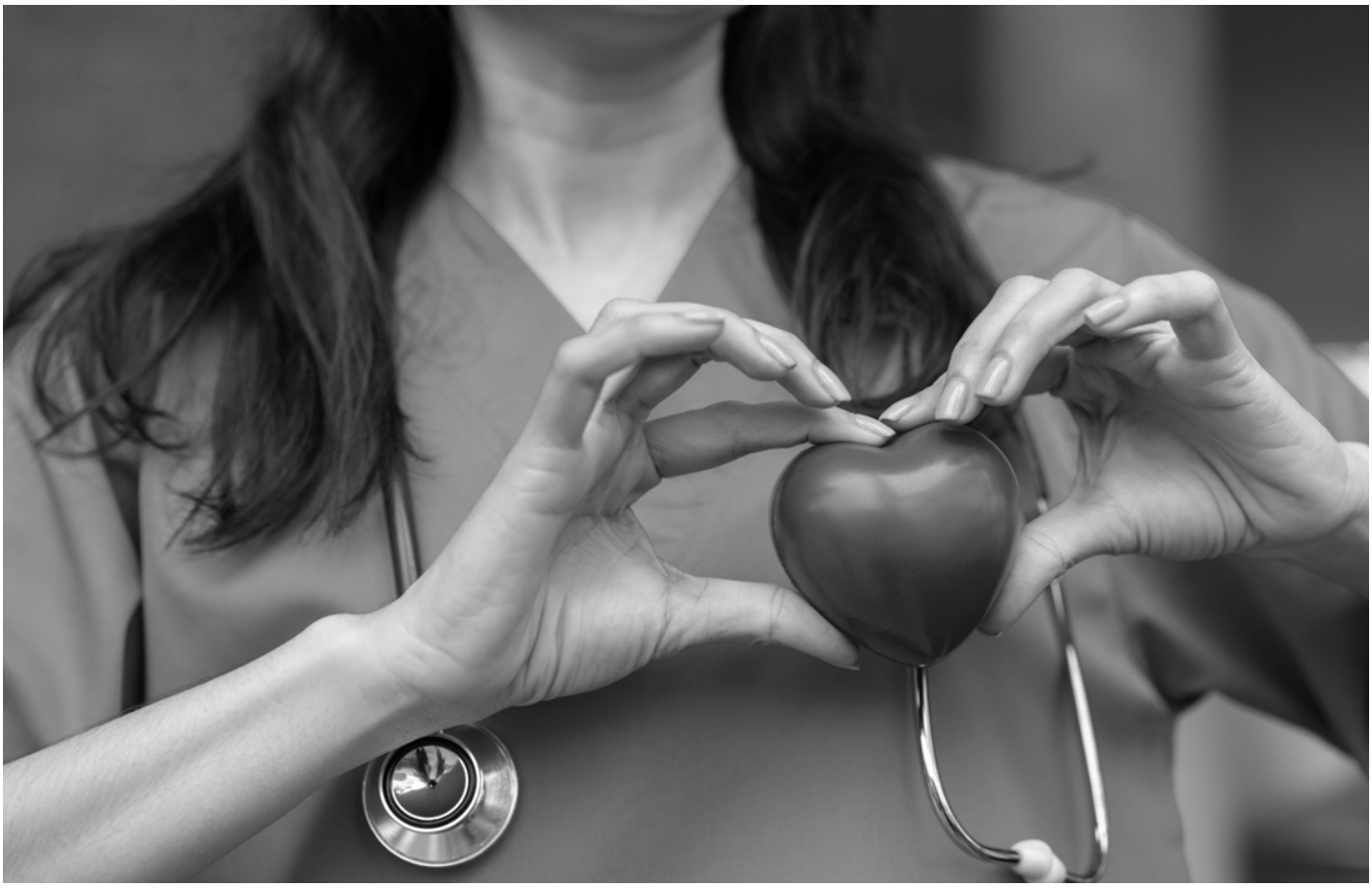
Aetna Student Health
Plan Design and Benefits Summary

George Washington University

Policy Year: 2026 – 2027
Policy Number: 474952
https://www.aetnastudenthealth.com
(800) 213-0579

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC



This is a brief description of the Student Health Plan. The plan is available for George Washington University students and their eligible dependents. The plan is insured by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Certificate issued to you and may be viewed online at **https://www.aetnastudenthealth.com.** If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

GW Student Health Center

The Student Health Center is the University's on-campus health facility. It is located at 800 21st St., NW; University Student Center Ground Floor, Washington D.C, 20052. It is staffed by Physicians, Nurse Practitioners, Physician Assistants, Mental Health Providers and Registered Nurses. Please visit **https://healthcenter.gwu.edu/** or call **202-994-5300** for more information and hours of operation.

When the following services are provided at the GW Student Health Center (SHC) they are covered at **100%** with no Copay or Deductible.

- Medical office visits,
- Prescription medications routinely dispensed at Health Service,
- Routine STD screenings, (once annually)
- Physical Examinations
- Immunizations
- A yearly influenza vaccination when provided at the SHC only

Annual Deductible waived for services rendered at GW Counseling and Psychological Services (CAPS)

Office Visits are covered at **100%**.

