Quality Health Plans & Benefits
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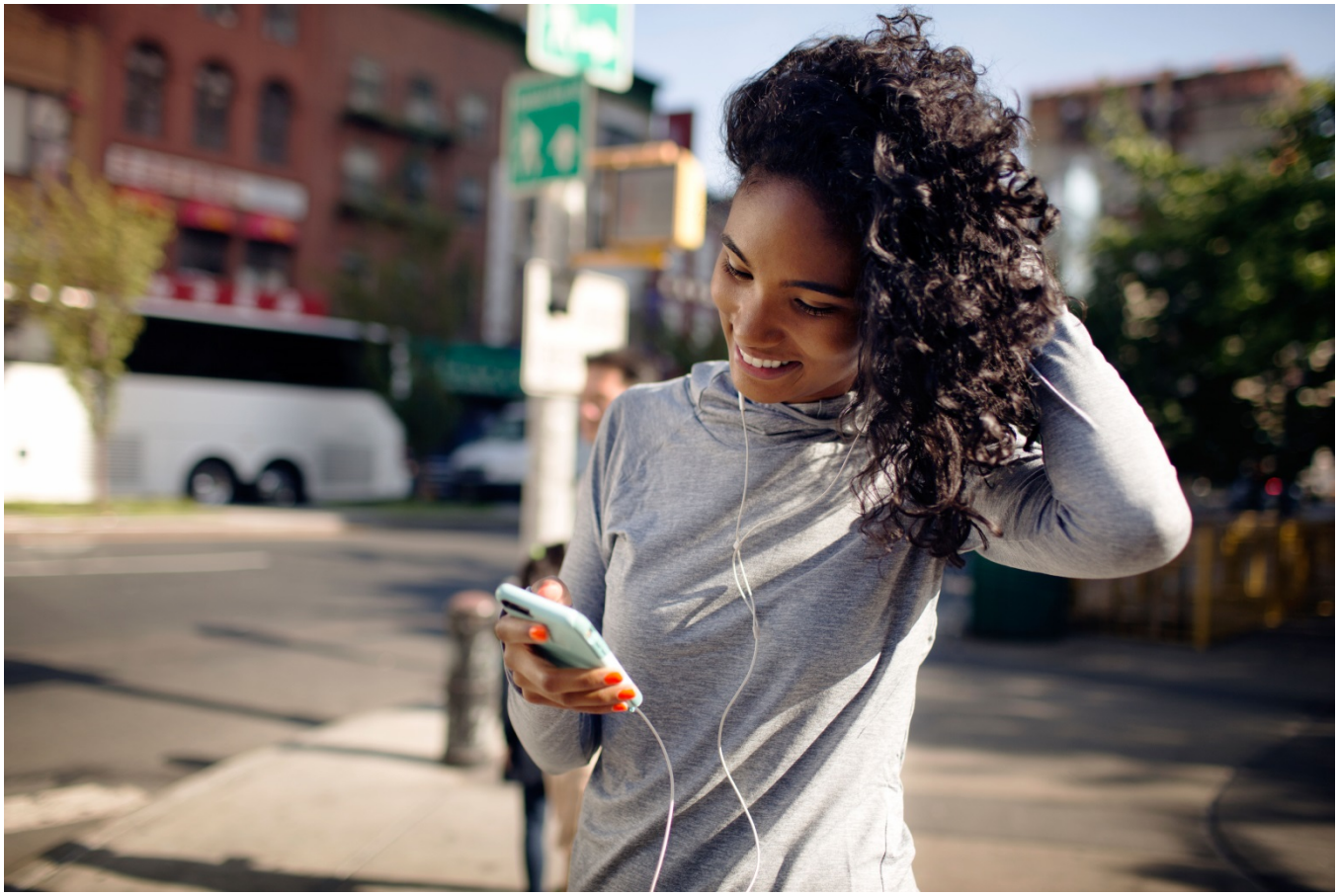
Aetna Student Health
Plan Design and Benefits Summary
Houston Community College

Policy Year: 2017-2018
Policy Number: 686150

hccs.myahpcare.com
1-855-844-3018
Enrollment/Waiver

www.aetnastudenthealth.com
(877) 480-4161
Claims/Benefits



This is a brief description of the Student Health Plan. The Plan is available for Houston Community College students. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Policy issued to you and may be viewed online at **hccs.myahpcare.com**. If there is a difference between this Benefit Summary and the Policy, the Master Policy will control.

