

# Aetna Student Health

## Plan Design and Benefits Summary

### YESHIVA UNIVERSITY

Policy Year: 2015 - 2016

Policy Number: 867898



**aetna**<sup>®</sup>  
www.aetnastudenthealth.com  
(800) 954-5792

This is a brief description of the Student Health Plan. The Plan is available for Yeshiva 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 Certificate of Coverage issued to you and may be viewed online at [www.aetnastudenthealth.com](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.

## Yeshiva University Health Services

The University Health Services is the University's on-campus health facility. Staffed by nurse practitioners and registered nurses, it is open Monday – Thursday from 8:30 a.m. to 12:30 p.m. – 1:30 p.m. to 4:30 p.m. and Friday 8:30 a.m. to 12:30 p.m. – 1:30 p.m. to 2:30 p.m. during the Fall and Spring semesters. A Physician and nurse practitioner are on call at all times, and conduct clinics during the week.

For more information, call the Health Services at:

Beren Campus	Wilf Campus
Brookdale Residence Hall 2B	116 Laurel Hill Terrace (bet. 186 and 187 Sts.)
<b>(212) 340-7792</b>	<b>(646) 592-4290</b>
After Hours: <b>(212) 340-7460</b>	After Hours: <b>(212) 960-5200</b>
<b>Counseling Center:</b>	<b>Counseling Center:</b>
205 Lexington Ave, set 401	116 Laurel Hill Terrace (bet. 186 and 187 Sts.)
<b>(646) 592-4210</b>	<b>(646) 592-4200</b>

## 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
<b>Fall</b>	08/15/2015	01/15/2016	07/11/2015 – 10/15/2015
<b>Spring/Summer</b>	01/16/2016	08/14/2016	11/15/2015 – 02/28/2016

**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
<b>Fall</b>	08/15/2015	01/15/2016	07/11/2015 – 10/15/2015
<b>Spring/Summer</b>	01/16/2016	08/14/2016	11/15/2015 – 02/28/2016

## Rates

The rates below include both premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna), as well as the Academic Emergency Services fee.

	Fall Semester	Spring/Summer Semester
Domestic and International Undergraduate Student	\$1,128.00	\$1,128.00
Domestic and International Graduate Student	\$1,128.00	\$1,128.00
Spouse	\$1,128.00	\$1,128.00
Each Child	\$1,128.00	\$1,128.00

## Student Coverage

### Eligibility

#### First Time on Campus Students (FTOC)

If you are an **undergraduate** enrolled in **six (6)** or more credit hours at Yeshiva University for the first time this year, you are required to be covered by an adequate health insurance plan. You will be automatically enrolled in the Student Health Insurance Plan for 2015-2016 and the premium of **\$1,128** for the fall semester and **\$1,128** for the spring/summer semester will be added to your tuition bill. If you currently have insurance coverage and want to waive out of the University's coverage, you must complete the online waiver form at [yu.myahpcare.com](http://yu.myahpcare.com). The deadline to complete the waiver is October 15, 2015 for the fall semester, and February 28, 2016 for the spring. Please note that if you waive out of the plan now but choose to enroll later, you will have to purchase the insurance directly from Academic HealthPlans for **\$2,256**.

#### Returning Domestic Students who were insured on the 2015-2016 Student Health Insurance Plan

All returning **undergraduate** students who completed a waiver and were approved will not be required to complete a new waiver. If you choose to enroll in the School Student Health Insurance Plan at a later date, students may only purchase the insurance online directly from Academic HealthPlans for the annual premium cost of **\$2,256**.

#### Returning Domestic Students who have previously waived coverage

All **undergraduate** students enrolled in **six (6)** or more credit hours are required to be covered by an adequate health insurance plan. All returning undergraduate students who completed a waiver in 2014-2015 will not be required to complete a new waiver for 2015-2016 as long as the student is currently insured under an adequate health insurance plan. If you choose to enroll in the school Student Health Insurance Plan at a later date, students may only purchase the insurance online directly from Academic HealthPlans for the annual premium cost of **\$2,256**.