Group Counseling is covered at **100%.** Referrals are available to providers in the community.

For more information, call CAPS at **(202) 994-5300**. In the event of an emergency on-campus, call GW Emergency Services at (202) 994-6111, or for off campus call **911.**

Additional Products

Vital Savings Dental

Here's an easy way to keep your smile it's healthiest. No insurance necessary. In most cases, you can save 15 to 50 percent* on many dental services.
Over 200,000 dental practices welcome your card. Just show it to save on:
• Exams, cleanings, and X-rays
• Fillings and crowns
• Root canals and extractions
• Even braces and whitening
Simply pay the discounted rate directly to the dental office.

Just log in to your member website at **https://www.aetnastudenthealth.com**.

Telemedicine

What is Telemedicine? Telemedicine means the practice of health care delivery, evaluation, diagnosis, consultation, or treatment, using the transfer of medical data through audio, video, or data communications that are engaged in over two or more locations between health care practitioners who are physically separated from the patient or from each other.

Requesting a Telemedicine appointment Members request a telemedicine appointment by contacting their health care practitioner just as they would to make an in-office appointment.

Policy Period

Mandatory Students and Dependents

1. **Students:** Coverage for all insured students that enroll in the Fall semester, will become effective at 12:01 a.m. on **8/12/2026**, and will terminate at 11:59 p.m. on **12/31/2026**. Students who maintain eligibility for the Spring / Summer semester will automatically be re-enrolled effective 12:01 a.m. on **01/01/2027** and will terminate 11:59 p.m. on **08/11/2027**.

2. **New Spring Semester students**: Coverage for all insured students enrolled for the Spring / Summer Semester, will become effective at 12:01 a.m. on **01/01/2027**, and will terminate at 11:59 p.m. on **08/11/2027**.

3. **Insured dependents**: Coverage will become effective on the same date the insured student's coverage becomes effective, or the day after the postmarked date when the completed application and premium are sent, if later. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy. Examples include but are not limited to the date the student's coverage terminates; the date the dependent no longer meets the definition of a dependent.

Mandatory Student Health Insurance Coverage

Eligibility

All undergraduate, graduate (Including those enrolled in continuous research), law, health sciences, and doctoral students, who are enrolled in classes on the Foggy Bottom, Mount Vernon, VSTC, and Corcoran campuses, all medical students, and international students on a J1 or F1 Visa are required to have health insurance while they study at GW.

The plan is also available on a voluntary basis for:

- All undergraduate and graduate students on all remaining campuses including Arlington or Alexandria campus
- All non-degree seeking students with 9 or more credit hours
- All students on Continuous enrollment
- All students on school-approved leave of absence
- All online Medical and Nursing students who participate in clinical rotation on campus

You must actively attend classes until your program's add/drop deadline to remain eligible for the Policy.

You cannot meet this eligibility requirement if you take courses through:

- Pre-college program
- Online students (except for medical and nursing students who participate in clinical rotation on campus.)

Coverage Periods

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

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	08/12/2026	08/11/2027	09/12/2026
Fall	08/12/2026	12/31/2026	09/12/2026
Spring	01/01/2027	08/11/2027	02/01/2027
Summer Only	05/01/2027	08/11/2027	05/20/2027

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

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	08/12/2026	08/11/2027	09/12/2026
Fall	08/15/2026	12/31/2026	09/12/2026
Spring	01/01/2027	08/11/2027	02/01/2027
Summer Only	05/01/2027	08/11/2027	05/20/2027

Rates

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

	Rates			
	Annual 08/12/26-08/11/27	Fall Semester 08/12/26-12/31/26	Spring/Summer Semester 01/01/27-08/11/27	Summer Only 05/01/27-08/11/27
Student	$3,355	$1,305.	$2,050	$947
Spouse	$3,355	$1,305	$2,050	$947
One Child	$3,355	$1,305	$2,050	$947
Children	$6,710	$2,610	$4,100	$1,894

Please Note: *Some* GW graduate assistants or graduate research assistants receive subsidized funding to cover the costs of the GW SHIP. Contact your department or research advisor for more information.

Annual Waiver Deadline for Students: 9/12/2026

WAIVE/ENROLLMENT INFORMATION:

HOW TO WAIVE:

The premium for the Plan will be added to your tuition bill. If you have comparable coverage and wish to waive coverage under the Plan, you must submit an Online Waiver Form. To complete the Online Waiver Form, visit **www.universityhealthplans.com/GWU** or call 833-251-1721.

Voluntarily Enrolled Students and Dependents

1. **Students:** Coverage for all insured students enrolled for the Fall Semester will become effective at 12:01 a.m. on **08/12/2026** and will terminate at 11:59 p.m. on **12/31/2026.** Students who maintain eligibility for the Spring/Summer semester can re-enroll in coverage that will become effective 12:01 a.m. on **01/01/2027** and terminate at 11:59 p.m. on **08/11/2027**.

