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# Aetna Student Health
# Plan Design and Benefits Summary

## Preferred Provider Organization (PPO)

## Virginia Tech

Policy Year: 2021–2022
Policy Number: 474968
www.aetnastudenthealth.com
(866) 577-7027

This is a brief description of the Student Health Plan. The Plan is available for Virginia Tech students and their eligible dependents. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Certificate of Coverage and may be viewed online at **www.aetnastudenthealth.com.** If there is a difference between this Benefit Summary and the Certificate of Coverage, the Certificate will control.

## Virginia Tech Health Services

The Schiffert Health Center is the University's on-campus health facility. Staffed by physicians, nurse practitioners and registered nurses, it is open weekdays from 8:00 a.m. to 5:00 p.m., during the Fall and Spring semesters. A Physician and nurse practitioner are on call at all times, and conduct clinics during the week.

**For more information**, call the Health Services at **(540) 231-6444**. In the event of an emergency, call **911**.

## Coverage Periods

**Students/Eligible Dependents:** Coverage will become effective at 12:00 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.

| Coverage Period | Coverage Start Date | Coverage End Date | Open Enrollment Deadline |
|---|---|---|---|
| **Annual** | 08/01/2021 | 07/31/2022 | 09/10/2021 |
| **Spring /Summer** | 01/01/2022 | 07/31/2022 | 01/31/2022 |

## Rates

| | Annual | Spring Semester |
|---|---|---|
| **Student** | $3,343.00 | $1,941.69 |
| **Spouse/Domestic Partner** | $3,343.00 | $1,941.69 |
| **Child** | $3,343.00 | $1,941.69 |
| **2+ Children** | $6,686.00 | $3,883.38 |

## Coverage

### Eligibility

Students must be enrolled as **full-time** students at the university on the first day that coverage will be effective. Students in Cooperative Education and serving approved internships off-campus or performing credited research hours are considered to be full-time students of the university. However, if the student takes fewer than full-time hours but is enrolled in the maximum number of hours allowed toward graduation (i.e. working on a dissertation), the student may obtain a statement to this effect in writing on the department's letterhead and with the signature of the department head. This confirmation may be attached to the application for insurance. The student shall then be considered as full-time and shall be eligible to enroll in the university's insurance plans.

- Undergraduate Eligibility: 12 or more credit hours
- Graduate Eligibility: 9 or more credit hours

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- International Students & Veterinary Medicine DVM Students are required to maintain health insurance either through the school sponsored plan or a comparable plan.
- Eligible Graduate Assistants wishing to use the health care subsidy must in enroll in the Virginia Tech sponsored plan.
- Graduate students who are defending their thesis are eligible to remain on the insurance program if previously insured through the end of the month in which they defend. Documentation from the department head must be provided to the Student Medical Insurance office.
- Visiting Scholars are required to maintain health insurance either though the schools sponsored plan or a comparable plan during their stay at Virginia Tech.
- Language and Culture Institute VT Advantage students.

Students must actively attend classes for at least the first **31 days**, after the date when coverage becomes effective.

Home study, correspondence, Internet classes, and television (**TV**) courses, do not fulfill the eligibility requirement that the student actively attend classes. If it is discovered that this eligibility requirement has not been met, our only obligation is to refund premium, less any claims paid.

### Enrollment

To enroll online, log on to **www.aetnastudenthealth.com,** search for your school, click on Enroll and follow the steps. Enrollment will not be accepted after the enrollment deadline unless there is a significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage under another health plan.) The completed Enrollment and premium must be sent to Aetna Student Health.

**ID Cards:** To print an ID card, log on to **www.aetnastudenthealth.com**, search for your school, click on Get your ID card and follow the steps. Please note that the ID card will be available within 7-10 business days after enrollment is completed.

**Please note: Visiting Scholars and Language and Culture Institute students must enroll through the Virginia Tech Student Medical Insurance office.**

## Waiver Process/Procedure

International Students & Veterinary Medicine DVM Students are required to maintain health insurance either through the school sponsored plan or a comparable plan.

**To meet the criteria of a comparable insurance plan, coverage must meet or exceed all of the following:**

1. The policy must offer adequate provider care within a 50-mile radius of the campus of enrollment. Coverage for emergency only care does not satisfy this requirement. (Adequate means Preferred Care coverage for non-emergency care.)
2. The policy must have a deductible of **$500** per accident or illness or less.
3. The policy must provide major medical benefits of at least **$500,000** per accident or illness.
4. The policy must provide a minimum benefit of **$25,000** for repatriation of remains and **$50,000** medical evacuation to the home country. (Repatriation provides transportation to your home country in the event of death.)
5. Medical expenses for pregnancy, childbirth and complications of pregnancy must be treated as any other illness under the policy.

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6. The policy must provide Prescription Medication coverage (after co-pays) with a minimum of **$500,000** per insured per policy year.
7. Coverage must be valid from either August 01, 2021, or the first day of enrollment at Virginia Tech, until July 31, 2022 or, if graduating, the last day of the month of the student's graduation.
8. The policy must cover Outpatient and Inpatient Mental Health Care as any other illness.
9. The policy **must not** have limits or internal dollar caps on coverage, including services, treatment or surgery.
10. The policy **must not** have a pre-existing condition waiting period.

**Waiver submissions** will be audited by Virginia Tech, and/or their contractors or representatives. You may be required to provide, upon request, any coverage documents and/or other records demonstrating that you meet the school's requirements for waiving the student health insurance plan.

All International and Veterinary Medicine DVM Students records will be blocked and students will be unable to register for classes until the university-sponsored insurance or alternate approved insurance is purchased. There are no exemptions from this requirement. Waivers must be remitted by the deadlines listed below.

**Waiver Deadline Dates**
1. Students enrolling for the Fall Semester- 09/10/2021
2. Students enrolling for the Spring Semester- 01/31/2022

In order to avoid having a block placed on a student's account the student must enroll in the Student Medical Insurance Program or provide details of their current comparable coverage to the Student Medical Insurance Office before the deadline.

## Dependent Coverage

### Eligibility

Covered students may also enroll their lawful spouse or domestic partner (same-sex, opposite sex) and any dependent children up to the age of **26**. ***Verification of Dependent status may be required.***

If a child is covered based on being a full-time student and he/she can't attend school because of a medical condition, the plan must allow the child to stay on the plan, if certified by a physician as medically necessary, until the earlier of 12 months or when coverage would otherwise terminate for the dependent.

### Enrollment

To enroll the dependent(s) of a covered student, please complete the Enrollment by visiting **www.aetnastudenthealth.com**, selecting the school name, and clicking on Enroll. Please refer to the Coverage Periods section of this document for coverage dates and deadline dates. Dependent enrollment will not be accepted after the enrollment deadline unless there is a significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage under another health plan.) The completed Enrollment and premium must be sent to Aetna Student Health.

### Important note regarding coverage for a newborn infant or newly adopted child:

- A newborn child - Your newborn child is covered on your health plan for the first 60 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 60-day period.
  - If coverage does not require an additional premium contribution for the newborn, you must still notify us (or our agent) within 60 days of birth to enroll the child.
  - If you miss this deadline, your newborn will not have health benefits after the first 60 days.
  - If your coverage ends during this 60-day period, then your newborn's coverage will end on the same date as your coverage. This applies even if the 60-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 or domestic partner adopts or is placed with you for adoption, is covered on your plan for the first 60 days after the adoption or the placement is complete.
  - To keep your child covered, we must receive your completed enrollment information within 60 days after the adoption or placement for adoption.
  - If coverage does not require an additional premium contribution for the adopted child, you must still notify us (or our agent) within 60 days of adoption or placement for adoption to enroll 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 60 days.
  - If your coverage ends during this 60-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 60-day period has not ended.

**For information** or general questions on dependent enrollment, contact Student Medical Insurance at **(540) 231-6226**

## 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.

## Termination and Refunds

### Withdrawal from Classes – Leave of Absence

If you withdraw from classes under a school-approved leave of absence, your coverage will remain in force through the end of the period for which payment has been received and no premiums will be refunded.

