

Quality Health Plans & Benefits  
Healthier Living  
Financial Well-Being  
Intelligent Solutions



THE GEORGE  
WASHINGTON  
UNIVERSITY

WASHINGTON, DC

# Aetna Student Health Plan Design and Benefits Summary George Washington University

Policy Year: 2021 - 2022

Policy Number: 474952

[www.aetnastudenthealth.com](http://www.aetnastudenthealth.com)

(800) 213-0579



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 [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com). If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

## GW Colonial Health Center-Medical Services

The Colonial Health Center is the University's on-campus health facility. It is located at 800 21<sup>st</sup> St. NW, Ground Floor, Washington D.C, 20052. 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 Colonial Health Center (CHC) 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 CHC only

### Annual Deductible waived for services rendered at GW Mental Health Services

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

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

For more information, call the CHC Mental Health Services at **(202) 994-5300**. In the event of an emergency, call **911** or the Campus Police at **(202) 994-6111**.

## 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 [www.aetnastudenthealth.com](http://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 Healthcare practitioners who are physically separated from the patient or from each other.

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

## Policy Period

### Mandatory and Subsidized Graduate Assistants and Dependents

1. **Students:** Coverage for all insured students that enroll in the Fall 2021 semester, will become effective at 12:01 a.m. on **8/12/2021**, and will terminate at 11:59 p.m. on **12/31/2021**. Students who maintain eligibility for the Spring / Summer 2022 semester will automatically be re-enrolled effective 12:01 a.m. on **01/01/2022** and will terminate 11:59 p.m. on **08/11/2022**.
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 **01/01/2022**, and will terminate at 11:59 p.m. on **08/11/2022**.
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

The following groups of students are automatically enrolled in the Plan unless proof of comparable coverage is furnished:

- All Undergraduate students matriculated in a degree granting program.
- All international students on a J1 or F1 Visa.
- All Medical, On Campus Nursing, On-Campus Health Science students.

The plan is also available on a voluntary basis for:

- All Graduate students not listed above matriculated in a degree granting program (Note that 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.)
- All non-degree seeking undergraduate students with at least 12 credit hours.
- Non-degree seeking graduate students with at least 9 credit hours.
- All students on Continuous Enrollment.
- All students on a school-approved leave of absence.

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:

- Online courses;
- Correspondence;
- Television (TV).

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

## 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	08/12/2021	08/11/2022	09/12/2021
Fall	08/12/2021	12/31/2021	09/12/2021
Spring	01/01/2022	08/11/2022	02/01/2022
Summer Only	05/01/2022	08/11/2022	05/20/2022

**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	08/12/2021	08/11/2022	09/12/2021
Fall	08/15/2021	12/31/2021	09/12/2021
Spring	01/01/2022	08/11/2022	02/01/2022
Summer Only	05/01/2022	08/11/2022	05/20/2022

## Rates

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

Rates All Mandatory Students				
	Annual 08/12/21-08/11/22	Fall Semester 08/12/21-12/31/21	Spring/Summer Semester 01/01/22-08/11/22	Summer Only 05/01/22-08/11/22
<b>Student</b>	\$2,465	\$959	\$1,506	\$696
<b>Spouse</b>	\$2,332	\$907	\$1,425	\$658
<b>One Child</b>	\$2,332	\$907	\$1,425	\$658
<b>Children</b>	\$4,664	\$1,814	\$2,851	\$1,316

**Please Note:** Some GW graduate assistants or graduate research assistants receive subsidized funding to cover the costs of the GW SHIP. Those students and their dependents are eligible for the above hard waiver rates. Contact your department or research advisor for more information.

