, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three (3) business days of receipt of the request.

If we need additional information, we will request it within three (3) business days. You or your provider will then have 45 calendar days to submit the information. If we receive the requested information within 45 days, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within three (3) business days of our receipt of the information. If all necessary information is not received within 45 days, we will make a determination within 15 calendar days of the earlier of the receipt of part of the requested information or the end of the 45-day period.

2. Urgent preauthorization reviews. With respect to urgent preauthorization requests, if we have all information necessary to make a determination, we will make a determination and provide notice to you (or your designee) and your provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If we need additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. We will make a determination and provide notice to you (or your designee) and your provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour period.

3. Court-ordered treatment. With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if you (or your designee) certify, in a format prescribed by the Superintendent of Financial Services, that you will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, we will make a determination and provide notice to you (or your designee) or your provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three (3) business days of our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.

4. Inpatient rehabilitation services reviews. After receiving a preauthorization request for coverage of inpatient rehabilitation services following an inpatient hospital admission provided by a hospital or skilled nursing facility, we will make a determination and provide notice to you (or your designee) and your provider, by telephone and in writing, within one (1) business day of receipt of the necessary information.

5. Crisis stabilization centers. Effective January 1, 2022, coverage for participating crisis stabilization centers licensed under Mental Hygiene Law section 36.1 is not subject to preauthorization. We may review the treatment provided at crisis stabilization centers retrospectively to determine whether it is medically necessary, and we will use clinical review tools designated by OASAS or approved by OMH. If any treatment is denied as not medically necessary, you are only responsible for the in-network cost-sharing that would otherwise apply to your treatment.

B. Concurrent reviews

1. Non-urgent concurrent reviews. Utilization review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to you (or your designee) or your provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If we need additional information, we will request it within one (1) business day. You or your provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to you (or your designee) or your provider, by telephone and in writing, within one (1) business day of our receipt of the information or, if we do not receive the information, within 15 calendar days of the earlier of the receipt of part of the requested information or the end of the 45-day period.

2. Urgent concurrent reviews. For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, we will make a determination and provide notice to you (or your designee) or your provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and we have all the information necessary to make a determination, we will make a determination and provide written notice to you (or your designee) or your provider within the earlier of 72 hours or one (1) business day of receipt of the request. If we need additional information, we will request it within 24 hours. You or your provider will then have 48 hours to submit the information. We will make a determination and provide written notice to you (or your designee) or your provider within the earlier of one (1) business day or 48 hours of our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour period.

3. Home health care reviews. After receiving a request for coverage of home care services following an inpatient hospital admission, we will make a determination and provide notice to you (or your designee) or your provider, by telephone and in writing, within one (1) business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, we will make a determination and provide notice to you (or your designee) or your provider within 72 hours of receipt of the necessary information. When we receive a request for home care services and all necessary information prior to your discharge from an inpatient hospital admission, we will not deny coverage for home care services while our decision on the request is pending.

4. Inpatient substance use disorder treatment reviews. If a request for inpatient substance use disorder treatment is submitted to us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, we will make a determination within 24 hours of receipt of the request and we will provide coverage for the inpatient substance use disorder treatment while our determination is pending.

5. Inpatient mental health treatment for members under 18 at participating hospitals licensed by the Office of Mental Health (OMH). Coverage for inpatient mental health treatment at a participating OMH-licensed hospital is not subject to preauthorization. Coverage will not be subject to concurrent review for the first 14 days of the inpatient admission if the OMH-licensed hospital notifies us of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 14 days of the inpatient admission, we may review the entire stay to determine whether it is medically necessary, and we will use clinical review tools approved by OMH. If any portion of the stay is denied as not medically necessary, you are only responsible for the in-network cost-sharing that would otherwise apply to your inpatient admission.

6. Inpatient substance use disorder treatment at participating OASAS-certified facilities. Coverage for inpatient substance use disorder treatment at a participating OASAS-certified facility is not subject to preauthorization. Coverage will not be subject to concurrent review for the first 28 days of the inpatient admission if the OASAS-certified facility notifies us of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 28 days of the inpatient admission, we may review the entire stay to determine whether it is medically necessary, and we will use clinical review tools designated by OASAS. If any portion of the stay is denied as not medically necessary, you are only responsible for the in-network cost- sharing that would otherwise apply to your inpatient admission.

