Alfred University

Aetna Student Health

Plan Design and Benefits Summary
Alfred University

Policy Year: 2015 - 2016
Policy Number: 474924

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(888) 295-0148

This is a brief description of the Student Health Plan. The Plan is available for Alfred University students and their eligible dependents. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions governing this insurance are contained in the Master Policy issued to Alfred University and may be viewed online **https://www.alfred.myahpcare.com.** If any discrepancy exists between this Brochure and the Policy, the Master Policy will govern and control the payment of benefits.

Alfred University Health Services

The Alfred University Wellness Center is the University's on-campus health facility. Staffed by a Physician, nurse practitioners and registered nurses, it is open weekdays from 8:30 a.m. to 4:30 p.m. and closed from 12 p.m. to 1:00 p.m. during the Fall and Spring semesters.

For more information, call the Wellness Center at **(607) 871-2400**. In the event of an emergency, call **911** or the Campus Police at **(607) 871-2108.**

Coverage Periods

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

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	08/14/2015	08/13/2016	08/15/2015 - Waiver 10/01/2015 - Enrollment
Spring/Summer	01/14/2016	08/13/2016	03/02/2016

Eligible Dependents: Coverage for dependents eligible under the Plan for the following Coverage Periods. Coverage will become effective at 12:01 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicated below. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	08/14/2015	08/13/2016	08/15/2015 –Waiver 10/01/2015 - Enrollment
Spring/Summer	01/14/2016	08/13/2016	03/02/2016

Rates

The rates below include both premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna), as well as Alfred University's administrative fee.

	Annual	Spring/Summer Semester
Student	$1,482	$867
Spouse	$1,482	$867
Child	$1,482	$867

Student Coverage

Eligibility

All registered undergraduate students and graduate students (matriculating and non-matriculating) attending Alfred University are expected to carry health insurance. **Domestic students** will need to show proof of insurance coverage prior to their arrival on campus by completing the online waiver form. If any student does not have insurance in place, Alfred University offers a Student Health Insurance plan through Aetna.

International Students are required to participate in the program unless coverage is waived. In order to waive coverage, the student must show proof of insurance coverage prior to the waiver deadline date of August 15th, 2015 for fall and March 2nd, 2016 for spring.

Enrollment

Eligible students will be automatically enrolled in This Plan, unless the completed Waiver Form has been received by the University by the waiver deadline date.

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

Waiver Process/Procedure

Eligible students will automatically be enrolled in this plan, unless an online Waiver Form has been received by the specified deadline dates listed below. The waiver form must be completed online at **http://www.alfred.myahpcare.com.**

Please note that international students on F-1 visas are not eligible for this waiver and must carry the AU insurance.

	Waiver Deadline Date
Students Enrolling for the Fall Semester	**August 15, 2015**
Students Enrolling for the Spring Semester	**March 2, 2016**

Waiver submissions may be audited by Alfred University, Aetna Student Health, and/or their contractors or representatives. You may be required to provide, upon request, any coverage documents and/or other records demonstrating that you meet the school's requirements for waiving the student health insurance plan. By submitting the waiver request, you agree that your current insurance plan may be contacted for confirmation that your coverage is in force for the applicable policy year and that it meets the school's waiver requirements.

Refund Policy

If you withdraw from school within the first 31 days of a coverage period, you will not be covered under the Policy and the full premium will be refunded, less any claims paid. After 31 days, you will be covered for the full period that you have paid the premium for, and no refund will be allowed. (This refund policy will not apply if you withdraw due to a covered **Accident** or **Sickness**).

A person who is eligible for Medicare at the time of enrollment under this plan is not eligible for medical expense coverage and prescribed medicines expense coverage. If a covered person becomes eligible for Medicare after he or she is enrolled in this plan, such Medicare eligibility will not result in the termination of medical expense coverage and

prescribed medicines expense coverage under this plan. As used within this provision, persons are "eligible for Medicare" if they are entitled to benefits under Part A (receiving free Part A) or enrolled in Part B or Premium Part A.

Dependent Coverage

Eligibility

Covered students may also enroll their lawful spouse, or domestic partner (either same sex or opposite sex) and **dependent** children under 26 years of age.