2. **New Spring Semester students**: Coverage for all insured students enrolled for the Spring/Summer Semester, will become effective at 12:01 a.m. on **01/01/2027**, and will terminate at 11:59 p.m. on **8/11/2027**.

3. **Insured dependents**: Coverage will become effective on the same date the insured student's coverage becomes effective, or the day after the postmarked date when the completed application and premium are sent, if later. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy. Examples include but are not limited to the date the student's coverage terminates; the date the dependent no longer meets the definition of a dependent.

Enrollment

Voluntary Eligibility: All undergraduate and graduate student on all remaining campuses including Arlington or Alexandria campus, all non-degree seeking students with 9 or more credit hours, students on continuous enrollment, students on a school-approved leave of absence, and all online Medical and Nursing students who participate in clinical rotation on campus are eligible to enroll on a voluntary basis.

Voluntary students may purchase coverage for themselves and their eligible dependents by submitting an Enrollment Form by the deadline applicable to the desired coverage period. Full payment must be paid online with a credit card or with a check or money order. The enrollment form is available at **www.universityhealthplans.com/GWU**. Please call 833-251-1721 for questions regarding enrollment instructions.

If you withdraw from school before your program's add/drop deadline, you will not be covered under the Policy and the full premium will be refunded, less any claims paid. After your program's add/drop deadline, you will be covered for the full period that you have paid the premium for, and no refund will be allowed. (This refund policy will not apply if you withdraw due to a covered Accident or Sickness.)

Dependent Coverage

Eligibility

Covered students may also enroll their lawful spouse, domestic partner (same-sex, opposite sex), and dependent children up to the age of 26.

Enrollment

To enroll the dependent(s) of a covered student, please complete the Enrollment Form by visiting **www.universityhealthplans.com/GWU**. Please refer to the Coverage Periods section of this document for coverage dates and deadline dates. Dependent enrollment applications will not be accepted after the enrollment deadline, unless there is a significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage under another health plan.) The completed Enrollment Form and premium must be sent to University Health Plans. Please call University Health Plans at 833-251-1721 for questions regarding enrollment instructions.

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 31 days from the moment of birth.

- To keep your newborn covered, you must notify us (or our agent) of the birth and pay any required premium contribution during that 31 day period.
- You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional premium contribution for the newborn.
- If you miss this deadline, your newborn will not have health benefits after the first 31 days.
- If your coverage ends during this 31 day period, then your newborn's coverage will end on the same date as your coverage. This applies even if the 31 day period has not ended.

Adopted child or a child legally placed with you for adoption
A child that you, or your spouse, domestic partner adopts or is placed with you for adoption, is covered on your plan for the first 31 days after the adoption or the placement is complete.

- To keep your child covered, we must receive your completed enrollment information within 31 days after the adoption or placement for adoption.
- You must still enroll the child within 31 days of the adoption or placement for adoption even when coverage does not require payment of an additional premium contribution for the child.

- If you miss this deadline, your adopted child or child placed with you for adoption will not have health benefits after the first 31 days.
- If your coverage ends during this 31 day period, then coverage for your adopted child or child placed with you for adoption will end on the same date as your coverage. This applies even if the 31 day period has not ended.

Dependent coverage due to a court order
If you must provide coverage to a dependent because of a court order, your dependent is covered on your health plan for the first 31 days from the court order.

- To keep your dependent covered, we must receive your completed enrollment information within 31 days of the court order.
- You must still enroll the dependent within 31 days of the court order even when coverage does not require payment of an additional premium contribution for the dependent.
- If you miss this deadline, your dependent will not have health benefits after the first 31 days.
- If your coverage ends during this 31 day period, then your dependent's coverage will end on the same date as your coverage. This applies even if the 31 day period has not ended.

If you need information or have general questions on dependent enrollment, call Member Services at (800)213-0579.

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 before your program's add/drop deadline, 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 before your program's add/drop deadline, from classes other than under a school-approved leave of absence before your program's add/drop deadline, you will be considered ineligible for coverage, your coverage will be terminated retroactively and any premiums collected will be refunded. If the withdrawal is after your program's add/drop deadline, 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.

In-network Provider Network

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

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

Precertification

You need pre-approval from us for some covered services. Pre-approval is also called precertification. Your in-network physician is responsible for obtaining any necessary precertification before you get the care. When you go to an out-of-network provider, it is your responsibility to obtain precertification from us for any services and supplies on the precertification list. If you do not pre-certify when required, there is a $500 penalty for each type of covered service that was not pre-certified. For a current listing of the health services or prescription drugs that require precertification, contact Member Services or go to www.aetna.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. You, your physician or the facility must call us within these timelines:

Non-emergency admissions	Call at least 14 days before the date you are scheduled to be admitted.
Emergency admission	Call within 48 hours or as soon as reasonably possible after you have been admitted.
Urgent admission	Call before you are scheduled to be admitted.
Outpatient non-emergency medical services	Call at least 14 days before the care is provided, or the treatment is scheduled

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.

We will provide a written notification to you and your physician of the precertification decision, where required by state law and within the timeframe specified by state law. If your pre-certified services are approved, the approval is valid for 60 days as long as you remain enrolled in the plan.