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

Rates All Voluntary Students				
	Annual 08/12/21- 08/11/22	Fall 08/12/21- 12/31/21	Spring/Summer 01/01/22- 08/11/22	Summer Only 05/01/22-08/11/22
<b>Student</b>	\$3,758	\$1,462	\$2,296	\$1,060
<b>Spouse</b>	\$3,624	\$1,410	\$2,214	\$1,022
<b>One Child</b>	\$3,624	\$1,410	\$2,214	\$1,022
<b>Children</b>	\$7,248	\$2,820	\$4,428	\$2,044

### Annual Monthly Option:

#### **Voluntarily Enrolled Students and Dependents**

This option is only available when paying by credit card. You may authorize installments by auto-debiting via credit card. Your signature provides authorization to charge your credit card for the installments. If for any reason your credit card does not accept the monthly debit, an alternate credit card payment must be provided within 30 days of the end of the month for which premium has been previously received.

We will attempt to charge your credit card/bank account 3 times.

For any reason, if the charge is unable to be processed on the 1st or 2nd attempt, a warning email will be sent to your email address on file.

If the charge fails on the 3<sup>rd</sup> attempt, a termination email will be sent notifying you that payment has failed, and coverage will be terminated.

## Termination of Coverage & Re-Enrollment Options:

- Electing the monthly payment option requires you to pay each month.
- If you fail to make a payment, a termination email will be sent describing the re-enrollment guidelines.

If you terminate for lack of payment and wish to re-enroll, you must re-send the application information, an email explaining the reason for the request for an exception request and premium payment for the remainder of the plan year. **(A petition to be reinstated is not a guarantee of reinstatement of the policy)**

## Annual Waiver Deadline for Students: 9/12/2021

### 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](http://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 2021 Semester will become effective at 12:01 a.m. on **08/12/2021** and will terminate at 11:59 p.m. on **12/31/2021**. Students who maintain eligibility for the Spring/Summer 2022 semester can re-enroll in coverage that will become effective 12:01 a.m. on **01/01/2022** and terminate at 11:59 p.m. on **08/11/2022**.
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 **01/01/2022**, and will terminate at 11:59 p.m. on **8/11/2022**.
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 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](http://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](http://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:

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.

A child that you, or that you and 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.

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 eligible health 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 eligible health 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.aetnastudenthealth.com](http://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 14 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 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

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

## Coordination of Benefits (COB)

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB). 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](http://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.		
<b>Student</b>	\$300 per policy year	\$3,000 per policy year
<b>Spouse</b>	\$300 per policy year	\$3,000 per policy year
<b>Each child</b>	\$300 per policy year	\$3,000 per policy year
<b>Family</b>	None	None
<b>PRESCRIBED MEDICINES EXPENSE</b>		
<b>Student</b>	\$100 per policy year	
<b>Spouse</b>	\$100 per policy year	
<b>Each child</b>	\$100 per policy year	
<b>Individual</b> This is the amount you owe for in-network and out-of-network eligible health services each policy year before the plan begins to pay for eligible health services. This policy year deductible applies separately to you and each of your covered dependents. After the amount you pay for eligible health services reaches the policy year deductible, this plan will begin to pay for eligible health services for the rest of the policy year.		
<b>Policy year deductible waiver</b>		
The policy year deductible is waived for all of the following eligible health services: <ul style="list-style-type: none"> <li>• In-network care for <i>Preventive care and wellness</i></li> <li>• Pap Smear Screening Expense; and</li> <li>• Mammogram Expense.</li> </ul> In addition to state and federal requirements for waiver of the policy year deductible, the plan will waive the policy year deductible for: <ul style="list-style-type: none"> <li>• Preferred Care Laboratory and X-Ray Expense;</li> <li>• Preferred Care Allergy Testing Expense;</li> <li>• Preferred Care Diagnostic Testing For Learning Disabilities Expense; Preferred Care Maternity Expense;</li> <li>• Preferred Care Gynecology;</li> <li>• Preferred Care Outpatient Treatment of Mental Health;</li> <li>• Preferred Care Pediatric Preventive Dental; and</li> <li>• Preferred and Non-Preferred Care Pediatric Vision Services.</li> </ul> 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.		
<b>Maximum out-of-pocket limit per policy year</b>		
<b>Student</b>	\$6,350 per policy year	\$15,000 per policy year
<b>Spouse</b>	\$6,350 per policy year	\$15,000 per policy year
<b>Each child</b>	\$6,350 per policy year	\$15,000 per policy year
<b>Family</b>	\$12,700 per policy year	\$30,000 per policy year