Coverage is provided for **covered dependent** children who are on a certified leave of absence from school due to illness; for a period of twelve months from the last day of attendance in school. The medical necessity of a leave of absence from school must be certified by the **covered dependent** student's **Attending Physician** who is licensed to practice. Written documentation of the illness must be submitted to Aetna.

Enrollment

Covered students may enroll their eligible **dependents** by contacting Academic HealthPlans. **Dependent** enrollment will not be accepted after the Fall enrollment deadline of **October 1, 2015,** unless there is a significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage, under another health plan.) The Spring enrollment deadline is **March 2, 2016.**

For information or general questions on dependent enrollment, contact Academic HealthPlans at **(855) 844-3016.**

Newborn Infant and Adopted Child Coverage

A child born to a **Covered Person** shall be covered for **Accident**, **Sickness**, and congenital defects, for 31 days from the date of birth. At the end of this 31 day period, coverage will cease under the Alfred University Student Health Insurance Plan. To extend coverage for a newborn past the 31 days, the **Covered Student** must: 1) enroll the child within 31 days of birth, and 2) pay the additional premium, starting from the date of birth.

Coverage is provided for a child legally placed for adoption with a **Covered Student** for 31 days from the moment of placement provided the child lives in the household of the **Covered Student**, and is **dependent** upon the **Covered Student** for support. To extend coverage for an adopted child past the 31 days, the **Covered Student** must: 1) enroll the child within 31 days of placement of such child, and 2) pay any additional premium, if necessary, starting from the date of placement.

Please note: Previously Covered Persons must re-enroll for dependent coverage by October 1, 2015 for the Fall Semester, and by March 2, 2016 for the Spring Semester, in order to avoid a break in coverage for conditions which existed in prior policy years.

"Continuously insured" means a person who was insured under prior Student Health Insurance policies issued to the school; and is now insured under this Policy. Persons who have remained continuously insured will be covered for conditions first manifesting themselves while continuously insured; except for expenses payable under prior policies in the absence of this Policy. Previously insured **dependents** and students must re-enroll for coverage in order to avoid a break in coverage for conditions which existed in prior Policy Years. Once a break in continuous insurance occurs; the definition of **injury** or **sickness** will apply in determining coverage of any condition which existed during such break.

For information or general questions on dependent enrollment, contact Academic HealthPlans at **(855) 844-3016.**

Special Enrollment Periods

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

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

You, your spouse or child can also enroll 60 days from exhaustion of your COBRA or continuation coverage.

We must receive notice and premium payment within 60 days of the loss of coverage. The effective date of your coverage will depend on when we receive your application. If your application is received between the first and fifteenth day of the month, your coverage will begin on the first day of the following month. If your application is received between the sixteenth day and the last day of the month, your coverage will begin on the first day of the second month.

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

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

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

Participating Provider Network

Aetna Student Health has arranged for you to access a Participating Provider Network in your local community. To maximize your savings and reduce your out-of-pocket expenses, select a Participating Provider. It is to your advantage to use a Participating Provider because savings may be achieved from the Negotiated Charges these providers have agreed to accept as payment for their services.

Preauthorization/Notification Procedure

If you seek coverage for services that require preauthorization, you must call Aetna at the number on your ID card.

You must contact Aetna to request preauthorization as follows:

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

You must contact Aetna to provide notification as follows:

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

After receiving a request for approval, Aetna 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.

Please see the Schedule of Benefits section of the Certificate of Coverage for a list of services that require preauthorization.

Description of Benefits

The Plan excludes coverage for certain services and contains limitations on the amounts it will pay. While this Plan Design and Benefits Summary document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. To look at the full Plan description, which is contained in the Certificate of Coverage issued to You, you may access it online at **http://www.aetnastudenthealth.com** If any discrepancy exists between this Benefit Summary and the Certificate, the Certificate of Coverage will govern and control the payment of benefits.

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

"Allowed Amount" means the maximum amount We will pay for the services or supplies covered under the 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 100% of the Medicare rate.
2. For All Other Providers.
   For all other Providers, the Allowed Amount will be 100% of the Medicare rate.