Coordination of Benefits (COB)

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB). A complete description of the Coordination of Benefits provision is contained in the certificate issued to you.

CVS Virtual Care®

From everyday illnesses and chronic conditions to mental health support, we've got your back. Once you tell us what you need, we'll connect you with trusted, in-network providers so you can schedule a virtual visit. Most mental health visits are available within two weeks. You can access 24/7 care through our virtual clinic. General Care: 100% coverage. Behavioral Health**:** See the schedule of benefits for more information. Go to **www.cvs.com/virtual-care** to register and schedule an appointment.

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 **https://www.aetnastudenthealth.com.**

This Plan will pay benefits in accordance with any applicable **District of Columbia** Insurance Law(s).

Policy year deductible	**In-network coverage**	**Out-of-network coverage**
You have to meet your policy year deductible before this plan pays for benefits.		
Student	$300 per policy year	$3,000 per policy year
Spouse	$300 per policy year	$3,000 per policy year
Each child	$300 per policy year	$3,000 per policy year
Family	None	None
PRESCRIBED MEDICINES EXPENSE		
Student	$250 per policy year	
Spouse	$250 per policy year	
Each child	$250 per policy year	
Individual This is the amount you owe for in-network and out-of-network covered services each policy year before the plan begins to pay for covered services. This policy year deductible applies separately to you and each of your covered dependents. After the amount you pay for covered services reaches the policy year deductible, this plan will begin to pay for covered services for the rest of the policy year.		
Policy year deductible waiver		
The policy year deductible is waived for all of the following covered services: • In-network care for *Preventive care and wellness* • Pap Smear Screening Expense; and • Mammogram Expense. In addition to state and federal requirements for waiver of the policy year deductible, the plan will waive the policy year deductible for: • Preferred Care for Abortion-physician or specialist surgical services • Preferred Care for Voluntary sterilization for males-physician or specialist surgical services • Preferred Care Laboratory and X-Ray Expense; • Preferred Care Allergy Testing Expense; • Preferred Care Diagnostic Testing For Learning Disabilities Expense; Preferred Care Maternity Expense; • Preferred Care Gynecology; • Preferred Care Outpatient Treatment of Mental Health; • Preferred Care Pediatric Preventive Dental; and • Preferred and Non-Preferred Care Pediatric Vision Services. Per visit or admission Deductibles do not apply towards satisfying the Policy Year Deductible. This Policy Year Deductible and the Prescribed Medicine Expense Deductible do not apply towards satisfying each other.		
Maximum out-of-pocket limit per policy year		
Student	$10,000 per policy year	$20,000 per policy year
Spouse	$10,000 per policy year	$20,000 per policy year
Each child	$10,000 per policy year	$20,000 per policy year
Family	$20,000 per policy year	$40,000 per policy year

	In-network coverage	Out-of-network coverage
Preventative care and wellness **Routine physical exams** **Performed at a physician's office**		
Routine Physical exam	100% (of the negotiated charge) per visit Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Routine physical exam limits for covered persons through age 21: maximum age and visit limits per policy year	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.	
Routine physical exam limits for covered persons age 22 and over: maximum visits per policy year	1 visit	
Preventive care immunizations **Performed in a facility or at a physician's office**		
Preventive care immunizations	100% (of the negotiated charge) per visit. Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Preventive care immunization 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.	
The following is not covered under this benefit: • Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment or travel		
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 Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Well woman routine gynecological exam maximums	1 visit	
Well woman preventive visits **Preventive screening and counseling services**		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies

	In-network coverage	Out-of-network coverage
Obesity and/or healthy diet counseling Maximum visits	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	
Misuse of alcohol and/or drugs counseling Maximum visits per policy year	5 visits	
Use of tobacco products counseling Maximum visits per policy year	8 visits	
Sexually transmitted infection counseling Maximum visits per policy year	2 visits	
Genetic risk counseling for breast and ovarian cancer limitations	Not subject to any age or frequency limitations	
Genetic risk counseling for breast and ovarian cancer Maximum visits per policy year	1 visit	
Routine cancer screenings Deductible does not apply to routine mammography	100% (of the negotiated charge) per visit Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Routine cancer screening maximums:	Subject to any age; family history; and frequency guidelines as set forth in the most current: • 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 • The comprehensive guidelines supported by the Health Resources and Services Administration.	
Lung cancer screening maximums	1 screening every 12 months	
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Lactation counseling services	100% (of the negotiated charge) per visit Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies

	In-network coverage	Out-of-network coverage
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits	
Breast pump supplies and accessories	100% (of the negotiated charge) per item Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Family planning services – female contraceptives **Counseling services**		
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Contraceptive counseling services maximum visits per policy year either in a group or individual setting	2 visits	
Female contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit	100% (of the negotiated charge) per item Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Female Voluntary sterilization		
Inpatient provider services	100% (of the negotiated charge) Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Outpatient provider services	100% (of the negotiated charge) Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
The following are not covered under this benefit: • Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care • Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA • Male contraceptive methods, sterilization procedures or devices, except for male condoms prescribed by a provider		
Physicians and other health professionals		
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist) includes telemedicine consultations)	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies

