Aetna Student Health℠
Plan Design and Benefits Summary
Preferred Provider Organization (PPO)

Andrews University

Policy Year: 2020 – 2021
Policy Number: 686197
andrews.myahpcare.com
(888) 407-0427
This is a brief description of the Student Health Plan. The plan is available for Andrews University students and their eligible dependents. The plan is insured by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Certificate issued to you and may be viewed online at andrews.myahpcare.com. If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

**STUDENT HEALTH SERVICES**

Students may direct their health needs to University Medical Specialties, located next to the Apple Valley Plaza. Phone 269-473-2222 during regular office hours (Monday–Thursday, 8 a.m.–5 p.m., and Friday, 8 a.m.–12 p.m.) to schedule appointments. Residence hall students are eligible for limited health care with University Medical Specialties as part of their residence hall package (see the Andrews University Bulletin at bulletin.andrews.edu). Non-residence hall students living in the apartments or off-campus housing may also use University Medical Specialties for a fee, all students with student health insurance can use the University Medical Center deductible is waived.

If an emergency arises outside of regularly scheduled office hours, students may contact a physician by calling the answering service at University Medical Specialties at 269-473-2222. In the event of an emergency, call 911 or the Campus Police at 269-471-3321.

**Who is eligible?**

All domestic students registered for ½ time status or more are eligible to purchase the Plan. All international students, regardless of credit hours, are required to purchase the Plan. Exceptions to this policy will be considered for Canadian students, and those who are sponsored by an employer. Please see the student insurance office for details.

You must actively attend classes for at least the first 31 days after the date your coverage becomes effective. You cannot meet this eligibility requirement if you take courses through:

- Home study
- Correspondence
- The internet
- Television (TV)

If we find out that you do not meet this eligibility requirement, we are only required to refund any premium contribution minus any claims that we have paid.

**Enrollment**

To enroll, log on to andrews.myahpcare.com.

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.)
Dependent Coverage

Eligibility
Covered students may also enroll their lawful spouse and dependent children up to the age of 26.

Enrollment
To enroll the dependent(s) of a covered student, please log on to andrews.myahpcare.com. 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.) This form can be found on andrews.myahpcare.com.

Important note regarding coverage for a newborn infant or newly adopted child:
- A newborn child - Your newborn child is covered on your health plan from the moment of birth and through the first 31 days from the moment of birth.
  - To keep your newborn covered, you must notify us (or our agent) of the birth and pay any required premium contribution during that 31-day period.
  - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional premium contribution for the newborn.
  - If you miss this deadline, your newborn will not have health benefits after the first 31 days.
  - If your coverage ends during this 31-day period, then your newborns coverage will end on the same date as your coverage. This applies even if the 31-day period has not ended.
- An adopted child or a child legally placed with you for adoption - A child that you, or that you and your spouse, civil union partner or domestic partner adopts or is placed with you for adoption is covered on your plan for the first 31 days after the adoption or the placement is complete.
  - To keep your child covered, we must receive your completed enrollment information within 31 days after the adoption or placement for adoption.
  - You must still enroll the child within 31 days of the adoption or placement for adoption even when coverage does not require payment of an additional premium contribution for the child.
  - If you miss this deadline, your adopted child or child placed with you for adoption will not have health benefits after the first 31 days.
  - If your coverage ends during this 31-day period, then coverage for your adopted child or child placed with you for adoption will end on the same date as your coverage. This applies even if the 31-day period has not ended.

If you need information or have general questions on dependent enrollment, call Member Services at (888) 407-0427.
Coverage Dates and Rates

Coverage for all insured students and eligible dependents 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 for insured dependents terminates in accordance with the Termination Provisions described in the Certificate of Coverage.

<table>
<thead>
<tr>
<th>Coverage Period</th>
<th>Coverage Start Date</th>
<th>Coverage End Date</th>
<th>Enrollment Deadline</th>
<th>Waiver Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual</td>
<td>08/18/2020</td>
<td>08/17/2021</td>
<td>09/30/2020</td>
<td>09/30/2020</td>
</tr>
<tr>
<td>Fall</td>
<td>08/18/2020</td>
<td>01/04/2021</td>
<td>09/30/2020</td>
<td>09/30/2020</td>
</tr>
<tr>
<td>Spring/Summer</td>
<td>01/05/2021</td>
<td>08/17/2021</td>
<td>01/31/2021</td>
<td>01/31/2021</td>
</tr>
<tr>
<td>Summer</td>
<td>05/11/2021</td>
<td>08/17/2021</td>
<td>05/31/2021</td>
<td>05/31/2021</td>
</tr>
</tbody>
</table>

Rates

The rates below include both premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna), as well as any Andrews University administrative fees.

<table>
<thead>
<tr>
<th></th>
<th>Fall</th>
<th>Spring/Summer</th>
<th>Summer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$518.00</td>
<td>$832.00</td>
<td>$366.00</td>
</tr>
<tr>
<td>Spouse</td>
<td>$518.00</td>
<td>$832.00</td>
<td>$366.00</td>
</tr>
<tr>
<td>Each Child</td>
<td>$518.00</td>
<td>$832.00</td>
<td>$366.00</td>
</tr>
</tbody>
</table>

Medicare Eligibility Notice

You are not eligible to enroll in the student health plan if you have Medicare at the time of enrollment in this student plan. The plan does not provide coverage for people who have Medicare.

In-network Provider Network

Aetna Student Health offers Aetna’s broad network of In-network Providers. You can save money by seeing In-network 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 an In-network 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 an Out-of-network Provider. When a pre-approval is issued by Aetna, the benefit level is the same as for In-network Providers.

Precertification

You need pre-approval from us for some eligible health services. Pre-approval is also called precertification. You're in-network physician is responsible for obtaining any necessary precertification before you get the care. When you go to an out-of-network provider, it is your responsibility to obtain precertification from us for any services and supplies on the precertification list. If you do not precertify when required, there is a $500 penalty for each type of eligible health service that was not precertified. For a current listing of the health services or prescription drugs that require precertification, contact Member Services or go to www.aetnastudenthealth.com.
**Precertification Call**

Precertification should be secured within the timeframes specified below. To obtain precertification, call Member Services at the toll-free number on your ID card. This call must be made:

<table>
<thead>
<tr>
<th>Type of Admission</th>
<th>Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-emergency admissions</td>
<td>You, your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.</td>
</tr>
<tr>
<td>An emergency admission</td>
<td>You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.</td>
</tr>
<tr>
<td>An urgent admission</td>
<td>You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.</td>
</tr>
<tr>
<td>Outpatient non-emergency services requiring precertification</td>
<td>You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.</td>
</tr>
</tbody>
</table>

We will provide a written notification to you and your physician of the precertification decision, where required by state law. If your precertified services are approved, the approval is valid for 30 days as long as you remain enrolled in the plan.

**Coordination of Benefits (COB)**

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB). We will apply benefits paid or payable by any primary insurer to satisfy any deductibles, coinsurance and copayments with the policy, and we will not apply payments made by a primary insurer to reduce your policy maximum limits on the policy. A complete description of the Coordination of Benefits provision is contained in the certificate issued to you.
Description of Benefits
The Plan excludes coverage for certain services and has limitations on the amounts it will pay. While this Plan Summary document will tell you about some of the important features of the Plan, other features that may be important to you are defined in the Certificate. To look at the full Plan description, which is contained in the Certificate issued to you, go to www.aetnastudenthealth.com.

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

<table>
<thead>
<tr>
<th>Policy year deductible</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Student</strong></td>
<td>$100 per policy year</td>
<td>$200 per policy year</td>
</tr>
<tr>
<td><strong>Spouse</strong></td>
<td>$100 per policy year</td>
<td>$200 per policy year</td>
</tr>
<tr>
<td><strong>Each child</strong></td>
<td>$100 per policy year</td>
<td>$200 per policy year</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

You have to meet your policy year deductible before this plan pays for benefits.