#### Graduate Students

All **graduate** students who are enrolled in full-time programs and taking one (1) or more credit hours as part of the required Masters or PhD degree program are eligible to enroll in the Student Health Insurance Plan. This includes students receiving one (1) or more credits in class, practical training, internships, and students teaching, counseling or working on their dissertation. Graduate students may enroll on a voluntary basis.

## International Students

All full-time international **undergraduate** and first time on campus students are required to enroll in the Student Health Insurance Plan. You will be automatically enrolled in the Student Health Insurance Plan for 2015-2016 and the premium of **\$1,128** for the fall semester and **\$1,128** for the spring/summer semester will be added to your tuition bill.

If you currently have insurance coverage and want to waive out of the University's coverage, you must complete the online waiver form at [yu.myahpcare.com](http://yu.myahpcare.com). The deadline to complete the waiver is **October 15, 2015** for the fall semester, and **February 28, 2016** for the spring. Please note that if you waive out of the plan now but choose to enroll later, you will have to purchase the insurance directly from Academic HealthPlans for **\$2,256**.

Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Home study, correspondence and television courses do not fulfill the Eligibility requirement that the students actively attend classes. The Company maintains the right to investigate student status and attendance records to verify that the Eligibility requirements have been met, if not, its only obligation is to refund premium.

Eligible students who enroll may also insure their Dependents for an additional premium.

You are entitled to the benefits described in this brochure, if you have enrolled for this insurance and paid the required premium.

## Returning International Students who have previously waived coverage

All returning undergraduate students who completed a waiver and were approved will not be required to complete a new waiver. If you choose to enroll in the School Student Health Insurance Plan at a later date, students may only purchase the insurance directly from Academic HealthPlans for the annual premium cost of **\$2, 256**.

## Waiver Instructions

### Domestic Students and First Time on Campus Students (FTOC)

If you have insurance coverage, please complete the online waiver at [yu.myahpcare.com](http://yu.myahpcare.com). In addition, you must send a copy of your current insurance card either by mail to the Academic HealthPlans or by email to [waiver@ahpcare.com](mailto:waiver@ahpcare.com) to be reviewed. If the student does not meet the criteria stated, your waiver will be denied. If you do not choose to waive by the deadline, the premium costs will be added to your tuition bill in the fall and again in the spring. If you are a FTOC student, and choose to waive the insurance plan, you will need to complete the waiver during your first year on campus only as long as you maintain continuous and adequate coverage during your enrollment at Yeshiva University. If you have a break in coverage, you will be required to complete a new waiver.

## International Students

Health insurance is required by Yeshiva University and is a necessity in the U.S. because of the very high cost of health care. When you are registered for classes, you will be charged automatically for the Yeshiva sponsored Student Health Insurance Plan. You will remain enrolled in that program unless you submit your waiver before the semester deadline and take action to waive the Yeshiva-sponsored plans. If you maintain other insurance coverage that meets the University's criteria described below, or if you maintain other insurance coverage that is equal to or greater than that of the YU Plan, you may choose to waive the Yeshiva-sponsored plans. Specific University criteria include:

- The insurance company must be headquartered and operating in the U.S., with a U.S. claims address and customer service telephone number.
- The insurance coverage must remain in effect from August 15, 2015 through August 14, 2016.
- The plan must provide inpatient hospitalization benefits in the New York City area including mental health benefits.

- The plan must provide outpatient benefits in the New York City area (including office visits, outpatient mental health benefits, maternity, and laboratory and radiology procedures). Coverage for emergency only care does not satisfy the requirement.
- The maximum benefit payable under the insurance plan must be at least **\$50,000** in U.S. currency. The insurance plan must also include coverage for medical evacuation of at least US **\$25,000**; repatriation of remains of at least **\$15,000** per year in U.S. currency; and a deductible not to exceed US **\$250** per year in U.S. currency. The following types of insurance plans will NOT be acceptable for waiving the Yeshiva plans:
  - Travel policies
  - Insurance plans that always require you to pay for treatment yourself and then apply for reimbursement.
  - Your waiver will not be processed until the Student Health Insurance Committee confirms that your insurance plan meets the University’s criteria. Waiver process for F-1 and J-1 Visa Status You must submit the following insurance plan documentation to the Student Health Insurance Committee for review:
- The completed 2015–2016 Waiver Form (may be downloaded online at **yu.myahpcare.com**)
- A copy of your insurance ID card, and

**A copy of your insurance Policy, in English, indicating:**

- The date that insurance coverage begins and terminates
- Any Deductibles, Copayment and other Out-of-Pocket expenses
- Your plan benefits, including a list of medical and mental health treatments that are excluded from coverage. (your plan may not be accepted depending on these exclusions.)

