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# Aetna Student Health Plan Design and Benefits Summary Illinois Institute of Technology

Policy Year: 2020 - 2021  
Policy Number: 724532  
[www.aetnastudenthealth.com](http://www.aetnastudenthealth.com)  
(800) 841-3140



This is a brief description of the Student Health Plan. The Plan is available for Illinois Institute of Technology students and their eligible dependents. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Policy issued to you and may be viewed online at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com). If there is a difference between this Benefit Summary and the Master Policy, the Policy will control.

## Illinois Institute of Technology Health Services

The Student Health and Wellness Center is the University's on-campus health facility. Staffed by Nurse Practitioners, Medical Assistants, Physician Assistants, a part-time Physician and Psychiatrist, Psychologist, LCPC's, Psychology Externs and a Post-Doctoral Fellow and Administrative Professionals

The Student Health and Wellness Center is open Monday - Friday from 8:30 -5pm. To view hours of operation, go online to [www.iit.edu/shwc](http://www.iit.edu/shwc).

For more information about them, call the Student Health and Wellness Center at **(312) 567-7550**. In the event of an emergency, call **911** or the Campus Police at **(312) 808-6300**.

## Coverage Periods

- Students:** Coverage for all insured students enrolled for the Fall Semester will become effective at 12:01 AM on **August 10, 2020** and will terminate at 11:59 PM on **August 09, 2021**.
- New Spring Semester students:** Coverage for all insured students enrolled for the Spring Semester will become effective at 12:01 AM on **January 6, 2021** and will terminate at 11:59 PM on **August 09, 2021**.
- 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.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	08/10/2020	08/09/2021	09/01/2020
Fall	08/10/2020	01/05/2021	09/01/2020
Spring	01/06/2021	08/09/2021	01/26/2021
Summer	05/20/2021	08/09/2021	06/24/2021

**Eligible Dependents:** Coverage will, will become effective at 12:01 AM on the Coverage Start Date indicated below August 10, 2019, and will terminate at 11:59 PM on the Coverage End Date indicated August 09, 2020. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	08/10/2020	08/09/2021	09/01/2020
Fall	08/10/2020	01/05/2021	09/01/2020
Spring	01/06/2021	08/09/2021	01/26/2021
Summer	05/20/2021	08/09/2021	06/24/2021

## Rates

The rates below include both premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna), as well as the Illinois Institute of Technology administrative fee.

	Annual	Spring	Summer
Student	\$1,687	\$994	\$373
Spouse	\$1,671	\$984	\$369
Child	\$1,671	\$984	\$369
Children	\$3,342	\$1,957	\$738

## Student Coverage

### Who is eligible?

You must purchase the IL Tech Student Health Insurance Plan if you are registered for "1" or more academic credit hours during the semester if you are not covered under another comparable plan.

### Enrollment

Eligible students will be automatically enrolled in this plan, unless the electronic Waiver Form has been received and approved by the Student Health and Wellness Center, by the specified enrollment deadline dates listed in the next section of this brochure.

If you withdraw from school within the first **31 days** of a coverage period, you will not be covered under the Policy and the full premium will be refunded, less any claims paid. After **31 days**, you will be covered for the full period that you have paid the premium for, and no refund will be allowed. (This refund policy will not apply if you withdraw due to a covered Accident or Sickness.)

**Exception:** A Covered Person entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro rata refund of premium will be made for such person, and any covered dependents, upon written request received by Aetna within **90 days** of withdrawal from school.

## Dependent Coverage

### Eligibility

Covered students may also enroll their lawful spouse, civil union partner, and dependent children under age **26**.

### Enrollment

An Enrollment Form for **dependents** is located online at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com) and must be submitted by the same Enrollment Deadline listed.

### To Enroll a Dependent

- Log onto [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com)
- Click on "Find My School's Plan" under Member Quick Links
- Enter IIT
- Click on "Plans and Products Offered to You"

## Waiver Process/Procedure

Domestic students may waive this coverage if the student presents evidence of other health insurance coverage under a plan, which provides benefits equivalent to the Plan. Students must complete the online Waiver Form by the Waiver Deadline below. Waiver Forms are available at [www.universityhealthplans.com/iit](http://www.universityhealthplans.com/iit)

To ensure all international students meet the Federal Visa Insurance Requirements, coverage is mandatory for all Full-Time and Part-Time J-1 and F-1 international students.