### Withdrawal from Classes – Other than Leave of Absence

If you withdraw from classes other than under a school-approved leave of absence within 31 days after the policy effective date, you will be considered ineligible for coverage, your coverage will be terminated retroactively and any premiums collected will be refunded. If the withdrawal is more than 31 days after the policy effective date, your coverage will remain in force through the end of the period for which payment has been received and no premiums will be refunded. If you withdraw from classes to enter the armed forces of any country, coverage will terminate as of the effective date of such entry and a pro rata refund of premiums will be made if you submit a written request within 90 days of withdrawal from classes.

## Preferred Provider Network

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

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

## Precertification

You need pre-approval from us for some eligible health services. Pre-approval is also called precertification. Your Preferred Care physician is responsible for obtaining any necessary precertification before you get the care. When you go to an Non-Preferred Care 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 **$200** 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:

| | |
|---|---|
| Non-emergency admissions: | You, your physician or the facility will need to call and request precertification at least 15 days before the date you are scheduled to be admitted. |
| An emergency admission: | You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted. |
| An urgent admission: | 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. |
| Outpatient non-emergency services requiring precertification: | You or your physician must call at least 15 days before the outpatient care is provided, or the treatment or procedure is scheduled. |
| Delivery: | You, your physician, or the facility must call within 48 hours of the birth or as soon thereafter as possible. No penalty will be applied for the first 48 hours after delivery for a routine delivery and 96 hours for a cesarean delivery. |

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.

### What if you don't obtain the required pre-certification?

If you don't obtain the required pre-certification:

- Your benefits may be reduced, or the plan may not pay any benefits. See the schedule of benefits *Pre-certification penalty* section.
- You will be responsible for the unpaid balance of the bills.
- Any additional out-of-pocket expenses incurred will not count toward your deductibles or maximum out-of-pocket limits.

### What types of services and supplies require pre-certification?

Pre-certification is required for the following types of services and supplies:

| Inpatient services and supplies | Outpatient services and supplies |
|---|---|
| Gender reassignment surgery | Applied behavior analysis |
| Obesity (bariatric) surgery | Certain **prescription drugs** and devices***** |
| **Stays** in a **hospice** facility | Complex imaging |
| **Stays** in a **hospital** | **Cosmetic** and reconstructive **surgery** |
| **Stays** in a **rehabilitation facility** | Emergency transportation by airplane |
| **Stays** in a **residential treatment facility** for treatment of **mental disorders** and **substance abuse** | Gender reassignment surgery |
| **Stays** in a **skilled nursing facility** | Home health care |
| | Hospice services |
| | **Intensive outpatient program (IOP)** – **mental disorder** and **substance abuse** diagnoses |
| | Kidney dialysis |
| | Knee **surgery** |
| | Medical **injectable drugs**, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, botox, hepatitis C medications)***** |
| | Outpatient back **surgery** not performed in a **physician's** office |
| | **Partial hospitalization treatment** – **mental disorder** and **substance abuse** diagnoses |
| | Private duty nursing services |
| | Psychological testing/neuropsychological testing |
| | Sleep studies |
| | Transcranial magnetic stimulation (TMS) |
| | Wrist **surgery** |

**For a current listing of the prescription drugs and medical injectable drugs that require pre-certification, contact Member Services by calling the toll-free number on your ID card in the How to contact us for help section or by logging onto the Aetna website at **www.aetnastudenthealth.com**.*

## 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). 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**. If any discrepancy exists between this Benefit Summary and the Certificate of Coverage, the Certificate will control.

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

| | Preferred Care Coverage | Non-Preferred Care Coverage |
|---|---|---|
| **Policy year deductibles** | | |
| You have to meet your policy year deductible before this plan pays for benefits. | | |
| Student | $450 per policy year | $1,000 per policy year |
| Spouse or domestic partner | $450 per policy year | $1,000 per policy year |
| Each child | $450 per policy year | $1,000 per policy year |
| Family | $900 per policy year | $2,000 per policy year |

**Policy year deductible waiver**

The policy year deductible is waived for Preferred Care covered medical expenses that apply to Preventive Care Expense benefits.

In addition to federal requirements for waiver of the policy year deductible, this Plan will waive the Deductible for:

- Preferred and Non-Preferred Care Emergency Room Services,
- Non-Preferred Care Preventive Health Care Services up to age 7,
- Preferred and Non-Preferred Care Pediatric Care Vision Benefit Expenses,
- Preferred Care Pediatric Dental Services Expenses,
- Preferred and Non-Preferred Care Prescribed Medicines expenses,
- Preferred Care Adult Vision Exam and Vision Supplies Expense,
- Preferred Care Office Visit Expense,
- Preferred Care Walk-in Clinic Visit Expense
- Preferred Care Outpatient Treatment of Mental Disorders Expense,
- Preferred Care Outpatient Treatment of Substance Abuse Expense,
- Preferred Care Urgent Care Expense, and
- Preferred Care Non-Elective Second Surgical Opinion Expense.

Per visit or admission deductibles do not apply towards satisfying the policy year deductible.

**Individual Deductible**

This is the amount you are obliged to pay for Preferred Care and Non-Preferred Care 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. Refer to the schedule of benefits section of this document for coverage percentages of individual services.

**Family Deductible**

This is the amount you and your covered dependents are obliged to pay for Preferred Care and Non-Preferred Care eligible health services each policy year before the plan begins to pay for eligible health services. After the amount you and your covered dependents pay for eligible health services reaches this family policy year deductible, this plan will begin to pay for eligible health services that you and your covered dependents incur for the rest of the policy year. Refer to the schedule of benefits section of this document for coverage percentages of individual services.

To satisfy this family policy year deductible limit for the rest of the policy year, the following must happen:

- The combined eligible health services that you and each of your covered dependents incur towards the individual policy year deductibles must reach this family policy year deductible limit in a policy year.

When this occurs in a policy year, the individual policy year deductibles for you and your covered dependents will be considered to be met for the rest of the policy year.

Eligible health services applied to the Non-Preferred Care policy year deductibles will not be applied to satisfy the Preferred Care policy year deductibles. Eligible health services applied to the Preferred Care policy year deductibles will not be applied to satisfy the Non-Preferred Care policy year deductibles.

| Maximum out-of-pocket limits | | |
|---|---|---|
| | **Preferred Care Coverage** | **Non-Preferred Care Coverage** |
| Student | $6,250 per policy year | |
| Spouse or domestic partner | $6,250 per policy year | |
| Each child | $6,250 per policy year | |
| Family | $12,500 per policy year | |

Once the Individual or Family Out-of-Pocket Limit has been satisfied, Covered Medical Expenses will be payable at **100%** for the remainder of the policy year.

The following expenses do not apply toward meeting the plan's out-of-pocket limits:

- Non-covered medical expenses; and
- Expenses that are not paid or pre-certification benefit reductions or penalties because a required pre-certification for the service(s) or supply was not obtained from Aetna.

**Referral requirement**

Students who have initiated care at Schiffert Health Center prior to seeking care in the community and have been referred to an outside provider for treatment are eligible to receive enhanced benefits for services when care is provided by a preferred care provider shown as preferred coverage with Referral in the below schedule of benefits. **A new referral must be obtained each policy year**.

If a referral is received, preferred care coinsurance increases from 80% to 90% for services rendered at a hospital. A referral is not required in the following circumstances:

- Emergency Room Services
- Treatment received when Schiffert Health Center is closed.
- Care received outside a 20-mile radius from the Blacksburg Campus
- Maternity
- Satellite Campus enrolled students
- Treatment is for an Emergency Medical Condition
- Obstetric and Gynecological Treatment
- Pediatric Care
- Preventive/Routine Services (services considered preventive according to Health Care Reform and/or services rendered not to diagnosis or treat an Accident or Sickness).

*Dependents and Visiting Scholars are not eligible to use the services of the School Health Service and therefore cannot received enhanced benefits shown in tier 1 of the schedule of benefits.

