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# Aetna Student Health

# Plan Design and Benefits Summary
# Syracuse University

Policy Year: 2017 - 2018
Policy Number: 474908

www.aetnastudenthealth.com
(877) 480-4161

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

## Syracuse University Health Services (SUHS)

Located on campus at 111 Waverly Avenue, Syracuse University Health Services (SUHS) provides student-centered ambulatory health care services to SU students. A staff of physicians, nurse practitioners, nurses and other health care professionals provide services. SUHS is fully accredited by the Accreditation Association for Ambulatory Health Care. Services paid at 100% are as follows:

- Office Visits
- Laboratory
- Nutritional Counseling
- Psychiatric Services
- Immunizations, Vaccines, and Travel Medicine
- Syracuse University Ambulance (SUA)
- Medical Transportation (MTS)
- Health Education
- Public Health Oversight

Patients are seen by appointment, for an appointment, call **(315) 443-9005**. Hours of operation are as follows:

Monday and Tuesday: 8:30 a.m. – 7:00 p.m.
Wednesday, Thursday and Friday: 8:30 a.m. – 5:00 p.m.
Saturday: 10:00 a.m. – 4:00 p.m.
Sunday: Closed

Hours may vary on holidays and during other periods when University work hours are altered. After hours, a nurse practitioner or physician is available for telephone consultation when appropriate, and Syracuse University Ambulance and Medical Transportation Services are available to provide professional emergency care and medical transportation. For more information on Health Services, visit our website at: **http://health.syr.edu**.

For Claims Information and ID Card Information:

**Aetna Student Health (877) 480-4161**

## 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** | 08/01/2017 | 07/31/2018 | 09/18/2017 |
| **Fall** | 08/01/2017 | 12/31/2017 | 09/18/2017 |
| **Spring/Summer** | 01/01/2018 | 07/31/2018 | 02/06/2018 |

**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 August 1, 2017, and will terminate at 11:59 PM on the Coverage End Date indicated July 31, 2018. 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** | 08/01/2017 | 07/31/2018 | 09/18/2017 |
| **Fall** | 08/01/2017 | 12/31/2017 | 09/18/2017 |
| **Spring/Summer** | 01/01/2018 | 07/31/2018 | 02/06/2018 |

## Student Rates

The rates below include both premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna) as well as a Syracuse University administrative fee.*

| Undergraduate, Graduate, Law and International Students with Insurance Requirement | | | |
|---|---|---|---|
| | Annual | Fall Semester | Spring Semester |
| **Student** | **$1,666*** | **$745*** | **$1,001*** |

## Dependent Rates

The rates below include premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna). as well as a Syracuse University administrative fee.*

| Dependents of Undergraduate, Graduate, Law and International Students with Insurance Requirement | | | |
|---|---|---|---|
| | Annual | Fall Semester | Spring Semester |
| **Spouse Only** | **$1,666*** | **$745*** | **$1,001*** |
| **One Child** | **$1,666*** | **$745*** | **$1,001*** |
| **2 or More Children** | **$3,332*** | **$1,490*** | **$2,002*** |

## Student Coverage

### Eligibility for students subject to the 2017-2018 Insurance Requirement

Syracuse University requires students for the 2017-2018 academic year to maintain insurance coverage. This insurance requirement applies to the following student groups:

- All full-time, matriculated undergraduate, graduate and law students.

* *Full-time status for Undergraduate and Law Students is 12 credit hours*
*Full-time status for Graduate Students is 9 credit hours or a departmental certification as full-time.*

The aforementioned students are required to be enrolled in a health insurance plan with qualifying coverage in order to waive the Syracuse University Student Health Insurance Plan. If you are currently enrolled in a health insurance plan with qualifying coverage, you can document your coverage by completing an Online Waiver Form through https://**myslice**.syr.edu. **Please note: the waiver deadline is September 18, 2017**. If you do not submit a waiver form by this date, you will remain enrolled in the Syracuse University Student Health Insurance Plan for the entire year and the insurance premium will be billed from the Bursar's Office.