This is the amount you owe for in-network and out-of-network eligible health services each policy year before the plan begins to pay for eligible health services. This policy year deductible applies separately to you and each of your covered dependents. After the amount you pay for eligible health services reaches the policy year deductible, this plan will begin to pay for eligible health services for the rest of the policy year.

Eligible health services applied to the out-of-network policy year deductibles will not be applied to satisfy the in-network policy year deductibles. Eligible health services applied to the in-network policy year deductibles will not be applied to satisfy the out-of-network policy year deductibles.

Policy year deductible waiver
The policy year deductible is waived for all of the following eligible health services:
- In-network care for Preventive care and wellness, Pediatric Dental Type A services, and Pediatric Vision care Services
- In-network care and out-of-network care for Well newborn nursery care and Outpatient prescription drugs
- Deductible Waived at University Medical Center

<table>
<thead>
<tr>
<th>Maximum out-of-pocket limit per policy year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Student</strong></td>
</tr>
<tr>
<td><strong>Spouse</strong></td>
</tr>
<tr>
<td><strong>Each child</strong></td>
</tr>
<tr>
<td><strong>Family</strong></td>
</tr>
</tbody>
</table>

Eligible health services applied to the out-of-network maximum out-of-pocket limit will not be applied to satisfy the in-network maximum out-of-pocket limit and eligible health services applied to the in-network maximum out-of-pocket limit will not be applied to satisfy the out-of-network maximum out-of-pocket limit.
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine physical exams</strong></td>
<td>100% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Performed at a physician's office</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Maximum age and visit limits per policy year through age 21</td>
<td>Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.</td>
<td></td>
</tr>
<tr>
<td>Maximum visits per policy year age 22 and over</td>
<td></td>
<td>1 visit</td>
</tr>
<tr>
<td><strong>Preventive care immunizations</strong></td>
<td>100% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Performed in a facility or at a physician's office</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Maximums</td>
<td>Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.</td>
<td></td>
</tr>
<tr>
<td><strong>Routine gynecological exams (including Pap smears and cytology tests)</strong></td>
<td>100% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td></td>
<td>1 visit</td>
</tr>
<tr>
<td><strong>Preventive screening and counseling services</strong></td>
<td>100% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol &amp; drugs, Tobacco Products, Depression Screening, Sexually transmitted infection counseling &amp; Genetic risk counseling for breast and ovarian cancer</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Eligible health services</td>
<td>In-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Obesity/Healthy Diet maximum per policy year (Applies to covered persons age 22 and older)</td>
<td>26 visits (10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)</td>
<td></td>
</tr>
<tr>
<td>Misuse of Alcohol maximum per policy year</td>
<td></td>
<td>5 visits</td>
</tr>
<tr>
<td>Tobacco Products Counseling maximum per policy year</td>
<td></td>
<td>8 visits</td>
</tr>
<tr>
<td>Depression screening maximum per policy year</td>
<td></td>
<td>1 visit</td>
</tr>
<tr>
<td>STI maximum per policy year</td>
<td></td>
<td>2 visits</td>
</tr>
<tr>
<td>Routine cancer screenings</td>
<td>100% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Maximums</td>
<td>Subject to any age; family history; and frequency guidelines as set forth in the most current:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• The comprehensive guidelines supported by the Health Resources and Services Administration.</td>
<td></td>
</tr>
<tr>
<td>Lung cancer screening maximums</td>
<td>1 screenings every 12 months</td>
<td></td>
</tr>
<tr>
<td>Prenatal care services (Preventive care services only)</td>
<td>100% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Lactation support and counseling services</td>
<td>100% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Lactation counseling services maximum per policy year</td>
<td></td>
<td>6 visits</td>
</tr>
<tr>
<td>Breast pump supplies and accessories</td>
<td>100% (of the negotiated charge) per item</td>
<td>60% (of the recognized charge) per item</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Eligible health services</td>
<td>In-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>Female contraceptive counseling services office visit</td>
<td>100% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per item</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Contraceptive counseling services maximum per policy year</td>
<td>2 visits</td>
<td></td>
</tr>
<tr>
<td>Female contraceptive prescription drugs and devices</td>
<td>100% (of the negotiated charge) per item</td>
<td>60% (of the recognized charge) per item</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Female voluntary sterilization-Inpatient &amp; Outpatient provider services</td>
<td>100% (of the negotiated charge)</td>
<td>60% (of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Physicians and other health professionals</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist) (includes telemedicine consultations)</td>
<td>$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit</td>
<td>$25 copayment then the plan pays 60% (of the balance of the recognized charge) per visit</td>
</tr>
<tr>
<td>Allergy testing and treatment</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Allergy testing &amp; Allergy injections treatment performed at a physician's or specialist's office</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician and specialist - surgical services</td>
<td>80% (of the negotiated charge)</td>
<td>60% (of the recognized charge)</td>
</tr>
<tr>
<td>Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligible health services</td>
<td>In-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Alternatives to physician office visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walk-in clinic visits (non-emergency visit)</td>
<td>$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit</td>
<td>$25 copayment then the plan pays 60% (of the balance of the recognized charge) per visit</td>
</tr>
<tr>
<td>Hospital and other facility care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital (room and board) and other miscellaneous services and supplies)</td>
<td>$150 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission</td>
<td>$150 copayment then the plan pays 60% (of the balance of the recognized charge) per admission</td>
</tr>
<tr>
<td>Includes birthing center facility charges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-hospital non-surgical physician services</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Alternatives to hospital stays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center</td>
<td>$150 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit</td>
<td>$150 copayment then the plan pays 60% (of the balance of the recognized charge) per visit</td>
</tr>
<tr>
<td>Home health care</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Hospice-Inpatient</td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Hospice-Outpatient</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td></td>
<td>45</td>
</tr>
<tr>
<td>Skilled nursing facility-Inpatient</td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Eligible health services</td>
<td>In-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Hospital emergency room</td>
<td>$250 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit</td>
<td>Paid the same as in-network coverage</td>
</tr>
<tr>
<td>Non-emergency care in a hospital emergency room</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**Important note:**
- As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment/coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill.
- A separate hospital emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived, and your inpatient copayment/coinsurance will apply.
- Covered benefits that are applied to the hospital emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment/coinsurance.
- Separate copayment/coinsurance amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment/coinsurance amounts may be different from the hospital emergency room copayment/coinsurance. They are based on the specific service given to you.
- Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment/coinsurance amounts that are different from the hospital emergency room copayment/coinsurance amounts.

<table>
<thead>
<tr>
<th>Urgent Care</th>
<th>80% (of the negotiated charge) per visit</th>
<th>60% (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-urgent use of urgent care provider</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**Pediatric dental care** (Limited to covered persons through the end of the month in which the person turns age 19.)