Eligible health services	In-network coverage	Out-of-network coverage
Routine physical exams		
Performed at a physician’s office	100% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
	Deductible does not apply	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.	
Maximum visits per policy year age 22 and over	1 visit	
Preventive care immunizations		
Performed in a facility or at a physician's office	100% (of the negotiated charge) per visit.	60% (of the recognized charge) per visit
	Deductible does not apply	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	60% (of the recognized charge) per visit
	Deductible does not apply	Policy year deductible applies
Maximum visits per policy year	1 visit	
Preventive screening and counseling services		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Depression Screening, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
	Deductible does not apply	Policy year deductible applies

Eligible health services	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	
Depression screening counseling Maximum visits per policy year	1 visit	
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	100% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Deductible does not apply to routine mammography	Deductible does not apply	Policy year deductible applies
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> <li>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</li> <li>The comprehensive guidelines supported by the Health Resources and Services Administration.</li> </ul>	
Lung cancer screening maximums	1 screening every 12 months	
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
	Deductible does not apply	Policy year deductible applies
Lactation support and counseling services	100% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
	Deductible does not apply	Policy year deductible applies

Eligible health services	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
<b>Family planning services – female contraceptives</b>		
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 & Outpatient provider services	100% (of the negotiated charge)  Deductible does not apply	60% (of the recognized charge) per visit  Policy year deductible applies
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care</li> <li>• Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA</li> <li>• Male contraceptive methods, sterilization procedures or devices</li> </ul>		
<b>Physicians and other health professionals</b>		
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
<b>Allergy testing and treatment</b>		
Allergy testing & 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.

Eligible health services	In-network coverage	Out-of-network coverage
<b>Physician and specialist - surgical services</b>		
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: <ul style="list-style-type: none"> <li>• The services of any other physician who helps the operating physician</li> <li>• A stay in a hospital (Hospital stays are covered in the Eligible health services and exclusions – Hospital and other facility care section)</li> <li>• Services of another physician for the administration of a local anesthetic</li> </ul>		
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: <ul style="list-style-type: none"> <li>• The services of any other physician who helps the operating physician</li> <li>• A stay in a hospital (Hospital stays are covered in the Eligible health services and exclusions – Hospital and other facility care section)</li> <li>• A separate facility charge for surgery performed in a physician's office</li> <li>• Services of another physician for the administration of a local anesthetic</li> </ul>		
<b>Alternatives to physician office visits</b>		
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
<b>Hospital and other facility care</b>		
Inpatient hospital (room and board) and other miscellaneous services and supplies)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Includes birthing center facility charges	Policy year deductible applies	Policy year deductible applies
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
<b>Alternatives to hospital stays</b>		
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:

- The services of any other physician who helps the operating physician
- 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

Eligible health services	In-network coverage	Out-of-network coverage
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
Maximum visits per episode per policy year	Unlimited	

The following are not covered under this benefit:

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

Hospice-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

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
---------------------------------	--	--

Eligible health services	In-network coverage	Out-of-network coverage
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
Hospital 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 a hospital 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 hospital emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived and your inpatient copayment/coinsurance will apply.
- Covered benefits that are applied to the hospital emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment/coinsurance.
- Separate copayment/coinsurance amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment/coinsurance amounts may be different from the hospital emergency room copayment/coinsurance. They are based on the specific service given to you.
- Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment/coinsurance amounts that are different from the hospital emergency room copayment/coinsurance amounts.