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 **http://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.

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

COST-SHARING	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Deductible*		
Individual	$250	$250
Family	N/A	N/A
Out-of-Pocket Limit**		
Individual	$6,350	N/A
Family	$12,700	N/A
*Applicable to benefits unless indicated otherwise below. ** This limit never includes your Premium, Balance Billing charges or the cost of health care services We do not Cover.		
OUTPATIENT AND PROFESSIONAL SERVICES (for other than Mental Health and Substance Use)	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**
Office Visits - Primary Care (or home visits)	$25 Copayment after the Policy Year Deductible then you pay 0%	30% Coinsurance after Deductible
Office Visits - Specialists (or home visits)	$25 Copayment after the Policy Year Deductible then you pay 0%	30% Coinsurance after Deductible
PREVENTIVE CARE	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**
Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP").		
Well-Baby and Well-Child Care*	Covered in full	30% Coinsurance after Deductible
Adult Annual Physical Examinations*	Covered in full	30% Coinsurance after Deductible
Adult Immunizations*	Covered in full	30% Coinsurance after Deductible
Well-Woman Examinations *	Covered in full	30% Coinsurance after Deductible

PREVENTIVE CARE (continued)	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Mammograms*	Covered in full	30% Coinsurance after Deductible
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 the certificate, counseling on use of contraceptives and related topics, and sterilization procedures for women. We do not cover services related to the reversal of elective sterilizations.	Covered in full	30% Coinsurance after Deductible
Vasectomy We do not cover services related to the reversal of elective sterilizations.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Bone Mineral Density Measurements or Testing*	Covered in full	30% Coinsurance after Deductible
Screening for Prostate Cancer	Covered in full	30% Coinsurance after Deductible
All other preventive services required by USPSTF and HRSA.	Covered in full	30% Coinsurance after Deductible
***When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.** You may contact Us at the number on your ID card or visit Our website at www.aetnastudenthealth.com for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP.	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)	Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing)
EMERGENCY CARE	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**
Emergency Ambulance Transportation (Pre-Hospital Emergency Medical Services) We do not cover travel or transportation expenses, unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician. We do not cover non-ambulance transportation such as ambulette, van or taxi cab.	0% Coinsurance after Deductible	0% Coinsurance after Deductible
Non-Emergency Ambulance Services	0% Coinsurance after Deductible	0% Coinsurance after Deductible

EMERGENCY CARE (continued)	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Emergency Services *Copayment/Coinsurance waived if Hospital admission. 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. The amount we pay a Non-Participating Provider for Emergency Services will be the greater of: the amount We have negotiated with Participating Providers for the Emergency Service (and if more than one amount is negotiated, the median of the amounts); 100% of the Allowed Amount for services provided by a Non-Participating Provider (i.e., the amount We would pay in the absence of any Cost-Sharing that would otherwise apply for services of Non-Participating Providers);or the amount that would be paid under Medicare. The amounts described above exclude any Copayment or Coinsurance that applies to Emergency Services provided by a Participating Provider. You are responsible for any Copayment, Deductible or Coinsurance. You will be held harmless for any Non-Participating Provider charges that exceed your Copayment, Deductible or Coinsurance.	$150 Copayment after Policy Year Deductible then you pay 0%	$150 Copayment after Policy Year Deductible then you pay 0%
Urgent Care Center Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
OUTPATIENT AND PROFESSIONAL SERVICES (for other than Mental Health and Substance Use)	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**
Advanced Imaging Services (Performed in a Freestanding Radiology Facility or Office Setting)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Advanced Imaging Services (Performed as Outpatient Hospital Services)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Allergy Testing and Treatment (Performed in a PCP Office)	20% Coinsurance after Deductible	40% Coinsurance after Deductible