## Medicare Eligibility Notice

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

## Termination and Refunds

Withdrawal from Classes – Leave of Absence:

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

Withdrawal from Classes – Other than Leave of Absence:

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

## 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. 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 precertified services are approved, the approval is valid for 30 days as long as you remain enrolled in the plan.

## Coordination of Benefits (COB)

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB). 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 **Illinois** 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	\$400 per policy year
<b>Spouse</b>	\$300 per policy year	\$400 per policy year
<b>Each child</b>	\$300 per policy year	\$400 per policy year
<b>Family</b>	None	None

<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 Preventive care and wellness and Pediatric Preventive Dental Benefits</li> <li>In-network and out-of-network care for victims of sexual assault or abuse, Pediatric Vision Benefits, and Prescribed Medicines Expense</li> </ul>		
<b>Maximum out-of-pocket limit per policy year</b>		
<b>Student</b>	\$6,850 per policy year	None
<b>Spouse</b>	\$6,850 per policy year	None
<b>Each child</b>	\$6,850 per policy year	None
<b>Family</b>	\$13,700 per policy year	None

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

<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>Routine physical exams</b>		
Performed at a physician's office	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	80% (of the recognized charge) per visit  Policy year deductible applies
Maximum age and visit limits per policy year through age 21	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents.	
Maximum visits per policy year age 22 and over	1 visit	
<b>Preventive care immunizations</b>		
Performed in a facility or at a physician's office	100% (of the negotiated charge) per visit.  No copayment or policy year deductible applies	80% (of the recognized charge) per visit  Policy year deductible applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	
<b>Routine gynecological exams (including Pap smears and cytology tests)</b>		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	80% (of the recognized charge) per visit  Policy year deductible applies
Maximum visits per policy year	1 visit	

Eligible health services	In-network coverage	Out-of-network coverage
<b>Preventive screening and counseling services</b>		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Substance use disorders, Tobacco Products, Depression Screening, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	80% (of the recognized charge) per visit  Policy year deductible applies
Obesity/Healthy Diet maximum per policy year (Applies to covered persons age 22 and older)	26 visits (10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)	
Substance use disorders maximum per policy year	5 visits	
Tobacco Products Counseling maximum per policy year	8 visits	
Depression screening maximum per policy year	1 visit	
STI maximum per policy year	2 visits	
Skin cancer behavioral counseling office visits	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	80% (of the recognized charge) per visit  Policy year deductible applies
Falls prevention counseling office visits	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	80% (of the recognized charge) per visit  Policy year deductible applies
Routine cancer screenings	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	80% (of the recognized charge) per visit  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> </ul>	

	<ul style="list-style-type: none"> <li>The comprehensive guidelines supported by the Health Resources and Services Administration.</li> </ul>
Lung cancer screening maximums	1 screenings every 12 months

Eligible health services	In-network coverage	Out-of-network coverage
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
Lactation support and counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
Lactation counseling services maximum per policy year	6 visits	
Breast pump supplies and accessories	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
Contraceptive counseling services maximum per policy year	2 visits	
Female contraceptive prescription drugs and devices	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
Female voluntary sterilization-Inpatient & Outpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
<b>Physicians and other health professionals</b>		
Physician, specialist including Consultants Office visits	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies

(non-surgical/non-preventive care by a physician and specialist) includes telemedicine consultations)		
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Eligible health services	In-network coverage	Out-of-network coverage
<b>Allergy testing and treatment</b>		
Allergy testing & Allergy injections treatment 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.
<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) Policy year deductible applies	60% (of the recognized charge) Policy year deductible applies
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
<b>Alternatives to physician office visits</b>		
Walk-in clinic visits(non-emergency visit)	80% (of the negotiated charge) Policy year deductible applies	60% (of the recognized charge) Policy year deductible applies
<b>Hospital and other facility care</b>		
Inpatient hospital (room and board) and other miscellaneous services and supplies)  Includes birthing center facility charges	80% (of the negotiated charge) per admission Policy year deductible applies	60% (of the recognized charge) per admission Policy year deductible applies
In-hospital non-surgical physician services	80% (of the negotiated charge) per admission Policy year deductible applies	60% (of the recognized charge) per admission 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
Home health Care	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	