Students must actively attend classes for at least the first 31 days after the effective date of the period for which coverage is purchased. Home study, correspondence, Internet classes, and television (TV) courses, do not fulfill the eligibility requirement that the student actively attend classes. If it is discovered that this eligibility requirement has not been met, our only obligation is to refund premium, less any claims paid.

**Waiver Process for students subject to the 2017-2018 Insurance Requirement**

- Waiver requests must be submitted through https://**myslice**.syr.edu by **September 18, 2017**.
- Log in using your Net ID and password to access the waiver form.
- Questions? Contact the Student Health Insurance Office at 1-315-443-9019 or email: healthinsurance@syr.edu

**Enrollment Process for students subject to the 2017-2018 Insurance Requirement**

- Enrollment requests must be submitted through https://myslice.syr.edu by **September 18, 2017**.
- Log in using your Net ID and password to access the enrollment form.
- If no action is taken, eligible students will be automatically enrolled in and billed for the SHIP.

Questions? Contact the Student Health Insurance Office at 1-315-443-9019 or email: healthinsurance@syr.edu

## 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 visit www.haylor.com/su or contact Haylor, Freyer & Coon, Inc. at 866-535-0456 or by email at student@haylor.com. Dependent enrollment applications will not be accepted after **September 18, 2017**, 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 **February 6, 2018** for dependents of new spring students only.

To complete a Dependent Enrollment Form:

1. Students must be currently enrolled in the Syracuse University SHIP through https://myslice.syr.edu 24-48 hours prior.
2. Proceed to www.haylor.com/su.
3. Click on “Dependent Enrollment” under the Domestic Health caption.
4. Follow the instructions for completing the form and submitting payment.
5.

## Petition to Add

Students should login to https://myslice.syr.edu and complete the form for Petition to Add for personal coverage. For coverage for a dependent spouse or child, contact Haylor, Freyer & Coon, Inc. at 866-535-0456 or visit www.haylor.com/su and click on “Dependent Enrollment” under the Domestic Health caption. This must occur within 60 days of the loss of coverage.

## 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:

- Termination of employment;
- Termination of the other health plan;
- Death of the spouse;

- Legal separation, divorce or annulment;
- Reduction of hours of employment;
- Employer contributions toward a health plan were terminated; or
- 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.

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.

## Participating Provider Network

Aetna Student Health offers Aetna's broad network of Participating Providers. You can save money by seeing Participating Providers because Aetna has negotiated special rates with them, and because the Plan's benefits are better.

If you need care that is covered under the Plan but not available from a Participating Provider, contact Member Services for assistance at the toll-free number on the back of your ID card. In this situation, Aetna may issue a pre-approval for you to receive the care from a Non- Participating Provider. When a pre-approval is issued by Aetna, the benefit level is the same as for Participating Providers.

## Precertification

Some services have to be pre-certified by Aetna beforehand if you want the Plan to cover them. Participating Providers are responsible for requesting precertification for their services. You are responsible for requesting precertification if you seek care from a Non-Participating Provider for any of the services listed in the Schedule of Benefits section of the Certificate. Precertification is not required for Participating facilities certified by the New York office of alcoholism and substance abuse services.

If you want the Plan to cover a service from a Non-Participating Provider that requires precertification, you must call Aetna at the number on your ID card. After Aetna receives a request for precertification, we will review the reasons for your planned treatment and determine if benefits are available.

### You must contact Aetna to request precertification as follows:

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

### You must also contact Aetna to provide notification after the fact as follows:

- As soon as reasonably possible when air ambulance services are rendered for an emergency condition.

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

## Description of Benefits

The Plan excludes coverage for certain services and has limitations on the amounts it will pay. While this Plan Design and Benefits Summary document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. To look at the full Plan description, which is contained in the Policy issued to you, go to **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Policy, the Master Policy will control.