All labs and services provided at Schiffert Health Center are covered at **100%**. Students should submit their itemized paid statements to Aetna Student Health for reimbursement. Retroactive referral requests will not be accepted or processed.

The coinsurance listed in the schedule of benefits below reflects the plan coinsurance percentage. This is the coinsurance amount that the plan pays. You are responsible for paying any remaining coinsurance.

**Tier I**: When a Schiffert Health Center referral is obtained, benefits will be paid at the **Tier I** Level when rendered by a **Preferred Care** provider.

**Tier II:** When a referral is not obtained but care is rendered by a **Preferred Care** provider, benefits will be paid at the **Tier II** Level.

**Tier III:** When care is rendered by a **Non-Preferred Care** provider, benefits will be paid at the **Tier III** Level.

| **Eligible health services** | **Tier I Preferred Care Coverage with Referral** | **Tier II Preferred Care Coverage without Referral** | **Tier III Non-Preferred Care Coverage** |
|---|---|---|---|
| **Physician and specialist services** | | | |
| Physician and specialist services (non-surgical and non-preventive) - Office hours visits (non-surgical and non-preventive care by a physician and specialist, includes telemedicine consultations) | $25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies | $25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies | 65% (of the recognized charge) per visit |
| **Urgent care** | | | |
| Urgent care provided by an urgent care provider – visit charge<br><br>*For coverage of complex imaging services, lab work, and radiological services performed during an urgent medical care visit, refer to the "outpatient diagnostic testing" section.* | $25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies | $25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies | $25 copayment then the plan pays 65% (of the balance of the recognized charge) per visit |
| **Urgent care facility:** A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an urgent condition.<br><br>**Urgent condition:** An illness or injury that requires prompt medical attention but is not an emergency medical condition. An urgent condition includes earache, sore throat, and fever (not above 104 degrees). | | | |
| Non-urgent use of an urgent care provider | Not covered | Not covered | Not covered |

The following is not covered under this benefit:

- Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)

If you go to an urgent care facility for what is not an urgent condition, the plan will not cover your expenses.

Examples of non-urgent care are:

- Routine or preventive care (this includes immunizations)
- Follow-up care
- Physical therapy
- Elective treatment
- Any diagnostic lab work and radiological services which are not related to the treatment of the urgent condition

| Eligible health services | Tier I<br>Preferred Care Coverage with Referral | Tier II<br>Preferred Care Coverage without Referral | Tier III<br>Non-Preferred Care Coverage |
|---|---|---|---|
| **Alternatives to physician office visits** | | | |
| Walk-in clinic visits (non-emergency visit) | $25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies | $25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies | 65% (of the recognized charge) per visit |
| **Consultant services (non-surgical and non-preventive)** | | | |
| Consultant services - Office hours visits (non-surgical and non-preventive care)<br><br>Includes telemedicine consultations | 80% (of the negotiated charge) per visit | 80% (of the negotiated charge) per visit | 80% (of the recognized charge) per visit |
| **Routine physical exams** | | | |
| Performed at a physician's office | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | Under 7 years of age – 100% of the recognized charge per visit, no copayment or deductible applies<br><br>7 years of age or older - 100% of the recognized charge per visit, policy year deductible applies |
| Maximum age and visit limits per policy year through age 21 | 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. | | |
| Covered persons age 22 and over: Maximum visits per policy year | 1 visit | | |

| Eligible health services | Tier I<br>Preferred Care Coverage with Referral | Tier II<br>Preferred Care Coverage without Referral | Tier III<br>Non-Preferred Care Coverage |
|---|---|---|---|
| **Preventive care immunizations** | | | |
| Performed in a facility or at a physician's office | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | Under 7 years of age – 100% of the recognized charge per visit, no copayment or deductible applies<br><br>7 years of age or older - 100% of the recognized charge per visit, policy year deductible applies |
| Maximums | 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 | | |
| **Routine gynecological exams (including Pap smears and cytology tests)** | | | |
| Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | 65% (of the recognized charge) per visit |
| Maximum visits per policy year | Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. | | |
| **Preventive screening and counseling services** | | | |
| Preventive screening and counseling services for obesity and/or healthy diet counseling | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | 65% (of the recognized charge) per visit |
| Obesity and/or healthy diet counseling - Maximum visits | Age 0-22: unlimited visits.<br>Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling. | | |
| Preventive screening and counseling services for misuse of alcohol & drugs | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | 65% (of the recognized charge) per visit |
| Misuse of alcohol and/or drugs counseling - Maximum visits per policy year | 5 visits | | |

| Eligible health services | Tier I<br>Preferred Care Coverage with Referral | Tier II<br>Preferred Care Coverage without Referral | Tier III<br>Non-Preferred Care Coverage |
|---|---|---|---|
| **Preventive screening and counseling services (continued)** | | | |
| Preventive screening and counseling services for use of tobacco products | 100% (of the negotiated charge) per visit<br>No copayment or policy year deductible applies | 100% (of the negotiated charge) per visit<br>No copayment or policy year deductible applies | 65% (of the recognized charge) per visit |
| Use of tobacco products counseling - Maximum visits per policy year | 8 visits | | |
| Preventive screening and counseling services for depression screening | 100% (of the negotiated charge) per visit<br>No copayment or policy year deductible applies | 100% (of the negotiated charge) per visit<br>No copayment or policy year deductible applies | 65% (of the recognized charge) per visit |
| Depression screening and counseling - Maximum visits per policy year | 1 visit | | |
| Preventive screening and counseling services for sexually transmitted infection counseling | 100% (of the negotiated charge) per visit<br>No copayment or policy year deductible applies | 100% (of the negotiated charge) per visit<br>No copayment or policy year deductible applies | 65% (of the recognized charge) per visit |
| Sexually transmitted infection counseling - Maximum visits per policy year | 2 visits | | |
| Preventive screening and counseling services genetic risk counseling for breast and ovarian cancer | 100% (of the negotiated charge) per visit<br>No copayment or policy year deductible applies | 100% (of the negotiated charge) per visit<br>No copayment or policy year deductible applies | 65% (of the recognized charge) per visit |
| Genetic risk counseling for breast and ovarian cancer limitations | Not subject to any age or frequency limitations | | |
| Routine cancer screenings | 100% (of the negotiated charge) per visit<br>No copayment or policy year deductible applies | 100% (of the negotiated charge) per visit<br>No copayment or policy year deductible applies | 65% (of the recognized charge) per visit |
| Maximum: | Subject to any age; family history; and frequency guidelines as set forth in the most current:<br>• 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<br>• The comprehensive guidelines supported by the Health Resources and Services Administration. | | |
| Lung cancer screening maximum | 1 screening every 12 months* | | |
| ***Important note:** Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section. | | | |

| Eligible health services | Tier I<br>Preferred Care Coverage with Referral | Tier II<br>Preferred Care Coverage without Referral | Tier III<br>Non-Preferred Care Coverage |
|---|---|---|---|
| **Prenatal care services (provided by a physician, an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)** | | | |
| Preventive care services only | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | 65% (of the recognized charge) per visit |
| **Important note:** You should review the *Maternity care and Well newborn nursery care* sections. They will give you more information on coverage levels for maternity care under this plan. | | | |
| **Comprehensive lactation support and counseling services** | | | |
| Lactation support and counseling services | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | 65% (of the recognized charge) per visit |
| Lactation counseling services maximum visits per policy year either in a group or individual setting | 6 visits | | |
| **Important note:** Any visits that exceed the lactation counseling services maximum are covered under the *Physicians and other health professionals* section. | | | |
| Breast pump supplies and accessories | 100% (of the negotiated charge) per item<br><br>No copayment or policy year deductible applies | 100% (of the negotiated charge) per item<br><br>No copayment or policy year deductible applies | 80% (of the recognized charge) per item |
| Maximums | An electric breast pump (non-hospital grade, cost is covered by your plan once every three years) or a manual breast pump (cost is covered by your plan once per pregnancy)<br><br>If an electric breast pump was purchased within the previous three-year period, the purchase of another electric breast pump will not be covered until a three-year period has elapsed since the last purchase. | | |
| **Family planning services – female contraceptives** | | | |
| Female contraceptive counseling services office visit | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | 100% (of the negotiated charge) per visit<br><br>No copayment or policy year deductible applies | 65% (of the recognized charge) per visit |
| **Contraceptives (prescription drugs and devices)** | | | |
| Female contraceptive prescription drugs and devices provided, administered, or removed, by a physician during an office visit | 100% (of the negotiated charge) per item<br><br>No copayment or policy year deductible applies | 100% (of the negotiated charge) per item<br><br>No copayment or policy year deductible applies | 65% (of the recognized charge) per item |

