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# Aetna Student Health

## *Major Medical*

### *Outline of Coverage*

#### **Preferred Provider Organization (PPO)**

## Lafayette College

Policy Year: 2019 - 2020

Policy Number: 686158

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

(877) 480-4161



This is a brief description of the Student Health Plan. The Plan is available for Lafayette College students. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this

insurance are contained in the Certificate of Coverage 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 Certificate of Coverage, the Certificate will control.

## Bailey Health Center

Bailey Health Center is the University's on-campus health facility. The Center provides quality health care and promotes an environment of wellness. The Center's staff of well-trained medical professionals can assess, diagnose and treat a wide variety of medical concerns and dispense some commonly used medications at an additional cost. A receipt for medications is provided so that students can submit the cost to their insurance plan for partial or full reimbursement. Appointments can be made on the Patient Portal at <https://lafayette.medicatconnect.com> or by calling X5001. Emergency cases are taken on a walk-in basis.

## 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	8/1/2019	7/31/2020	8/1/2019
Fall	8/1/2019	12/31/2019	8/1/2019
Spring/Summer	1/1/2020	7/31/2020	2/1/2019

## Rates

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

Rates Lafayette College Students			
	Annual	Fall Semester	Spring Semester
Student	\$1,638	\$685	\$953

## **Student Coverage**

### **Who is eligible?**

You are eligible if you are a:

- Full-time student

You are not eligible if you are a:

- Part-time student

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

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

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

## **Enrollment**

Eligible students will be automatically enrolled in this Student Health Insurance Plan (SHIP), unless the completed waiver application has been received by Lafayette College by the specified enrollment deadline dates listed in the Coverage Period section of this Plan Design and Benefits Summary

## **Waiver Process**

To waive off the SHIP plan, students should go to [www.universityhealthplans.com](http://www.universityhealthplans.com) and select Lafayette College from the list of colleges and universities. Click on the box that says, "Waive SHIP" and follow the instructions and entered the required information. Students must provide proof of comparable coverage and submit the online waiver form by the established waiver deadline.

**NOTE: Students who do not waive by the stated annual deadline of 8/1/2019 (New spring semester students must waive by 2/1/2020) will automatically be placed on the Lafayette College Student Health Insurance Plan.**

## **Refund Policy**

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.)

## **Medicare Eligibility Notice**

You are not eligible for health coverage under this student policy if you have Medicare at the time of enrollment in this student plan.

If you obtain Medicare after you enrolled in this student plan, your health coverage under this plan will not end.

As used here, “have Medicare” means that you are entitled to benefits under Part A (receiving free Part A) or enrolled in Part B or Premium Part A.

## **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. 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.

### **Precertification for medical services and supplies**

#### **In-network care**

Your in-network physician is responsible for obtaining any necessary precertification before you get the care. If your in-network physician doesn't get a required precertification, we won't pay the provider who gives you the care. You won't have to pay either if your in-network physician fails to ask us for precertification. If your in-network physician requests precertification and we refuse it, you can still get the care, but the plan won't pay for it. You will find additional details on requirements in the Certificate of Coverage.

#### **Out-of-network care**

When you go to an out-of-network provider, it is your responsibility to obtain precertification from us for any services and supplies on the precertification list. If you do not precertify, your benefits may be reduced, or the plan may not pay any benefits. Refer to your schedule of benefits for this information. The list of services and supplies requiring precertification appears later in this section.

### 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.

If you require an extension to the services that have been precertified, you, your physician, or the facility will need to call us at the number on your ID card as soon as reasonably possible, but no later than the final authorized day.

If precertification determines that the stay or outpatient services and supplies are not covered benefits, the notification will explain why and how you can appeal our decision. You or your provider may request a review of the precertification decision. See the *When you disagree - claim decisions and appeals procedures* section of Certificate of Coverage.

### What if you don't obtain the required precertification?

If you don't obtain the required precertification:

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

## What types of services and supplies require precertification?

Precertification is required for the following types of services and supplies:

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

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

## Coordination of Benefits (COB)

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB).