7. Outpatient substance use disorder treatment at participating OASAS-certified facilities. Coverage for outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment at a participating OASAS-certified facility is not subject to preauthorization. Coverage will not be subject to concurrent review for the first four (4) weeks of continuous treatment, not to exceed 28 visits, if the OASAS-certified facility notifies us of both the start of treatment and the initial treatment plan within two (2) business days. After the first four (4) weeks of continuous treatment, not to exceed 28 visits, we may review the entire outpatient treatment to determine whether it is medically necessary, and we will use clinical review tools designated by OASAS. If any portion of the outpatient treatment is denied as not medically necessary, you are only responsible for the in-network cost-sharing that would otherwise apply to your outpatient treatment.

C. Retrospective reviews

If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and notify you and your provider within 30 calendar days of the receipt of the request. If we need additional information, we will request it within 30 calendar days. You or your provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to you and your provider in writing within 15 calendar days of the earlier of our receipt of all or part of the requested information or the end of the 45-day period.

Once we have all the information to make a decision, our failure to make a utilization review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal appeal.

D. Retrospective review of preauthorized services

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to us upon retrospective review is materially different from the information presented during the preauthorization review;
- The relevant medical information presented to us upon retrospective review existed at the time of the preauthorization but was withheld or not made available to us;
- We were not aware of the existence of such information at the time of the preauthorization review; and
- Had we been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the preauthorization review.

E. Step therapy override determinations

You, your designee, or your health care professional may request a step therapy protocol override determination for coverage of a prescription drug selected by your health care professional. When conducting utilization review for a step therapy protocol override determination, we will use recognized evidence-based and peer reviewed clinical review criteria that is appropriate
for you and your medical condition.

1. Supporting rationale and documentation. A step therapy protocol override determination request must include supporting rationale and documentation from a health care professional, demonstrating that:

- The required prescription drug(s) is contraindicated or will likely cause an adverse reaction or physical or mental harm to you;
- The required prescription drug(s) is expected to be ineffective based on your known clinical history, condition, and prescription drug regimen;
- You have tried the required prescription drug(s) while covered by us or under your previous health insurance coverage, or another prescription drug in the same pharmacologic class or with the same mechanism of action, and that prescription drug(s) was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
- You are stable on a prescription drug(s) selected by your health care professional for your medical condition, provided this does not prevent us from requiring you to try an AB-rated generic equivalent; or
- The required prescription drug(s) is not in your best interest because it will likely cause a significant barrier to your adherence to or compliance with your plan of care, will likely worsen a comorbid condition, or will likely decrease your ability to achieve or maintain reasonable functional ability in performing daily activities.

2. Standard review. We will make a step therapy protocol override determination and provide notification to you (or your designee) and where appropriate, your health care professional, within 72 hours of receipt of the supporting rationale and documentation.

3. Expedited review. If you have a medical condition that places your health in serious jeopardy without the prescription drug prescribed by your health care professional, we will make a step therapy protocol override determination and provide notification to you (or your designee) and your health care professional within 24 hours of receipt of the supporting rationale and documentation.

If the required supporting rationale and documentation are not submitted with a step therapy protocol override determination request, we will request the information within 72 hours for preauthorization and retrospective reviews, the lesser of 72 hours or one (1) business day for concurrent reviews, and 24 hours for expedited reviews. You or your health care professional will have 45 calendar days to submit the information for preauthorization, concurrent and retrospective reviews, and 48 hours
for expedited reviews.

For preauthorization reviews, we will make a determination and provide notification to you (or your designee) and your health care professional within the earlier of 72 hours of our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For concurrent reviews, we will make a determination and provide notification to you (or your designee) and your health care professional within the earlier of 72 hours or one (1) business day of our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For retrospective reviews, we will make a determination and provide notification to you (or your designee) and your health care professional within the earlier of 72 hours of our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For expedited reviews, we will make a determination and provide notification to you (or your designee) and your health care professional within the earlier of 24 hours of our receipt of the information or 48 hours of the end of the 48-hour period if the information is not received.