<table>
<thead>
<tr>
<th>Type A services</th>
<th>100% (of the negotiated charge) per visit</th>
<th>60% (of the recognized charge) per visit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No copayment or deductible applies</td>
<td></td>
</tr>
<tr>
<td>Type B services</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Type C services</td>
<td>50% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Orthodontic services</td>
<td>50% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Dental emergency treatment</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Eligible health services</td>
<td>In-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>--------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Specific Conditions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetic services and supplies (including equipment and training)</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Impacted wisdom teeth</td>
<td>80% (of the negotiated charge)</td>
<td>60% (of the recognized charge)</td>
</tr>
<tr>
<td>Accidental injury to sound natural teeth</td>
<td>80% (of the negotiated charge)</td>
<td>60% (of the recognized charge)</td>
</tr>
<tr>
<td>Obesity bariatric Surgery</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Maternity care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity care (includes delivery and postpartum care services in a hospital or birthing center)</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Well newborn nursery care in a hospital or birthing center</td>
<td>80% (of the negotiated charge)</td>
<td>60% (of the recognized charge)</td>
</tr>
<tr>
<td><strong>Family planning services – other</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Voluntary sterilization for males-surgical services</td>
<td>80% (of the negotiated charge)</td>
<td>60% (of the recognized charge)</td>
</tr>
<tr>
<td><strong>Autism spectrum disorder</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autism spectrum disorder treatment, diagnosis and testing and Applied behavior analysis</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Mental Health &amp; Substance Abuse Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital (room and board and other miscellaneous hospital services and supplies)</td>
<td>$150 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission</td>
<td>$150 copayment then the plan pays 60% (of the balance of the recognized charge) per admission</td>
</tr>
<tr>
<td>Outpatient office visits (includes telemedicine consultations)</td>
<td>$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit</td>
<td>$25 copayment then the plan pays 60% (of the balance of the recognized charge) per visit</td>
</tr>
<tr>
<td>Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Eligible health services</td>
<td>In-network coverage (IOE facility)</td>
<td>In-network coverage (Non-IOE facility)</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------------------------------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>Transplant services Inpatient and outpatient facility services</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Transplant services Inpatient and outpatient physician and specialist services</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Transplant services-travel and lodging</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Lifetime Maximum Travel and Lodging Expenses for any one transplant</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Maximum Lodging Expenses per IOE patient</td>
<td>$50 per night</td>
<td>$50 per night</td>
</tr>
<tr>
<td>Maximum Lodging Expenses per companion</td>
<td>$50 per night</td>
<td>$50 per night</td>
</tr>
<tr>
<td>Basic infertility services</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Specific therapies and tests</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Outpatient diagnostic testing</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Outpatient Chemotherapy, Radiation &amp; Respiratory Therapy</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy)</td>
<td>$15 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit</td>
<td>$15 copayment then the plan pays 60% (of the balance of the recognized charge) per visit</td>
</tr>
<tr>
<td>Combined for short-term rehabilitation services and habilitation therapy services</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Eligible health services</td>
<td>In-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>$15 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit</td>
<td>$15 copayment then the plan pays 60% (of the balance of the recognized charge) per visit</td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td><strong>Other services and supplies</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency ground, air, and water ambulance (includes non-emergency ambulance)</td>
<td>80% (of the negotiated charge) per trip</td>
<td>Paid the same as in-network coverage</td>
</tr>
<tr>
<td>Durable medical and surgical equipment</td>
<td>80% (of the negotiated charge) per item</td>
<td>60% (of the recognized charge) per item</td>
</tr>
<tr>
<td>Enteral formulas and nutritional supplements</td>
<td>80% (of the negotiated charge) per item</td>
<td>60% (of the recognized charge) per item</td>
</tr>
<tr>
<td>Prosthetic Devices (including breast prosthetic devices) &amp; Orthotics Includes Cranial prosthetics (<em>Medical wigs</em>)</td>
<td>80% (of the negotiated charge) per item</td>
<td>60% (of the recognized charge) per item</td>
</tr>
<tr>
<td>Cochlear implants</td>
<td>80% (of the negotiated charge) per item</td>
<td>60% (of the recognized charge) per item</td>
</tr>
<tr>
<td><strong>Pediatric vision care</strong> (Limited to covered persons through the end of the month in which the person turns age 19)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric routine vision exams (including refraction) - Performed by a legally qualified ophthalmologist or optometrist</td>
<td>100% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Includes comprehensive low vision evaluations</td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Includes visit for fitting of contact lenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td>1 visit</td>
<td></td>
</tr>
<tr>
<td>Low vision Maximum</td>
<td></td>
<td>One comprehensive low vision evaluation every policy year</td>
</tr>
<tr>
<td>Fitting of contact Maximum</td>
<td>1 visit</td>
<td></td>
</tr>
<tr>
<td>Eligible health services</td>
<td>In-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Pediatric vision care services &amp; supplies-Eyeglass frames, prescription lenses or prescription contact lenses</td>
<td>100% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Maximum number Per year:</td>
<td>One set of eyeglass frames</td>
<td></td>
</tr>
<tr>
<td>Eyeglass frames</td>
<td>One pair of prescription lenses</td>
<td></td>
</tr>
<tr>
<td>Prescription lenses</td>
<td>Daily disposables: up to 3-month supply</td>
<td></td>
</tr>
<tr>
<td>Contact lenses (includes non-conventional prescription contact lenses &amp; aphakic lenses prescribed after cataract surgery)</td>
<td>Extended wear disposable: up to 6-month supply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-disposable lenses: one set</td>
<td></td>
</tr>
</tbody>
</table>

*Important note: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both. Coverage does not include the office visit for the fitting of prescription contact lenses.

**Vision Care-Limited to covered persons age 19 and over**

<table>
<thead>
<tr>
<th></th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult routine vision exams (including refraction)</td>
<td>100% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Performed by a legally qualified ophthalmologist or optometrist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Includes fitting of prescription contact lenses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td>1 visit</td>
<td></td>
</tr>
<tr>
<td>Eyeglass frames, prescription lenses or prescription contact lenses</td>
<td>100% (of the negotiated charge) per item</td>
<td>60% (of the recognized charge) per item</td>
</tr>
<tr>
<td>Maximum number per policy year: Eyeglass frames Prescription lenses</td>
<td>One set of eyeglass frames One pair of prescription lenses</td>
<td></td>
</tr>
<tr>
<td>Maximum number of prescription contact lenses per policy year</td>
<td>Daily disposables: up to 3 month supply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Extended wear disposable: up to 6 month supply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-disposable lenses: one set</td>
<td></td>
</tr>
</tbody>
</table>

*Important note: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.*
### Eligible health services

<table>
<thead>
<tr>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient prescription drugs</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Copayment/coinsurance waiver for risk reducing breast cancer</strong></td>
<td>The per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network, pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.</td>
</tr>
<tr>
<td><strong>Copayment waiver for tobacco cessation prescription and over-the-counter drugs</strong></td>
<td>The prescription drug copayment will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at an in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%. Any prescription drug copayment will apply after those two regimens per policy year have been exhausted.</td>
</tr>
</tbody>
</table>
| **Copayment waiver for contraceptives** | The prescription drug copayment will not apply to female contraceptive methods when obtained at an in-network pharmacy. This means that such contraceptive methods are paid at 100% for:  
  - Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%.  
  - If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug or device for that method paid at 100%. The prescription drug copayment continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at an in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception. |

### Generic prescription drugs (including specialty drugs)

<table>
<thead>
<tr>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
</table>
| For each fill up to a 30-day supply filled at a retail pharmacy | $15 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  
No policy year deductible applies |
| 50% (of the recognized charge)  
No policy year deductible applies |

### Preferred brand-name prescription drugs (including specialty drugs)

<table>
<thead>
<tr>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
</table>
| For each fill up to a 30-day supply filled at a retail pharmacy | $40 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  
No policy year deductible applies |
| 50% (of the recognized charge)  
No policy year deductible applies |
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-preferred brand-name prescription drugs (including specialty drugs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>For each fill up to a 30-day supply filled at a retail pharmacy</td>
<td>$75 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>50% (of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Orally administered anti-cancer prescription drugs: For each fill up to a 30-day supply filled at a retail pharmacy</td>
<td>100% (of the negotiated charge)</td>
<td>100% (of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Preventive care drugs and supplements filled at a retail pharmacy</td>
<td>100% (of the negotiated charge per prescription or refill)</td>
<td>Paid according to the type of drug per the schedule of benefits, above</td>
</tr>
<tr>
<td>For each 30-day supply</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Risk reducing breast cancer prescription drugs filled at a pharmacy</td>
<td>100% (of the negotiated charge) per prescription or refill</td>
<td>Paid according to the type of drug per the schedule of benefits, above</td>
</tr>
<tr>
<td>For each 30-day supply</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Maximums:</td>
<td>Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.</td>
<td></td>
</tr>
<tr>
<td>Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy</td>
<td>100% (of the negotiated charge per prescription or refill)</td>
<td>Paid according to the type of drug per the schedule of benefits, above</td>
</tr>
<tr>
<td>For each 30-day supply</td>
<td>No copayment or policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Maximums:</td>
<td>Coverage is permitted for two 90-day treatment regimens only. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.</td>
<td></td>
</tr>
</tbody>
</table>