	In-network coverage	Out-of-network coverage
Allergy testing and treatment		
Allergy testing performed at a physician's or specialist's office	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.
Allergy injections treatment including Allergy sera and extracts administered via injection performed at a physician's or specialist's office	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.
Physician and specialist - surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the Covered services and exclusions – Hospital and other facility care section) • Services of another physician for the administration of a local anesthetic		
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the Covered services and exclusions – Hospital and other facility care section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		
Alternatives to physician office visits		
Walk-in clinic visits(non-emergency visit)	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Hospital and other facility care		
Inpatient hospital (room and board) and other miscellaneous services and supplies) Includes birthing center facility charges	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
The following are not covered services:		

- All services and supplies provided in:
  - Rest homes
  - Any place considered a person's main residence or providing mainly custodial or rest care
  - Health resorts
  - Spas
  - Schools or camps

	In-network coverage	**Out-of-network coverage**
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Preadmission testing	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.
Alternatives to hospital stays		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
The following are not covered under this benefit: • A stay in a hospital (See the Hospital care – facility charges benefit in this section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		
Home health Care	80% (of the negotiated charge) per visit Policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
Home health care maximum visits per episode per policy year	Unlimited	
The following are not covered under this benefit: • Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities) • Transportation • Homemaker or housekeeper services • Food or home delivered services • Maintenance therapy		
Hospice-Inpatient facility	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Maximum days per confinement per policy year	Unlimited	
Hospice-Outpatient	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies

Maximum visits per policy year	Unlimited

The following are not covered under this benefit:

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

	In-network coverage	**Out-of-network coverage**
Outpatient private duty nursing	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Skilled nursing facility-Inpatient facility	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Emergency room	$100 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit Policy year deductible applies	Paid the same as in-network coverage
Non-emergency care in an emergency room	Not covered	Not covered

Important note:

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

The following are not covered under this benefit:

- Non-emergency services in a hospital emergency room or an independent freestanding emergency department

	In-network coverage	**Out-of-network coverage**
Urgent Care	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Non-urgent use of urgent care provider	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)

Pediatric dental care (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 No copayment or deductible applies	70% (of the recognized charge) per visit Policy year deductible applies
Type B services	70% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Type C services	50% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Orthodontic services	50% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Dental emergency 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.

Pediatric dental care exclusions

The following are not covered under this benefit:

- Any instruction for diet, plaque control and oral hygiene
  - 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 *Covered 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
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants and braces (that are determined not to be medically necessary mouth guards, and other

devices to protect, replace or reposition teeth

- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Covered services and exclusions – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another covered service
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered above and in the [*Pediatric*] *dental care* section of the Policy
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication or analgesia (nitrous oxide)
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- 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 only for orthodontic reasons
- Treatment by other than a dental provider

	In-network coverage	**Out-of-network coverage**
Specific Conditions		
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.
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.

The following are not covered under this benefit:

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

	In-network coverage	Out-of-network coverage
Impacted wisdom teeth	100% (of the negotiated charge) per visit Policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies
Accidental injury to sound natural teeth	100% (of the negotiated charge) per visit Policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies
The following are not covered under this benefit: • The care, filling, removal or replacement of teeth and treatment of diseases of the teeth • Dental services related to the gums • Apicoectomy (dental root resection) • Orthodontics • Root canal treatment • Soft tissue impactions • Bony impacted teeth • Alveolectomy • Augmentation and vestibuloplasty treatment of periodontal disease • False teeth • Prosthetic restoration of dental implants • Dental implants		
Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment	Covered according to the type of benefit and the place where the service is received.	[Covered according Cinicalto the type of benefit and the place where the service is received.]
The following are not covered under this benefit: Dental implants		
Clinical trials		
Experimental or investigational therapies	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.]
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.]
Coverage is limited to routine patient services from in-network providers. The following are not covered under this benefit: • Services and supplies related to data collection and record-keeping for the clinical trial • Services and supplies provided by the trial sponsor for free • The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies)		

	In-network coverage	Out-of-network coverage
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.
The following are not covered under this benefit: Cosmetic treatment and procedures		
Maternity care		
Maternity care (includes delivery and postpartum care services in a hospital or birthing center)	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: Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries		
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Voluntary sterilization for males		
Inpatient Physician or specialist surgical services	100% (of the negotiated charge) per visit No Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Outpatient Physician or specialist surgical services	100% (of the negotiated charge) per visit No Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Abortion		
Inpatient physician or specialist surgical services	100% (of the negotiated charge) per visit No Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Outpatient physician or specialist surgical services	100% (of the negotiated charge) per visit No Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Gender affirming treatment		
Surgical, hormone replacement therapy, and counseling 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.
Gender affirming treatment additional services		
Reduction thyroid chondroplasty (tracheal shave) maximum per policy year	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.
Electrolysis, laser hair removal	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 this benefit:

- Any treatment, surgery, service or supply that is not in the list above of covered services