Eligible health services	In-network coverage	Out-of-network coverage
Hospice-Inpatient	80% (of the negotiated charge) per admission Policy year deductible applies	60% (of the recognized charge) per admission Policy year deductible applies
Hospice-Outpatient	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Outpatient private duty nursing	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Skilled nursing facility-Inpatient	80% (of the negotiated charge) per admission Policy year deductible applies	60% (of the recognized charge) per admission Policy year deductible applies
Hospital emergency room	80% (of the negotiated charge) per visit Policy year deductible applies	Paid the same as in-network coverage
Emergency services resulting from a criminal sexual assault or abuse	100% (of the negotiated charge) per visit	Paid the same as in-network coverage

**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.

Eligible health services	In-network coverage	Out-of-network coverage
Urgent care	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
<b>Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19)</b>		
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 policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Type C services	50% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Orthodontic services	50% (of the negotiated charge) per visit No policy year 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.
<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
Impacted wisdom teeth	80% (of the negotiated charge) Policy year deductible applies	80% (of the recognized charge) Policy year deductible applies
Accidental injury to sound natural teeth	80% (of the negotiated charge) Policy year deductible applies	80% (of the recognized charge) Policy year deductible applies

Anesthesia and related facility charges for oral surgery and certain dental care  Coverage is subject to certain conditions. See the benefit description in the certificate of coverage for details.	80% (of the negotiated charge)  Policy year deductible applies	80% (of the recognized charge)  Policy year deductible applies
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Eligible health services	In-network coverage	Out-of-network coverage
<b>Maternity care</b>		
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.
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
<b>Family planning services – other</b>		
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 physician or specialist 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.
<b>Gender reassignment (sex change) treatment</b>		
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.
<b>Autism spectrum disorder</b>		
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
<b>Mental Health &amp; Substance Abuse Treatment</b>		
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	80% (of the negotiated charge) per admission  Policy year deductible applies	60% (of the recognized charge) per admission  Policy year deductible applies
Outpatient office visits (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

Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit  Policy year deductible applies

Eligible health services	In-network coverage (IOE facility)	In-network coverage (Non-IOE facility)	Out-of-network coverage
Transplant services Inpatient and outpatient facility services	Covered according to the type of benefit and the place where the service is received.		
Transplant services Inpatient and outpatient physician and specialist services	Covered according to the type of benefit and the place where the service is received.		
Transplant services-travel and lodging	Covered	Covered	Covered
Lifetime Maximum Travel and lodging expenses for any one transplant	\$10,000	\$10,000	\$10,000
Maximum lodging expenses per IOE patient	\$50 per night	\$50 per night	\$50 per night
Maximum lodging expenses per companion	\$50 per night	\$50 per night	\$50 per night
Eligible health services	In-network coverage	Out-of-network coverage	
Basic infertility services Inpatient and outpatient care - basic infertility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	
Comprehensive infertility Services Inpatient and outpatient care - comprehensive infertility 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.	
Advanced reproductive technology (ART) services Inpatient and outpatient care – ART 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.	
For treatment that includes an oocyte retrieval, maximum number of oocyte retrievals	4, however if a live birth follows a completed oocyte retrieval, 2 additional oocyte retrievals will be covered.		