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

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

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

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

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

Metallic Level: Platinum, Tested at 88.69%

| COST-SHARING | Participating Provider – Member Responsibility for Cost-Sharing | Non-Participating Provider – Member Responsibility for Cost-Sharing |
|---|---|---|
| **Medical Deductible*** | | |
| **Individual** | **$100** per policy year | **$500** per policy year |
| **Family** | None | None |
| **Out-of-Pocket Limit**** | | |
| **Individual** | **$4,000** | **$10,000** |
| **Family** | **$8,000** | None |
| *Applicable to benefits unless indicated otherwise below.<br>** This limit never includes Your Premium, Balance Billing charges or the cost of health care services we do not Cover. | | Any charges of a Non-Participating Provider that are in excess of the Allowed Amount do not apply towards the Deductible or Out-of-Pocket Limit. You must pay the amount of the Non-Participating |

| | | |
|---|---|---|
| | | Provider's charge that exceeds Our Allowed Amount. |
| **Outpatient and Professional Services (for other than Mental Health and Substance Use)** | **Participating Provider – Member Responsibility for Cost-Sharing** | **Non-Participating Provider – Member Responsibility for Cost-Sharing** |
| **Office Visits - Primary Care (or home visits)** | **$25** Copayment then you pay **0%** Coinsurance<br><br>Not subject to Deductible | **30%** Coinsurance |
| **Office Visits - Specialists (or home visits)** | **$25** Copayment then you pay **0%** Coinsurance<br><br>Not subject to Deductible | **30%** Coinsurance |
| **PREVENTIVE CARE** | **Participating Provider – Member Responsibility for Cost-Sharing** | **Non-Participating Provider – Member Responsibility for Cost-Sharing** |
| Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA"), or if the items or services have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF"), or if the immunizations are recommended by the Advisory Committee on Immunization Practices ("ACIP"). | | |
| **Well-Baby and Well-Child Care*** | Covered in full | **30%** Coinsurance |
| **PREVENTIVE CARE (Continued)** | **Participating Provider – Member Responsibility for Cost-Sharing** | **Non-Participating Provider – Member Responsibility for Cost-Sharing** |
| **Adult Annual Physical Examinations*** | Covered in full | **30%** Coinsurance |
| **Adult Immunizations*** | Covered in full | **30%** Coinsurance |
| **Well-Woman Examinations *** | Covered in full | **30%** Coinsurance |
| **Mammograms*** | Covered in full | **30%** Coinsurance |
| **Family Planning and Reproductive Health Services ***<br>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 |
| **Vasectomy**<br>We do not cover services related to the reversal | **10%** Coinsurance | **40%** Coinsurance |

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|---|---|---|
| of elective sterilizations. | | |
| **Bone Mineral Density Measurements or Testing*** | Covered in full | **30%** Coinsurance |
| **PREVENTIVE CARE** | **Participating Provider – Member Responsibility for Cost-Sharing** | **Non-Participating Provider – Member Responsibility for Cost-Sharing** |
| **Screening for Prostate Cancer** | Covered in full | **30%** Coinsurance |
| **All other preventive services required by USPSTF and HRSA** | Covered in full | **30%** Coinsurance |
| ***When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA**<br>You may contact Us at the number on Your ID card or visit Our website at www.aetnastudenthealth.com for a copy of the comprehensive guidelines supported by HRSA, items or services with an "A" or "B" rating from USPSTF, and immunizations recommended by ACIP. | Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing) | Use Cost Sharing for Appropriate Service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures & Diagnostic Testing) |
| **EMERGENCY CARE** | **Participating Provider – Member Responsibility for Cost-Sharing** | **Non-Participating Provider – Member Responsibility for Cost-Sharing** |
| **Emergency Ambulance Transportation (Pre-Hospital Emergency Medical Services)**<br>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.<br>We do not Cover non-ambulance transportation such as ambulette, van or taxi cab. | **10%** Coinsurance | **10%** Coinsurance |
| **Non-Emergency Ambulance Services** | **10%** Coinsurance | **10%** Coinsurance |
| **EMERGENCY CARE** | **Participating Provider – Member Responsibility for Cost-Sharing** | **Non-Participating Provider – Member Responsibility for Cost-Sharing** |