The following are not covered under this benefit:

- Non-emergency services in a hospital emergency room facility, freestanding emergency medical care facility or comparable emergency facility

Urgent Care  Urgent medical care provided by an urgent care provider	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)

Eligible health services	In-network coverage	Out-of-network coverage
<b>Pediatric dental care</b> (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
- Asynchronous dental treatment
- Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *Eligible health services 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:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) and craniomandibular joint dysfunction disorder (CMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services 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 or analgesia (nitrous oxide)
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically provided in the [*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 only for orthodontic reasons
- Treatment by other than a dental provider

Eligible health services	In-network coverage	Out-of-network coverage
<b>Specific Conditions</b>		
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: <ul style="list-style-type: none"> <li>- Services and supplies for:               <ul style="list-style-type: none"> <li>• The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches</li> <li>• The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes</li> <li>• Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies</li> <li>• Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet</li> </ul> </li> </ul>		
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

Eligible health services	In-network coverage	Out-of-network coverage
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 to the type of benefit and the place where the service is received.]

The following are not covered under this benefit:

Dental implants

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.]
--	---	---

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 that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna's claim policies)

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

Eligible health services	In-network coverage	Out-of-network coverage
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
Family planning services – other		
Voluntary sterilization for males-surgical 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
Abortion	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: <ul style="list-style-type: none"><li>Reversal of voluntary sterilization procedures, including related follow-up care</li></ul>		
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.
Tracheal shave	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.
Tracheal shave maximum per policy year	Unlimited	
Electrolysis of face and neck	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 of face and neck maximum per policy year	\$1,200	
Except as required by law, all other <b>cosmetic</b> services and supplies not listed under <b>eligible health services</b> above are not covered under this benefit. This includes, but is not limited to the following: <ul style="list-style-type: none"><li>Rhinoplasty</li><li>Face-lifting</li><li>Lip enhancement</li><li>Facial bone reduction</li><li>Blepharoplasty</li><li>Liposuction of the waist (body contouring)</li><li>Nipple reconstruction</li><li>Voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which are used in feminization</li><li>Voice and communication therapy</li><li>Chest binders</li></ul>		

- Chin implants, nose implants, and lip reduction, which are used to assist masculinization, are considered cosmetic			
Eligible health services	In-network coverage		Out-of-network coverage
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.
Behavioral Health			
Mental Health & Substance Abuse Treatment			
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	80% (of the negotiated charge) per visit		60% (of the recognized charge) per visit
	Policy year deductible applies		Policy year deductible applies
Outpatient treatment office visits  (includes telemedicine cognitive behavioral therapy consultations)	80% (of the negotiated charge) per visit		60% (of the recognized charge) per visit
	Policy year deductible applies		Policy year deductible applies
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	80% (of the negotiated charge) per visit		60% (of the recognized charge) per visit
	Policy year deductible applies		Policy year deductible applies
Eligible health services	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

Eligible health services	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
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: <ul style="list-style-type: none"><li>- Services and supplies furnished to a donor when the recipient is not a covered person</li><li>- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness</li><li>- 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</li></ul>			
Eligible health services	In-network coverage	Out-of-network coverage	
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.	
The following are not covered services under the <b>infertility</b> treatment benefit: <ul style="list-style-type: none"><li>➤ Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.</li><li>➤ All charges associated with:<ul style="list-style-type: none"><li>• Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father</li><li>• Cryopreservation (freezing) of eggs, embryos or sperm</li><li>• Storage of eggs, embryos, or sperm</li><li>• Thawing of cryopreserved (frozen) eggs, embryos or sperm</li><li>• 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</li><li>• 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</li><li>• Obtaining sperm [from a person not covered under this plan] for ART services</li></ul></li><li>- Home ovulation prediction kits or home pregnancy tests</li><li>- The purchase of donor embryos, donor oocytes, or donor sperm</li><li>- [Reversal of voluntary sterilizations, including follow-up care]</li><li>• Ovulation induction with menotropins, Intrauterine insemination and any related services, products or procedures</li><li>• 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)</li></ul>			