### Here's how COB works

- When this is the primary plan, we will pay your medical claims first as if the other plan does not exist
- When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid
- We will never pay an amount that, together with payments from your other coverage, add up to more than 100% of the allowable submitted expenses

For more information about the Coordination of Benefits provision, including determining which plan is primary and which is secondary, you may call the Member Services telephone number shown on your ID card. A complete description of the Coordination of Benefits provision is contained in the Policy issued to Lafayette College and may be viewed online at [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).

## Description of Benefits

The Plan excludes coverage for certain services (referred to as exceptions in the certificate of coverage) and has limitations on the amounts it will pay. While this Plan Design and Benefit Summary document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. To look at the full Plan description, which is contained in the Certificate of Coverage issued to you, go to [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com). If any discrepancy exists between this Benefit Summary and the Certificate of Coverage, the Certificate will control.

## How your plan works while you are covered for in-network coverage

Your in-network coverage helps you:

- Get and pay for a lot of – but not all – health care services
- Pay less cost share when you use an in-network provider

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

Metallic Level: Platinum, Bronze, tested at 91.83%

Policy year deductible	In-network coverage	Out-of-network coverage
You have to meet your policy year deductible before this plan pays for benefits.		
Student	\$100 per policy year	\$350 per policy year

## Policy year deductible waiver

The policy year deductible is waived for all of the following eligible health services:

- In-network care for *Preventive care and wellness*
- In-network care for *Family planning services - female contraceptives*
- In-network care and out-of-network care for *Cervical Cytologic Screenings* and *Nutritional Supplement Services*
- In-network care and out-of-network care for *Prescribed Medicine Expense*
- In-network care for *Pediatric dental services*
- In-network care and out-of-network care for *Pediatric vision services*

## Maximum out-of-pocket limits

### Maximum out-of-pocket limit per policy year

Student	\$2,000 per policy year	\$6,000 per policy year
Eligible health services applied to the out-of-network maximum out-of-pocket limit will not be applied to satisfy the in-network maximum out-of-pocket limit and eligible health services applied to the in-network maximum out-of-pocket limit will not be applied to satisfy the out-of-network maximum out-of-pocket limit.		

## Precertification covered benefit penalty

This only applies to out-of-network coverage: The certificate of coverage contains a complete description of the precertification program. You will find details on precertification requirements in the *Medical necessity and precertification requirements* section.

Failure to precertify your eligible health services when required will result in the following benefit penalties:

- A **\$500** benefit penalty will be applied separately to each type of eligible health services.

The additional percentage or dollar amount of the recognized charge which you may pay as a penalty for failure to obtain precertification is not a covered benefit and will not be applied to the policy year deductible amount or the maximum out-of-pocket limit, if any.

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.

Eligible health services	In-network coverage	Out-of-network coverage
<b>Preventive care and wellness</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	70% (of the recognized charge) per visit
Covered persons through age 21: Maximum age and visit limits per policy year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.  For details, contact your physician or 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 your ID card.	
Covered persons age 22 and over: Maximum visits per policy year	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	70% (of the recognized charge) per visit
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  For details, contact your physician or 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 your ID card.	

<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>Preventive care and wellness (continued)</b>		
<b>Well woman preventive visits</b>		
<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	70% (of the recognized charge) per visit
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	
Maximum visits per policy year	1 visit	
<b>Preventive screening and counseling services</b>		
Obesity and/or healthy diet counseling office visits	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Maximum visits per policy year (This maximum applies only to covered persons age 22 and older.)	26 visits. However, of these only 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.	
Misuse of alcohol and/or drugs counseling office visits	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Maximum visits per policy year	5 visits	
Use of tobacco products counseling office visits	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Maximum visits per policy year	8 visits	
Depression screening counseling office visits	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Maximum visits per policy year	1 visit	