<b>Specific therapies and tests</b>		
<b>Outpatient diagnostic testing</b>		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
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

<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
Outpatient Chemotherapy, Radiation & Respiratory Therapy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient 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
Spinal manipulation 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 (includes non-emergency ambulance)	80% (of the negotiated charge) per trip	Paid the same as in-network coverage
Durable medical and surgical equipment	100% (of the negotiated charge) per item Policy year deductible applies	80% (of the recognized charge) per item Policy year deductible applies
Enteral formulas and nutritional supplements	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.
Prosthetic and customized orthotic devices Includes Cranial prosthetics ( <i>Medical wigs</i> )	100% (of the negotiated charge) per item Policy year deductible applies	80% (of the recognized charge) per item Policy year deductible applies

Hearing aid exams	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Hearing aids	80% (of the negotiated charge) per item Policy year deductible applies	60% (of the recognized charge) per item Policy year deductible applies
Hearing aids maximum per ear	One hearing aid per ear every policy year	

Eligible health services	In-network coverage	Out-of-network coverage
<b>Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)</b>		
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	80% (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  2 visits	
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	80% (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	
* <b>Important note:</b> Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both. Coverage does not include the office visit for the fitting of prescription contact lenses.		
<b>Outpatient prescription drugs</b>		
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%.		
<b>Policy year deductible and copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs</b>		
The policy year deductible and the per prescription copayment/coinsurance 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 copayment/coinsurance will apply after those two regimens per policy year have been exhausted.		

### Policy year deductible and copayment/coinsurance waiver for contraceptives

The policy year deductible and the per prescription copayment/coinsurance will not apply to female contraceptive methods when obtained at an in-network pharmacy.

This means that such contraceptive methods are paid at 100% for:

- Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%.
- If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug or device for that method paid at 100%.

The policy year deductible prescription drug policy year deductible and the per prescription copayment/coinsurance 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
<b>Preferred Generic prescription drugs</b>		
For each fill up to a 30 day supply filled at a retail pharmacy	\$12 copayment per supply then the plan pays 100% (of the negotiated charge)  No policy year deductible applies	Not Covered
<b>Preferred brand-name prescription drugs</b>		
For each fill up to a 30 day supply filled at a retail pharmacy	\$40 copayment per supply then the plan pays 100% (of the negotiated charge)  No policy year deductible applies	Not Covered
<b>Non-preferred generic prescription drugs</b>		
For each fill up to a 30 day supply filled at a retail pharmacy	\$55 copayment per supply then the plan pays 100% (of the negotiated charge)  No 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	\$55 copayment per supply then the plan pays 100% (of the negotiated charge)  No policy year deductible applies	Not Covered
<b>Value Plus</b>		
For each fill up to a 30 day supply filled at a retail pharmacy	Copayment is the greater of \$150 or 20% (of the negotiated charge) but will be no more than \$250 per supply  No policy year deductible applies	Not Covered

Eligible health services	In-network coverage	Out-of-network coverage
<b>Orally administered anti-cancer prescription drugs</b>		
For each fill up to a 30 day supply filled at a retail pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
<b>Preventive care drugs and supplements</b>		
Preventive care drugs and supplements filled at a retail 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. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure website at <a href="http://www.aetnastudenthealth.com">www.aetnastudenthealth.com</a> or calling the toll-free number on the back of your ID card.	
<b>Risk reducing breast cancer prescription drugs</b>		
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. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure website at <a href="http://www.aetnastudenthealth.com">www.aetnastudenthealth.com</a> or calling the toll-free number on the back of your ID card.	
<b>Tobacco cessation prescription and over-the-counter drugs</b>		
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. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna secure website at <a href="http://www.aetnastudenthealth.com">www.aetnastudenthealth.com</a> or calling the toll-free number on the back of your ID card.	

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

### **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.

### **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

### **Clinical trial therapies (experimental or investigational)**

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

### **Clinical trial therapies (routine patient costs)**

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna's claim policies)
- In-network coverage limited to benefits for routine patient services provided within the network

### **Contraceptive methods, procedures, services, and supplies for contraceptive purposes**

- Contraceptive methods, procedures, services, and supplies for contraceptive purposes as elected by the policyholder due to an exemption or accommodation in accordance with applicable federal or state law and regulation
- Services provided as a result of complications resulting from voluntary sterilization procedure and related follow-up care

### **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, except where described in the Eligible health services under your plan - Reconstructive surgery and supplies section. 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.
- This exclusion does not apply to:
  - The removal of breast implants due to an illness or injury

### **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. This exclusion does not apply to court-ordered FDA-approved prescription drugs for the treatment of substance use disorders and any associated counseling or wraparound services.