| Eligible health services | Tier I<br>Preferred Care Coverage with Referral | Tier II<br>Preferred Care Coverage without Referral | Tier III<br>Non-Preferred Care Coverage |
|---|---|---|---|
| **Female voluntary sterilization** | | | |
| Female Voluntary sterilization - Inpatient & Outpatient provider services | 100% (of the negotiated charge)<br>No copayment or policy year deductible applies | 100% (of the negotiated charge)<br>No copayment or policy year deductible applies | 65% (of the recognized charge) |
| The following are not covered under this benefit:<br>• Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care<br>• Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA<br>• Contraception services during a **stay** in a **hospital** or other facility for medical care<br>• Male contraceptive methods, sterilization procedures or devices | | | |
| **Family planning services – other** | | | |
| Voluntary sterilization for males - surgical services | 90% (of the negotiated charge) | 80% (of the negotiated charge) | 65% (of the recognized charge) |
| The following are not covered under this benefit:<br>• Abortion except when the life of the mother is endangered by a physical disorder, physical illness or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or when the pregnancy is the result of an alleged act of rape or incest<br>• Reversal of voluntary sterilization procedures, including related follow-up care<br>• Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care | | | |
| **Maternity care** | | | |
| Maternity care (includes delivery and postpartum care services in a hospital or birthing center)<br><br>Coverage is provided under the same terms, conditions as any other **illness**. | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| The following are not covered under this benefit:<br>• Any services and supplies related to births that take place in the home, except for home delivery by a certified nurse midwife, or in any other place not licensed to perform deliveries | | | |
| Well newborn nursery care in a hospital or birthing center | 90% (of the negotiated charge)<br><br>No policy year deductible applies | 90% (of the negotiated charge)<br><br>No policy year deductible applies | 65% (of the recognized charge)<br><br>No policy year deductible applies |
| ***Note:*** *The per admission copayment amount and/or policy year deductible for newborns will be waived for nursery charges for the duration of the newborn's initial routine facility stay. The nursery charges waiver will not apply for non-routine facility stays.* | | | |

| Eligible health services | Tier I<br>Preferred Care Coverage with Referral | Tier II<br>Preferred Care Coverage without Referral | Tier III<br>Non-Preferred Care Coverage |
|---|---|---|---|
| **Physician and specialist -inpatient surgical services** | | | |
| Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthesiologist, anesthetist and surgical assistant expenses) | 90% (of the negotiated charge) | 80% (of the negotiated charge) | 65% (of the recognized charge) |
| The following are not covered under this benefit:<br>• The services of any other physician who helps the operating physician<br>• A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section)<br>• Services of another physician for the administration of a local anesthetic unless approved by the plan as **medically necessary** | | | |
| **Physician and specialist -outpatient surgical services** | | | |
| Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthesiologist, anesthetist and surgical assistant expenses) | 90% (of the negotiated charge) per visit | 80% (of the negotiated charge) per visit | 65% (of the recognized charge) per visit |
| The following are not covered under this benefit:<br>• The services of any other physician who helps the operating physician<br>• A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section)<br>• A separate facility charge for surgery performed in a physician's office<br>• Services of another physician for the administration of a local anesthetic unless approved by the plan as medically necessary | | | |
| **Outpatient surgery (facility charges)** | | | |
| Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center | 90% (of the negotiated charge) per visit | 80% (of the negotiated charge) per visit | 65% (of the recognized charge) per visit |
| The following are not covered under this benefit:<br>• The services of any other physician who helps the operating physician<br>• A stay in a hospital (See the *Hospital care – facility charges* benefit in this section)<br>• A separate facility charge for surgery performed in a physician's office<br>• Services of another physician for the administration of a local anesthetic unless approved by the plan as medically necessary | | | |

| Eligible health services | Tier I<br>Preferred Care Coverage with Referral | Tier II<br>Preferred Care Coverage without Referral | Tier III<br>Non-Preferred Care Coverage |
|---|---|---|---|
| **Hospital and other facility care** | | | |
| Inpatient hospital (room and board) and other miscellaneous services and supplies)<br><br>Includes birthing center facility charges | $300 copayment then the plan pays 90% (of the balance of the negotiated charge) per admission | $300 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission | $300 copayment then the plan pays 65% (of the balance of the recognized charge) per admission |
| **In-hospital non-surgical physician services** | | | |
| In-hospital non-surgical physician services | 90% (of the negotiated charge) per visit | 80% (of the negotiated charge) per visit | 65% (of the recognized charge) per visit |
| **Adult vision care - Limited to covered persons age 19 and over** | | | |
| Adult routine vision exams (including refraction) performed by a legally qualified ophthalmologist or therapeutic optometrist, or any other providers acting within the scope of their license | $15 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies | $15 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies | 65% (of the recognized charge) per visit |
| Maximum visits per policy year | 1 visit | | |
| Vision correction after surgery or accident | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| Eyeglass frames, prescription lenses or prescription contact lenses* | $15 copayment then the plan pays 100% (of the balance of the negotiated charge) per item<br><br>No policy year deductible applies | $15 copayment then the plan pays 100% (of the balance of the negotiated charge) per item<br><br>No policy year deductible applies | $15 copayment then the plan pays 65% (of the balance of the recognized charge) per item |
| Maximum per policy year eyeglass frames, prescription lenses or prescription contact lenses | $120 | | |

***Important note**:
Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies.

**Coverage does not include the office visit for the fitting of prescription contact lenses.**

*(continued on next page)*

| Eligible health services | Tier I<br>Preferred Care Coverage with Referral | Tier II<br>Preferred Care Coverage without Referral | Tier III<br>Non-Preferred Care Coverage |
|---|---|---|---|
| **Adult vision care - Limited to covered persons age 19 and over (continued)** | | | |
| The following are not covered under this benefit:<br>Adult vision care<br>• Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses<br>• Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes<br><br>Adult vision care services and supplies<br>• Special supplies such as non-prescription sunglasses<br>• Special vision procedures, such as orthoptics or vision therapy<br>• Eye exams during your stay in a hospital or other facility for health care<br>• Replacement of lenses or frames that are lost or stolen or broken<br>• Acuity tests<br>• Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures<br>• Services to treat errors of refraction | | | |
| **Behavioral Health & Substance Abuse Treatment** | | | |
| Inpatient hospital<br>(room and board and other miscellaneous hospital services and supplies)<br><br>Coverage is provided under the same terms, conditions as any other illness | $300 copayment then the plan pays 90% (of the balance of the negotiated charge) per admission | $300 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission | $300 copayment then the plan pays 65% (of the balance of the recognized charge) per admission |
| Outpatient office visits<br>(includes telemedicine consultations) | $25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies | $25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies | 65% (of the recognized charge) per visit |
| Other outpatient treatment<br>(includes Partial hospitalization and Intensive Outpatient Program)<br>(includes skilled behavioral health services in the home) | 90% (of the negotiated charge) | 80% (of the negotiated charge) | 65% (of the recognized charge) |
| **Transplant services** | | | |
| Inpatient and outpatient transplant facility services | Covered according to the type of benefit and the place where the service is received | | |
| Inpatient and outpatient transplant physician and specialist services | Covered according to the type of benefit and the place where the service is received | | |