Eligible health services	In-network coverage	Out-of-network coverage		
<b>Preventive screening and counseling services (continued)</b>				
Sexually transmitted infection counseling office visits	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	70% (of the recognized charge) per visit		
Maximum visits per policy year	2 visits			
Genetic risk counseling for breast and ovarian cancer counseling office visits	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	70% (of the recognized charge) per visit		
Age and frequency limitations	Not subject to any age or frequency limitations			
<b>Routine cancer screenings performed at a physician's office, specialist's office or facility.</b>				
Routine cancer screenings	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	70% (of the recognized charge) per visit		
Maximums	<p>Subject to any age, family history, and frequency guidelines as set forth in the most current:</p> <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> <p>For details, contact your physician or 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 your ID card.</p>			
Lung cancer screening maximums	1 screenings every 12 months*			
<p><b>*Important note:</b> Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the <i>Outpatient diagnostic testing</i> section.</p>				
<b>Prenatal care services (provided by a physician, an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)</b>				
Preventive care services only	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	70% (of the recognized charge) per visit		
<p><b>Important note:</b> You should review the <i>Maternity care</i> and <i>Well newborn nursery care</i> sections. They will give you more information on coverage levels for maternity care under this plan.</p>				

Eligible health services	In-network coverage	Out-of-network coverage
<b>Comprehensive lactation support and counseling services</b>		
Lactation counseling services - facility or office visits	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Lactation counseling services maximum visits per policy year either in a group or individual setting		6 visits
<p><b>*Important note:</b> Any visits that exceed the lactation counseling services maximum are covered under the <i>Physicians and other health professionals' section</i>.</p>		
<b>Breast feeding durable medical equipment</b>		
Breast pump supplies and accessories	100% (of the negotiated charge) per item  No copayment or policy year deductible applies	70% (of the recognized charge) per item
<p><b>Important note:</b> See the <i>Breast feeding durable medical equipment</i> section of the certificate of coverage for limitations on breast pump and supplies.</p>		
<b>Family planning services – female contraceptives</b>		
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Contraceptive counseling services maximum visits per policy year either in a group or individual setting		2 visits
<p><b>Important note:</b> Any visits that exceed the contraceptive counseling services maximum are covered under Physician services office visits.</p>		
<b>Contraceptives (prescription drugs and devices)</b>		
Female contraceptive prescription drugs and devices provided, administered, or removed, by a physician during an office visit	100% (of the negotiated charge) per item  No copayment or policy year deductible applies	70% (of the recognized charge) per item

<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>Family planning services (continued)</b>		
<b>Female voluntary sterilization</b>		
Inpatient provider services	100% (of the negotiated charge)  No copayment or policy year deductible applies	70% (of the recognized charge)
Outpatient provider services	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	70% (of the recognized charge) per visit
<b>Physicians and other health professionals</b>		
<b>Physician and specialist services</b>		
Office hours visits (non-surgical and non-preventive care by a physician and specialist)	\$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	80% (of the recognized charge) per visit
Telemedicine consultation by a physician or specialist	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>Allergy testing and treatment</b>		
Allergy testing performed at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Allergy injections treatment performed at a physician's, or specialist office	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Allergy sera and extracts administered via injection 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 - inpatient surgical services</b>		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	90% (of the negotiated charge)	70% (of the recognized charge)
<b>Physician and specialist - outpatient surgical services</b>		
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)	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit

<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>In-hospital non-surgical physician services</b>		
In-hospital non-surgical physician services	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
<b>Consultant services (non-surgical and non-preventive)</b>		
Office hours visits (non-surgical and non-preventive care)	\$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	80% (of the recognized charge) per visit
Telemedicine consultation by a consultant	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
Second surgical opinion	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>Alternatives to physician office visits</b>		
Walk-in clinic visits (non-emergency visit)	\$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	80% (of the recognized charge) per visit
<b>Hospital and other facility care</b>		
Inpatient hospital (room and board) and other miscellaneous services and supplies  Subject to semi-private room rate unless intensive care unit required  Room and board includes intensive care  For physician charges, refer to the <i>Physician and specialist – inpatient surgical services</i> benefit	90% (of the negotiated charge) per admission	70% (of the recognized charge) per admission
Preadmission testing	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
<b>Alternatives to hospital stays</b>		
<b>Outpatient surgery (facility charges)</b>		
Facility charges for surgery performed in the outpatient department of a hospital or surgery center  For physician charges, refer to the <i>Physician and specialist - outpatient surgical services</i> benefit	90% (of the negotiated charge)	70% (of the recognized charge)