### **Custodial care**

Examples are:

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

## Dental care for adults

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

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

## Durable medical equipment (DME)

Except as described in the Eligible health services under your plan – Durable medical equipment (DME) section, examples of these items are:

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

## Educational services

Examples of these services are:

- Any service or supply for education, training or retraining services or testing. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment program
  - Job training
  - Job hardening programs
- Services provided by a governmental school district

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

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

### **Enteral formulas and nutritional supplements**

- Any food item, including infant formulas, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in the *Eligible health services under your plan – Enteral formulas and nutritional supplements* section

### **Examinations**

Any health or dental examinations needed:

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

### **Experimental or investigational**

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

### **Facility charges**

For care, services or supplies provided in:

- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

### **Family planning services - other**

- Reversal of voluntary sterilization procedures, including related follow-up care
- Family planning services received while confined as an inpatient in a hospital or other facility
- Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care

## **Foot care**

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

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

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

## **Genetic care**

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

## **Growth/Height care**

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

## Hearing aids

If you are under age 18, the following services or supplies:

- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 36 month period
- Replacement parts for a hearing aid
- Batteries or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any hearing aid prescribed by someone other than a hearing care professional
- Any tests, appliances and devices to:
  - Improve your hearing. This includes hearing aid batteries and auxiliary equipment.
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech.

## Hearing aids and exams

Except as described in the *Eligible health services under your plan – Hearing aids* section, the following services or supplies:

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

## Home health care

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

## **Hospice care**

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

## **Illegal Occupation**

- Services and supplies that you receive as a result of an injury due to your commission of a felony to which the contributing cause was the engagement of an illegal occupation.

## **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 under your plan – Habilitation therapy services* section

## Medicare

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

## Mental health and substance abuse related disorders treatment

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

## Motor vehicle accidents

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

## Non-medically necessary services and supplies

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

## Non-U.S. citizen

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

### **Obesity (bariatric) surgery**

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

### **Organ removal**

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

### **Other primary payer**

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

### **Outpatient surgery**

Except as described in the *Eligible health services under your plan* section:

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

### **Personal care, comfort or convenience items**

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

### **Preventive care and wellness**

- Services not given by or under a physician's direction
- Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- Male contraceptive methods or devices
- The reversal of voluntary sterilization procedures, including any related follow-up care
- Female voluntary sterilization procedures that were not billed separately by the provider or were not the primary purpose of a confinement

## **Prosthetic devices**

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

## **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 orby health professionals who
  - Are employed by
  - Are Affiliated with
  - Have an agreement or arrangement with, or
  - Are otherwise designated by the policyholder.

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

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

## **Sexual dysfunction and enhancement**

- Any treatment, prescription drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services
- Not eligible for coverage are prescription drugs in 60-100 day supplies

## **Strength and performance**

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

Physical performance

## **Therapies and tests**

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

## **Tobacco cessation**

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

## **Transplant services**

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

## **Treatment as part of training**

- Any services and supplies provided to a covered student who receives treatment from a provider as part of their training in their field of study

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

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

## Treatment of infertility

- All charges associated with:
  - Cryopreservation (freezing) of eggs, embryos or sperm. However, subsequent non-experimental **or investigational** procedures that use the cryopreserved substance are covered
- Reversal of voluntary sterilizations, including follow-up care. However, if a voluntary sterilization is successfully reversed, infertility benefits are available if your diagnosis meets the definition of infertility
- Travel costs within 100 miles of your home or travel cost not required by Aetna
- Infertility treatment for covered dependents under age 18
- Non-medical costs of an egg or sperm donor
- Selected termination of an embryo, unless the life of the mother would be in danger if all embryos were carried to full term
- Experimental or investigational infertility treatment as determined by the American Society for Reproductive Medicine
- Services provided to a surrogate. If you choose to use a surrogate, this does not apply to the cost for procedures to obtain the eggs, sperm or embryo from a covered individual
- ART services are not provided for out-of-network care

## Vision Care

### Pediatric vision care services and supplies

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

### Adult vision care

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

### Adult vision care services and supplies

Your plan does not cover adult vision care services and supplies, except as described in the *Eligible health services under your plan – Other services* section.