| Eligible health services | Tier I<br>Preferred Care Coverage with Referral | Tier II<br>Preferred Care Coverage without Referral | Tier III<br>Non-Preferred Care Coverage |
|---|---|---|---|
| **Transplant services (continued)** | | | |
| Transplant services - reasonable and necessary travel and lodging costs for the covered person and for one companion, or for two companions if the covered person is a minor child, and for the donor if the donor and the covered person are both covered under this plan | Covered | | |
| The following are not covered under this benefit:<br>• Services and supplies furnished to a donor when the recipient is not a **covered person** | | | |
| **Pediatric dental care**<br>(Limited to covered persons through the end of the month in which the person turns age 19) | | | |
| Type A services | 100% (of the negotiated charge) per visit<br><br>No copayment or deductible applies | 100% (of the negotiated charge) per visit<br><br>No copayment or deductible applies | 65% (of the recognized charge) per visit |
| Type B services | 70% (of the negotiated charge) per visit<br><br>No policy year deductible applies | 70% (of the negotiated charge) per visit<br><br>No policy year deductible applies | 50% (of the recognized charge) per visit |
| Type C services | 50% (of the negotiated charge) per visit<br><br>No policy year deductible applies | 50% (of the negotiated charge) per visit<br><br>No policy year deductible applies | 50% (of the recognized charge) per visit |
| Orthodontic services | 50% (of the negotiated charge) per visit<br><br>No policy year deductible applies | 50% (of the negotiated charge) per visit<br><br>No policy year deductible applies | 50% (of the recognized charge) per visit |
| Dental emergency **services** | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| **Pediatric dental care exclusions**<br>The following are not covered under this benefit:<br>• Any instruction for diet, plaque control and oral hygiene<br>• Asynchronous dental treatment<br><br>(*continued on next page)* | | | |

| Eligible health services | Tier I<br>Preferred Care Coverage with Referral | Tier II<br>Preferred Care Coverage without Referral | Tier III<br>Non-Preferred Care Coverage |
|---|---|---|---|

**Pediatric dental care exclusions (continued)**

The following are not covered under this benefit:

- **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 and exclusions* 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:
  - 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 and exclusions – 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 *Pediatric dental care* section of the schedule of benefits
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication
- 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, except for replacement of a lost or broken retainer
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically provided in the *Pediatric dental care* section of the schedule of benefits
- 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 another person, including a provider
  - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth that is not medically necessary and only for orthodontic reasons
- Treatment by other than a **dental provider** that is legally qualified to furnish dental services or supplies

| Eligible health services | Tier I<br>Preferred Care Coverage with Referral | Tier II<br>Preferred Care Coverage without Referral | Tier III<br>Non-Preferred Care Coverage |
|---|---|---|---|
| **Pediatric vision care**<br>(Limited to covered persons through the end of the month in which the person turns age 19) | | | |
| Performed by a legally qualified ophthalmologist or optometrist (includes comprehensive low vision evaluations) | 100% (of the negotiated charge) per visit<br><br>No policy year deductible applies | 100% (of the negotiated charge) per visit<br><br>No policy year deductible applies | 65% (of the recognized charge) per visit<br><br>No policy year deductible applies |
| Maximum visits per policy year<br><br>Low vision Maximum<br><br>Fitting of contact Maximum | 1 visit<br><br>One comprehensive low vision evaluation every policy year<br><br>1 visit | | |
| Vision correction after surgery or accident | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| Pediatric vision care services & supplies - Eyeglass frames, prescription lenses or prescription contact lenses | 100% (of the negotiated charge) per item<br><br>No policy year deductible applies | 100% (of the negotiated charge) per item<br><br>No policy year deductible applies | 65% (of the recognized charge) per item<br><br>No policy year deductible applies |
| Maximum number Per year:<br>Eyeglass frames<br><br>Prescription lenses<br><br>Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery) | One set of eyeglass frames<br><br>One pair of standard single vision, bifocal, trifocal, or progressive prescription lenses<br><br>Daily disposables: up to 3-month supply<br>Extended wear disposable: up to 6-month supply<br>Non-disposable lenses: one set | | |
| Optical devices | 100% (of the negotiated charge) per item<br><br>No policy year deductible applies | 100% (of the negotiated charge) per item<br><br>No policy year deductible applies | 65% (of the recognized charge) per item<br><br>No policy year deductible applies |
| Maximum number of optical devices per policy year | One optical device | | |
| *__Important note__:<br>Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies.<br><br>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. | | | |
| The following are not covered under this benefit:<br>• Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes | | | |

| Eligible health services | Tier I<br>Preferred Care Coverage with Referral | Tier II<br>Preferred Care Coverage without Referral | Tier III<br>Non-Preferred Care Coverage |
|---|---|---|---|
| **Allergy testing and treatment** | | | |
| Allergy testing & Allergy injections treatment, including Allergy sera and extracts administered via injection, performed at a physician's or specialist's office | 80% (of the negotiated charge) per visit | 80% (of the negotiated charge) per visit | 65% (of the recognized charge) per visit |
| **Alternatives to hospital stays** | | | |
| **Home Health Care** | | | |
| Outpatient | 80% (of the negotiated charge) per visit | 80% (of the negotiated charge) per visit | 80% (of the recognized charge) per visit |
| The following are not covered under this benefit:<br>• 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)<br>• Transportation<br>• Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present<br>• Homemaker or housekeeper services<br>• Food or home delivered services<br>• Maintenance therapy | | | |
| **Hospice Care** | | | |
| Hospice - Inpatient | 80% (of the negotiated charge) per admission | 80% (of the negotiated charge) per admission | 65% (of the recognized charge) per admission |
| Hospice - Outpatient | 80% (of the negotiated charge) per visit | 80% (of the negotiated charge) per visit | 65% (of the recognized charge) per visit |
| The following are not covered under this benefit:<br>• Funeral arrangements<br>• Pastoral counseling<br>• Financial or legal counseling which includes estate planning and the drafting of a will<br>• Services which are not related to your care and may include:<br>- Sitter or companion services for either you or other family members except for respite care<br>- Transportation<br>- Maintenance of the house | | | |
| **Skilled Nursing Facility** | | | |
| Inpatient | $300 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission | $300 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission | $300 copayment then the plan pays 65% (of the balance of the recognized charge) per admission |

| Eligible health services | Tier I<br>Preferred Care Coverage with Referral | Tier II<br>Preferred Care Coverage without Referral | Tier III<br>Non-Preferred Care Coverage |
|---|---|---|---|
| **Emergency Services** | | | |
| Hospital emergency room | $300 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies | $300 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies | Paid the same as Preferred Care coverage |
| The following are not covered under this benefit:<br>• Non-**emergency services** in a **hospital** emergency room facility<br><br>If you go to an emergency room for what is not an emergency medical condition, the plan will not cover your expenses. We will consider a medical condition an "emergency medical condition" based upon whichever one of the following is most favorable to you as they are reported to us by the hospital emergency room provider:<br>• The presenting symptoms, or<br>• The final diagnosis of the medical condition | | | |
| **Important note:**<br>• As Non-Preferred Care 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.<br>• 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.<br>• 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.<br>• 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.<br>• 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. | | | |
| **Adult dental care for cancer treatments and dental injuries** | | | |
| Adult dental care for cancer treatments and dental injuries | 80% (of the negotiated charge) per visit | 80% (of the negotiated charge) per visit | 80% (of the actual charge) per visit |