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
Fall	08/22/2017	01/14/2018	09/18/2017
Spring/Summer	01/15/2018	08/21/2018	02/12/2018
Summer (New Students Only)	06/04/2018	08/21/2018	06/05/2018

Rates

The rates below include both premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna).

	Rates		
	Fall Semester	Spring/Summer Semester	Summer Semester (New Students Only)
Student	$758.00	$1135.00	$408.00
Spouse	$758.00	$1135.00	$408.00
Child	$758.00	$1135.00	$408.00
2 or more children	$1516.00	$2270.00	$816.00

Student Coverage

Eligibility

All international students holding an “F-1” or “J-1” visa and enrolled at Houston Community College will be automatically enrolled in and billed each semester for coverage under the Plan unless a waiver of coverage has been submitted and approved online at **https://hccs.myahpcare.com/waiver** by the waiver deadline date each semester. No waivers will be accepted after the waiver deadline date.

A student who initially waived coverage under the Plan but subsequently experiences ineligibility under another creditable coverage plan may elect to enroll for coverage under the Plan within 31 days of the date of ineligibility. Proof of ineligibility under another creditable coverage is required at the time the enrollment form is submitted.

An eligible student must actively attend classes at the College for at least the first 45 days of the period for which he or she is enrolled. Students who fully withdraw after 45 days will remain covered under the Plan and no refund will be made. Eligibility requirements must be met each time premium is paid to continue coverage. The Company maintains the right to investigate student status and attendance records to verify that the Plan eligibility requirements have been met. If it is discovered that the Plan eligibility requirements have not been met, the Company's only obligation is to refund premium, less any claims paid.

Enrollment

Eligible students will be automatically enrolled in this Plan, unless the completed waiver application has been received by Houston Community College by the specified enrollment deadline dates listed in the Coverage Periods section of this Plan Design and Benefits Summary. Eligible students may also insure their Dependents. Eligible Dependents are the student's legal spouse and dependent children under 26 years of age.

OR

To enroll online or obtain an enrollment application for voluntary dependent coverage, log on to **hccs.myahpcare.com** then click on Enrollment tab to enroll or download the appropriate form.

If you withdraw from school within the first **45 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 **45 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

You are <u>not</u> 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.

Preferred Provider Network

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

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

Texas Department of Insurance Notice

You have the right to an adequate network of preferred providers.

If you believe that the network is inadequate, you may file a complaint with the Department of Insurance.

If you obtain out-of-network services because no preferred provider was reasonably available, you may be entitled to have the claim paid at the in-network coinsurance rate and your out-of-pocket expenses counted toward your in-network, out-of-network, or general out-of-pocket maximum, as appropriate.

You have the right to obtain advance estimates: of the amounts that the providers may bill for projected services, from your out-of-network provider; and of the amounts that the insurer may pay for the projected services, from your insurer.

You may obtain a current directory of preferred providers at the following website: **hccs.myahpcare.com** or by calling **1- 855-844-3018** for assistance in finding available preferred providers.

If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

If you are treated by a provider or hospital that is not contracted with your insurer, you may be billed for anything not paid by the insurer.

If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, or neonatologist is greater than $1,000 (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: **www.tdi.texas.gov/consumer/cpmmediation.html.**

Texas Department of Insurance
333 Guadalupe Street, Austin, Texas 78701
512-676-6000 · **800-578-4677**

Pre-authorization

Some services have to be pre-authorized by Aetna beforehand if you want the Plan to cover them. Preferred Providers are responsible for requesting pre-certification for their services. You are responsible for requesting pre-certification if you seek care from a Non-Preferred Provider for any of the services listed in the Schedule of Benefits section of the Certificate.