If we do not make a determination within 72 hours (or 24 hours for expedited reviews) of receipt of the supporting rationale and documentation, the step therapy protocol override request will be approved. If
we determine that the step therapy protocol should be overridden, we will authorize immediate coverage for the prescription drug prescribed by your treating health care professional. An adverse step therapy override determination is eligible for an appeal.

F. Reconsideration

If we did not attempt to consult with your provider who recommended the covered service before making an adverse determination, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to you and your provider, by telephone and in writing.

G. Utilization review internal appeals

You, your designee, and, in retrospective review cases, your provider, may request an internal appeal of an adverse determination, either by phone, in person, or in writing.

You have up to 180 calendar days after you receive notice of the adverse determination to file an appeal. We will acknowledge your request for an internal appeal within 15 calendar days of receipt. This acknowledgment will include the name, address, and phone number of the person handling your appeal and, if necessary, inform you of any additional information needed before a decision can be made. The appeal will be decided by a clinical peer reviewer who is not a subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) a physician or 2) a health care professional in the same or similar specialty as the provider who typically manages the disease or condition at issue.

1. Out-of-network service denial. You also have the right to appeal the denial of a preauthorization request for an out-of-network health service when we determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a non-participating provider, but only when the service is not available from a participating provider. For a utilization review appeal of denial of an out-of network health service, you or your designee must submit:

- A written statement from your attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat your condition, that the requested out-of-network health service is materially different from the alternate health service available from a participating provider that we approved to treat your condition; and
- Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to you than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. Out-of-network referral denial. You also have the right to appeal the denial of a request for a referral to a non-participating provider when we determine that we have a participating provider with the appropriate training and experience to meet your particular health care needs who is able to provide the requested health care service. For a utilization review appeal of an out-of-network referral denial, you or your designee must submit a written statement from your attending physician, who must be a licensed, board-certified or board-eligible physician qualified to practice in the specialty area of practice appropriate to treat your condition:

- That the participating provider recommended by us does not have the appropriate training and experience to meet your particular health care needs for the health care service; and
- Recommending a non-participating provider with the appropriate training and experience to meet your particular health care needs who is able to provide the requested health care service.

H. First-level appeal

1. Preauthorization appeal. If your appeal relates to a preauthorization request, we will decide the appeal within 15 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you (or your designee), and where appropriate, your provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the appeal request.

2. Retrospective appeal. If your appeal relates to a retrospective claim, we will decide the appeal within 30 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you (or your designee), and where appropriate, your provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the appeal request.

3. Expedited appeal. An appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient hospital admission, services in which a provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order, or any other urgent matter will be handled on an expedited basis. An expedited appeal is not available for retrospective reviews. For an expedited appeal, your provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one (1) business day of receipt of the request for an appeal. Your provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited appeal will be determined within the earlier of 72 hours of receipt of the appeal or two (2) business days of receipt of the information necessary to conduct the appeal.

Written notice of the determination will be provided to you (or your designee) within 24 hours after the determination is made, but no later than 72 hours after receipt of the appeal request.

If you are not satisfied with the resolution of your expedited appeal, you may file a standard internal appeal or an external appeal.

Our failure to render a determination of your appeal within 30 calendar days of receipt of the necessary information for a standard appeal or within two (2) business days of receipt of the necessary information for an expedited appeal will be deemed a reversal of the initial adverse determination.

4. Substance-use appeal. If we deny a request for inpatient substance use disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and you or your provider file an expedited internal appeal of our adverse determination, we will decide the appeal within 24 hours of receipt of the appeal request. If you or your provider file the expedited internal appeal and an expedited external appeal within 24 hours of receipt of our adverse determination, we will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal appeal and external appeal is pending.

I. Full and fair review of an appeal

We will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by us or any new or additional rationale in connection with your appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give you a reasonable opportunity to respond prior to that date.

J. Second-level appeal

(Does not apply to Student Health plans.)
If you disagree with the first-level appeal determination, you or your designee can file a second-level appeal. You or your designee can also file an external appeal. The four-month time frame for filing an external appeal begins on receipt of the final adverse determination on the first level of appeal. By choosing to file a second-level appeal, the time may expire for you to file an external appeal.

A second-level appeal must be filed within 45 days of receipt of the final adverse determination on the first-level appeal. We will acknowledge your request for an internal appeal within 15 calendar days of receipt. This acknowledgment will inform you, if necessary, of any additional information needed before a decision can be made.