| Eligible health services | Tier I<br>Preferred Care Coverage with Referral | Tier II<br>Preferred Care Coverage without Referral | Tier III<br>Non-Preferred Care Coverage |
|---|---|---|---|
| **Specific conditions** | | | |
| **Diabetic services and supplies (including equipment and training)** | | | |
| Diabetic services and supplies (including equipment and training) | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| **Impacted wisdom teeth** | | | |
| Impacted wisdom teeth | 80% (of the negotiated charge) per visit | 80% (of the negotiated charge) per visit | 80% (of the actual charge) per visit |
| **Accidental injury to sound natural teeth** | | | |
| Accidental injury to sound natural teeth | 80% (of the negotiated charge) per visit | 80% (of the negotiated charge) per visit | 80% (of the actual charge) per visit |
| **Blood and body fluid exposure** | | | |
| Blood and body fluid exposure | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| **Bones or joints of the head, neck, face or jaw treatment** | | | |
| Jaw joint disorder, temporomandibular joint dysfunction (TMJ) and craniomandibular disorders (CMJ) treatment | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| The following are not covered under this benefit:<br>• Dental implants | | | |
| **Dermatological treatment** | | | |
| Dermatological treatment | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| The following are not covered under this benefit:<br>• Cosmetic treatment and procedures | | | |

| Eligible health services | Tier I<br>Preferred Care Coverage with Referral | Tier II<br>Preferred Care Coverage without Referral | Tier III<br>Non-Preferred Care Coverage |
|---|---|---|---|
| **Gender affirming treatment** | | | |
| Surgical, hormone replacement therapy, and counseling treatment*<br>**Pre-certification needed for some services. See important note below.* | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| ***Important Note**: Just log into your secure website at **www.aetnastudenthealth.com** for detailed information about this covered benefit, including eligibility requirements in Aetna's clinical policy bulletin #0615. You can also call *Member Services* at the toll-free number on the back of your ID card. | | | |
| All other cosmetic services and supplies not listed under eligible health services above are not covered under this benefit. This includes, but is not limited to the following:<br>• Rhinoplasty<br>• Face-lifting<br>• Lip enhancement<br>• Facial bone reduction<br>• Blepharoplasty<br>• Liposuction of the waist (body contouring)<br>• Reduction thyroid chondroplasty (tracheal shave)<br>• Nipple reconstruction<br>• Hair removal (including electrolysis of face and neck)<br>• Voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which are used in feminization<br>• Voice and communication therapy<br>• Chest binders<br>• Chin implants, nose implants, and lip reduction, which are used to assist masculinization, are considered cosmetic | | | |
| **Autism spectrum disorder** | | | |
| Autism spectrum disorder treatment, diagnosis and testing and Applied behavior analysis** | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| ****Important note**: Applied behavior analysis requires pre-certification by Aetna. Your Preferred Care provider is responsible for obtaining pre-certification. You are responsible for obtaining pre-certification when you use a Non-Preferred Care provider. | | | |

| Eligible health services | Tier I<br>Preferred Care Coverage with Referral | Tier II<br>Preferred Care Coverage without Referral | Tier III<br>Non-Preferred Care Coverage |
|---|---|---|---|
| **Obesity (bariatric) Surgery** | | | |
| Obesity (bariatric) Surgery and services | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| **Obesity (bariatric) Surgery and services exclusions**<br>• 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 and exclusions – 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:<br>- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications<br>- Hypnosis or other forms of therapy<br>- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement | | | |
| **Oral Surgery** | | | |
| Oral surgery | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| **Treatment of infertility** | | | |
| Basic infertility services - Inpatient and outpatient care | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| The following are not covered services under the **infertility** treatment benefit:<br>• Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.<br>• All charges associated with:<br>- Surrogacy when the surrogate is not a **covered person** under your plan. 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<br>- Cryopreservation (freezing) of eggs, embryos or sperm<br>- Storage of eggs, embryos, or sperm<br>- Thawing of cryopreserved (frozen) eggs, embryos or sperm<br>- 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<br>- 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<br>- Obtaining sperm for ART services<br><br>*(continued on next page)* | | | |

| Eligible health services | Tier I<br>Preferred Care Coverage with Referral | Tier II<br>Preferred Care Coverage without Referral | Tier III<br>Non-Preferred Care Coverage |
|---|---|---|---|
| The following are not covered services under the **infertility** treatment benefit: (continued)<br>• All charges associated with:<br>- Home ovulation prediction kits or home pregnancy tests<br>- The purchase of donor embryos, donor oocytes, or donor sperm<br>- Reversal of voluntary sterilizations, including follow-up care<br>• Ovulation induction with menotropins, Intrauterine insemination and any related services, products or procedures<br>• 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) | | | |
| **Specific therapies and tests** | | | |
| **Outpatient diagnostic testing** | | | |
| Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility | 90% (of the negotiated charge) | 80% (of the negotiated charge) | 65% (of the recognized charge) |
| Diagnostic lab work and radiological services performed in a physician's office, the outpatient department of a hospital or other facility | 90% (of the negotiated charge) | 80% (of the negotiated charge) | 65% (of the recognized charge) |
| **Outpatient Chemotherapy, Radiation, Respiratory & Outpatient infusion therapy (including medical formulas)** | | | |
| Outpatient Chemotherapy, Radiation, Respiratory & Outpatient infusion therapy (including medical formulas) | 90% (of the negotiated charge) per visit | 80% (of the negotiated charge) per visit | 65% (of the recognized charge) per visit |
| The following are not covered under this benefit:<br>• Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan | | | |
| **Rehabilitation and habilitation therapy services** | | | |
| Outpatient physical, occupational, speech (including speech language therapies) and cognitive therapies (including Cardiac and Pulmonary Therapy)<br><br>Combined for short-term rehabilitation services and habilitation therapy services | 90% (of the negotiated charge) per visit | 80% (of the negotiated charge) per visit | 65% (of the recognized charge) per visit |

| Eligible health services | Tier I<br>Preferred Care Coverage with Referral | Tier II<br>Preferred Care Coverage without Referral | Tier III<br>Non-Preferred Care Coverage |
|---|---|---|---|
| **Early intervention services** | | | |
| Early intervention services include speech and language therapy, physical and occupational therapies and assistive technology services and devices<br><br>Limited to covered dependents to age 3<br><br>No visit limit applies for physical, occupational or speech therapy services | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| **Spinal manipulation (chiropractic, osteopathic and manipulation therapy services)** | | | |
| Spinal manipulation chiropractic, osteopathic, and manipulation services<br><br>Includes rehabilitation and habilitation services | 90% (of the negotiated charge) per visit | 80% (of the negotiated charge) per visit | 65% (of the recognized charge) per visit |
| **Specialty prescription drugs (Purchased and injected or infused by your provider in an outpatient setting)** | | | |
| Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| **Other services and supplies** | | | |
| Emergency ground, air, and water ambulance (includes non-emergency ambulance) | 80% (of the negotiated charge) per trip | 80% (of the negotiated charge) per trip | Paid the same as Preferred Care coverage |
| The following are not covered under this benefit:<br>• Non-emergency fixed wing air ambulance from a Non-Preferred Care provider<br>• Ambulance services for routine transportation to receive outpatient or inpatient care | | | |
| Clinical trial (routine patient costs) | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| The following are not covered under this benefit:<br>• Services and supplies related to data collection and record-keeping that is not used in the direct clinical management of the patient<br>• Services and supplies provided by the trial sponsor without charge to you<br>• 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) | | | |

| Eligible health services | Tier I<br>Preferred Care Coverage with Referral | Tier II<br>Preferred Care Coverage without Referral | Tier III<br>Non-Preferred Care Coverage |
|---|---|---|---|
| **Other services and supplies (continued)** | | | |
| Durable medical and surgical equipment including supplies and equipment needed for the use of DME | 80% (of the negotiated charge) per item | 80% (of the negotiated charge) per item | 80% (of the recognized charge) per item |
| The following are not covered under this benefit:<br>• Whirlpools<br>• Portable whirlpool pumps<br>• Sauna baths<br>• Massage devices<br>• Over bed tables<br>• Elevators<br>• Communication aids<br>• Vision aids<br>• Telephone alert systems<br>• Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician | | | |
| Enteral formulas and nutritional supplements | 90% (of the negotiated charge) per item | 80% (of the negotiated charge) per item | 65% (of the recognized charge) per item |
| Enteral formulas and nutritional supplements<br>Eligible health services include enteral formulas and nutritional supplements used to treat malabsorption of food caused by:<br>• Crohn's Disease<br>• Ulcerative colitis<br>• Gastroesophageal reflux<br>• Gastrointestinal motility<br>• Chronic intestinal pseudo-obstruction<br>• Phenylketonuria<br>• Eosinophilic gastrointestinal disorders<br>• Inherited diseases of amino acids and organic acids<br><br>Covered benefits also include food products modified to be low in protein for inherited diseases of amino acids and organic acids. For purposes of this benefit, "low protein modified food product" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of any inherited metabolic illness. Low protein modified food products do not include foods that are naturally low in protein.<br><br>Your physician must give you a written order for these supplies. | | | |
| Enteral formulas and nutritional supplements<br>The following are not covered under this benefit:<br>• Any other food item, including infant formulas, nutritional supplements, vitamins, plus **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as described above. | | | |