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| **Emergency Services**<br>*Copayment /Coinsurance waived if Hospital admission.<br><br>**Important Notice:**<br>A separate hospital emergency room visit benefit deductible or copay applies for each visit to an emergency room for emergency care. If a covered person is admitted to a hospital as an inpatient immediately following a visit to an emergency room, the emergency room visit benefit deductible or copay is waived.<br><br>Covered medical expenses that are applied to the emergency room visit benefit deductible or copay cannot be applied to any other benefit deductible or copay under the plan. Likewise, covered medical expenses that are applied to any of the plan's other benefit deductibles or copays cannot be applied to the emergency room visit benefit deductible or copay.<br><br>Separate benefit deductibles or copays may apply for certain services rendered in the emergency room that are not included in the hospital emergency room visit benefit. These benefit deductibles or copays may be different from the hospital emergency room visit benefit deductible or copay, and will be based on the specific service rendered.<br><br>Similarly, services rendered in the emergency room that are not included in the hospital emergency room visit benefit may be subject to coinsurance rates that are different from the coinsurance rate applicable to the hospital emergency room visit benefit. | **10%** Coinsurance | **10%** Coinsurance |

| EMERGENCY CARE | Participating Provider – Member Responsibility for Cost-Sharing | Non-Participating Provider – Member Responsibility for Cost-Sharing |
|---|---|---|
| **Urgent Care Center**<br>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. | **$50** Copayment after Policy Year Deductible then you pay **10%** Coinsurance | **40%** Coinsurance |
| **Outpatient and Professional Services (for other than Mental Health and Substance Use)** | **Participating Provider – Member Responsibility for Cost-Sharing** | **Non-Participating Provider – Member Responsibility for Cost-Sharing** |
| **Advanced Imaging Services (Performed in a Freestanding Radiology Facility or Office Setting)** | **10%** Coinsurance<br><br>Pre-authorization Required | **40%** Coinsurance<br><br>Pre-authorization Required |
| **Advanced Imaging Services (Performed as Outpatient Hospital Services)** | **10%** Coinsurance<br><br>Pre-authorization Required | **40%** Coinsurance<br><br>Pre-authorization Required |
| **Allergy Testing and Treatment (Performed in a PCP Office)** | **10%** Coinsurance | **40%** Coinsurance |
| **Allergy Testing and Treatment (Performed in a Specialist Office)** | **10%** Coinsurance | **40%** Coinsurance |
| **Ambulatory Surgery Center** | **10%** Coinsurance | **40%** Coinsurance |
| **Anesthesia Services (all settings)** | **10%** Coinsurance | **40%** Coinsurance |
| **Autologous Blood Banking Services** | **10%** Coinsurance | **40%** Coinsurance |
| **Cardiac & Pulmonary Rehabilitation (Performed in a Specialist Office)** | **10%** Coinsurance | **40%** Coinsurance |
| **Cardiac & Pulmonary Rehabilitation (Performed as Outpatient Hospital Services)** | **10%** Coinsurance | **40%** Coinsurance |
| **Cardiac & Pulmonary Rehabilitation (Performed as Inpatient Hospital Services)** | Included As Part of Inpatient Hospital Service Cost-Sharing | Included As Part of Inpatient Hospital Service Cost-Sharing |
| **Chemotherapy (Performed in a PCP Office)** | **10%** Coinsurance | **40%** Coinsurance |
| **Chemotherapy (Performed in a Specialist Office)** | **10%** Coinsurance | **40%** Coinsurance |
| **Outpatient and Professional Services (for other than Mental Health and Substance Use)** | **Participating Provider – Member Responsibility for Cost-Sharing** | **Non-Participating Provider – Member Responsibility for Cost-Sharing** |