If you want the Plan to cover a service from a Non-Preferred Provider that requires pre-authorization, you must call Aetna at the number on your ID card. After Aetna receives a request for pre-certification, we will review the reasons for your planned treatment and determine if benefits are available.

If you do not secure pre-authorization for the below listed inpatient and outpatient covered medical services and supplies obtained from a non-preferred provider your covered medical expenses will be subject to a **$500** per service, treatment, procedure, visit, or supply benefit reduction.

Pre-authorization for the following inpatient and outpatient services or supplies may be needed*:

All inpatient maternity and newborn care, after the initial 48 hours for a vaginal delivery or 96 hours for a cesarean section;

- Ambulance (emergency transportation by airplane);
- Autologous chondrocyte implantation, Carticel®;
- Bariatric surgery (bariatric surgery is not covered under the Policy unless specifically described in the Policy);
- BRCA genetic testing;
- Cardiac rhythm implantable devices;
- Cochlear device and/or implantation;
- Dental implants and oral appliances;
- Dorsal column (lumbar) neurostimulators: trial or implantation;
- Drugs and Medical Injectables;

- Electric or motorized wheelchairs and scooters;
- Gender Reassignment (Sex Change) Treatment;
- Home health care related services (i.e. private duty nursing);
- Hyperbaric oxygen therapy;
- Infertility treatment (Comprehensive and ART infertility treatment is not covered under the plan unless specifically described in the Policy);
- Inpatient Confinements (surgical and non-surgical); hospital, skilled nursing facility, rehabilitation facility, residential treatment facility for mental disorders and substance abuse, hospice care;
- Inpatient mental disorders treatment;
- Inpatient substance abuse treatment;
- Kidney dialysis;
- Knee surgery;
- Limb Prosthetics;
- Non-Preferred Care freestanding ambulatory surgical facility services when referred by a Preferred Care Provider;
- Oncotype DX;
- Orthognatic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint;
- Osseointegrated implant;
- Osteochondral allograft/knee;
- Outpatient back surgery not performed in a physician's office;
- Pediatric Congenital Heart Surgery;
- Pre-implantation genetic testing;
- Procedures that may be considered cosmetic. Cosmetic services and supplies are not covered under the plan unless specifically described in the Policy;
- Proton beam radiotherapy;
- Referral or use of Non-Preferred Care Providers for non-emergency services, unless the covered person understands and consents to the use of a Non-Preferred Care Provider under their under Non-Preferred Care benefits when available in their plan;
- Spinal Procedures;
- Transplant Services;
- Uvulopalatopharyngoplasty, including laser-assisted procedures; and
- Ventricular assist devices.

*Your Plan may not include coverage for all of the services and supplies listed above. Please check your Master Policy for confirmation of which services and supplies are covered and which services and supplies are excluded under your Plan. If you cannot locate the benefit you are looking for in your Master Policy, contact Customer Service at the number listed on your ID card for further assistance.

Pre-authorization DOES NOT guarantee the payment of benefits for your inpatient stays, certain tests, procedures, outpatient surgeries, therapies and equipment, and prescribed medications

Each claim is subject to medical policy review, in accordance with the exclusions and limitations contained in the Master Policy. The Master Policy also includes information regarding your eligibility criteria, notification guidelines, and benefit coverage.

Pre-authorization of non-emergency admissions

Non-emergency admissions must be requested at least **fifteen (15) days** prior to the date they are scheduled to be admitted.

Pre-authorization of emergency admissions

Emergency admissions must be requested within **twenty-four (24) hours** or as soon as reasonably possible after the admission.

Pre-authorization of urgent admissions

Urgent admissions must be requested before you are scheduled to be admitted.

Pre-authorization of outpatient non-emergency medical services

Outpatient non-emergency medical services must be requested within **fifteen (15) days** before the outpatient services, treatments, procedures, visits or supplies are provided or scheduled.