1. Preauthorization appeal. If your appeal relates to a preauthorization request, we will decide the appeal within 15 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you (or your designee), and where appropriate, your provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the appeal request.

2. Retrospective appeal. If your appeal relates to a retrospective claim, we will decide the appeal within 30 calendar days of receipt of the appeal request. Written notice of the determination will be provided to you (or your designee), and where appropriate, your provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the appeal request.

3. Expedited appeal. If your appeal relates to an urgent matter, we will decide the appeal and provide written notice of the determination to you (or your designee), and where appropriate, your provider, within 72 hours of receipt of the appeal request.

K. Appeal assistance

If you need assistance filing an appeal, you may contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017

Or call toll free: **1-888-614-5400**, or Email **cha@cssny.org**

Website: **www.communityhealthadvocates.org**

External appeal

A. Your right to an external appeal

In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is an out-of-network treatment, You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal, You must meet the following two (2) requirements:

- The service, procedure or treatment must otherwise be a Covered Service under this Certificate; and
- In general, You must have received a final adverse determination through the first level of Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through the first level of Our internal Appeal process if:
  - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
  - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
  - We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

B. Your right to appeal a determination that a service is not medically necessary

If We have denied coverage on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph "A" above.

C. Your right to appeal a determination that a service is experimental or investigational

If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph "A" above and Your attending Physician must certify that Your condition or disease is one for which:

(1) Standard health services are ineffective or medically inappropriate; or

(2) There does not exist a more beneficial standard service or procedure Covered by Us; or

(3) There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one (1) of the following:

(1) A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation — Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or

(2) A clinical trial for which You are eligible (only certain clinical trials can be considered); or

(3) A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board-eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

D. Your right to appeal a determination that a service is out-of-network

If We have denied coverage of an out-of-network treatment because it is not materially different from the health service available in network, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above and You have requested Preauthorization for the out-of-network treatment.

In addition, Your attending Physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service and, based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment; and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

E. Your right to appeal an out-of-network referral denial to a non-participating provider

If We have denied coverage of a request for a Referral to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above.

In addition, Your attending Physician must: 1) certify that the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs; and 2) recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

F. Your right to appeal a formulary exception denial

If We have denied Your request for coverage of a non-formulary Prescription Drug through Our formulary exception process, You, Your designee or the prescribing Health Care Professional may appeal the formulary exception denial to an External Appeal Agent. See the Prescription Drug Coverage section of your plan documents for more information on the formulary exception process.

G. The external appeal process

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through the first level of Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at **1-800-400-8882**. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited external appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received Emergency Services and have not been discharged from a Facility and the denial concerns an admission, availability of care, or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application.
Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If Your internal formulary exception request received a standard review through Our formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within 72 hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within two (2) business days of making a determination. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You are taking the Prescription Drug.

If Your internal formulary exception request received an expedited review through Our formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within 24 hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within 72 hours of receipt of Your completed application. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-formulary Prescription Drug.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, We will provide coverage subject to the other terms and conditions of your Certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial, We will only Cover the cost of services required to provide treatment to
You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be Covered under your Certificate for non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

We will charge You a fee of $25 for each external appeal, not to exceed $75 in a single Plan Year. The external appeal application will explain how to submit the fee.
We will waive the fee if We determine that paying the fee would be a hardship to You. If the External Appeal Agent overturns the denial of coverage, the fee will be refunded to You.

H. Your responsibilities

It is Your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

More information is available upon request

In accordance with New York law, the following information is available to a member or prospective member upon request by contacting the Member Services department:

(1) A list of the names, business addresses and official positions of the membership of the board of directors, officers, controlling persons, owners or partners of the plan

(2) The most recent certified financial statements of the plan, including a balance sheet and summary of receipts and disbursements prepared by a certified public accountant

(3) A copy of the most recent individual conversion, direct-pay subscriber contracts

(4) Information relating to consumer complaints compiled pursuant to Section 210 of the New York insurance law

(5) Procedures for protecting the confidentiality of medical records and other enrollee information

(6) Drug formularies, if any, used by the plan and the inclusion/exclusion of individual drugs

(7) Written description of the organizational arrangements and ongoing procedures of the plan's quality assurance program