A covered person, a covered person’s designee or a covered person’s prescriber may seek an expedited medical exception process to obtain coverage for non-covered drugs in exigent circumstances. An “exigent circumstance” exists when a covered person is suffering from a health condition that may seriously jeopardize a covered person’s life, health, or ability to regain maximum function or when a covered person is undergoing a current course of treatment using a non-formulary drug. The request for an expedited review of an exigent circumstance may be submitted by contacting Aetna’s Pre-certification Department at 1-855-240-0535, faxing the request to 1-877-269-9916, or submitting the request in writing to:
CVS Health
ATTN: Aetna PA
1300 E Campbell Road
Richardson, TX 75081
Exclusions

Acupuncture therapy

- Maintenance treatment
- Acupuncture when provided for the following conditions:
  - Acute low back pain
  - Addiction
  - AIDS
  - Amblyopia
  - Allergic rhinitis
  - Asthma
  - Autism spectrum disorders
  - Bell's Palsy
  - Burning mouth syndrome
  - Cancer-related dyspnea
  - Carpal tunnel syndrome
  - Chemotherapy-induced leukopenia
  - Chemotherapy-induced neuropathic pain
  - Chronic pain syndrome (e.g., RSD, facial pain)
  - Chronic obstructive pulmonary disease
  - Diabetic peripheral neuropathy
  - Dry eyes
  - Erectile dysfunction
  - Facial spasm
  - Fetal breech presentation
  - Fibromyalgia
  - Fibrotic contractures
  - Glaucoma
  - Hypertension
  - Induction of labor
  - Infertility (e.g., to assist oocyte retrieval and embryo transfer during IVF treatment cycle)
  - Insomnia
  - Irritable bowel syndrome
  - Menstrual cramps/dysmenorrhea
  - Mumps
  - Myofascial pain
  - Myopia
  - Neck pain/cervical spondylosis
  - Obesity
  - Painful neuropathies
  - Parkinson's disease
  - Peripheral arterial disease (e.g., intermittent claudication)
  - Phantom leg pain
  - Polycystic ovary syndrome
  - Post-herpetic neuralgia
  - Psoriasis
  - Psychiatric disorders (e.g., depression)
  - Raynaud's disease pain
- Respiratory disorders
- Rheumatoid arthritis
- Rhinitis
- Sensorineural deafness
- Shoulder pain (e.g., bursitis)
- Stroke rehabilitation (e.g., dysphagia)
- Tennis elbow/ epicondylitis
- Tension headache
- Tinnitus
- Tobacco Cessation
- Urinary incontinence
- Uterine fibroids
- Xerostomia
- Whiplash

**Air or space travel**

- Traveling in, on or descending from any aircraft, including a hang glider, while the aircraft is in flight. This includes descending by a parachute, wingsuit or any other similar device.

This exclusion does not apply if:
- You are traveling solely as a fare-paying passenger
- You are traveling on a licensed, commercial, regularly scheduled non-military aircraft
- You are traveling solely in a civil aircraft with a current valid “Standard Federal Aviation Agency Airworthiness Certificate” and:
  - The civil aircraft is piloted by a person with a current valid pilot’s certificate with proper ratings for the type of flight and aircraft involved
  - You are as a passenger with no duties at all on an aircraft used only to carry passengers or you are a pilot or a part of the flight crew on an aircraft owned or leased by the policyholder performing duties for the policyholder

**Allergy testing and allergy injections treatment**

- Allergy sera and extracts administered via injection

**Alternative health care**

- Services and supplies given by a provider for alternative health care. This includes but is not limited to aromatherapy, naturopathic medicine, herbal remedies, homeopathy, energy medicine, Christian faith-healing medicine, Ayurvedic medicine, yoga, hypnotherapy, and traditional Chinese medicine.

**Ambulance services**

- Non-emergency fixed wing air ambulance from an out-of-network provider
- Non-emergency ambulance transports except as covered under the *Eligible health services under your plan* section of this certificate of coverage

**Armed forces**

- Services and supplies received from a provider as a result of an injury sustained, or illness contracted, while in the service of the armed forces of any country. When you enter the armed forces of any country, we will refund any unearned pro-rata premium to the policyholder.
Artificial organs
- Any device that would perform the function of a body organ

Behavioral health treatment
- Services for the following categories (or equivalent terms as listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) of the American Psychiatric Association):
  - Stay in a facility for treatment for dementias and amnesia without a behavioral disturbance that necessitates mental health treatment
  - School and/or education service including special education, remedial education, wilderness treatment programs, or any such related or similar programs
  - Services provided in conjunction with school, vocation, work or recreational activities
  - Transportation

Beyond legal authority
- Services and supplies provided by a health professional or other provider that is acting beyond the scope of its legal authority

Blood and body fluid exposure
- Services and supplies provided for the treatment of an illness that results from your clinical related injury as these are covered elsewhere in the student policy

Blood, blood plasma, synthetic blood, blood derivatives or substitutes
Examples of these are:
- The provision of blood to the hospital, other than blood derived clotting factors
- Any related services including processing, storage or replacement expenses
- The services of blood donors, apheresis or plasmapheresis
- For autologous blood donations, only administration and processing expenses are covered

Breasts
- Services and supplies given by a provider for breast reduction or gynecomastia (unless provided as part of post-mastectomy reconstructive services)

Clinical trial therapies (experimental or investigational)
- Your plan does not cover clinical trial therapies (experimental or investigational), except as described in the Eligible health services under your plan - Clinical trial therapies (experimental or investigational) section

Clinical trial therapies (routine patient costs)
- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna's claim policies)
- Select care or in-network coverage limited to benefits for routine patient services provided within the network
Cornea or cartilage transplants
- Cornea (corneal graft with amniotic membrane)
- Cartilage (autologous chondrocyte implant or osteochondral allograft or autograft) transplants

Cosmetic services and plastic surgery
- Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body. Whether or not for psychological or emotional reasons. Injuries that occur during medical treatments are not considered accidental injuries even if unplanned or unexpected.

This exclusion does not apply to:
- Surgery after an accidental injury when performed as soon as medically feasible.
- Coverage that may be provided under the Eligible health services under your plan - Gender reassignment (sex change) treatment section.

Injuries that occur during medical treatments are not considered accidental injuries even if unplanned or unexpected.

Court-ordered services and supplies
- This includes court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding, unless they are a covered benefit under your plan

Custodial care
Examples are:
- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care except in connection with hospice care, adult (or child) day care, or convalescent care
- Institutional care. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training

Dermatological treatment
- Cosmetic treatment and procedures

Dental care for adults
- Dental services for adults including services related to:
  - The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
  - Dental services related to the gums
  - Apicoectomy (dental root resection)
  - Orthodontics
  - Root canal treatment
  - Soft tissue impactions
- Alveolectomy
- Augmentation and vestibuloplasty treatment of periodontal disease
- False teeth
- Prosthetic restoration of dental implants
- Dental implants

This exception does not include removal of bony impacted teeth, bone fractures, removal of tumors, and odontogenic cysts.