Pre-authorization of prenatal care and delivery

Pre-natal care medical services must be requested as soon as possible after the attending physician confirms pregnancy. Delivery medical services, which exceed the first 48 hours after delivery for a routine delivery and 96 hours for a cesarean delivery, must be requested within **twenty-four (24) hours** of the birth or as soon thereafter as possible.

Please see the "Pre-authorization" provision in the Master Policy for a list of services under the Plan that require pre-certification. Please see the Schedule of Benefits for any penalty or benefit reduction that may apply to your coverage when pre-certification is not obtained for the listed services or supplies when received from a non-preferred care provider.

Description of Benefits

The Plan excludes coverage for certain services and has limitations on the amounts it will pay. While this Plan Design and Benefits 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 Policy issued to you, go to **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Policy, the Master Policy will control.

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

Metallic Level: Gold, Tested at 78.74%

DEDUCTIBLE	Preferred Care	Non-Preferred Care
The policy year deductible is waived for Preferred Care covered medical expenses that apply to Preventive Care Expense benefits, Preferred Care Pediatric Dental Benefits and Preferred Care and Non Preferred Care Pediatric Vision Benefits. In compliance with Texas State mandate(s) the policy year deductible is also waived for: • Immunizations covered for a dependent child from birth through the date of the child's sixth birthday Per visit or admission Deductibles do not apply towards satisfying the Policy Year Deductible. *Annual Deductible does not apply to these services.	Individual: $500 Per Policy Year	Individual: $1,000 Per Policy Year

COINSURANCE	Preferred Care	Non-Preferred Care
Coinsurance is both the percentage of covered medical expenses that the plan pays, and the percentage of covered medical expenses that you pay. The percentage that the plan pays is referred to as "plan coinsurance" or the "payment percentage," and varies by the type of expense. Please refer to the Schedule of Benefits for specific information on coinsurance amounts.	Covered Medical Expenses are payable at the plan coinsurance percentage specified below, after any applicable Deductible.	
OUT-OF-POCKET MAXIMUMS	**Preferred Care**	**Non-Preferred Care**
Once the Individual Out-of-Pocket Limit has been satisfied, Covered Medical Expenses will be payable at 100% for the remainder of the Policy Year. The following expenses do not apply toward meeting the plan's out-of-pocket limits: • Non-covered medical expenses; and • Expenses that are not paid or pre-certification benefit reductions or penalties because a required pre-certification for the service(s) or supply was not obtained from Aetna.	Individual Out-of-Pocket: $6,800 Per Policy Year	Individual Out-of-Pocket: $13,600 Per Policy Year
INPATIENT HOSPITALIZATION BENEFITS	**Preferred Care**	**Non-Preferred Care**
Room and Board Expense The covered room and board expense does not include any charge in excess of the daily room and board maximum.	80% of the Negotiated Charge	50% of the Recognized Charge for a semi-private room
Intensive Care The covered room and board expense does not include any charge in excess of the daily room and board maximum.	80% of the Negotiated Charge	50% of the Recognized Charge
Miscellaneous Hospital Expense Includes but not limited to: operating room, laboratory tests/X rays, oxygen tent, drugs, medicines and dressings.	80% of the Negotiated Charge	50% of the Recognized Charge
Licensed Nurse Expense Includes charges incurred by a covered person who is confined in a hospital as a resident bed patient and requires the services of a registered nurse or licensed practical nurse.	80% of the Negotiated Charge	50% of the Recognized Charge
Well Newborn Nursery Care	80% of the Negotiated Charge	50% of the Recognized Charge
Non-Surgical Physicians Expense Includes hospital charges incurred by a covered person who is confined as an inpatient in a hospital for a surgical procedure for the services of a physician who is not the physician who may have performed surgery on the covered person.	80% of the Negotiated Charge	50% of the Recognized Charge
SURGICAL EXPENSES	**Preferred Care**	**Non-Preferred Care**
Surgical Expense (Inpatient and Outpatient) When injury or sickness requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, covered medical expenses only include expenses incurred for the most expensive procedure.	80% of the Negotiated Charge	50% of the Recognized Charge