(8) A description of the procedures followed in making decisions about the experimental or investigational nature of individual drugs, medical devices or treatments in clinical trials

(9) Individual health practitioner affiliations with participating hospitals, if any

(10) Upon written request, specific written clinical review criteria relating to a particular condition or disease and, where appropriate, other clinical information the plan might consider in its patient management program; the plan may include with the information a description of how it will be used in the patient management process, provided, however, that to the extent such information is proprietary to the plan, the enrollee or prospective enrollee shall only use the information for the purposes of assisting the enrollee or prospective enrollee in evaluating the covered services provided by the plan

Member Services can help you with this request by calling the number on your Aetna ID card. You can also send a request to Aetna by writing to:

Aetna
Attn: CRC Requests 1800 E
Interstate Ave Bismarck,
ND 58503

(11) Written application procedures and minimum qualification requirements for health care providers considered by the plan

(12) Such other information as required by the Superintendent of Insurance provided that such requirements are promulgated pursuant to the state administrative procedure act

(13) If you are scheduled to receive health care services, you can ask us if that health care provider participates in the plan's network

(14) The approximate dollar amount the plan will pay for a specific out-of-network health care service. This information is nonbinding and the approximate dollar amount for a specific out-of-network service may change.

Your rights and protections against surprise medical bills

This notice explains how you can get help with unexpected bills from out-of-network providers. This applies to members enrolled in health plans subject to New York regulations. Check your plan documents for more details on balance bills. You can also call Member Services at the toll-free number on your ID card.

What is "balance billing" (sometimes called "surprise billing")?

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

When you see a doctor or other health care provider, you may owe certain **out-of-pocket costs**, like a **copayment**, **coinsurance** or **deductible**. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care — like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.
Surprise medical bills could cost thousands of dollars, depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or hospital, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in a stable condition.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist and intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections. You **can't** give up your protections for these other services if they are a surprise bill. Surprise bills are when you're at an in-network hospital or ambulatory surgical facility and a participating doctor was not available, a non-participating doctor provided services without your knowledge or unforeseen medical services were provided.

Services referred by your in-network doctor Surprise bills include when your in-network doctor refers you to an out-of-network provider without your consent (including lab and pathology services). These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed. You may need to sign a form (available on the Department of Financial Services' website at **DFS.NY.gov**) for the full balance billing protection to apply.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your Explanation of Benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, follow the steps below to notify us or contact the New York State Department of Financial Services at **(800) 342-3736** or **surprisemedicalbills@dfs.ny.gov**. Visit **DFS.NY.gov** for information about your rights under state law.

1. **Tell us if you had a New York Surprise Bill** Complete the New York State Surprise Bill Certification form (previously Assignment of Benefits) if you got a surprise balance bill. The form is:
   - Attached to this notice
   - On the New York Department of Financial Services website at **DFS.NY.gov**
   - On **Aetna.com** under our state-specific legal notices

2. **How to send us a Surprise Bill Certification form**
   1. Through your member website:
      Log in to your secure member website at **Aetna.com**. Click "Contact Us" in upper right corner.
      Attach your form and bill. Click submit.
   2. Mail it to us on the Aetna® address on your ID card.
   3. Mail it to us at:
      Aetna
      Member Correspondence Unit PO
      Box 981106
      El Paso, Texas 79998-1106

3. **Tell your provider this is a New York surprise bill**
   Send a copy of your Surprise Bill Certification form to your provider. This alerts the office not to bill you over your in-network cost share.

4. **What happens after Aetna gets my Surprise Bill Certification form?**
   - We'll review the balance over your network cost share (copayment, deductible or coinsurance).
   - We will send you an Explanation of Benefits (EOB) if we pay more to the provider. It will tell you if you owe more cost share.
   - If we don't settle, the provider may file a fee dispute called Independent Dispute Resolution (IDR).

Emergency services

You only need to pay your network cost share for emergency services. Your plan documents explain how emergency services are defined. Follow the steps in item four above if you get a balance bill over your network cost share for emergency services. We'll handle it following the benefits in your plan documents.

Out-of-network hospital bills when you're admitted after an emergency room visit

Balance billing protections under New York law include inpatient services provided by a physician or hospital following an emergency room visit at an out-of-network hospital.