	In-network coverage	Out-of-network coverage
Autism spectrum disorder		
Autism spectrum disorder treatment, diagnosis and testing. Includes Applied behavior analysis and Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	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.
Behavioral Health		
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Outpatient treatment office visits (includes telemedicine cognitive behavioral therapy consultations)	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies

	In-network coverage Network (IOE facility)	**In-network coverage Network (Non-IOE facility)**	**Out-of-network coverage Network Non-IOE facility and out-of-network facility**
Inpatient and outpatient transplant facility 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.
Inpatient and outpatient transplant physician and specialist 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.
Transplant services-travel and lodging	Covered	Covered	Covered
Lifetime Maximum Travel and Lodging Expenses for any one transplant	$10,000	$10,000	$10,000

Maximum Lodging Expenses per **IOE** patient	$50 per night	$50 per night	$50 per night
Maximum Lodging Expenses per companion	$50 per night	$50 per night	$50 per night

The following are not covered under this benefit:

- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
- Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness

	In-network coverage	**Out-of-network coverage**
Treatment of basic infertility	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.
Limited 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
Advanced reproductive technology (ART)		
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
Fertility preservation	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
For treatment that includes oocyte retrieval, maximum number of retrievals	3, with unlimited embryo transfers from those oocyte retrievals	3, with unlimited embryo transfers from those oocyte retrievals

Infertility services exclusions

The following are not covered under the infertility services benefit:

- The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.
- A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- Obtaining sperm from a person not covered under this plan.
- Infertility treatment when a successful pregnancy could have been obtained through less costly treatment.
- Infertility treatment when either partner has had voluntary sterilization surgery, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.

- Infertility treatment when infertility is due to a natural physiologic process such as age related ovarian insufficiency (e.g., perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period [or other abnormal testing results as outlined in Aetna's infertility clinical policy..
- Treatment for dependent children, except for fertility preservation as described above.

	In-network coverage	**Out-of-network coverage**
Specific therapies and tests		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Diagnostic lab work performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Diagnostic radiological services performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Outpatient Chemotherapy, Radiation & Respiratory Therapy	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Hormone replacement therapy	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 infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	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:

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

	In-network coverage	Out-of-network coverage
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for short-term rehabilitation services and habilitation therapy services	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Chiropractic services	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Other services		
Emergency ground, air, and water ambulance	100% (of the negotiated charge) per visit Policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies
The following are not covered services: - Ambulance services for routine transportation to receive outpatient or inpatient services		
Durable medical and surgical equipment	80% (of the negotiated charge) per visit Policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
The following are not covered under this benefit: • Whirlpools • Portable whirlpool pumps • Sauna baths • Massage devices • Over bed tables • Elevators • Communication aids • Vision aids • Telephone alert systems • Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician		
Nutritional support	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: - Any 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		
Osteoporosis (non-preventive care) Physician's or specialist's office visits	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.

	In-network coverage	Out-of-network coverage
Prosthetic Devices	80% (of the negotiated charge) per item Policy year deductible applies	60% (of the recognized charge) per item Policy year deductible applies
Cranial prosthetics *(Medical wigs)*	80% (of the negotiated charge) per item Policy year deductible applies	80% (of the actual charge) per item Policy year deductible applies
The following are not covered under this benefit: • Services covered under any other benefit • 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 • Trusses, corsets, and other support items • Repair and replacement due to loss, misuse, abuse or theft • Communication aids • Cochlear implants		
Hearing aids and Exams		
Hearing exams	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Hearing exam maximum	One hearing exam every policy year	
The following are not covered under this benefit: - Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay		
Hearing aids	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Hearing aids maximum per ear	One hearing aid per ear every policy year	
The following are not covered under this benefit: • A replacement of: • A hearing aid that is lost, stolen or broken ▪ Replacement parts or repairs for a hearing aid ▪ Batteries or cords ▪ Cochlear implants ▪ A hearing aid that does not meet the specifications prescribed for correction of hearing loss ▪ Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist		

	In-network coverage	Out-of-network coverage
Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)		
Pediatric routine vision exams (including refraction)- Performed by a legally qualified ophthalmologist or optometrist Includes comprehensive low vision evaluations.	100% (of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit No policy year deductible applies
Office visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit No policy year deductible applies
Maximum visits per policy year Low vision Maximum Fitting of contact Maximum	1 visit One comprehensive low vision evaluation every policy year 1 visit	
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit No policy year deductible applies
Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	One set of eyeglass frames One pair of prescription lenses Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set	
*__Important note__: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.		
The following are not covered under this benefit: • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes		

Outpatient prescription drugs	
Outpatient prescription drug policy year deductibles **A separate policy year deductible applies to prescription drugs**	
You have to meet your prescription drug policy year deductible below before this plan pays for outpatient prescription drug benefits.	
Student	$250 per policy year
Spouse	$250 per policy year
Each child	$250 per policy year
Policy year deductible and copayment waiver for risk reducing breast cancer	
The policy year deductible and the per prescription copayment will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network, pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.	
Outpatient prescription drug policy year deductible and copayment waiver for tobacco cessation prescription and over-the-counter drugs	
The outpatient prescription drug policy year deductible and the prescription drug copayment will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a retail in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%. Your policy year deductible and any prescription drug copayment will apply after those two regimens per policy year have been exhausted.	
Outpatient prescription drug policy year deductible and copayment waiver for contraceptives	
The outpatient prescription drug policy year deductible and the prescription drug copayment will not apply to female contraceptive methods when obtained at an in-network. This means that such contraceptive methods are paid at 100% for: • Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. • If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug or device for that method paid at 100%. The outpatient prescription drug policy year deductible and the per prescription drug copayment continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at an in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.	