| Eligible health services | Tier I<br>Preferred Care Coverage with Referral | Tier II<br>Preferred Care Coverage without Referral | Tier III<br>Non-Preferred Care Coverage |
|---|---|---|---|
| **Prosthetic devices** | | | |
| Orthotics | 80% (of the negotiated charge) per item | 80% (of the negotiated charge) per item | 80% (of the recognized charge) per item |
| Prosthetic Devices & Cranial prosthetics (medical wigs) after cancer treatment | 80% (of the negotiated charge) per item | 80% (of the negotiated charge) per item | 80% (of the recognized charge) per item |
| The following are not covered under this benefit:<br>• Services covered under any other benefit<br>• Orthopedic shoes, therapeutic shoes, foot orthotics, 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<br>• Trusses, corsets, and other support items<br>• Repair and replacement due to loss, misuse, abuse or theft<br>• Communication aids | | | |
| **Podiatric (foot care) treatment** | | | |
| Podiatric (foot care) treatment - Physician and specialist non-routine foot care treatment | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| The following are not covered under this benefit:<br>• Services and supplies for:<br>- The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches<br>- The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes<br>- Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies<br>- Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet | | | |
| **Sleep Treatment** | | | |
| Sleep treatment | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |

| Outpatient prescription drugs | | |
|---|---|---|
| **Policy year copayment/coinsurance waiver for risk reducing breast cancer drugs** | | |
| The policy year deductible and the per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs when obtained at a retail Preferred Care pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%. | | |
| **Outpatient prescription drug copayment waiver for tobacco cessation prescription and over-the-counter drugs** | | |
| The outpatient 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 a retail Preferred Care pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%. Your outpatient prescription drug copayment will apply after those two regimens per policy year have been exhausted. | | |
| **Outpatient prescription drug copayment waiver for contraceptives** | | |
| The outpatient prescription drug copayment will not apply to female contraceptive methods when obtained at a Preferred Care pharmacy.<br><br>This means that such contraceptive methods are paid at 100% for:<br>• 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%.<br>• 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%.<br><br>The outpatient prescription drug copayment will continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at a Preferred Care pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception. | | |
| **Eligible health services** | **Preferred Care coverage** | **Non-Preferred Care coverage** |
| **Preferred generic prescription drugs** | | |
| 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)<br><br>No policy year deductible applies | $15 copayment per supply then the plan pays 100% (of the balance of the recognized charge)<br><br>No policy year deductible applies |
| More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy | $45 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)<br><br>No policy year deductible applies | Not covered |

| Eligible health services | Preferred Care coverage | Non-Preferred Care coverage |
|---|---|---|
| **Outpatient prescription drugs (continued)** | | |
| **Preferred brand-name prescription drugs** | | |
| For each fill up to a 30-day supply filled at a retail pharmacy | $45 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)<br><br>No policy year deductible applies | $45 copayment per supply then the plan pays 100% (of the balance of the recognized charge)<br><br>No policy year deductible applies |
| More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy | $135 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)<br><br>No policy year deductible applies | Not covered |
| **Non-preferred generic prescription drugs** | | |
| For each fill up to a 30-day supply filled at a retail pharmacy | $75 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)<br><br>No policy year deductible applies | $75 copayment per supply then the plan pays 100% (of the balance of the recognized charge)<br><br>No policy year deductible applies |
| More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy | $225 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)<br><br>No policy year deductible applies | Not covered |
| **Non-preferred brand-name prescription drugs** | | |
| For each fill up to a 30-day supply filled at a retail pharmacy | $75 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)<br><br>No policy year deductible applies | $75 copayment per supply then the plan pays 100% (of the balance of the recognized charge)<br><br>No policy year deductible applies |
| More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy | $225 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)<br><br>No policy year deductible applies | Not covered |
| **Important note:**<br>You will not be required to pay more than $50 for a 30-day supply of a covered prescription insulin drug. | | |
| **Specialty drugs** | | |
| For each fill up to a 30-day supply filled at a **specialty pharmacy** or a retail pharmacy | Copayment is the greater of $250 or 20% (of the negotiated charge) but will be no more than $500 per supply<br><br>No policy year deductible applies | Copayment is the greater of $250 or 20% (of the recognized charge) but will be no more than $500 per supply<br><br>No policy year deductible applies |

| Eligible health services | Preferred Care coverage | Non-Preferred Care coverage |
|---|---|---|
| **Outpatient prescription drugs (continued)** | | |
| Orally administered anti-cancer prescription drugs<br><br>For each fill up to a 30-day supply filled at a retail pharmacy | 100% (of the negotiated charge)<br><br>No policy year deductible applies | 100% (of the recognized charge)<br><br>No policy year deductible applies |
| Preventive care drugs and supplements filled at a retail pharmacy<br><br>For each 30–day supply | 100% (of the negotiated charge per prescription or refill<br><br>No copayment or policy year deductible applies | Paid according to the type of drug per the schedule of benefits, above |
| Risk reducing breast cancer prescription drugs filled at a pharmacy<br><br>For each 30–day supply | 100% (of the negotiated charge) per prescription or refill<br><br>No copayment or policy year deductible applies | Paid according to the type of drug per the schedule of benefits, above |
| Maximums: | 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. | |
| Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy<br><br>For each 30–day supply | 100% (of the negotiated charge per prescription or refill<br><br>No copayment or policy year deductible applies | Paid according to the type of drug per the schedule of benefits, above |
| Maximums: | Coverage is permitted for two 90-day treatment regimens only.<br><br>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. | |

**Outpatient prescription drugs exclusions**

The following are not covered under the outpatient prescription drugs benefit:

- Abortion drugs
- Any services related to the dispensing, injecting or application of a drug
- Biological sera
- Compounded prescriptions containing bulk chemicals not approved by the U.S. Food and Drug Administration (FDA) including compounded bioidentical hormones
- Cosmetic drugs including medications and preparations used for cosmetic purposes
- Devices, products and appliances, except those that are specially covered
- Dietary supplements including medical foods

(continued on next page)

**Outpatient prescription drugs exclusions (continued)**

The following are not covered under the outpatient prescription drugs benefit:

- Drugs or medications
  - Administered or entirely consumed at the time and place it is prescribed or provided
  - 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 above
  - That include the same active ingredient or a modified version of an active ingredient as a covered prescription drug (unless a medical exception is approved)
  - That are therapeutically equivalent or therapeutically alternative to a covered prescription drug (unless a medical exception is approved)
  - That are 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 or effective
  - Provided under your medical plan while an inpatient of a healthcare facility
  - That include 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 except Medicaid plans (for example: 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 shape 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 covered person 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 work
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
- Implantable drugs and associated devices except as specifically provided above
- Infertility
  - 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.

*(continued on next page)*

**Outpatient prescription drugs exclusions (continued)**

The following are not covered under the outpatient prescription drugs benefit:

- 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, except for injectable insulin and drugs that must be covered as recommended for preventive care.
  - Packaged in a 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 and 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 to 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 person identified on the ID card.
- 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 products unless recommended by the United States Preventive Services Task Force (USPSTF)
- We reserve the right to exclude:
  - A manufacturer's product when the 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

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

## Out of Country Claims

Out of Country claims should be submitted with appropriate medical service and payment information from the provider of service. Covered services received outside the United States will be considered at the Non-Preferred Care level of benefits.