Eligible health services	In-network coverage	Out-of-network coverage
<b>Specific therapies and tests</b>		
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 and radiological services performed in a physician's office, 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
Outpatient Chemotherapy, Radiation, Infusion & Respiratory Therapy	80% (of the negotiated charge) per visit  Policy year deductible applies	60% (of the recognized charge) per visit  Policy year deductible applies
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
<b>Other services and supplies</b>		
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 under this benefit: <ul style="list-style-type: none"> <li>- Non-emergency fixed wing air ambulance from an out-of-network provider</li> <li>- Ambulance services for routine transportation to receive outpatient or inpatient care</li> </ul>		
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: <ul style="list-style-type: none"> <li>• Whirlpools</li> <li>• Portable whirlpool pumps</li> <li>• Sauna baths</li> </ul>		

<ul style="list-style-type: none"><li>• Massage devices</li><li>• Over bed tables</li><li>• Elevators</li><li>• Communication aids</li><li>• Vision aids</li><li>• Telephone alert systems</li><li>• Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician</li></ul>		
Eligible health services	In-network coverage	Out-of-network coverage
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.
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"><li>- 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</li></ul>		
Prosthetic Devices	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
	Policy year deductible applies	Policy year deductible applies
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"><li>• Services covered under any other benefit</li><li>• 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</li><li>• Trusses, corsets, and other support items</li><li>• Repair and replacement due to loss, misuse, abuse or theft</li><li>• Communication aids</li><li>• Cochlear implants</li></ul>		
<b>Hearing aids and Exams</b>		
Hearing exams	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
	Policy year deductible applies	Policy year deductible applies
Hearing exam maximum	One hearing exam every policy year	
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"><li>- Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay</li></ul>		

Eligible health services	In-network coverage	Out-of-network coverage
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: <ul style="list-style-type: none"><li>• A replacement of:</li><li>• A hearing aid that is lost, stolen or broken<ul style="list-style-type: none"><li>▪ Replacement parts or repairs for a hearing aid</li><li>▪ Batteries or cords</li><li>▪ Cochlear implants</li><li>▪ A hearing aid that does not meet the specifications prescribed for correction of hearing loss</li><li>▪ Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist</li></ul></li></ul>		
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. Includes 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: <ul style="list-style-type: none"><li>• Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes</li></ul>		



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	\$100 per policy year	
Spouse	\$100 per policy year	
Each child	\$100 per policy year	
Policy year deductible and copayment/coinsurance waiver for risk reducing breast cancer		
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 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:		
<ul style="list-style-type: none"><li>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%.</li><li>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%.</li></ul>		
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.		
Eligible health services	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)	40% (of the recognized charge)
	No policy year deductible applies	Policy year deductible applies
More than a 30 day supply but less than a 101 day supply filled at a mail order pharmacy	\$30 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	Not covered
	Policy year deductible applies	

Eligible health services	In-network coverage	Out-of-network coverage
<b>Preferred brand-name prescription drugs</b>		
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)  No policy year deductible applies	40% (of the recognized charge)  Policy year deductible applies
More than a 30 day supply but less than a 101 day supply filled at a mail order pharmacy	\$90 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  Policy year deductible applies	Not covered
<b>Non-preferred brand-name prescription drugs</b>		
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)  No policy year deductible applies	40% (of the recognized charge)  Policy year deductible applies
More than a 30 day supply but less than a 101 day supply filled at a mail order pharmacy	\$140 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  Policy year deductible applies	Not covered
<b>Specialty drugs</b>		
For each fill up to a 30 day supply filled at a retail pharmacy	\$120 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  Policy year deductible applies	Not covered
Orally administered anti-cancer prescription drugs- For each fill up to a 30 day supply filled at a retail pharmacy	\$120 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  Policy year deductible applies	Not covered
Preventive care drugs and supplements filled at a retail pharmacy  For each 30 day supply	100% (of the negotiated charge)  No policy year deductible applies	100% (of the recognized charge)  No policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
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 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  For each 30 day supply	100% (of the negotiated charge) per prescription or refill  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. 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:

- Biological sera
- Cosmetic drugs including medications and preparations used for cosmetic purposes
- Devices, products and appliances, except those that are specially covered
- 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
  - Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by our Pharmacy and Therapeutics Committee
  - 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 (for example: Medicaid or Veterans Administration)
  - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the 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
- 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]
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
- 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.
- Prescription drugs:
  - For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a prescription is written.
  - Packaged in 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
- 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

## Exclusions

### Acupuncture therapy

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

- Respiratory disorders
- Rheumatoid arthritis
- Rhinitis
- Sensorineural deafness
- Shoulder pain (e.g., bursitis)
- Stroke rehabilitation (e.g., dysphagia)
- Tennis elbow/ epicondylitis
- Tension headache
- Tinnitus
- Tobacco Cessation
- Urinary incontinence
- Uterine fibroids
- Xerostomia
- Whiplash

#### **Air or space travel**

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

This exclusion does not apply if:

- You are traveling solely as a fare-paying passenger
- You are traveling on a licensed, commercial, regularly scheduled non-military aircraft
- You are traveling solely in a civil aircraft with a current valid "Standard Federal Aviation Agency Airworthiness Certificate" and:
  - The civil aircraft is piloted by a person with a current valid pilot's certificate with proper ratings for the type of flight and aircraft involved
  - You are as a passenger with no duties at all on an aircraft used only to carry passengers or you are a pilot or a part of the flight crew on an aircraft owned or leased by the policyholder performing duties for the policyholder

#### **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 to the policyholder.

#### **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
  - Services provided in conjunction with school, vocation, work or recreational activities
  - Transportation

- Sexual deviations and disorders except for gender identity disorders
- Tobacco use disorders except as described in the *Eligible health services and exclusions – Preventive care and wellness* section
- Pathological gambling, kleptomania, pyromania
- Specific developmental disorders of scholastic skills (learning disorders/learning disabilities)
- Specific developmental disorder of motor functions
- Specific developmental disorders of speech and language
- Other disorders of psychological development

### **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
- Any related services including processing, storage or replacement expenses
- The services of blood donors, apheresis or plasmapheresis
- For autologous blood donations, only administration and processing expenses are covered

### **Breasts**

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

### **Cosmetic services and plastic surgery**

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

This exclusion does not apply to:

- Surgery after an accidental injury when performed as soon as medically feasible
- Coverage that may be provided under the *Eligible health services under your plan - Gender reassignment (sex change) treatment* section.

### **Court-ordered services and supplies**

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

### **Dental care for adults**

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



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

### **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 in the certificate. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

### **Elective treatment or elective surgery**

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

### **Examinations**

Any health or dental examinations needed:

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

### **Experimental or investigational**

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

### **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

### **Gender reassignment (sex change) treatment**

- Cosmetic services and supplies such as:
  - Rhinoplasty
  - Face-lifting
  - Lip enhancement
  - Facial bone reduction
  - Lopharoplasty
  - 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)**

Therapies and treatments including:

- Cellular immunotherapies.
- Genetically modified viral therapy.
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for treatment of certain conditions.
- All human gene therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
  - Luxturna® (Voretigene neparvovec)
  - Zolgensma® (Onasemnogene abeparvovec-xioi)
  - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9.
- Oligonucleotide-based therapies. Examples include:
  - Antisense. An example is Spinraza® (Nusinersen).
  - siRNA.
  - mRNA.
  - microRNA therapies.

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

The services have a basis in genetic/molecular medicine and are not covered under the **Institutes of Excellence™ (IOE)** programs.

### **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

**Incidental surgeries**

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

**Jaw joint disorder**

- Surgical treatment of jaw joint disorders
- 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 *Eligible health services under your plan – Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment* section.