Durable medical equipment (DME)
Examples of these items are:
- Whirlpools
- Portable whirlpool pumps
- Sauna baths
- Massage devices
- Over bed tables
- Elevators
- Communication aids
- Vision aids
- Telephone alert systems
- Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician

Educational services
Examples of these services are:
- Any service or supply for education, training or retraining services or testing, except where described in the Eligible health services under your plan – Diabetic services and supplies (including equipment and training) section. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Elective treatment or elective surgery
- Elective treatment or elective surgery except as specifically covered under the student policy and provided while the student policy is in effect

Enteral formulas and nutritional supplements
- Any food item, including infant formulas, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in the Eligible health services under your plan – Enteral formulas and nutritional supplements section
Examinations
Any health or dental examinations needed:
- Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract
- Because a law requires it
- To buy insurance or to get or keep a license
- To travel
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity

Experimental or investigational
- Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (experimental or investigational) or covered under clinical trials (routine patient costs). See the Eligible health services under your plan – Other services section.

Emergency services and urgent care
- Non-emergency services in a hospital emergency room facility
- Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)

Facility charges
For care, services or supplies provided in:
- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons’ main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

Family planning services - other
- Abortion unless specifically covered under the Abortion rider if it applies to this plan
- Reversal of voluntary sterilization procedures, including related follow-up care
- Family planning services received while confined as an inpatient in a hospital or other facility
- Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care

Felony
- Services and supplies that you receive as a result of an injury due to your commission of or attempt to commit a felony or to which a contributing cause was being engaged in an illegal occupation

Foot care
- Services and supplies for:
  - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches
  - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
  - Supplies (including orthopedic shoes), arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
  - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet
Gender reassignment (sex change) treatment

- Cosmetic services and supplies such as:
  - Rhinoplasty
  - Face-lifting
  - Lip enhancement
  - Facial bone reduction
  - Blepharoplasty
  - Breast augmentation
  - Liposuction of the waist (body contouring)
  - Reduction thyroid chondroplasty (tracheal shave)
  - Hair removal (including electrolysis of face and neck)
  - Voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which are used in feminization
  - Chin implants, nose implants, and lip reduction, which are used to assist masculinization, are considered cosmetic

Gene-based, cellular and other innovative therapies (GCIT)

The following are not eligible health services unless you receive prior written approval from us:

- GCIT services received at a facility or with a provider that is not a GCIT-designated facility/provider
- All associated services when GCIT services are not covered. Examples include infusion, laboratory, radiology, anesthesia, and nursing services.

Please refer to the Medical necessity, referral and precertification requirements section.

Genetic care

- Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects

Growth/Height care

- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
- Surgical procedures, devices and growth hormones to stimulate growth

Hearing aids and exams

The following services or supplies:

- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 24-month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- Cochlear implants
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist
- Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay
- Any tests, appliances and devices to:
  - Improve your hearing. This includes hearing aid batteries, amplifiers, and auxiliary equipment
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech
Home health care

- Services for infusion therapy
- Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present
- Homemaker or housekeeper services
- Food or home delivered services
- Maintenance therapy

Hospice care

- Funeral arrangements
- Pastoral counseling
- Bereavement counseling
- Financial or legal counseling which includes estate planning and the drafting of a will
- Homemaker or caretaker services that are services which are not solely related to your care and may include:
  - Sitter or companion services for either you or other family members
  - Transportation
  - Maintenance of the house

Illegal occupation or criminal activity

Services and supplies you receive in which the contributing cause was your:
- Commission of or attempt to commit a felony
- Engagement in an illegal occupation or other willful criminal activity.

A "Willful criminal activity" includes, but is not limited to, either of the following:
- Operating a vehicle while intoxicated
- Operating a methamphetamine laboratory.

"Willful criminal activity" does not include a civil infraction or other activity that does not rise to the level of a misdemeanor or felony.

Incidental surgeries

- Charges made by a physician for incidental surgeries. These are non-medically necessary surgeries performed during the same procedure as a medically necessary surgery.

Jaw joint disorder

- Surgical treatment of jaw joint disorders
- Diagnosis and treatment of temporomandibular joint dysfunction
- Jaw joint disorder treatment performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to jaw joint disorders including associated myofascial pain
This exclusion does not apply to **covered benefits** for treatment of **TMJ** and **CMJ** as described in the *Eligible health services under your plan – Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment* section.

**Judgment or settlement**
- Services and supplies for the treatment of an injury or illness to the extent that payment is made as a judgment or settlement by any person deemed responsible for the injury or illness (or their insurers)

**Mandatory no-fault laws**
- Treatment for an injury to the extent benefits are payable under any state no-fault automobile coverage or first party medical benefits payable under any other mandatory no-fault law

**Maintenance care**
- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services. See the *Eligible health services under your plan – Habilitation therapy services* section

**Maternity and related newborn care**
- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries

**Medical supplies – outpatient disposable**
- Any outpatient disposable supply or device. Examples of these are:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Syringes
  - Blood or urine testing supplies
  - Other home test kits
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

**Medicare**
- Services and supplies available under Medicare, if you are entitled to premium-free Medicare Part A or enrolled in Medicare Part B, or if you are not entitled to premium-free Medicare Part A or enrolled in Medicare Part B because you refused it, dropped it, or did not make a proper request for it

**Mental health and substance abuse related disorders treatment**
- The following categories (or equivalent terms as listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association) are not covered:
  - Sexual deviations and disorders except for gender identity disorders
  - Tobacco use disorders except as described in the *Eligible health services under your plan – Preventive care*
and wellness section
- Pathological gambling, kleptomania, pyromania
- Specific developmental disorders of scholastic skills (learning disorders/learning disabilities)
- Specific developmental disorder of motor functions
- Specific developmental disorders of speech and language
- Other disorders of psychological development

Motor vehicle accidents
- Services and supplies given by a provider for injuries sustained from a motor vehicle accident but only when benefits are payable under other valid and collectible insurance. This applies whether or not a claim is made for such benefits.

Non-medically necessary services and supplies
- Services and supplies which are not medically necessary for the diagnosis, care, or treatment of an illness or injury or the restoration of physiological functions. This includes behavioral health services that are not primarily aimed at the treatment of illness, injury, restoration of physiological functions or that do not have a physiological or organic basis. This applies even if they are prescribed, recommended, or approved by your physician, dental provider, or vision care provider. This exception does not apply to Preventive care and wellness benefits.

Non-U.S. citizen
- Services and supplies received by a covered person (who is not a United States citizen) within the covered person's home country but only if the home country has a socialized medicine program.

Obesity (bariatric) surgery
- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described in the Eligible health services under your plan - Preventive care and wellness section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Organ removal
- Services and supplies given by a provider to remove an organ from your body for the purpose of donating or selling the organ except as described in the Eligible health services under your plan section. This does not apply if you are donating the organ to a spouse, domestic partner, civil union partner, child, brother, sister, or parent.

Other primary payer
- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer.