## General Exclusions

**Acupuncture therapy**

**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.

**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.

**Behavioral health treatment**

- Services for the following based on categories, conditions, diagnoses or equivalent terms as listed in the most recent version 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 Therapy by a licensed counselor will be covered if provided on an outpatient basis as part of a wilderness treatment program.
  - Services provided in conjunction with school, vocation, or work activities
  - Transportation
  - Specific developmental disorders of scholastic skills (learning disorders/learning disabilities)
  - Specific developmental disorder of motor functions except as described in the *Eligible health services – Early intervention services* section
  - Specific developmental disorders of speech and language except as described in the *Eligible health services – Early intervention services* section
  - Other disorders of psychological development

**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, 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
- The services of blood donors, apheresis or plasmapheresis
- For autologous blood donations, only administration and processing expenses are covered

**This exclusion does not apply to blood products for treatment of hemophilia and congenital bleeding disorders including, but not limited to, Factor VII, Factor VIII, Factor IX, and cryoprecipitate.

**Breasts**
- Services and supplies given by a provider for breast reduction or gynecomastia.

**Cardiac rehabilitation**
- Services for home programs, on-going conditioning, and maintenance care

**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 and exclusions - Clinical trial therapies (experimental or investigational)* section,

**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.

**This exclusion does not apply to:
- Surgery after an accidental injury when performed as soon as medically feasible. (Injuries that occur during medical treatments are not considered accidental injuries even if unplanned or unexpected.)
- Coverage that may be provided under the *Eligible health services and exclusions - Gender affirming treatment* section.

**Court-ordered services and supplies**
- This Includes those 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
- A dministering 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

This exclusion does not apply to services covered in the *Hospice care* section.

**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 apply to services covered under the *Adult dental care for cancer treatments and dental injuries* section.

**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 and exclusions – 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.

**Examinations**

Except as covered under the *Preventive care and wellness* section, 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 and exclusions – Other services* section.

**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

**Felony**

- Services and supplies that you receive as a result of an injury due to your commission of a felony.

**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**
Any tests, appliances and devices to:
- Improve your hearing
- Enhance other forms of communication to make up for hearing loss or devices that simulate speech

**Hearing exams**
- Hearing exams performed for the evaluation and treatment of illness, injury or hearing

**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.

**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 and exclusions – Rehabilitation and habilitation services* section.

**Medical supplies – outpatient disposable over-the-counter items**
- Examples of these are:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Other home test kits
  - Compresses

**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, terminated it , or did not make a proper request for it

**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 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.

**Other primary payer**

- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer This exclusion does not apply to laws that make the government program the secondary payer after benefits under this policy have been paid. See the *Coordination of benefits (COB)* section for details.

**Outpatient prescription or non-prescription drugs and medicines**

- Outpatient prescription drugs or non-prescription drugs and medicines provided by the policyholder

**Personal care, comfort or convenience items**

- Any service or supply primarily for your convenience and personal comfort or that of a third party

**Riot**

- Services and supplies that you receive from providers as a result of an injury from your "participation in a riot". This means when you take part in a riot in any way such as inciting, or conspiring to incite, the 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 and exclusions

**Services provided by a family member**

- Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, or in-law.

**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 60-day supplies

**Strength and performance**

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

**Treatment as part of your training**
- Any services and supplies provided to a covered student who receives treatment from a provider as part of their training.

**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 and exclusions – Preventive care and wellness section
  - Hypnosis and other therapies
  - Medications, except as specifically provided in the *Eligible health services and exclusions – Outpatient prescription drugs* section
  - Nicotine patches
  - Gum

**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

**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.

The Virginia Tech Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health[SM] 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 1-866-577-7027.

**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 is committed to being an inclusive health care company. Aetna does not discriminate on the basis of ancestry, race, ethnicity, color, religion, sex/gender (including pregnancy), national origin, sexual orientation, gender identity or expression, physical or mental disability, medical condition, age, veteran status, military status, marital status, genetic information, citizenship status, unemployment status, political affiliation, or on any other basis or characteristic prohibited by applicable federal, state or local law.

Aetna provides free aids and services to people with disabilities and free language services to people whose primary language is not English.

These aids and services include:
- Qualified language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Qualified interpreters
- Information written in other languages

If you need these services, contact the number on your ID card. Not an Aetna member? Call us at 1-866-577-7027.

If you have questions about our nondiscrimination policy or have a discrimination-related concern that you would like to discuss, please call us at 1-866-577-7027.

*Please note, Aetna covers health services in compliance with applicable federal and state laws. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations, and conditions of coverage.*

**Language accessibility statement**
***Interpreter services are available for free.***

Attention: If you speak English, language assistance services, free of charge, are available to you. Call **1-866-577-7027** (TTY: **711**).

**Español/Spanish**
Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-866-577-7027** (TTY: **711**).

አማርኛ**/Amharic**
ልብ ይበሉ: አማርኛ ቋንቋ የሚናገሩ ከሆነ፥ የትርጉም ድጋፍ ሰጪ ድርጅቶች፣ ያለምንም ክፍያ እርስዎን ለማገልገል ተዘጋጅተዋል። የሚከተለው ቁጥር ላይ ይደውሉ **1-866-577-7027** (መስማት ለተሳናቸው: **711**).

العربية**/Arabic**
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-866-577-7027** (رقم الهاتف النصي: **711**).

**Bàsɔ̀ɔ̀ Wùqù/Bassa**

Dè dɛ nìà kɛ dyeʼqeʼ gbo: ɔ juʋ keʼ m̀ dyi Bàsɔ̀ɔ̀-wùqù-po-nyɔ̀ juʋ nïʼ, nìïʼ à wuqu kà kò qò po-poɔ̀ ɓɛ́ m̀ gbo kpaʼa. Ɓaʼ **1-866-577-7027** (TTY: **711**).

**中文/Chinese**

注意：如果您说中文，我们可为您提供免费的语言协助服务。请致电 **1-866-577-7027** (TTY: **711**)。

فارسی**/Farsi**

توجه: اگر به زبان فارسی صحبت می کنید، خدمات زبانی رایگان به شما ارایه میگردد، با شماره **1-866-577-7027** (TTY: **711**) تماس بگیرید.

**Français/French**

Attention : Si vous parlez français, vous pouvez disposer d’une assistance gratuite dans votre langue en composant le **1-866-577-7027** (TTY: **711**).

ગુજરાતી**/Gujarati**

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો ભાષાકીય સહાયતા સેવા તમને નિ:શુલ્ક ઉપલબ્ધ છે. કૉલ કરો **1-866-577-7027** (TTY: **711**).

**Kreyòl Ayisyen/Haitian Creole**

Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-866-577-7027** (TTY: **711**).

**Igbo**

Nrụbama: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-866-577-7027** (TTY: **711**).

**한국어/Korean**

주의: 한국어를 사용하시는 경우, 언어 지원 서비스가 무료로 제공됩니다. **1-866-577-7027** (TTY: **711**)번으로 전화해 주십시오.

**Português/Portuguese**

Atenção: a ajuda está disponível em português por meio do número **1-866-577-7027** (TTY: **711**).
Estes serviços são oferecidos gratuitamente.

**Русский/Russian**

Внимание: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Звоните по телефону **1-866-577-7027** (TTY: **711**).

**Tagalog**

Paunawa: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-866-577-7027** (TTY: **711**).

**/Urdu**اردو

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت دستیاب ہیں ۔ (**711** :TTY) **1-866-577-7027** پر کال کریں.

**Tiếng Việt/Vietnamese**

Lưu ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số **1-866-577-7027** (TTY: **711**).

**Yorùbá/Yoruba**

Àkíyèsí: Bí o bá nsọ èdè Yorùbá, ìrànlọ́wọ́ lórí èdè, lófẹ̀ẹ́, wà fún ọ. Pe **1-866-577-7027** (TTY: **711**).

*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 (Aetna).*