**Submit documentation to:**

Academic HealthPlans  
 Enrollment Department  
 P.O. Box 1605  
 Colleyville, TX 76034-1605  
 Or fax documentation to **(817) 809-4701**

If the insurance plan meets the University’s criteria, the Risk Management Office will notify the Bursar to remove the health insurance fee from your account.

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, including same-sex marriage, domestic partner and dependent children up to the age of 26.

### Enrollment

To enroll the dependent(s) of a covered student, please contact Academic HealthPlans Customer Service at (855) 856-4198 and requesting that an Enrollment Form be sent in the mail. Please refer to the Coverage Periods section of this document for coverage dates and deadline dates. Dependent enrollment applications will not be accepted after the enrollment deadline, 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 completed Enrollment Form and premium must be sent to Aetna Student Health.

### 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.

## Services Subject to Preauthorization

Preauthorization is required before you receive certain covered services. You are responsible for requesting preauthorization for the out-of-network services listed in the Schedule of Benefits section of the Certificate. Participating Providers are 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 the Certificate.

## 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.

## 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 [www.aetnastudenthealth.com](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 [www.aetnastudenthealth.com](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).

<b>COST-SHARING</b>	<b>Participating Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Member Responsibility for Cost-Sharing</b>
<b>Deductible*</b> <b>Individual</b> <b>Family</b>  <b>Out-of-Pocket Limit**</b> <b>Individual</b> <b>Family</b> *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.	\$400 N/A  \$5,625 \$11,250	\$400 N/A  N/A N/A
<b>OUTPATIENT AND PROFESSIONAL SERVICES (for other than Mental Health and Substance Use)</b>	<b>Participating Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Member Responsibility for Cost-Sharing</b>
<b>Office Visits - Primary Care (or home visits)</b>	\$20 Copayment then you pay 0%  Not subject to Deductible	\$40 Copayment then you pay 30%  Not subject to Deductible
<b>Office Visits - Specialists (or home visits)</b>	\$20 Copayment then you pay 0%  Not subject to Deductible	\$40 Copayment then you pay 30%  Not subject to 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”).		
<b>Well-Baby and Well-Child Care*</b>	Covered in full	30% Coinsurance after Deductible
<b>Adult Annual Physical Examinations*</b>	Covered in full	30% Coinsurance after Deductible
<b>Adult Immunizations*</b>	Covered in full	30% Coinsurance after Deductible
<b>Well-Woman Examinations *</b>	Covered in full	30% Coinsurance after Deductible
<b>Mammograms*</b>	Covered in full	30% Coinsurance after Deductible
<p><b>Family Planning and Reproductive Health Services *</b></p> <p>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.</p> <p>We do not cover services related to the reversal of elective sterilizations.</p>	Covered in full	30% Coinsurance after Deductible
<p><b>Vasectomy</b></p> <p>We do not cover services related to the reversal of elective sterilizations</p>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Bone Mineral Density Measurements or Testing*</b>	Covered in full	30% Coinsurance after Deductible
<b>Screening for Prostate Cancer</b>	Covered in full	30% Coinsurance after Deductible
<b>All other preventive services required by USPSTF and HRSA.</b>	Covered in full	30% Coinsurance after Deductible
<p><b>*When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA.</b></p> <p>You may contact Us at the number on your ID card or visit Our website at <a href="http://www.aetnastudenthealth.com">www.aetnastudenthealth.com</a> 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.</p>	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
<p><b>Emergency Ambulance Transportation (Pre-Hospital Emergency Medical Services)</b></p> <p>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.</p> <p>We do not cover non-ambulance transportation such as ambulette, van or taxi cab.</p>	20% Coinsurance after Deductible	20% Coinsurance after Deductible
<p><b>Non-Emergency Ambulance Services</b></p>	20% Coinsurance after Deductible	20% Coinsurance after Deductible
<p><b>Emergency Services</b></p> <p>*Copayment /Coinsurance waived if Hospital admission.</p> <p>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.</p> <p>We do not cover follow-up care or routine care provided in a Hospital emergency department.</p> <p>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.</p> <p>The amounts described above exclude any Copayment or Coinsurance that applies to Emergency Services provided by a Participating Provider.</p> <p>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.</p>	<p>\$150 Copayment then you pay 20%</p> <p>Not subject to Deductible</p>	<p>\$150 Copayment then you pay 20%</p> <p>Not subject to Deductible</p>
<p><b>Urgent Care Center</b></p> <p>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.</p>	<p>\$20 Copayment then you pay 0%</p> <p>Not subject to Deductible</p>	<p>\$40 Copayment then you pay 30%</p> <p>Not subject to Deductible</p>