You can also use the Surprise Bill Certification form to send us your balance bill for these services. The form is attached to this notice.

Independent Dispute Resolution Process (IDR)

Certain fee disputes can be sent to the New York IDR process.

IDR for surprise bills

We or a provider may file IDR.

The IDR application is on the New York Department of Financial Services website, **DFS.NY.gov**.

The process starts by completing an IDR application and sending it to the New York Department of Financial Services.

The IDR will be reviewed by a state-assigned independent dispute resolution entity (IDRE).

The IDRE will decide if our payment or the provider's fee is more reasonable within 30 days of receiving the IDR application.

If we need to pay more to the provider, your cost share may go up.

A member of a self-funded health plan or a patient who does not have insurance may also file IDR on their own.

IDR for emergency services

The following are eligible for IDR:

- Emergency physician services
- Emergency services provided by an out-of-network hospital
- Inpatient services provided by a physician or hospital following an emergency room visit at an out-of-network hospital
- Services by out-of-network providers at in-network ambulatory surgical centers

We or the provider can file IDR following the same steps noted above. A member of a self-funded plan or a patient who does not have insurance may also file IDR on their own. IDR is for services performed in New York. If you get a balance bill for emergency services outside of New York, you can also send it to us for review. Upon receipt, we'll handle it based upon the benefits of your health plan.

NEW YORK STATE SURPRISE MEDICAL BILL CERTIFICATION FORM

You are protected from surprise medical bills. Your health plan must pay your health care provider, and your provider cannot bill you, except for any in-network cost-sharing.

- This form is required for surprise bills in (1) below for dates of service before 1/1/22 and for surprise bills in (2) below for all dates of service. This form is **NOT** required for surprise bills in (1) below for dates of service on and after 1/1/22 but helps identify when services are a surprise bill.
- Send a copy of this form to your **provider** and **health plan** (include a copy of any bill you received).
- Your provider may complete this form for a surprise bill described in (1) below for dates of service on and after 1/1/22, and your provider must send it to your **health plan**.

A surprise bill is when:

1. You're at an in-network hospital or ambulatory surgical facility and an in-network provider was not available; an out-of-network provider provided services without your knowledge; or you needed unforeseen medical services. Also, you did not choose to receive services from an out-of-network provider instead of from an available in-network provider before you went to the hospital or ambulatory surgical facility. (Emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services in an in-network hospital or ambulatory surgical facility are usually a surprise bill.)
2. During a visit with your in-network doctor, an out-of-network provider treats you; your in-network doctor takes a specimen from you and sends it to an out-of-network lab or pathologist; or your in-network doctor refers you to an out-of-network provider (and referrals are required under your health plan). Also, you did not sign a written consent that you knew the services would be out-of-network and result in costs not covered by your health plan.

I certify to the best of my knowledge that (check one):

☐ I received services that are a surprise bill as described in (1) or (2) above and I want the provider to seek payment for this bill from my health plan (this is an "assignment") **OR**

☐ I am a **health care provider**, and the insured received services that are a surprise bill as described in (1) above for dates of service on and after 1/1/22.

Patient Name:		**Date of Service:**	
Patient Mailing Address:			
Insurer Name:		**Insurance ID No.:**	
Provider Name:		**Provider Phone Number:**	
Provider Mailing Address:			
Provider Contact Name (if different from provider name)			
Provider Contact Email Address:			
Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.			
Signature (of patient or provider):		**Date signed:**	

If you have questions about this form, contact the Department of Financial Services at 1-800-342-3736.

NYS FORM SURPRISE BILL (12/30/21)

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

We provide 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**).

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

To access language services at no cost to you, call 1-888-982-3862 .

Para acceder a los servicios de idiomas sin costo, llame al 1-888-982-3862. (Spanish)

如欲使用免費語言服務，請致電 1-888-982-3862 。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862 . (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862 . (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an. (German)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء االتصال على الرقم 1-888-982-3862 . (Arabic)

Pou jwenn sèvis lang gratis, rele 1-888-982-3862 . (French Creole-Haitian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-982-3862 . (Italian)

무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오. (Korean)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-888-982-3862 تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-982-3862 . (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862 . (Portuguese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862 . (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862 . (Vietnamese)

852206-01-04 (3/23)