OUTPATIENT AND PROFESSIONAL SERVICES (continued) (for other than Mental Health and Substance Use)	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Allergy Testing and Treatment (Performed in a Specialist Office)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Ambulatory Surgery Center	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Anesthesia Services (all settings)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Autologous Blood Banking Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Cardiac & Pulmonary Rehabilitation (Performed in a Specialist Office)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Cardiac & Pulmonary Rehabilitation (Performed as Outpatient Hospital Services)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Cardiac & Pulmonary Rehabilitation (Performed as Inpatient Hospital Services)	Included As Part of Inpatient Hospital Service Cost-Sharing	Included As Part of Inpatient Hospital Service Cost-Sharing
Chemotherapy (Performed in a PCP Office)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Chemotherapy (Performed in a Specialist Office)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Chemotherapy (Performed as Outpatient Hospital Services)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Chiropractic Services	$25 Copayment after the Policy Year Deductible then you pay 0%	30% Coinsurance after Deductible
Clinical Trials	Use Cost-Sharing for Appropriate Service	Use Cost-Sharing for Appropriate Service
Diagnostic Testing - Performed in a PCP Office We cover x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic Testing - Performed in a Specialists Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic Testing - Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Dialysis - Performed in a PCP Office	$25 Copayment after the Policy Year Deductible then you pay 0%	30% Coinsurance after Deductible

OUTPATIENT AND PROFESSIONAL SERVICES (continued) (for other than Mental Health and Substance Use)	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Dialysis - Performed in a Freestanding Center or Specialist Office Setting	$25 Copayment after the Policy Year Deductible then you pay 0%	30% Coinsurance after Deductible
Dialysis - Performed as Outpatient Hospital Services	$25 Copayment after the Policy Year Deductible then you pay 0%	30% Coinsurance after Deductible
Habilitation Services - Physical Therapy, Occupational Therapy, or Speech Therapy	$25 Copayment after the Policy Year Deductible then you pay 0%	30% Coinsurance after Deductible
Home Health Care Benefit limited to 40 Visits per Plan Year.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Infertility Services We cover services for the diagnosis and treatment (surgical and medical) of infertility when such infertility is the result of malformation, disease or dysfunction. Such coverage is available as follows: **Basic Infertility Services.** Basic infertility services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York. However, Members must be between the ages of 21 and 44 (inclusive) in order to be considered a candidate for these services. Services include: Initial evaluation; Semen analysis; Laboratory evaluation; Evaluation of ovulatory function; Postcoital test; Endometrial biopsy; Pelvic ultra sound; Hysterosalpingogram; Sono-hystogram; Testis biopsy; Blood tests; and Medically appropriate treatment of ovulatory dysfunction. Additional tests may be covered if the tests are determined to be Medically Necessary. **Comprehensive Infertility Services.** If the basic infertility services do not result in increased fertility, We cover comprehensive infertility services. Services include: Ovulation induction and monitoring; Pelvic ultra sound; Artificial insemination; Hysteroscopy; Laparoscopy; and Laparotomy.	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)

OUTPATIENT AND PROFESSIONAL SERVICES (continued) (for other than Mental Health and Substance Use)	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Infertility Services (continued) **Exclusions and Limitations.** We do not cover: In vitro fertilization, gamete intrafallopian tube transfers or zygote intrafallopian tube transfers; Costs for an ovum donor or donor sperm; Sperm storage costs; Cryopreservation and storage of embryos; Ovulation predictor kits; Reversal of tubal ligations; Reversal of vasectomies; Costs for and relating to surrogate motherhood (maternity services are covered for Members acting as surrogate mothers); Cloning; or Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent. All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine.	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)
Infusion Therapy - Performed in a PCP Office We cover infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required you to be hospitalized. Drugs or nutrients administered directly into the veins are considered infusion therapy.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Infusion Therapy - Performed in a Specialists Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Infusion Therapy - Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Infusion Therapy - Home Infusion Therapy Home Infusion counts towards Home Health Care Visit Limits	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Laboratory Procedures - Performed in a PCP Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Laboratory Procedures - Performed in a Specialist Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Laboratory Procedures - Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Maternity and Newborn Care - Prenatal Care	Covered In Full	30% Coinsurance after Deductible
Maternity and Newborn Care - Inpatient Hospital Services and Birthing Center 1 Home Care Visit is covered at no Cost-Sharing if mother is discharged from Hospital early	20% Coinsurance after Deductible	$250 Copayment after Policy Year Deductible then you pay 40% Coinsurance per admission