<b>OUTPATIENT AND PROFESSIONAL SERVICES (for other than Mental Health and Substance Use)</b>	<b>Participating Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Member Responsibility for Cost-Sharing</b>
<b>Advanced Imaging Services (Performed in a Freestanding Radiology Facility or Office Setting)</b>	20% Coinsurance  Not subject to Deductible	40% Coinsurance  Not subject to Deductible
<b>Advanced Imaging Services (Performed as Outpatient Hospital Services)</b>	20% Coinsurance  Not subject to Deductible	40% Coinsurance  Not subject to Deductible
<b>Allergy Testing and Treatment (Performed in a PCP Office)</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Allergy Testing and Treatment (Performed in a Specialist Office)</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Ambulatory Surgery Center</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Anesthesia Services (all settings)</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Autologous Blood Banking Services</b>	20% Coinsurance  Not subject to Deductible	40% Coinsurance  Not subject to Deductible
<b>Cardiac &amp; Pulmonary Rehabilitation (Performed in a Specialist Office)</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Cardiac &amp; Pulmonary Rehabilitation (Performed as Outpatient Hospital Services)</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Cardiac &amp; Pulmonary Rehabilitation (Performed as Inpatient Hospital Services)</b>	Included As Part of Inpatient Hospital Service Cost-Sharing	
<b>Chemotherapy (Performed in a PCP Office)</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Chemotherapy (Performed in a Specialist Office)</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Chemotherapy (Performed as Outpatient Hospital Services)</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Chiropractic Services</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Clinical Trials</b>	Use Cost-Sharing for Appropriate Service	Use Cost-Sharing for Appropriate Service
<b>Diagnostic Testing - Performed in a PCP Office</b>  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  Not subject to Deductible	40% Coinsurance  Not subject to 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
<b>Diagnostic Testing - Performed in a Specialists Office</b>	20% Coinsurance Not subject to Deductible	40% Coinsurance Not subject to Deductible
<b>Diagnostic Testing - Performed as Outpatient Hospital Services</b>	20% Coinsurance Not subject to Deductible	40% Coinsurance Not subject to Deductible
<b>Dialysis - Performed in a PCP Office</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Dialysis - Performed in a Freestanding Center or Specialist Office Setting</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Dialysis - Performed as Outpatient Hospital Services</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Habilitation Services - Physical Therapy, Occupational Therapy, or Speech Therapy</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Home Health Care</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<p><b>Infertility Services</b></p> <p>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:</p> <p><b>Basic Infertility Services.</b> 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.</p> <p>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.</p> <p>Additional tests may be covered if the tests are determined to be Medically Necessary.</p> <p><b>Comprehensive Infertility Services.</b> If the basic infertility services do not result in increased fertility, We cover comprehensive infertility services.</p>	<p>Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory &amp; Diagnostic Procedures) Preauthorization Required</p>	<p>Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory &amp; Diagnostic Procedures) Preauthorization Required</p>