<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>Home health care</b>		
Outpatient	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Outpatient private duty nursing	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
<b>Hospice care</b>		
Inpatient facility (room and board and other miscellaneous services and supplies)	90% (of the negotiated charge) per admission	70% (of the recognized charge) per admission
Outpatient	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
<b>Skilled nursing facility</b>		
Inpatient facility (room and board and miscellaneous inpatient care services and supplies) Subject to semi-private room rate unless intensive care unit is required Room and board includes intensive care	90% (of the negotiated charge) per admission	70% (of the recognized charge) per admission
<b>Emergency services and urgent care</b>		
<b>Emergency services</b>		
Hospital emergency room	\$100 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered
<b>Important note:</b>		
<ul style="list-style-type: none"> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> <li>• 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.</li> </ul>		

<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>Urgent care</b>		
Urgent medical care provided by an urgent care provider	\$50 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	\$50 copayment then the plan pays 80% (of the balance of the recognized charge) per visit thereafter
Non-urgent use of urgent care provider	Not covered	Not covered
<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
Type B services	70% (of the negotiated charge) per visit  No policy year deductible applies	50% (of the recognized charge) per visit
Type C services	50% (of the negotiated charge) per visit  No policy year deductible applies	50% (of the recognized charge) per visit
Orthodontic services	50% (of the negotiated charge) per visit  No policy year deductible applies	50% (of the recognized charge) per visit
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>		
<b>Birthing center (facility charges)</b>		
Inpatient (room and board and other miscellaneous services and supplies)	Paid at the same cost-sharing as hospital care.	Paid at the same cost-sharing as hospital care.
<b>Diabetic services and supplies (including equipment and training)</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
<b>Impacted wisdom teeth</b>		
Impacted wisdom teeth	90% (of the negotiated charge)	90% (of the recognized charge)
<b>Accidental injury to sound natural teeth</b>		
Accidental injury to sound natural teeth	90% (of the negotiated charge)	90% (of the recognized charge)

Eligible health services	In-network coverage	Out-of-network coverage
<b>Anesthesia and related facility charges for dental care</b> <i>Coverage is subject to certain conditions. See the benefit description in the certificate of coverage for details.</i>		
Anesthesia and related facility charges for oral surgery a dental 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
<b>Blood and body fluid exposure</b>		
Blood and body fluid exposure	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
<b>Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment</b>		
TMJ and 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
<b>Dermatological treatment</b>		
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
<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	90% (of the negotiated charge)  No policy year deductible applies	70% (of the recognized charge)  No policy year deductible applies
<b>Pregnancy complications</b>		
Inpatient (room and board and other miscellaneous services and supplies)  Subject to semi-private room rate unless intensive care unit required  Room and board includes intensive 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
<b>Family planning services – other</b>		
Voluntary sterilization for males Inpatient 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
Voluntary sterilization for males Outpatient 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>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<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 diagnosis and testing	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Autism spectrum disorder treatment (includes physician and specialist office visits)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
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 treatment</b>		
<b>Mental health treatment – inpatient</b>		
Inpatient hospital mental disorders treatment (room and board and other miscellaneous hospital services and supplies)	90% (of the negotiated charge) per admission	70% (of the recognized charge) per admission
Inpatient residential treatment facility mental disorders treatment (room and board and other miscellaneous residential treatment facility services and supplies)		
Subject to semi-private room rate unless intensive care unit is required		
Mental disorder room and board intensive care		
<b>Mental health treatment - outpatient</b>		
Outpatient mental disorders treatment office visits to a physician or behavioral health provider	\$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	80% (of the recognized charge) per visit

<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>Mental health treatment – outpatient (continued)</b>		
Other outpatient mental disorders treatment (includes skilled behavioral health services in the home)	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Partial hospitalization treatment Intensive Outpatient Program		
<b>Substance abuse related disorders treatment-inpatient</b>		
Inpatient hospital substance abuse detoxification (room and board and other miscellaneous hospital services and supplies)	90% (of the negotiated charge) per admission	70% (of the recognized charge) per admission
Inpatient hospital substance abuse rehabilitation (room and board and other miscellaneous hospital services and supplies)		
Inpatient residential treatment facility substance abuse (room and board and other miscellaneous residential treatment facility services and supplies)		
Subject to semi-private room rate unless intensive care unit is required		
Substance abuse room and board intensive care		
<b>Substance abuse related disorders treatment-outpatient: detoxification and rehabilitation</b>		
Outpatient substance abuse office visits to a physician or behavioral health provider	\$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	80% (of the recognized charge) per visit
Other outpatient substance abuse services	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Partial hospitalization treatment		
Intensive Outpatient Program		
<b>Obesity (bariatric) Surgery</b>		
Inpatient and outpatient facility and physician 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>Reconstructive surgery and supplies</b>		
Reconstructive surgery and supplies (includes reconstructive breast surgery)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