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|---|---|---|
| **Chemotherapy (Performed as Outpatient Hospital Services)** | **10%** Coinsurance | **40%** Coinsurance |
| **Chiropractic Services** | **10%** Coinsurance | **40%** Coinsurance |
| **Clinical Trials** | Use Cost-Sharing for Appropriate Service<br>Pre-authorization Required | Use Cost-Sharing for Appropriate Service<br>Pre-authorization Required |
| **Diagnostic Testing - Performed in a PCP Office**<br>We Cover x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services. | **10%** Coinsurance | **40%** Coinsurance |
| **Diagnostic Testing - Performed in a Specialists Office** | **10%** Coinsurance | **40%** Coinsurance |
| **Diagnostic Testing - Performed as Outpatient Hospital Services** | **10%** Coinsurance | **40%** Coinsurance |
| **Dialysis - Performed in a PCP Office** | **10%** Coinsurance<br>Pre-authorization Required | **40%** Coinsurance<br>Pre-authorization Required |
| **Dialysis - Performed in a Freestanding Center or Specialist Office Setting** | **10%** Coinsurance<br>Pre-authorization Required | **40%** Coinsurance<br>Pre-authorization Required |
| **Dialysis - Performed as Outpatient Hospital Services** | **10%** Coinsurance<br>Pre-authorization Required | **40%** Coinsurance<br>Pre-authorization Required |
| **Habilitation Services - Physical Therapy, Occupational Therapy, or Speech Therapy** | **10%** Coinsurance | **40%** Coinsurance |
| **Home Health Care**<br>Unlimited Visits per Plan Year | **10%** Coinsurance<br>Pre-authorization Required | **40%** Coinsurance<br>Pre-authorization Required |

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| **Infertility Services**<br>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:<br><br>**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; Post coital 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.<br><br>**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. **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.<br><br>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)<br><br>Pre-authorization Required for Comprehensive Infertility Services |

| Outpatient and Professional Services (for other than Mental Health and Substance Use) | Participating Provider - Member Responsibility for Cost-Sharing | Non-Participating Provider - Member Responsibility for Cost-Sharing |
|---|---|---|
| **Infusion Therapy - Performed in a PCP Office**<br>We cover infusion therapy which is the administration of drugs using specialized delivery systems which otherwise would have required you to be hospitalized. Drugs or nutrients administered directly into the veins are considered infusion therapy. | **10%** Coinsurance | **40%** Coinsurance |
| **Infusion Therapy - Performed in a Specialists Office** | **10%** Coinsurance | **40%** Coinsurance |
| **Infusion Therapy - Performed as Outpatient Hospital Services** | **10%** Coinsurance | **40%** Coinsurance |
| **Infusion Therapy - Home Infusion Therapy**<br>Home Infusion counts towards Home Health Care Visit Limits. | **10%** Coinsurance | **40%** Coinsurance |
| **Laboratory Procedures - Performed in a PCP Office** | **10%** Coinsurance | **40%** Coinsurance |
| **Laboratory Procedures - Performed in a Specialist Office** | **10%** Coinsurance | **40%** Coinsurance |
| **Laboratory Procedures - Performed as Outpatient Hospital Services** | **10%** Coinsurance | **40%** Coinsurance |
| **Acupuncture** | **10%** Coinsurance | **40%** Coinsurance |
| **Maternity and Newborn Care - Prenatal Care** | Covered In Full | **30%** Coinsurance |
| **Maternity and Newborn Care - Inpatient Hospital Services and Birthing Center**<br>One Home Care Visit is Covered at no Cost-Sharing if mother is discharged from Hospital early. | **10%** Coinsurance | **40%** Coinsurance |
| **Maternity and Newborn Care - Physician and Midwife Services for Delivery** | **10%** Coinsurance | **40%** Coinsurance |
| **Maternity and Newborn Care - Breast Pump**<br>We cover the cost of renting one breast pump per pregnancy for duration of breast feeding. | Covered in Full | **30%** Coinsurance per item |
| **Maternity and Newborn Care - Postnatal Care** | Covered in Full | **40%** Coinsurance |
| **Outpatient and Professional Services (for other** | **Participating Provider - Member Responsibility for** | **Non-Participating Provider - Member Responsibility for** |