	In-network coverage	Out-of-network 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 negotiated charge) Prescription deductible applies	40% (of the recognized charge) Prescription deductible applies
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	$30 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) Prescription deductible applies	Not covered
	In-network coverage	**Out-of-network coverage**
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 negotiated charge) Prescription deductible applies	40% (of the recognized charge) Prescription deductible applies
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	$90 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) Prescription deductible applies	Not covered
Non-preferred generic prescription drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	$70 copayment per supply then the plan pays 100% (of the negotiated charge) Prescription deductible applies	40% (of the recognized charge) Prescription deductible applies
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	$140 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) Prescription deductible applies	Not covered
Non-preferred brand-name prescription drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	$70 copayment per supply then the plan pays 100% (of the negotiated charge) Prescription deductible applies	40% (of the recognized charge) Prescription deductible applies
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	$140 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) Prescription deductible applies	Not covered

	In-network coverage	Out-of-network coverage
Specialty drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	Copayment per supply of 20% of the negotiated charge Prescription deductible applies	Not covered
Important note: Your cost share will not exceed $150 per 30 day supply of a covered specialty drug.		
Diabetic insulin & supplies		
30 day supply at retail pharmacy	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above
90 day supply at mail order pharmacy	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above
Diabetic insulin important note: Your cost share will not exceed $25 per 30 day supply of a covered prescription insulin drug filled at a network pharmacy. No deductible applies for preferred insulin.		
Contraceptives (birth control)		
For each fill up to a 12 month supply of generic and OTC drugs and devices filled at a retail or mail order pharmacy	100% (of the negotiated charge) No deductible applies	100% (of the recognized charge) No deductible applies
For each fill up to a 12 month supply of brand name prescription drugs and devices filled at a retail or mail order pharmacy	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above
	In-network coverage	**Out-of-network coverage**
Anti-cancer drugs taken by mouth- For each fill up to a 30 day supply	100% (of the negotiated charge) No deductible applies	100% (of the recognized charge) No deductible applies
Preventive care drugs and supplements filled at a retail pharmacy For each 30 day supply	100% (of the negotiated charge) No deductible applies	100% (of the recognized charge) No deductible applies
Risk reducing breast cancer prescription drugs filled at a pharmacy For each 30 day supply	100% (of the negotiated charge) per prescription or refill No 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.	

	In-network coverage	Out-of-network coverage
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each 30 day supply	100% (of the negotiated charge per prescription or refill No 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. 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 services:

- Any services related to providing, injecting or application of a drug
- Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as an covered service
- Drugs or medications:
  - Administered or entirely consumed at the time and place they are prescribed or provided
  - Which do not require a prescription by law, even if a prescription is written, unless we have approved a medical exception
  - That are therapeutically the same or an alternative to a covered prescription drug, unless we approve a medical exception
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility
  - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - 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 unless listed as a covered service
  - That are indicated or used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, non-prescription appetite suppressants or other medications except as described in the certificate
  - 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; for example, two antihistamines for the same condition
- Genetic care including:
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as a covered service
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
- Implantable drugs and associated devices except as specifically stated in the schedule of benefits or the certificate
- Injectables including:
  - Any charges for the administration or injection of prescription drugs

- Needles and syringes except for those used for insulin administration
- 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 with the exception of Depo Provera and other injectable drugs for contraception

- Off-label drug use except for indications recognized through peer-reviewed medical literature
- Prescription drugs:
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or prescription drugs for the treatment of a dental condition
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's drug guide
  - That are used for the purpose of improving visual acuity or field of vision
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card
- Prescription drugs indicated for the purpose of weight loss.
- Replacement of lost or stolen prescriptions
- Test agents except diabetic test agents
- Tobacco cessation drugs, unless recommended by the USPSTF
- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's drug guide
- Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's 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

Exclusions

The following are not covered services under your plan:

Acupuncture

- Acupuncture
- Acupressure

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:
  - School and/or education service including special education, remedial education, wilderness treatment programs, or any such related or similar programs
  - Services provided in conjunction with school, vocation, work or recreational activities
  - Transportation

Blood and blood products

- Blood, blood products, and related services that are supplied to your provider free of charge

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 except where described in the *Covered services and exclusions* section

Court-ordered testing

- Court-ordered testing or care unless medically necessary

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 except when part of an approved treatment plan for a covered service described in the *Covered services and exclusions – Reconstructive surgery and supplies* section.