**Judgment or settlement**

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

**Mandatory no-fault laws**

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

**Maintenance care**

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

**Medical supplies – outpatient disposable**

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

**Medicare**

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

**Non-medically necessary services and supplies**

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

**Obesity (bariatric) surgery**

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described in the *Eligible health services under your plan – Preventive care and wellness* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - 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

**Private duty nursing (outpatient only)****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 under your plan* section

**School health services**

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

by health professionals who

- Are employed by
- Are Affiliated with
- Have an agreement or arrangement with, or
- Are otherwise designated by the policyholder.

#### **Services provided by a family member**

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

#### **Sinus surgery**

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

#### **Sleep apnea**

- Any services or supplies given by providers for the treatment of obstructive sleep apnea and sleep disorders

#### **Strength and performance**

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

#### **Students in mental health field**

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

#### **Telemedicine**

- Services given by providers that are not contracted with Aetna as telemedicine providers
- Services given when you are not present at the same time as the provider
- Services including:
  - 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 modality
- Sensory or auditory integration therapy

#### **Tobacco cessation**

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

- Medications, except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section
- Nicotine patches
- Gum

#### **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

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

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.*

## **Language accessibility statement**

***Interpreter services are available for free.***

Attention: If you speak English, language assistance service, free of charge, are available to you. Call **1-877-480-4161** (TTY: **711**).

## **Español/Spanish**

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-480-4161** (TTY: **711**).

## **አማርኛ/Amharic**

ልብ ይበሉ፡ አማርኛ ቋንቋ የሚናገሩ ከሆነ፡ የትርጉም ድጋፍ ሰጪ ድርጅቶች፣ ያለምንም ክፍያ እርስዎን ለማገልገል ተዘጋጅተዋል። የሚከተለው ቁጥር ላይ ይደውሉ **1-877-480-4161** (መስማት ለተሳናቸው፡ **711**)።

#### العربية/Arabic

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-480-4161** (رقم الهاتف النصي: **711**).

#### Bàsòò Wùdù/Bassa

Dè dè nìà kè dyédè gbo: ɔ jù ké m̀ d̀yì Bàsòò-wùdù-po-nyò jù nì, nìi à wuɖu kà kò d̀ò po-poò b́é m̀ gbo kpáa.  
ፎል **1-877-480-4161** (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 **1-877-480-4161** (TTY: **711**)。

#### فارسی/Farsi

توجه: اگر به زبان فارسی صحبت می کنید، خدمات زبانی رایگان به شما ارایه میگردد، با شماره **1-877-480-4161** (TTY: **711**) تماس بگیرید.

#### Français/French

Attention : Si vous parlez français, vous pouvez disposer d'une assistance gratuite dans votre langue en composant le **1-877-480-4161** (TTY: **711**).

#### ગુજરાતી/Gujarati

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો ભાષાકીય સહાયતા સેવા તમને નિ:શુલ્ક ઉપલબ્ધ છે.

ફોન કરો **1-877-480-4161** (TTY: **711**).

#### Kreyòl Ayisyen/Haitian Creole

Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-877-480-4161** (TTY: **711**).

#### Igbo

Nrụbama: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dijirị gị. Kpọọ **1-877-480-4161** (TTY: **711**).

#### 한국어/Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스가 무료로 제공됩니다. **1-877-480-4161**(TTY: **711**)번으로 전화해 주십시오.

#### Português/Portuguese



Atenção: a ajuda está disponível em português por meio do número **1-877-480-4161** (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 **1-877-480-4161** (TTY: **711**).

#### **Tagalog**

Paunawa: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-480-4161** (TTY: **711**).

#### **اردو/Urdu**

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت دستیاب ہیں - **1-877-480-4161** (TTY: **711**) 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 **1-877-480-4161** (TTY: **711**).

#### **Yorùbá/Yoruba**

Àkíyèsí: Bí o bá nsọ èdè Yorùbá, ìrànlọ́wọ́ lórí èdè, lófẹ́ẹ̀, wà fún ọ. Pe **1-877-480-4161** (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).*