| | | |
|---|---|---|
| **than Mental Health and Substance Use)** | **Cost-Sharing** | **Cost-Sharing** |
| **Outpatient Hospital Surgery Facility Charge** | **10%** Coinsurance | **40%** Coinsurance |
| **Preadmission Testing** | **10%** Coinsurance | **40%** Coinsurance |
| **Diagnostic Radiology Services - Performed in a PCP Office** | **10%** Coinsurance | **40%** Coinsurance |
| **Diagnostic Radiology Services - Performed in a Freestanding Radiology Facility or Specialist Office** | **10%** Coinsurance | **40%** Coinsurance |
| **Diagnostic Radiology Services - Performed as Outpatient Hospital Services** | **10%** Coinsurance | **40%** Coinsurance |
| **Therapeutic Radiology Services - Performed in a Freestanding Radiology Facility or Specialist Office** | **10%** Coinsurance | **40%** Coinsurance |
| **Therapeutic Radiology Services - Performed as Outpatient Hospital Services** | **10%** Coinsurance | **40%** Coinsurance |
| **Rehabilitation Services - Physical Therapy, Occupational Therapy or Speech Therapy**<br><br>Unlimited visits per condition per Plan Year combined therapies. | **10%** Coinsurance | **40%** Coinsurance |
| **Second Opinions on the Diagnosis of Cancer, Surgery & Other** | **$25** Copayment after Policy Year Deductible then you pay **0%** Coinsurance<br><br>Not subject to Deductible | **30%** Coinsurance<br><br>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 Provider - Member Responsibility for Cost-Sharing** | **Non-Participating Provider - Member Responsibility for Cost-Sharing** |
| **Inpatient Hospital Surgery** | **10%** Coinsurance<br><br>Pre-authorization Required | **40%** Coinsurance<br><br>Pre-authorization Required |
| **Outpatient Hospital Surgery** | **10%** Coinsurance | **40%** Coinsurance |
| **Surgery Performed at an Ambulatory Surgical Center** | **10%** Coinsurance | **40%** Coinsurance |
| **Office Surgery** | **10%** Coinsurance | **40%** Coinsurance |
| **Additional Benefits, Equipment and Devices** | **Participating Provider - Member Responsibility for Cost-Sharing** | **Non-Participating Provider - Member Responsibility for Cost-Sharing** |

| | | |
|---|---|---|
| **Applied Behavioral Analysis Treatment for Autism Spectrum Disorder**<br>"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<br><br>Not subject to Deductible | **30%** Coinsurance |
| **Assistive Communication Devices for Autism Spectrum Disorder**<br>We cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if You are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. We will only cover devices that generally are not useful to a person in the absence of communication impairment. We do not cover items, such as, but not limited to, laptops, desktop, or tablet computers. We cover software and/or applications that enable a laptop, desktop, or tablet computer to function as a speech-generating device. | **10%** Coinsurance | **40%** Coinsurance |
| **Diabetic Equipment, Supplies and Insulin (30 day supply)** | **10%** Coinsurance | **40%** Coinsurance |
| **Diabetic Education** | **10%** Coinsurance | **40%** Coinsurance |
| **Durable Medical Equipment and Braces** | **10%** Coinsurance | **40%** Coinsurance |
| **Hearing Aids - External**<br>Single Purchase Once Every Plan Year. | **10%** Coinsurance | **40%** Coinsurance |
| **Hearing Aids - Cochlear Implants**<br>One Per Ear Per Time Covered. | **10%** Coinsurance | **40%** Coinsurance |

| Additional Benefits, Equipment and Devices (continued) | Participating Provider - Member Responsibility for Cost-Sharing | Non-Participating Provider - Member Responsibility for Cost-Sharing |
|---|---|---|
| **Hospice Care – Inpatient**<br><br>Unlimited Days per Plan Year. | **10%** Coinsurance<br><br>Pre-authorization Required | **40%** Coinsurance<br><br>Pre-authorization Required |
| **Hospice Care – Outpatient**<br><br>5 Visits for Family Bereavement Counseling. | **10%** Coinsurance | **40%** Coinsurance |
| **Medical Supplies**<br>We cover medical supplies that are required for the treatment of a disease or injury which is covered under the certificate. We also cover maintenance supplies (e.g., ostomy supplies) for conditions covered under the certificate. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not cover over-the-counter medical supplies. | **10%** Coinsurance | **40%** Coinsurance |
| **Prosthetics – External**<br>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.<br><br>We do not cover orthotics (e.g., shoe inserts). | **10%** Coinsurance | **40%** Coinsurance |
| **Prosthetics - Internal** | **10%** Coinsurance | **40%** Coinsurance |
| **Inpatient Services (for other than Mental Health and Substance Use)** | **Participating Provider - Member Responsibility for Cost-Sharing** | **Non-Participating Provider - Member Responsibility for Cost-Sharing** |
| **Inpatient Hospital for a Continuous Confinement (Including an Inpatient Stay for Mastectomy Care, Cardiac & Pulmonary Rehabilitation, & End of Life Care)** | **10%** Coinsurance<br><br>Pre-authorization Required | **40%** Coinsurance<br><br>Pre-authorization Required |
| **Observation Services** | **10%** Coinsurance | **40%** Coinsurance |
| **Inpatient Medical Visits Services** | **10%** Coinsurance<br><br>Pre-authorization Required | **40%** Coinsurance<br><br>Pre-authorization Required |