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

Educational services
Examples of these are:

- Any service or supply for education, training or retraining services or testing. 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
Any health or dental examinations needed:

- Because a third party requires the exam. Examples, include examinations to get or keep a job, and examinations required under a labor agreement or other contract.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, sporting event, or to join in a sport or other recreational activity.

Experimental, investigational, or unproven

- Experimental, investigational, or unproven drugs, devices, treatments or procedures unless otherwise covered under clinical trials

Gender reassignment (sex change) treatment

- Cosmetic services and supplies such as:
  - Rhinoplasty
  - Face-lifting
  - Lip enhancement
  - Facial bone reduction
  - Lepharoplasty
  - Breast augmentation
  - Liposuction of the waist (body contouring)
  - Voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which are used in feminization
  - Chin implants, nose implants, and lip reduction, which are used to assist masculinization, are considered cosmetic

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

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

Jaw joint disorder

- Surgical treatment of jaw joint disorders
- Non-surgical treatment of jaw joint disorders
- Jaw joint disorders treatment performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to jaw joint disorders including associated myofascial pain

This exclusion does not apply to covered benefits for treatment of TMJ and CMJ as described in the *Covered services under your plan –Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment* section.

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.

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. Examples of these are:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Home test kits not related to diabetic testing
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

Obesity surgery

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described in the *Covered services and exclusions* 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:
  - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery
  - Surgical procedures, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Other primary payer

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

Personal care, comfort or convenience items

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

Routine exams and preventive services and supplies

- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Covered services under your plan* section

School health services

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

- Services and supplies provided by health professionals who the policyholder:
  - Employs
  - Is affiliated with
  - Has an agreement or arrangement with
  - Otherwise designates

Services not permitted by law

- Some laws restrict the range of health care services a provider may perform under certain circumstances or in a particular state. When this happens, the services are not covered by the plan.

Services provided by a family member

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

Strength and performance

- Services, devices and supplies such as drugs or preparations designed primarily to enhance your strength, physical condition, endurance or physical performance

Students in mental health field

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

Telemedicine

- Services including:
  - Telephone calls
  - Telemedicine kiosks
  - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used as a physical therapy treatment
- Sensory or hearing and sound 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 *Covered services under your plan – Preventive care*

and wellness section
- Hypnosis and other therapies
- Medications, except as specifically provided in the *Covered services under your plan – 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, unless coverage is required by applicable laws

Vision care for adults

- Routine vision exam provided by an ophthalmologist or optometrist, including refraction and glaucoma testing
- Vision care services and supplies

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.

Important Note:

A source of coverage or reimbursement is 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 George Washington University Student Health Insurance Plan is underwritten by Aetna Life Insurance Company Aetna Student Health℠ is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).

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 1-877-480-4161.

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:

1. Qualified language interpreters
2. Written information in other formats (large print, audio, accessible electronic formats, other formats)
3. Qualified interpreters
4. Information written in other languages

If you need these services, contact the number on your ID card. Not an Aetna member? Call us at 1-877-480-4161.

If you have questions about our nondiscrimination policy or have a discrimination-related concern that you would like to discuss, please call us at 1-877-480-4161.

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.

TTY: **711**

English	To access language services at no cost to you, call the number on your ID card.
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ።
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով ավվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէրախոսահամարով հէրախոսահամարով
Carolinian (Kapasal Falawasch)	Ngir mëna am sarwis lakk yi te doo fay, woo nimero bi am ci sa kàrt.
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf, lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Greek	Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισής σας.
Gujarati	તમારે કોઇ પણ જાતના ખર્ચ વિના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇડી કાર્ડ પર રહેલ નંબર પર કૉલ કરવો.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Karen	လၫ်တၢ်ကမ္ၢၤကျိာတၢ်မၤစၫၤအတၢ်ဖံးတၢ်မၤတဖၣ လၫ်တအိၣ်ဒီးအပှၤလၫ်နကဘၣ်ဟ့ၣ်အီၤအဂီၢ်ကီးဘၣ်လီတဲစိနီၣ်ဂ့ၢ်လၫ်အအိၣ်လၫ်နခိၣ်ဂီၤ ၈ (ၪ) အလိၢ်ၣ်တက့ၢ်၍
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Laotian	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ą́h ílínígóó naaltsoos bee atah nílı̨́go nanitinígíí bee néého’dólzinígíí béésh bee hane’í biká’ígíí áajı̨’ hólne’.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian-Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Samoan	Mō le mauaina o 'au'aunaga tau gagana e aunoa ma se totogi, vala'au le numera i luga o lau pepa ID.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Syriac-Assyrian	ܠܡܬܚܫܒ ܒܫܘܬܐ ܕܠܫܢܐ ܕܠܝܬ ܠܗ ܥܠܘܬܐ ܒܠܚܘܕ، ܒܥܝ ܠܡܬܚܙܐ ܠܡܝܠܐ ܕܒܬܪ ܡܣܦܪܐ ܕܐܝܬ ܥܠ ܟܪܛܝܣ ܕܐܝܕܝ ܕܝܠܟ.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน
Ukrainian	Щоб безкоштовнj отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.