OUTPATIENT AND PROFESSIONAL SERVICES (continued) (for other than Mental Health and Substance Use)	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Maternity and Newborn Care - Physician and Midwife Services for Delivery	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Maternity and Newborn Care - Breast Pump We cover the cost of renting one breast pump per pregnancy for duration of breast feeding.	Covered in Full	20% Coinsurance after Deductible
Maternity and Newborn Care - Postnatal Care	0% Coinsurance Not subject to Deductible	30% Coinsurance after Deductible
Outpatient Hospital Surgery Facility Charge	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Preadmission Testing	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic Radiology Services - Performed in a PCP Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic Radiology Services - Performed in a Freestanding Radiology Facility or Specialist Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Diagnostic Radiology Services - Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Therapeutic Radiology Services - Performed in a Freestanding Radiology Facility or Specialist Office	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Therapeutic Radiology Services - Performed as Outpatient Hospital Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Rehabilitation Services - Physical Therapy, Occupational Therapy or Speech Therapy Speech and Physical Therapy are only covered following a Hospital stay or surgery.	$25 Copayment after the Policy Year Deductible then you pay 0%	30% Coinsurance after Deductible
Second Opinions on the Diagnosis of Cancer, Surgery & Other	$25 Copayment after the Policy Year Deductible then you pay 0%	30% Coinsurance after Deductible Second Opinions on Diagnosis of Cancer are covered at Participating Cost-Sharing for Non-Participating Specialist

SURGICAL SERVICES (surgeon, assistant surgeon, anesthetist) - Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive & Corrective Surgery; Transplants & Interruption of Pregnancy	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Inpatient Hospital Surgery	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Outpatient Hospital Surgery	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Surgery Performed at an Ambulatory Surgical Center	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Office Surgery	20% Coinsurance after Deductible	40% Coinsurance after Deductible
ADDITIONAL BENEFITS, EQUIPMENT AND DEVICES	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**
Applied Behavioral Analysis Treatment for Autism Spectrum Disorder "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.	0% Coinsurance after Deductible	30% Coinsurance after Deductible
Assistive Communication Devices for Autism Spectrum Disorder We cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if you are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide you with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. We will only cover devices that generally are not useful to a person in the absence of communication impairment. We do not cover items, such as, but not limited to, laptops, desktop, or tablet computers. We cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device.	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Diabetic Equipment, Supplies and Insulin (30 day supply)	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Diabetic Education	$25 Copayment after the Policy Year Deductible then you pay 0%	30% Coinsurance after Deductible
Durable Medical Equipment and Braces	20% Coinsurance after Deductible	20% Coinsurance after Deductible

ADDITIONAL BENEFITS, EQUIPMENT AND DEVICES (continued)	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Hearing Aids - External Single Purchase Once Every Plan Year.	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Hearing Aids - Cochlear Implants One Per Ear Per Time Covered.	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Hospice Care – Inpatient 210 Days per Plan Year.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Hospice Care – Outpatient 5 Visits for Family Bereavement Counseling.	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Medical Supplies We cover medical supplies that are required for the treatment of a disease or injury which is covered under the certificate. We also cover maintenance supplies (e.g., ostomy supplies) for conditions covered under the certificate. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not cover over-the-counter medical supplies.	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Prosthetics – External We do not cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly. We do not cover orthotics (e.g., shoe inserts).	20% Coinsurance after Deductible	20% Coinsurance after Deductible
Prosthetics - Internal	20% Coinsurance after Deductible	20% Coinsurance after Deductible
INPATIENT SERVICES (for other than Mental Health and Substance Use)	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**
Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)	20% Coinsurance after Deductible	$250 Copayment after Policy Year Deductible then you pay 40% Coinsurance per admission
Observation Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Inpatient Medical Visits Services	20% Coinsurance after Deductible	40% Coinsurance after Deductible