| Inpatient Services (for other than Mental Health and Substance Use) | Participating Provider - Member Responsibility for Cost-Sharing | Non-Participating Provider - Member Responsibility for Cost-Sharing |
|---|---|---|
| **Skilled Nursing Facility** | **10%** Coinsurance<br><br>Pre-authorization Required | **40%** Coinsurance<br><br>Pre-authorization Required |
| **Inpatient Rehabilitation Services - Physical Therapy, Occupational Therapy or Speech Therapy** | **10%** Coinsurance<br><br>Pre-authorization Required | **40%** Coinsurance<br><br>Pre-authorization Required |
| **Mental Health Care and Substance Use Services** | **Participating Provider - Member Responsibility for Cost-Sharing** | **Non-Participating Provider - Member Responsibility for Cost-Sharing** |
| **Mental Health Care Services Inpatient Services**<br>Pre-authorization is Not Required for Emergency Admissions. | **10%** Coinsurance<br><br>Pre-authorization Required | **40%** Coinsurance<br><br>Pre-authorization Required |
| **Mental Health Care Services Outpatient Services** | **$25** Copayment then you pay **0%** Coinsurance<br><br>Not subject to Deductible | **30%** Coinsurance |
| **Substance Use Services Inpatient Services**<br>Pre-authorization is Not Required for Emergency Admissions. | **10%** Coinsurance<br><br>Pre-authorization Required | **40%** Coinsurance<br><br>Pre-authorization Required |
| **Substance Use Services Outpatient Services**<br>Up to **20** Visits a Plan Year May Be Used For Family Counseling. | **$25** Copayment then you pay **0%** Coinsurance<br><br>Not subject to Deductible | **30%** Coinsurance |
| **Prescription Drug Coverage** | **Participating Provider - Member Responsibility for Cost-Sharing** | **Non-Participating Provider - Member Responsibility for Cost-Sharing** |
| **Retail Pharmacy (30 day supply) - Tier 1 (generic)** | **$15** Copayment per supply | Copayment per supply of **30%** of the Allowed Amount |
| **Retail Pharmacy (30 day supply) - Tier 2 (formulary brand)** | **$30** Copayment per supply | Copayment per supply of **30%** of the Allowed Amount |
| **Retail Pharmacy (30 day supply) - Tier 3 (non-formulary brand)** | **$50** Copayment per supply | Copayment per supply of **30%** of the Allowed Amount |
| **Mail Order Pharmacy (30 day supply) - Tier 1 (generic)** | Not Covered | Not Covered |
| **Mail Order Pharmacy (30 day supply) - Tier 2 (formulary brand)** | Not Covered | Not Covered |
| **Mail Order Pharmacy (30 day supply) - Tier 3 (non-formulary brand)** | Not Covered | Not Covered |
| **Mail Order More than 30-day supply Up to a 90-** | Copayment per supply of 2.5 times the 30 day Mail Order | Copayment per supply of 2.5 times the 30 day Mail Order Pharmacy |