<b>Eligible health services</b>	<b>In-network coverage Network (IOE facility)</b>	<b>In-network coverage Network (Non-IOE facility)</b>	<b>Out-of-network coverage</b>
<b>Transplant services</b>			
Inpatient and outpatient transplant facility services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received
Inpatient and outpatient transplant physician and specialist services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received
Transplant services-travel and lodging	Covered	Covered	Covered
Lifetime Maximum payable for Travel and Lodging Expenses for any one transplant, including tandem transplants	\$10,000	\$10,000	\$10,000
Maximum payable for Lodging Expenses per IOE patient	\$50 per night	\$50 per night	\$50 per night
Maximum payable for Lodging Expenses per companion	\$50 per night	\$50 per night	\$50 per night

<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>Treatment of infertility</b>		
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
<b>Comprehensive infertility services</b>		
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
<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	90% (of the negotiated charge) per visit	70% (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	90% (of the negotiated charge)	70% (of the recognized charge)

<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>Chemotherapy</b>		
Chemotherapy	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
<b>Outpatient infusion therapy</b>		
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
<b>Outpatient radiation therapy</b>		
Outpatient radiation therapy	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
<b>Outpatient respiratory therapy</b>		
Respiratory therapy	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
<b>Transfusion or kidney dialysis of blood</b>		
Transfusion or kidney dialysis of blood	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>Short-term cardiac and pulmonary rehabilitation services</b>		
Cardiac rehabilitation	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Pulmonary rehabilitation	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
<b>Short-term rehabilitation and habilitation therapy services</b>		
Outpatient physical, occupational, speech, and cognitive therapies	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
Combined for short-term rehabilitation services and habilitation therapy services		
<b>Chiropractic services</b>		
Chiropractic services	90% (of the negotiated charge) per visit	70% (of the recognized charge) per visit
<b>Diagnostic testing for learning disabilities</b>		
Diagnostic testing for learning disabilities	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>Specialty prescription drugs (Purchased and injected or infused by your provider in an outpatient setting)</b>		
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit or the place where the service is received	Covered according to the type of benefit or the place where the service is received

<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>Other services and supplies</b>		
Acupuncture in lieu of anesthesia	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
Ambulance Service-Emergency ground, air, and water ambulance	90% (of the negotiated charge) per trip	Paid the same as in-network coverage
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
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
Durable medical and surgical equipment	90% (of the negotiated charge) per item	70% (of the recognized charge) per item
Enteral formulas and nutritional supplements	90% (of the negotiated charge) per item	70% (of the recognized charge) per item
<b>Prosthetic devices</b>		
Prosthetic devices	90% (of the negotiated charge) per item	70% (of the recognized charge) per item
Orthotic devices	90% (of the negotiated charge) per item	70% (of the recognized charge) per item
<b>Hearing aids and exams</b>		
Hearing aid exams	\$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	80% (of the recognized charge) per visit
Hearing aid exam maximum	One hearing exam every policy year	
Hearing aids	90% (of the negotiated charge) per item	70% (of the recognized charge) per item
Hearing aids maximum per ear	One hearing aid per ear every policy year	
<b>Podiatric (foot care) treatment</b>		
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