<b>OUTPATIENT AND PROFESSIONAL SERVICES (continued) (for other than Mental Health and Substance Use)</b>	<b>Participating Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Member Responsibility for Cost-Sharing</b>
<p><b>Infertility Services (continued)</b> Services include: Ovulation induction and monitoring; Pelvic ultra sound; Artificial insemination; Hysteroscopy; Laparoscopy; and Laparotomy.</p> <p><b>Exclusions and Limitations.</b> 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.</p> <p>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.</p>	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) Preauthorization Required	Use Cost Sharing for Appropriate Service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures) Preauthorization Required
<p><b>Infusion Therapy - Performed in a PCP Office</b> 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.</p>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<p><b>Infusion Therapy - Performed in a Specialists Office</b></p>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<p><b>Infusion Therapy - Performed as Outpatient Hospital Services</b></p>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<p><b>Infusion Therapy - Home Infusion Therapy</b></p>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<p><b>Laboratory Procedures - Performed in a PCP Office</b></p>	20% Coinsurance Not subject to Deductible	40% Coinsurance Not subject to Deductible
<p><b>Laboratory Procedures - Performed in a Specialist Office</b></p>	20% Coinsurance Not subject to Deductible	40% Coinsurance Not subject to Deductible
<p><b>Laboratory Procedures - Performed as Outpatient Hospital Services</b></p>	20% Coinsurance Not subject to Deductible	40% Coinsurance Not subject to Deductible

<b>OUTPATIENT AND PROFESSIONAL SERVICES (continued) (for other than Mental Health and Substance Use)</b>	<b>Participating Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Member Responsibility for Cost-Sharing</b>
<b>Maternity and Newborn Care - Prenatal Care</b>	Covered In Full	30% Coinsurance Not subject to Deductible
<b>Maternity and Newborn Care - Inpatient Hospital Services and Birthing Center</b> 1 Home Care Visit is covered at no Cost-Sharing if mother is discharged from Hospital early	20% Coinsurance after Deductible Preauthorization Required	40% Coinsurance after Deductible Preauthorization Required
<b>Maternity and Newborn Care - Physician and Midwife Services for Delivery</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Maternity and Newborn Care - Breast Pump</b> We cover the cost of renting one breast pump per pregnancy for duration of breast feeding.	Covered in Full	30% Coinsurance after Deductible
<b>Maternity and Newborn Care - Postnatal Care</b>	0% Coinsurance Not subject to Deductible	30% Coinsurance Not subject to Deductible
<b>Outpatient Hospital Surgery Facility Charge</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Preadmission Testing</b>	20% Coinsurance Not subject to Deductible	40% Coinsurance Not subject to Deductible
<b>Diagnostic Radiology Services - Performed in a PCP Office</b>	20% Coinsurance Not subject to Deductible	40% Coinsurance Not subject to Deductible
<b>Diagnostic Radiology Services - Performed in a Freestanding Radiology Facility or Specialists Office</b>	20% Coinsurance Not subject to Deductible	40% Coinsurance Not subject to Deductible
<b>Diagnostic Radiology - Performed as Outpatient Hospital Services</b>	20% Coinsurance Not subject to Deductible	40% Coinsurance Not subject to Deductible
<b>Therapeutic Radiology Services - Performed in a Freestanding Radiology Facility or Specialist Office</b>	20% Coinsurance Not subject to Deductible	40% Coinsurance Not subject to Deductible
<b>Therapeutic Radiology Services - Performed as Outpatient Hospital Services</b>	20% Coinsurance Not subject to Deductible	40% Coinsurance Not subject to Deductible
<b>Rehabilitation Services - Physical Therapy, Occupational Therapy or Speech Therapy</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible

<b>OUTPATIENT AND PROFESSIONAL SERVICES (continued) (for other than Mental Health and Substance Use)</b>	<b>Participating Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Member Responsibility for Cost-Sharing</b>
<b>Second Opinions on the Diagnosis of Cancer, Surgery &amp; Other</b>	\$20 Copayment then you pay 0% Not subject to Deductible	\$40 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
<b>SURGICAL SERVICES (surgeon, assistant surgeon, anesthetist) - Including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive &amp; Corrective Surgery; Transplants &amp; Interruption of Pregnancy</b>	<b>Participating Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Member Responsibility for Cost-Sharing</b>
<b>Inpatient Hospital Surgery</b>	20% Coinsurance after Deductible Preauthorization Required	40% Coinsurance after Deductible Preauthorization Required
<b>Outpatient Hospital Surgery</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Surgery Performed at an Ambulatory Surgical Center</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Office Surgery</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>ADDITIONAL BENEFITS, EQUIPMENT AND DEVICES</b>	<b>Participating Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Member Responsibility for Cost-Sharing</b>
<b>Applied Behavioral Analysis Treatment for Autism Spectrum Disorder</b>  “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  Not subject to Deductible	30% Coinsurance  Not subject to Deductible

ADDITIONAL BENEFITS, EQUIPMENT AND DEVICES (continued)	Participating Member Responsibility for Cost-Sharing	Non-Participating Member Responsibility for Cost-Sharing
<p><b>Assistive Communication Devices for Autism Spectrum Disorder</b>            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.</p>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<p><b>Diabetic Equipment, Supplies and Insulin (30 day supply)</b></p>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<p><b>Diabetic Education</b></p>	\$20 Copayment then you pay 0% Not subject to Deductible	\$40 Copayment then you pay 30% Not subject to Deductible
<p><b>Durable Medical Equipment and Braces</b></p>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<p><b>Hearing Aids - External</b>            Single Purchase Once Every Plan Year</p>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<p><b>Hearing Aids - Cochlear Implants</b>            One Per Ear Per Time Covered</p>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<p><b>Hospice Care – Inpatient</b></p>	20% Coinsurance after Deductible  Preauthorization Required	40% Coinsurance after Deductible  Preauthorization Required
<p><b>Hospice Care – Outpatient</b>            5 Visits for Family Bereavement Counseling</p>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<p><b>Medical Supplies</b>            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.</p>	20% Coinsurance after Deductible	40% Coinsurance after Deductible



<b>ADDITIONAL BENEFITS, EQUIPMENT AND DEVICES (continued)</b>	<b>Participating Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Member Responsibility for Cost-Sharing</b>
<p><b>Prosthetics – External</b>            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.</p> <p>We do not cover orthotics (e.g., shoe inserts).            Benefits are limited to one prosthetic device, per limb, per Plan Year.</p>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Prosthetics - Internal</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>INPATIENT SERVICES (for other than Mental Health and Substance Use)</b>	<b>Participating Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Member Responsibility for Cost-Sharing</b>
<b>Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac &amp; Pulmonary Rehabilitation, &amp; End of Life Care)</b>	20% Coinsurance after Deductible Preauthorization Required	40% Coinsurance after Deductible Preauthorization Required
<b>Observation Services</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Inpatient Medical Visits Services</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Skilled Nursing Facility</b>	20% Coinsurance after Deductible Preauthorization Required	40% Coinsurance after Deductible Preauthorization Required
<b>Inpatient Rehabilitation Services - Physical Therapy, Occupational Therapy or Speech Therapy</b>	20% Coinsurance after Deductible Preauthorization Required	40% Coinsurance after Deductible Preauthorization Required
<b>MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES</b>	<b>Participating Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Member Responsibility for Cost-Sharing</b>
<b>Mental Health Care Services Inpatient Services</b> Preauthorization is Not Required for Emergency Admissions	20% Coinsurance after Deductible Preauthorization Required	40% Coinsurance after Deductible Preauthorization Required
<b>Mental Health Care Services Outpatient Services</b>	\$20 Copayment then you pay 0% Not subject to Deductible	\$40 Copayment then you pay 30% Not subject to Deductible