- Special supplies such as non-prescription sunglasses
- Special vision procedures, such as orthoptics or vision therapy
- Eye exams during your stay in a hospital or other facility for health care
- Eye exams for contact lenses or their fitting
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames
- Replacement of lenses or frames that are lost or stolen or broken
- Acuity tests
- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures
- Services to treat errors of refraction

## **Wilderness Treatment Programs**

- Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting

### **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.

## **Work related illness or injuries**

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

## **Exclusions that apply to outpatient prescription drugs**

### **Contraceptive methods, procedures, services, and supplies for contraceptive purposes**

- Contraceptive methods, procedures, services, and supplies for contraceptive purposes as elected by the policyholder due to an exemption or accommodation in accordance with applicable federal or state law and regulation
- Services provided as a result of complications resulting from voluntary sterilization procedure and related follow-up care

## **Drugs or medications**

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

## **Immunizations related to work**

Illinois Institute of Technology 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).

## Sanctioned Countries

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

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

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

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,  
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),  
1-800-648-7817, TTY: 711,  
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), [CRCoordinator@aetna.com](mailto:CRCoordinator@aetna.com).

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

*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).*



Hawaiian	No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i ka helu kelepona ma kāu kāleka ID. Kāki 'ole 'ia kēia kōkua nei.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Igbo	Inweta enyemaka asụsụ na akwughi ụgwọ obula, kpọọ nọmba nọ na kaadi njirimara gi
Ilocano	Tapno maakses dagiti serbisio ti pagsasao nga awanan ti bayadna, awagan ti numero nga adda ayan ti ID kardmo.
Indonesian	Untuk mengakses layanan bahasa tanpa dikenakan biaya, silakan hubungi nomor telepon di kartu asuransi Anda.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Karen	လၢတၢ်ကမၤန့ၢ်ဂ့ၢ်တၢ်မၤစၢအတၢ်ဖဲးတၢ်မၤတဖၣ် လၢတၢ်အိၣ်ဒီးအပူၤလၢနကတၢ်ဟ့ၣ်အီၤအဂီၢ်.ကိးတၢ်လီၤတဲၢ်နီၣ်ဂံၢ်လၢအအိၣ်လၢနခိၣ်ဂီၤ (ID) အလီၤန့ၣ်တက့ၢ်.
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Kru-Bassa	I nyuu kosna mahola ni language services ngui nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matibla
Kurdish	بۆ دەستگیر ئەگەشتن بە خزمەتگوزاری زمان بەی تێچوون بو تو، پەییوندی بکه بە ژمارە ی سەر ئای دی (ID) کارتی خۆت.
Lao	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໃບຫາເບີໂທລູນໃນບັດປະຈຳຕົວຂອງທ່ານ.
Marathi	आपल्याला कोणत्याही शुल्काशिवाय भाषा सेवांपर्यंत पोहोचण्यासाठी, आपल्या ID कार्डावरील क्रमांकावर फोन करा.
Marshallese	Ñan bōk jipañ kōn kajin ilo an ejjeļok wōņean ñan kwe, kwōn kallok nōmba eo ilo kaat in ID eo am.
Micronesian-Ponapean	Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlih nempe nan amhw doaropwe en ID.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលគេគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើប័ណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T'áá ni nizaad k'ehjí bee níká a'doowoł doo bą́ą́h ílínígóó naaltsoos bee atah nílįįgo nanitinígíí bee néého'dółzinígíí béésh bee hane'í biká'ígíí áajį' hólne'.
Nepali	भाषासम्बन्धी सेवाहरूमाथि निःशुल्क पहुँच राख्न आफ्नो कार्डमा रहेको नम्बरमा कल गर्नुहोस्।
Nilotic-Dinka	Të koor yin ran de wëër de thokic ke c'in wëu kør keek tënɔŋ yin. Ke yin col ran ye koc kuony në namba de abac tö në ID kard duön de tiit de nyin de panakim köu.
Norwegian	For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt.