Eligible health services	In-network coverage	Out-of-network coverage
<b>Vision care</b>		
<b>Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)</b>		
<b>Pediatric routine vision exams (including refraction)</b>		
Performed by a legally qualified ophthalmologist or optometrist	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	1 visit	
<b>Pediatric comprehensive low vision evaluations</b>		
Performed by a legally qualified ophthalmologist or optometrist	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
Maximum	One comprehensive low vision evaluation every policy year	
<b>Pediatric vision care services and supplies</b>		
Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item  No policy year deductible applies	70% (of the recognized charge) per item  No policy year deductible applies
Maximum number of eyeglass frames per policy year	One set of eyeglass frames	
Maximum number of prescription lenses per policy year	One pair of prescription lenses	
Maximum number of prescription contact lenses per policy year (includes non-conventional prescription contact lenses and aphakic lenses prescribed after cataract surgery)]	Daily disposables: up to 3-month supply  Extended wear disposable: up to 6-month supply  Non-disposable lenses: one set	
Office visit for fitting of contact lenses	100% (of the negotiated charge) per visit  No policy year deductible applies	70% (of the recognized charge) per visit  No policy year deductible applies
Maximum visits per policy year	1 visit	
Optical devices	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
Maximum number of optical devices per policy year	One optical device	
<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.		

<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>Adult vision care</b>		
<b>Limited to covered persons age 19 and over</b>		
Adult routine vision exams (including refraction) performed by a legally qualified ophthalmologist or optometrist Limited to covered persons age 19 and over	\$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter	80% (of the recognized charge) per visit
Maximum visits per policy year		1 visit
<b>Outpatient prescription drugs</b>		
<b>Outpatient prescription drug copayment waiver for risk reducing breast cancer</b>		
The prescription copayment will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.		
<b>Outpatient prescription drug copayment waiver for tobacco cessation prescription and over-the-counter drugs</b>		
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 prescription drug copayment will apply after those two regimens per policy year have been exhausted.		
<b>Outpatient prescription drug copayment waiver for contraceptives</b>		
The prescription drug copayment will not apply to female contraceptive methods when obtained at an in-network pharmacy. This means that such contraceptive methods are paid at 100% for:		
<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 prescription drug copayment will continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at an in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.		
<b>Preferred generic prescription drugs</b>		
<b>Per prescription copayment/coinsurance</b>		
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)  No policy year deductible applies	\$15 copayment per supply then the plan pays 70% (of the recognized charge)  No policy year deductible applies
More than a 30-day supply but less than a 101-day supply filled at a mail order pharmacy	\$37.50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies	Not covered

<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>Preferred brand-name prescription drugs</b>		
<b>Per prescription copayment/coinsurance]</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	\$45 copayment per supply then the plan pays 70% (of the recognized charge)  No policy year deductible applies
More than a 30-day supply but less than a 101-day supply filled at a mail order pharmacy	\$112.50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies	Not covered
<b>Non-preferred generic prescription drugs</b>		
<b>Per prescription copayment/coinsurance</b>		
For each fill up to a 30 day supply filled at a retail pharmacy	\$75 copayment per supply then the plan pays 100% (of the negotiated charge)  No policy year deductible applies	\$75 copayment per supply then the plan pays 70% (of the recognized charge)  No policy year deductible applies
More than a 30-day supply but less than a 101-day supply filled at a mail order pharmacy	\$187.50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies	Not covered
<b>Non-preferred brand-name prescription drugs</b>		
<b>Per prescription copayment/coinsurance</b>		
For each fill up to a 30 day supply filled at a retail pharmacy	\$75 copayment per supply then the plan pays 100% (of the negotiated charge)  No policy year deductible applies	\$75 copayment per supply then the plan pays 70% (of the recognized charge)  No policy year deductible applies
More than a 30-day supply but less than a 101-day supply filled at a mail order pharmacy	\$187.50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)  No policy year deductible applies	Not covered
<b>Orally administered anti-cancer prescription drugs</b>		
<b>Per prescription copayment/coinsurance</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>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>Preventive care drugs and supplements</b>		
Preventive care drugs and supplements filled at a retail pharmacy	100% (of the negotiated charge per prescription or refill)	Paid according to the type of drug per the schedule of benefits, above
For each 30-day supply	No copayment or policy year deductible applies	
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	100% (of the negotiated charge) per prescription or refill	Paid according to the type of drug per the schedule of benefits, above
For each 30-day supply	No copayment or policy year deductible applies	
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	100% (of the negotiated charge per prescription or refill)	Paid according to the type of drug per the schedule of benefits, above
For each 30-day supply	No copayment or policy year deductible applies	
Maximums:	<p>Coverage is permitted for two 90-day treatment regimens only.</p> <p>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.</p>	

Eligible health services	In-network coverage	Out-of-network coverage
<b>Tobacco cessation prescription drugs and over-the-counter drugs <i>(Other than preventive care)</i></b>		

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

## What your plan doesn't cover – eligible health service exceptions and exclusions

We already told you about the many health care services and supplies that are eligible for coverage under your plan in the *Eligible health services under your plan* section. In that section we also told you that some health care services and supplies have exceptions, and some are not covered at all which are called "exclusions".