<b>MENTAL HEALTH CARE AND SUBSTANCE USE SERVICES (continued)</b>	<b>Participating Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Member Responsibility for Cost-Sharing</b>
<b>Substance Use Services Inpatient Services Preauthorization is Not Required for Emergency Admissions</b>	20% Coinsurance after Deductible Preauthorization Required	40% Coinsurance after Deductible Preauthorization Required
<b>Substance Use Services Outpatient Services Unlimited Visits May Be Used For Family Counseling</b>	\$20 Copayment then you pay 0% Not subject to Deductible	\$40 Copayment then you pay 30% Not subject to Deductible
<b>PRESCRIPTION DRUG COVERAGE</b>	<b>Participating Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Member Responsibility for Cost-Sharing</b>
<b>Retail Pharmacy (30 day supply) - Tier 1 (generic)</b>	\$15 Copayment per supply	\$15 Copayment per supply
<b>Retail Pharmacy (30 day supply) - Tier 2 (formulary brand)</b>	\$30 Copayment per supply	\$30 Copayment per supply
<b>Retail Pharmacy (30 day supply) - Tier 3 (non-formulary brand)</b>	\$30 Copayment per supply	\$30 Copayment per supply
<b>Mail Order Pharmacy (30 day supply) - Tier 1 (generic)</b>	\$15 Copayment per supply	\$15 Copayment per supply
<b>Mail Order Pharmacy (30 day supply) - Tier 2 (formulary brand)</b>	\$30 Copayment per supply	\$30 Copayment per supply
<b>Mail Order Pharmacy (30 day supply) - Tier 3 (non-formulary brand)</b>	\$30 Copayment per supply	\$30 Copayment per supply
<b>Mail Order More than 30-day supply Up to a 90-day supply - Tier 1 (generic)</b>	Copayment per supply of 2.5 times the 30-day Retail Pharmacy Tier 1 Copayment per supply	Copayment per supply of 2.5 times the 30-day Retail Pharmacy Tier 1 Copayment per supply
<b>Mail Order More than 30-day supply Up to a 90-day supply - Tier 2 (formulary brand)</b>	Copayment per supply of 2.5 times the 30-day Retail Pharmacy Tier 2 Copayment per supply	Copayment per supply of 2.5 times the 30-day Retail Pharmacy Tier 2 Copayment per supply
<b>Mail Order More than 30-day supply Up to a 90-day supply - Tier 3 (non-formulary brand)</b>	Copayment per supply of 2.5 times the 30-day Retail Pharmacy Tier 3 Copayment per supply	Copayment per supply of 2.5 times the 30-day Retail Pharmacy Tier 3 Copayment per supply
<b>Enteral Formulas - Tier 1 (Generic)</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible

<b>PRESCRIPTION DRUG COVERAGE (continued)</b>	<b>Participating Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Member Responsibility for Cost-Sharing</b>
<b>Enteral Formulas - Tier 2 (formulary brand)</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>Enteral Formulas - Tier 3 (non-formulary brand)</b>	20% Coinsurance after Deductible	40% Coinsurance after Deductible
<b>WELLNESS BENEFITS</b>	<b>Participating Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Member Responsibility for Cost-Sharing</b>
<b>Exercise Facility Reimbursement</b> 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	
<b>PEDIATRIC VISION CARE</b> We cover emergency, preventive and routine vision care for Members up to age 19	<b>Participating Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Member Responsibility for Cost-Sharing</b>
<b>Vision Examinations</b> One Exam per 12-Month Period	0% Coinsurance	30% Coinsurance Not subject to Deductible
<b>Prescribed Lenses and Frames</b> 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	30% Coinsurance Not subject to Deductible
<b>Contact Lenses</b>	0% Coinsurance	30% Coinsurance Not subject to Deductible

<b>PEDIATRIC DENTAL CARE</b> We cover the following dental care services for Members up to age 19	<b>Participating Member Responsibility for Cost-Sharing</b>	<b>Non-Participating Member Responsibility for Cost-Sharing</b>
<b>Preventive/Routine Dental Care</b> 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 after Deductible
<b>Major Dental - Endodontics, Periodontics and Prosthodontics</b>	30% Coinsurance Not subject to Deductible	50% Coinsurance after Deductible
<b>Orthodontia</b>	50% Coinsurance Not subject to Deductible	50% Coinsurance after Deductible

## Exclusions

No coverage is available under the 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. 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. 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.

M. Services not Listed.

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

N. 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.

O. Services Separately Billed by Hospital Employees.

We do not cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

P. Services With No Charge.

We do not cover services for which no charge is normally made.

Q. 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.

R. 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 Yeshiva University Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health<sup>SM</sup> is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).