Outpatient infusion therapy
- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient...
prescription drug plan
- Enteral nutrition
- Blood transfusions and blood products
- Dialysis

Outpatient prescription or non-prescription drugs and medicines
- Outpatient prescription drugs or non-prescription drugs and medicines provided by the policyholder
- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan

Outpatient surgery
- The services of any other physician who helps the operating physician
- A stay in a hospital (Hospital stays are covered in the Eligible health services under your plan – Hospital and other facility care section)
- A separate facility charge for surgery performed in a physician’s office
- Services of another physician for the administration of a local anesthetic

Pediatric dental care
- Any instruction for diet, plaque control and oral hygiene
- Asynchronous dental treatment
- Cosmetic services and supplies, including:
  - Plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve, alter, or enhance appearance
  - Augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the Eligible health services under your plan section
  - Facings on molar crowns and pontics will always be considered cosmetic
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material or
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants and braces (that are determined not to be medically necessary), mouth guards, and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) and craniomandibular joint dysfunction disorder (CMJ) treatment, orthognathic surgery and treatment of malocclusion or devices to alter bite or alignment, except as covered in the Eligible health services under your plan – Specific conditions section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another eligible health service
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment, except as covered in the Eligible health services under your plan – Pediatric dental care section
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication or analgesia (nitrous oxide)
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances
that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
• Replacement of teeth beyond the normal complement of 32
• Routine dental exams and other preventive services and supplies, except as specifically provided in the Eligible health services under your plan – Pediatric dental care section
• Services and supplies:
  – Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  – Provided for your personal comfort or convenience, or the convenience of any other person, including a provider
  – Provided in connection with treatment or care that is not covered under your policy
  – Rendered before the effective date or after the termination of coverage
• Surgical removal of impacted wisdom teeth only for orthodontic reasons
• Treatment by other than a dental provider that is legally qualified to furnish dental services and supplies

Personal care, comfort or convenience items
• Any service or supply primarily for your convenience and personal comfort or that of a third party

Preventive care and wellness
• Services for diagnosis or treatment of a suspected or identified illness or injury
• Exams given during your stay for medical care
• Services not given by or under a physician's direction
• Psychiatric, psychological, personality or emotional testing or exams
• Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care
• Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
• Male contraceptive methods or devices
• The reversal of voluntary sterilization procedures, including any related follow-up care
• Female voluntary sterilization procedures that were not billed separately by the provider or were not the primary purpose of a confinement

Private duty nursing (outpatient only)

Prosthetic devices
• Services covered under any other benefit
• Orthopedic shoes, therapeutic shoes, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace
• Trusses, corsets, and other support items
• Repair and replacement due to loss, misuse, abuse or theft
• Communication aids
• Cochlear implants

Riot
• Services and supplies that you receive from providers as a result of an injury from your “participation in a riot” It does not include actions that you take in self-defense as long as they are not against people who are trying to restore law and order.
Routine exams
- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the Eligible health services under your plan section

School health services
- Services and supplies normally provided by the policyholder's:
  - School health services
  - Infirmary
  - Hospital
  - Pharmacy or

by health professionals who
  - Are employed by
  - Are Affiliated with
  - Have an agreement or arrangement with, or
  - Are otherwise designated by

the policyholder.

Services provided by a family member
- Services provided by a spouse, domestic partner, civil union partner parent, child, step-child, brother, sister, in-law or any household member

Sexual dysfunction and enhancement
- Any treatment, prescription drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services
- Not eligible for coverage are prescription drugs in 90 day supplies

Sinus surgery
- Any services or supplies given by providers for sinus surgery except for acute purulent sinusitis

Sleep apnea
- Any services (except for surgery) or supplies given by providers for the treatment of obstructive sleep apnea and sleep disorders

Specialty prescription drugs
- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug benefit

Sports
- Any services or supplies given by providers as a result from play or practice of collegiate or
intercollegiate sports, not including intercollegiate club sports and intramurals

**Strength and performance**
- Services, devices and supplies such as drugs or preparations designed primarily for enhancing your:
  - Strength
  - Physical condition
  - Endurance
  - Physical performance

**Students in mental health field**
- Any services and supplies provided to a covered student who is specializing in the mental health care field and who receives treatment from a provider as part of their training in that field

**Telemedicine**
- Services given by **providers** that are not contracted with Aetna as **telemedicine providers**.
- Services given when you are not present at the same time as the **provider**
- Services including:
  - Telephone calls for behavioral health services
  - **Telemedicine** kiosks
  - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

**Temporomandibular joint dysfunction treatment (TMJ) and craniomandibular joint dysfunction treatment (CMJ)**
- Dental implants

**Therapies and tests**
- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used as a physical therapy modality
- Sensory or auditory integration therapy

**Tobacco cessation**
- Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:
  - Counseling, except as specifically provided in the **Eligible health services under your plan – Preventive care and wellness** section
  - Hypnosis and other therapies
  - Medications, except as specifically provided in the **Eligible health services under your plan – Outpatient prescription drugs** section
  - Nicotine patches
  - Gum

**Transplant services**
- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for
your existing illness

- Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness
- Travel and lodging expenses

**Treatment in a federal, state, or governmental entity**

- Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

**Treatment of infertility**

- Injectable **infertility** medication, including but not limited to menotropins, hCG, and GnRH agonists.
- All charges associated with:
  - Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father
  - Cryopreservation (freezing) of eggs, embryos or sperm
  - Storage of eggs, embryos, or sperm
  - Thawing of cryopreserved (frozen) eggs, embryos or sperm
  - The care of the donor in a donor egg cycle which includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers
  - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which the person is not genetically related
  - Obtaining sperm from a person not covered under this plan for ART services
- Home ovulation prediction kits or home pregnancy tests
- The purchase of donor embryos, donor oocytes, or donor sperm
- Reversal of voluntary sterilizations, including follow-up care
- Ovulation induction with menotropins, Intrauterine insemination and any related services, products or procedures
- In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery)
- ART services are not provided for out-of-network care

**Vision Care**

**Pediatric vision care services and supplies**
- Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses
- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

**Adult vision care**
- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

**Adult vision care services and supplies**
- Your plan does not cover adult vision care services and supplies, except as described in the **Eligible health services under your plan – Other services** section.
- Special supplies such as non-prescription sunglasses
• Special vision procedures, such as orthoptics or vision therapy
• Eye exams during your stay in a hospital or other facility for health care
• Eye exams for contact lenses or their fitting
• Eyeglasses or duplicate or spare eyeglasses or lenses or frames
• Replacement of lenses or frames that are lost or stolen or broken
• Acuity tests
• Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures
• Services to treat errors of refraction

Wilderness treatment programs
See Educational services within this section

Work related illness or injuries
• Coverage available to you under worker's compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.
• A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers’ compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered “non-occupational” regardless of cause.

Exclusions that apply to outpatient prescription drugs

Abortion drugs

Allergy sera and extracts administered via injection

Any services related to the dispensing, injection or application of a drug

Biological sera

Compounded prescriptions
• Compound prescriptions containing bulk chemicals that have not been approved by the U.S. Food and Drug Administration (FDA) including compounded bioidentical hormones

Cosmetic drugs
• Medications or preparations used for cosmetic purposes

Devices, products and appliances, except those that are specially covered

Dietary supplements including medical foods

Drugs or medications
• Administered or entirely consumed at the time and place it is prescribed or dispensed
• Which do not, by federal or state law, require a prescription order (i.e. over-the-counter (OTC) drugs), even if a prescription is written except as specifically provided in the Eligible health services under your plan – Outpatient prescription drugs section
• That includes the same active ingredient or a modified version of an active ingredient as a covered prescription drug (unless a medical exception is approved)
• That is therapeutically equivalent or therapeutically alternative to a covered prescription drug including biosimilar (unless a medical exception is approved)
• That is therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product (unless a medical exception is approved)
• Not approved by the FDA or not proven safe and effective
• Provided under your medical plan while an inpatient of a healthcare facility
• Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by Aetna's Pharmacy and Therapeutics Committee
• That includes vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
• For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration)
• That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the share or appearance of a sex organ
• That are used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications
• That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the insured meets one or more clinical criteria detailed in our precertification and clinical policies

Duplicative drug therapy (e.g. two antihistamine drugs)

Genetic care
• Any treatment, device, drug, service or supply to alter the body’s genes, genetic make-up, or the expression of the body’s genes except for the correction of congenital birth defects.