In this section we tell you about the exceptions and exclusions that apply to your plan.

And just a reminder, you'll find coverage limitations in the [schedule of benefits].

### General exceptions and 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:
  - o 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
  - o 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.

### **Ambulance services**

- Non-emergency fixed wing air ambulance from an out-of-network provider
- Non-emergency ambulance transports

### **Armed Forces**

- Services and supplies received from a provider as a result of an injury sustained, or sickness contracted, while in the service of the Armed Forces of any country. When you enter the Armed Forces of any country, we will refund any unearned pro rata premium to the policyholder.

### **Artificial organs**

- Any device that would perform the function of a body organ.

### **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 (synthetic or substitutes)**

Examples of these are:

- The provision of blood to the hospital, other than blood derived clotting factors
- The services of blood donors, apheresis or plasmapheresis
- For autologous blood donations, including drawing, storage and transfusion, 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

**Cornea or cartilage transplants**

- Cornea (corneal graft with amniotic membrane)
- Cartilage (autologous chondrocyte implant or osteochondral allograft or autograft) transplants

**Cosmetic services and plastic surgery**

- Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons. This cosmetic services exclusion does not apply to surgery after an accidental injury when performed as soon as medically feasible. Injuries that occur during medical treatments are not considered accidental injuries even if unplanned or unexpected.

**Counseling**

- Marriage, religious, family, career, social adjustment, pastoral, or financial counseling

**Court-ordered services and supplies**

- Includes those court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding

**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
- Institutional care. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training

**Dermatological treatment**

- Cosmetic treatment and procedures

### **Dental care for adults**

- Dental services for adults including services related to:
  - The care, filling, removal or replacement of teeth and treatment of 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

### **Dental Care for Adults (continued)**

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

### **Durable medical equipment (DME)**

Examples of these items are:

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

### **Early intensive behavioral interventions**

Examples of these services are:

- Certain early intensive behavioral interventions (Denver, LEAP, TEACCH, Rutgers, floor time, Lovaas and similar programs) and other intensive educational interventions

### **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

### **Examinations**

Any health or dental examinations needed:

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

### **Experimental or investigational**

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

### **Emergency services and urgent care**

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

### **Facility charges**

For care, services or supplies provided in:

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

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

- Abortion except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger
- Reversal of voluntary sterilization procedures, including related follow-up care
- Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care

### **Felony**

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

### **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 unless diabetes related, 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
  - Hair removal
  - 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 and exams**

The following services or supplies:

- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 12 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- Cochlear implants
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist
- Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay
- Any tests, appliances and devices to:
  - Improve your hearing. This includes hearing aid batteries, amplifiers, and auxiliary equipment
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech.

### **Home health care**

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

### **Hospice care**

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

### **Incidental surgeries**

- Charges made by a physician for incidental surgeries

### **Judgment or settlement**

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

### **Mandatory no-fault laws**

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

### **Maintenance care**

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

### **Maternity and related prenatal care**

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

### **Medical supplies – outpatient disposable**

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

### **Medicare**

- Services and supplies to the extent they would have been covered under Medicare Part A or Part B even though you are eligible but did not enroll in Part B

### **Mental health treatment**

- Mental health services for the following categories (or equivalent terms as listed in the most recent version of the International Classification of Diseases (ICD)):
  - Stays in a facility for treatment of dementia and amnesia without a behavioral disturbance that necessitates mental health treatment
  - Sexual deviations and disorders except for gender identity disorders
  - Tobacco use disorders
  - Pathological gambling, kleptomania, pyromania
  - School and/or education service including special educational, remedial education, wilderness treatment programs, or any such related or similar programs
- Mental health services provided in conjunction with school, vocation, work or recreational activities