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| **day supply - Tier 1 (generic)** | Pharmacy Tier 1 Copayment per supply | Tier 1 Copayment per supply |
| **Mail Order More than 30-day supply Up to a 90-day supply - Tier 2 (formulary brand)** | Copayment per supply of 2.5 times the 30 day Mail Order Pharmacy Tier 2 Copayment per supply | Copayment per supply of 2.5 times the 30 day Mail Order Pharmacy Tier 2 Copayment per supply |
| **Mail Order More than 30-day supply Up to a 90-day supply - Tier 3 (non-formulary brand)** | Copayment per supply of 2.5 times the 30-day Mail Order Pharmacy Tier 3 Copayment per supply | Copayment per supply of 2.5 times the 30-day Mail Order Pharmacy Tier 3 Copayment per supply |
| **Enteral Formulas - Tier 1 (Generic)** | **10%** Coinsurance | **40%** Coinsurance |
| **Enteral Formulas - Tier 2 (formulary brand)** | **10%** Coinsurance | **40%** Coinsurance |
| **Enteral Formulas - Tier 3 (non-formulary brand)** | **10%** Coinsurance | **40%** Coinsurance |
| **WELLNESS BENEFITS** | **Participating Provider - Member Responsibility for Cost-Sharing** | **Non-Participating Provider - Member Responsibility for Cost-Sharing** |
| **Exercise Facility Reimbursement**<br>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**<br>We Cover emergency, preventive and routine vision care for Members through the end of the month in which the Member turns 19 years of age. | **Participating Provider - Member Responsibility for Cost-Sharing** | **Non-Participating Provider - Member Responsibility for Cost-Sharing** |
| **Vision Examinations**<br>One Exam per 12-Month Period. | **0%** Coinsurance<br><br>Not subject to Deductible | **30%** Coinsurance<br><br>Not subject to Deductible |

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| **Prescribed Lenses and Frames**<br>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<br><br>Not subject to Deductible | **30%** Coinsurance<br><br>Not subject to Deductible |
| **Contact Lenses** | **0%** Coinsurance<br><br>Not subject to Deductible | **30%** Coinsurance<br><br>Not subject to Deductible |
| **Pediatric Dental Care**<br>We Cover the following dental care services for Members up through the end of the month in which the Member turns [nineteen 19 years of age. | **Participating Provider - Member Responsibility for Cost-Sharing** | **Non-Participating Provider - Member Responsibility for Cost-Sharing** |
| **Preventive/Routine Dental Care**<br>One Dental Exam & Cleaning Per 6-Month Period<br>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 |
| **Major Dental - Endodontics, Periodontics and Prosthodontics** | **30%** Coinsurance<br><br>Not subject to Deductible | **50%** Coinsurance |
| **Orthodontia** | **50%** Coinsurance<br><br>Not subject to Deductible | **50%** Coinsurance |

## Exclusions

No coverage is available under the certificate for the following:

1. 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.

2. 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.

3. 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.

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

5. 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 this certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this certificate for a further explanation of your appeal rights.

6. 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).

7. 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.

8. 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.
9. 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.

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

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

12. 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.
13. We do not cover services that are not listed in this certificate as being covered.
14. 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.
15. We do not cover services rendered and separately billed by employees of hospitals, laboratories or other institutions.
16. We do not cover services for which no charge is normally made.
17. 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.
18. 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 Syracuse 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).

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

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

If you need a qualified interpreter, written information in other formats, translation or other services, call (877)480-4161.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

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

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TTY: 711

To access language services at no cost to you, call 1-(877) 480-4161.

Para acceder a los servicios de idiomas sin costo, llame al 1-(877) 480-4161. (Spanish)

如欲使用免費語言服務，請致電 1-(877) 480-4161。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-(877) 480-4161. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-(877) 480-4161. (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-(877) 480-4161. an. (German)

(Arabic) 1-(877) 480-4161. للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم

Pou jwenn sèvis lang gratis, rele 1-(877) 480-4161. (French Creole-Haitian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-(877) 480-4161. (Italian)

言語サービスを無料でご利用いただくには、1- (877) 480-4161. までお電話ください。 (Japanese)

무료 언어 서비스를 이용하려면 1- (877) 480-4161. 번으로 전화해 주십시오. (Korean)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 4161-480 (877)- تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1- (877) 480-4161. (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-(877) 480-4161. (Portuguese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-877-480-4161. (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-877-480-4161. (Vietnamese)