Immunizations related to travel or work

Immunization or immunological agents

Implantable drugs and associated devices except as specifically provided in the Eligible health services under your plan – Outpatient prescription drugs sections.

Infertility
• Injectable prescription drugs used primarily for the treatment of infertility.

Injectables
• Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by us
• Needles and syringes, except for those used for self-administration of an injectable drug
• Any drug, which due to its characteristics as determined by us must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps except as specifically provided in the Eligible health services under your plan – Diabetic services and supplies (including equipment and
**Prescription drugs:**
- For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a prescription is written.
- Packaged in unit dose form.
- Filled prior to the effective date or after the termination date of coverage under this plan.
- Dispensed by a mail order pharmacy that include prescription drugs that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.
- That include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and are not clinically superior to that drug as determined by the plan.
- That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or prescription drugs for the treatment of a dental condition.
- That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the preferred drug guide.
- That are non-preferred drugs, unless non-preferred drugs are specifically covered as described in your schedule of benefits. However, a non-preferred drug will be covered if in the judgment of the prescriber there is no equivalent prescription drug on the preferred drug guide or the product on the preferred drug guide is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.
- That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not medically necessary, or otherwise improper, and drugs obtained for use by anyone other than the identified on the ID card.

**Refills**
- Refills dispensed more than one year from the date the latest prescription order was written.

**Replacement of lost or stolen prescriptions**

**Test agents except diabetic test agents**

**Tobacco cessation**
- Tobacco cessation products unless recommended by the United States Preventive Services Task Force (USPSTF)

**We reserve the right to exclude:**
- A manufacturer's product when a same or similar drug (that is, a drug with the same active ingredient or same therapeutic effect), supply or equipment is on the preferred drug guide.
- Any dosage or form of a drug when the same drug (that is, a drug with the same active ingredient or same therapeutic effect) is available in a different dosage or form on our preferred drug guide.

The Andrews 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).
Sanctioned Countries

If coverage provided by this policy violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a written Office of Foreign Asset Control (OFAC) license. For more information, visit http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call the number listed on your ID card at no cost.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  ○ Qualified sign language interpreters
  ○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:
  ○ Qualified interpreters
  ○ Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human
Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)


*Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates.*
<table>
<thead>
<tr>
<th><strong>English</strong></th>
<th><strong>To access language services at no cost to you, call the number on your ID card.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Albanian</strong></td>
<td>Për shërbime përkthimi falas për ju, telefononi në numrin që gjendet në kartën tuaj të identitetit.</td>
</tr>
<tr>
<td><strong>Amharic</strong></td>
<td>የአማርኛ እንዲማን ያለው እንዳንፋን ከምንክፋል ከምርካብነትን ከተጠቀለ ያለው ከፋለም የአማርኛ ይምረጎች ከምርካብነትን ከፋለም እንዳንፋን ይርስን ይቻላል።</td>
</tr>
<tr>
<td><strong>Arabic</strong></td>
<td>للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الإتصال على الرقم الموجود على بطاقة اشتراكك</td>
</tr>
<tr>
<td><strong>Armenian</strong></td>
<td>Հեր համարական զանգերին քաշի պահեստանավորում ունենանք համար քաշվածքները երբ դրձնումքեն ապրահմանավորումը երբ կիրառեք հետազոտությունը</td>
</tr>
<tr>
<td><strong>Bantu-Kirundi</strong></td>
<td>Kugira uronke serivisi z’indimi ata kiguzi, hamagara inomeru iri ku karangamuntu kawe</td>
</tr>
<tr>
<td><strong>Bengali</strong></td>
<td>আপনাকে বিনামূল্যে ভাষা পরিষেবা পেতে হলে আপনার পরিচয়পত্রে দেওয়া নম্বরে টেলিফোন করন।</td>
</tr>
<tr>
<td><strong>Burmese</strong></td>
<td>များသော စာလုံးပေါင်း စာရင်း မှ စတင်ပါသည်။ နောက်ခံသော ID ကို စာရင်းမှ ရှာပါ။</td>
</tr>
<tr>
<td><strong>Catalan</strong></td>
<td>Per accedir a serveis lingüístics sense cap cost per a vostè, telefoni al número indicat a la seva targeta d'identificació.</td>
</tr>
<tr>
<td><strong>Cebuano</strong></td>
<td>Aron maakses ang mga serbisyo sa lengguwahe nga wala kay bayran, tawagi ang numero nga anaa sa imong kard sa ID.</td>
</tr>
<tr>
<td><strong>Chamorro</strong></td>
<td>Para un hago'i sebision lengguahi ni dibâtdhe para hâgu, âgangi ang numeri gi iyo-mu kard aidentifikasion.</td>
</tr>
<tr>
<td><strong>Cherokee</strong></td>
<td>Çʉwañ 50ëñëhë 10ëñëhë 1 ângëñi JCEGNWLI 1 ay, Ɂʉ̃ʔəwəłβ ɁơDU J4dđ IHSAWɁ DIHT ID Ínhẽñ C̱крут.</td>
</tr>
<tr>
<td><strong>Chinese Traditional</strong></td>
<td>如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼</td>
</tr>
<tr>
<td><strong>Choctaw</strong></td>
<td>Anumpa tosholi i toksvli ya peh pilla ho ish i payahinla kvt chi holisso kallo iskitini holhtena takanli ma i payah</td>
</tr>
<tr>
<td><strong>Chuukese</strong></td>
<td>Ren omw kopwe angei aninisin eman chon awewei (ese kamé), kopwe kééri ewe nampa mei mak won noum ena katen ID</td>
</tr>
<tr>
<td><strong>Cushitic-Oromo</strong></td>
<td>Tajaajiiloota afaanii gati bilisaa ati argaachuuff, lakkoofsa fuula waraaqaa eenyummmaa (ID) kee irraa jiruu bilibili.</td>
</tr>
<tr>
<td><strong>Dutch</strong></td>
<td>Voor gratis taaldiensten, bel het nummer op uw ziekteverzekeringskaart.</td>
</tr>
<tr>
<td><strong>French</strong></td>
<td>Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.</td>
</tr>
<tr>
<td><strong>French Creole (Haitian)</strong></td>
<td>Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefon ki sou kat identifikasyon asirans sante ou.</td>
</tr>
<tr>
<td><strong>German</strong></td>
<td>Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.</td>
</tr>
<tr>
<td><strong>Greek</strong></td>
<td>Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφαλίσεως σας.</td>
</tr>
<tr>
<td><strong>Gujarati</strong></td>
<td>તમારે કોઈ પણ જાતિના અંગે વિના લાભ સેવાઓ મેળવવા માટે, તમારા આઇડી કાર્ડ પર રહેલ નંબર પર કોલ કરો.</td>
</tr>
<tr>
<td>Language</td>
<td>Text</td>
</tr>
<tr>
<td>-----------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Hawaiian</td>
<td>No ka wala‘au ‘ana me ka lawelawe ‘ōlelo e kahea aku i ka helu kelepona ma kāu kāleka ID. Kāki ‘ole ‘ia kēia kōkua nei.</td>
</tr>
<tr>
<td>Hindi</td>
<td>बिना किसी किरदार के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।</td>
</tr>
<tr>
<td>Hmong</td>
<td>Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus nj npawb ntawm koj daim npav ID.</td>
</tr>
<tr>
<td>Igbo</td>
<td>Inweta enyemaka asuṣu na akwugh ugw o bupla, kpoq nomba no na kaadi njirimara gi</td>
</tr>
<tr>
<td>Ilocano</td>
<td>Tapno maakses dagiti serbisio ti pagsasao nga awanan ti bayadna, awagan ti numero nga adda ayan ti ID kardmo.</td>
</tr>
<tr>
<td>Indonesian</td>
<td>Untuk mengakses layanan bahasa tanpa dikenakan biaya, silakan hubungi nomor telepon di kartu asuransi Anda.</td>
</tr>
<tr>
<td>Italian</td>
<td>Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.</td>
</tr>
<tr>
<td>Japanese</td>
<td>無料の言語サービスは、IDカードにある番号にお電話ください。</td>
</tr>
<tr>
<td>Karen</td>
<td>ကြည့်နေသောစာသီးစီးပါသည်။ စိန်မှားသောစာသီးများ၏အကြောင်းအရာအားလုံးကို ID အကြောင်းအရာအားလုံးကိုသိရှိပါ။</td>
</tr>
<tr>
<td>Korean</td>
<td>무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.</td>
</tr>
<tr>
<td>Kru-Bassa</td>
<td>I nyu kosna mahola ni language services nguï nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matibla</td>
</tr>
<tr>
<td>Kurdish</td>
<td>نەو دەسپێرەگەیەندە بە خەزمەتگۆزەی زەمان بەم تی‌چوون بە تو، پەیوەندی بەکە بە زەمارمە سەر دای دی (ID) کاردەوەیە.</td>
</tr>
<tr>
<td>Lao</td>
<td>ເຊັີດແຫ່ງທີ່ມີສາມາດດີ່ແລ້ວ, ສູັ່ນສູ້ນທີ່ແກ່ນບັນຊາງເທດບູລິດ.</td>
</tr>
<tr>
<td>Marathi</td>
<td>आपल्या कोणाच्याही शूलकाळीवर भाषा सेवांप्रमाणे पहोचणासाठी, आपल्या ID कार्डवरील क्रमांकांवर फोन करा.</td>
</tr>
<tr>
<td>Marshalllese</td>
<td>Nan bōk jipaṅ kōn kajin ilo an ejjelok ᵃⁿ ṭônean ᵃⁿ kwe, kwôn kallok nomba eo ilo kaat in ID eo am.</td>
</tr>
<tr>
<td>Micronesian-Ponapean</td>
<td>Pwehn alehdi sawas en loka ka ni sohte pweipwei, koahlih nempne nam amhu doaropwe en ID.</td>
</tr>
<tr>
<td>Mon-Khmer, Cambodian</td>
<td>អនុម័តសំខាន់មួយនៃការសម្រាប់ការសម្រាប់ការសន្តិភាពអូនក្នុងប្រទេសបូលីហ្វូនីយ៍ ។</td>
</tr>
<tr>
<td>Navajo</td>
<td>T'áá ni nizaad k'ehjí bee níká a'doowot doo báágh illingóo naaltsos bee atah níljígo nanitíngíí bee néého'dólziníígíi béésh bee hane'í biká'ííjí áají' hólne'.</td>
</tr>
</tbody>
</table>
| Nepali    | आपासम्बन्धी सेवाहृत्ती के निष्क्रियता निष्क्रियता निष्क्रियता निष्क्रियता निष्क्रियता निष्क्रियता
<p>| Nilotic-Dinka | Tè koor yín ran de wëër de thökic ke cín wëur kër keek tènən yín. Ke yín cəl ran ye koc kuñy né namba de abac tə né ID kard duón de tit de nyin de panakim kòu. |
| Norwegian | For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt. |</p>
<table>
<thead>
<tr>
<th>Language</th>
<th>Translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pennsylvanian-Dutch</td>
<td>Um Schprooch Services zu griee mитаus Koscht, ruff die Nummer uff dei ID Kaart.</td>
</tr>
<tr>
<td>Persian Farsi</td>
<td>بردار دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود نام بگویید.</td>
</tr>
<tr>
<td>Polish</td>
<td>Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.</td>
</tr>
<tr>
<td>Portuguese</td>
<td>Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.</td>
</tr>
<tr>
<td>Punjabi</td>
<td>ਜਿਹ੍ਹਾਂ ਦੋਮੀ ਵਿਚ ਮੈਂ ਵੀਮੀ ਵਿਚ ਭੂਕਣ ਮਿੱਜ਼ ਦੇ ਹਵਾਂ ਦੇ ਕਿੱਲਾ ਕਿੱਲਾ, ਅਪਣੇ ਅਰਥਵਿੱਤ ਸੜਿਆ ਦਾ ਸੋਹਦ ਦਾ ਕਰੂੰਦੇ ਹਨ।</td>
</tr>
<tr>
<td>Romanian</td>
<td>Pentru a accesa gratuit serviciile de limbă, apelați numărul de pe cardul de membru.</td>
</tr>
<tr>
<td>Russian</td>
<td>Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.</td>
</tr>
<tr>
<td>Samoan</td>
<td>Mō le maualina o 'au'aunaga tau gagana e aunoa ma se tootog, vala'au le numera i luga o lau pepa ID.</td>
</tr>
<tr>
<td>Serbo-Croatian</td>
<td>Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.</td>
</tr>
<tr>
<td>Spanish</td>
<td>Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.</td>
</tr>
<tr>
<td>Sudanic Fulfulde</td>
<td>Heeba a naasta nder ekkitol jaangirde woldeji walla yobugo, ewn walba je don windi ha do derowol maada.</td>
</tr>
<tr>
<td>Swahili</td>
<td>Kupata huduma za lugha bila malipo kwako, piga nambari iliyo kwenye kadi yako ya kitambulisho.</td>
</tr>
<tr>
<td>Syriac-Assyrian</td>
<td>یک مصرف نرمکی ورودی به سطح های سازمانی در حوزه‌ی استاندارد معمولی، محققان خود، یک مصرف نرمکی ورودی به سطح های سازمانی در حوزه‌ی استاندارد معمولی، محققان خود.</td>
</tr>
<tr>
<td>Tagalog</td>
<td>Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.</td>
</tr>
<tr>
<td>Telugu</td>
<td>దీనికి అంశం లేదు, వాటి కోసం నా వ్యవస్థ రెండు సమాధానాలు ఉన్నాయని, కాని కొత్త పాఠశాల మాధ్యమాల ద్వారా దీనికి అంశం లేదు.</td>
</tr>
<tr>
<td>Thai</td>
<td>พักพิงต่อไปในการใช้และการทำงานด้านภาษาไม่สามารถใช้ภาษาไทยภาษามาตรฐานของการประจุตัวของทางาน</td>
</tr>
<tr>
<td>Tongan</td>
<td>Kapau ‘oku ke flema’u ta’etötongl ‘a e ngaahi sëvesi kotoa pë he ngaahi lea kotoa, telefoni ki he fika ‘oku hā atu ‘i ho’o ID kaati.</td>
</tr>
<tr>
<td>Turkish</td>
<td>Dil hizmetlerine ücretsiz olarak erişmek için kimlik kartınızdaki numarayi arayın.</td>
</tr>
<tr>
<td>Ukrainian</td>
<td>Щоб безкоштовно отримати мовні послуги, задзвоніть за номером, вказанім на вашій ідентифікаційній картці.</td>
</tr>
<tr>
<td>Urdu</td>
<td>لسانی خدمات تنق مفت رسمی کی لیے، اپنے بیمار کی کاروائی دی جانے کے لیے ID کا بر جدر تیار کیر کیا گیا ہے۔</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.</td>
</tr>
<tr>
<td>Yiddish</td>
<td>זא באָקאָItemClick פאַשפער אַרדוּטמאַק פירד פאַהפאַנוקראָ דאָגומער אַך יאָראַך גאָעשטע.</td>
</tr>
<tr>
<td>Yoruba</td>
<td>Láti ráyésì awọn isẹ̀ èdè fún ọ̀rọ̀ ọ̀fẹ̀, pe nómàbá tó wá ìlòrí káàdí iđánímọ̀ rẹ̀.</td>
</tr>
</tbody>
</table>