### **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.

### **Obesity (bariatric) surgery and weight management**

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

### **Oral and maxillofacial treatment (mouth, jaws and teeth)**

- Dental implants

### **Organ removal**

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

### **Other primary payer**

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

### **Outpatient infusion therapy**

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

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

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

### **Outpatient surgery and physician surgical services**

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

### **Pediatric dental care**

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

### **Pediatric dental care (continued)**

- Services rendered before the effective date or after the termination of coverage
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a dentist or dental provider that is legally qualified to furnish dental services or supplies
- Work related: Any illness or injury related to employment or self-employment including any injuries that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered "non-occupational" regardless of cause.

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

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

### **Preventive care and wellness**

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

### **Prosthetic devices**

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

### **Riot**

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

**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

**Services, supplies and drugs received outside of the United States**

- Non-emergency services, outpatient prescription drugs or supplies received outside of the United States. They are not covered even if they are covered in the United States under this certificate of coverage.

**Sexual dysfunction and enhancement**

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

**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

**Specialty prescription drugs**

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

**Sports**

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

**Strength and performance**

- Services, devices and supplies such as drugs or preparations designed primarily for the purpose of enhancing your strength, physical condition, endurance, or physical performance

**Students in mental health field**

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

**Telemedicine**

- Any services that are given by providers that are not contracted with Aetna as telemedicine providers.
- Any services that are not provided during an internet-based consult or via telephone.

**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, or hematopoietic stem cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness

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

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

### **Treatment of infertility**

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

### **Valid and collectable insurance**

- Services and supplies covered by any other valid and collectible medical, health, or accident insurance but only to the extent that benefits are payable under other valid and collectible insurance. This applies whether or not a claim is made for such benefits.

## **Vision Care**

Pediatric vision care services and supplies

- 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 licensed residential treatment facility or otherwise licensed institution)

## **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.

## **Exceptions and exclusions that apply to outpatient prescription drugs**

### **Abortion drugs**

### **Allergy sera and extracts administered via injection**

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

### **Biological sera**

### **Compounded prescriptions**

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

**Cosmetic drugs**

- Medications or preparations used for cosmetic purposes

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

**Dietary supplements** including medical foods

**Drugs or medications**

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 is therapeutically equivalent or therapeutically alternative to a covered outpatient prescription drug (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)
- 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 drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the covered person meets one or more clinical criteria detailed in our precertification and clinical policies

**Duplicative drug therapy (e.g. two antihistamine drugs)****Genetic care**

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

**Immunizations related to work****Immunization agents**

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

**Infertility**

- Injectable prescription drugs used primarily for the treatment of infertility.

**Injectables**

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

**Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps** except as specifically provided in the *Eligible health services under your plan – Diabetic equipment, supplies and education* section.

**Prescription drugs:**

- For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a prescription is written.
- Packaged in unit dose form.
- Filled prior to the effective date or after the termination date of coverage under this rider.
- Dispensed by a mail order pharmacy that include prescription drugs that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.
- That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the preferred drug guide.
- 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**

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

**Replacement of lost or stolen prescriptions****Test agents except diabetic test agents****Tobacco cessation**

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

**We reserve the right to exclude:**

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

The Lafayette College 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).*

TTY: 711

To access language services at no cost to you, call 1-877-480-4161 .

Para acceder a los servicios de idiomas sin costo, llame al 1-877-480-4161. (Spanish)

如欲使用免費語言服務，請致電 1-877-480-4161 。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-877-480-4161 . (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-877-480-4161 . (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-877-480-4161 an. (German)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-877-480-4161 . (Arabic)

Pou jwenn sèvis lang gratis, rele 1-877-480-4161 . (French Creole-Haitian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-877-480-4161 . (Italian)

言語サービスを無料でご利用いただくには、1-877-480-4161 までお電話ください。 (Japanese)

무료 언어 서비스를 이용하려면 1-877-480-4161 번으로 전화해 주십시오. (Korean)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-877-480-4161 تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-877-480-4161 . (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-877-480-4161 . (Portuguese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-877-480-4161 . (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-877-480-4161 . (Vietnamese)