INPATIENT SERVICES (for other than Mental Health and Substance Use)	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Skilled Nursing Facility	20% Coinsurance after Deductible	$250 Copayment after Policy Year Deductible then you pay 40% Coinsurance per admission
Inpatient Rehabilitation Services - Physical Therapy, Occupational Therapy or Speech Therapy	20% Coinsurance after Deductible	$250 Copayment after Policy Year Deductible then you pay 40% Coinsurance per admission
MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Mental Health Care Services Inpatient Services	20% Coinsurance after Deductible	$250 Copayment after Policy Year Deductible then you pay 40% Coinsurance per admission
Mental Health Care Services Outpatient Services	$25 Copayment after the Policy Year Deductible then you pay 0%	30% Coinsurance after Deductible
Substance Use Services Inpatient Services	20% Coinsurance after Deductible	$250 Copayment after Policy Year Deductible then you pay 40% Coinsurance per admission
Substance Use Services Outpatient Services Unlimited Visits May Be Used For Family Counseling.	$25 Copayment after the Policy Year Deductible then you pay 0%	30% Coinsurance after Deductible
PRESCRIPTION DRUG COVERAGE	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Retail Pharmacy (30 day supply) - Tier 1 (generic)	$15 Copayment per supply	$15 Copayment per supply

PRESCRIPTION DRUG COVERAGE (continued)	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Retail Pharmacy (30 day supply) - Tier 2 (formulary brand)	$30 Copayment per supply	$30 Copayment per supply
Retail Pharmacy (30 day supply) - Tier 3 (non-formulary brand)	$30 Copayment per supply	$30 Copayment per supply
Enteral Formulas - Tier 1 (Generic)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Enteral Formulas - Tier 2 (formulary brand)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
Enteral Formulas - Tier 3 (non-formulary brand)	20% Coinsurance after Deductible	40% Coinsurance after Deductible
WELLNESS BENEFITS	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**
Exercise Facility Reimbursement Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. Reimbursement is limited to actual workout visits. We will not provide reimbursement for equipment, clothing, vitamins or other services that may be offered by the facility (e.g., massages, etc.).	Up to $200 per 6 month period; up to an additional $100 per 6 month period for Spouse	
PEDIATRIC VISION CARE **We Cover emergency, preventive and routine vision care for Members up to age 19**	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**
Vision Examinations One Exam per 12-Month Period	0% Coinsurance Not subject to Deductible	30% Coinsurance Not subject to Deductible
Prescribed Lenses and Frames We cover standard prescription lenses or contact lenses, one (1) time in any twelve (12) month period, unless it is Medically Necessary for you to have new lenses or contact lenses more frequently, as evidenced by appropriate documentation. Prescription lenses may be constructed of either glass or plastic. We also cover standard frames adequate to hold lenses one (1) time in any twelve (12) month period, unless it is Medically Necessary for you to have new frames more frequently, as evidenced by appropriate documentation.	0% Coinsurance Not subject to Deductible	30% Coinsurance Not subject to Deductible

PEDIATRIC VISION CARE (continued) We Cover emergency, preventive and routine vision care for Members up to age 19	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
Contact Lenses	0% Coinsurance Not subject to Deductible	30% Coinsurance Not subject to Deductible
PEDIATRIC DENTAL CARE **We Cover the following dental care services for Members up to age 19**	**Participating Member Responsibility for Cost-Sharing**	**Non-Participating Member Responsibility for Cost-Sharing**
Preventive/Routine Dental Care One Dental Exam & Cleaning Per 6-Month Period Full mouth x-rays or panoramic x-rays at 36 month intervals and bitewing x-rays at 6 to 12-month intervals.	Covered in Full	Covered in Full
Major Dental - Endodontics, Periodontics and Prosthodontics	30% Coinsurance Not subject to Deductible	50% Coinsurance after Deductible
Orthodontia	50% Coinsurance Not subject to Deductible	50% Coinsurance after Deductible

Exclusions

This plan does not cover nor provide benefits for:

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. 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.

D. 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 except as specifically stated in the Outpatient and Professional Services and Pediatric Dental Care sections of this Certificate.

E. 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, or 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 the Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of your Appeal rights.

F. 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).

G. 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.

H. 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.

I. 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.

J. 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).

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

L. Services not Listed.
We do not cover services that are not listed in this Certificate as being covered.

M. Services Provided by a Family Member.
We do not cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of you or your Spouse.

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

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

P. 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.

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

The Alfred University Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health℠ is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).