SURGICAL EXPENSES (continued)	Preferred Care	Non-Preferred Care
Anesthesia Expense (Inpatient and Outpatient) If, in connection with such operation, the covered person requires the services of an anesthetist who is not employed or retained by the hospital in which the operation is performed, the expenses incurred will be Covered Medical Expenses.	80% of the Negotiated Charge	50% of the Recognized Charge
Assistant Surgeon Expense (Inpatient and Outpatient)	80% of the Negotiated Charge	50% of the Recognized Charge
OUTPATIENT EXPENSES	**Preferred Care**	**Non-Preferred Care**
Telemedicine Services and Physician or Specialist Office Visit Expense Includes the charges made by the physician or specialist if a covered person requires the services of a physician or specialist in the physician's or specialist's office while not confined as an inpatient in a hospital.	After a $15 Copay per visit, 80% of the Negotiated Charge	After a $15 Deductible per visit, 50% of the Recognized Charge
Laboratory and X-ray Expense	80% of the Negotiated Charge	50% of the Recognized Charge
Hospital Outpatient Department Expense	80% of the Negotiated Charge	50% of the Recognized Charge
Therapy Expense Covered medical expenses include charges incurred by a covered person for the following types of therapy provided on an outpatient basis: • Radiation therapy; • Inhalation therapy; • Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy; • Kidney dialysis; and • Respiratory therapy.	80% of the Negotiated Charge	50% of the Recognized Charge
Pre-Admission Testing Expense Includes charges incurred by a covered person for pre-admission testing charges made by a hospital, surgery center, licensed diagnostic lab facility, or physician, in its own behalf, to test a person while an outpatient before scheduled surgery.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Ambulatory Surgical Expense Covered medical expenses include expenses incurred by a covered person for outpatient surgery performed in an ambulatory surgical center. Covered medical expenses must be incurred on the day of the surgery or within 24 hours after the surgery.	80% of the Negotiated Charge	50% of the Recognized Charge
Walk-in Clinic Visit Expense	After a $15 Copay per visit, 80% of the Negotiated Charge	After a $15 Deductible per visit, 50% of the Recognized Charge

OUTPATIENT EXPENSES (continued)	Preferred Care	Non-Preferred Care
Emergency Room Expense Covered medical expenses incurred by a covered person for services received in the emergency room of a hospital while the covered person is not a full-time inpatient of the hospital. The treatment received must be emergency care for an emergency medical condition. There is no coverage for elective treatment, routine care or care for a non-emergency sickness. As to emergency care incurred for the treatment of an emergency medical condition or psychiatric condition, any referral requirement will not apply & any expenses incurred for non-preferred care will be paid at the same cost-sharing level as if they had been incurred for preferred care. **Important Notice:** A separate hospital emergency room visit benefit deductible or copay applies for each visit to an emergency room for emergency care. If a covered person is admitted to a hospital as an inpatient immediately following a visit to an emergency room, the emergency room visit benefit deductible or copay is waived. Covered medical expenses that are applied to the emergency room visit benefit deductible or copay cannot be applied to any other benefit deductible or copay under the plan. Likewise, covered medical expenses that are applied to any of the plan's other benefit deductibles or copays cannot be applied to the emergency room visit benefit deductible or copay. Separate benefit deductibles or copays may apply for certain services rendered in the emergency room that are not included in the hospital emergency room visit benefit. These benefit deductibles or copays may be different from the hospital emergency room visit benefit deductible or copay, and will be based on the specific service rendered. Similarly, services rendered in the emergency room that are not included in the hospital emergency room visit benefit may be subject to coinsurance rates that are different from the coinsurance rate applicable to the hospital emergency room visit benefit. **Important Note**: Please note that Non-Preferred Care Providers do not have a contract with Aetna; the provider may not accept payment of your cost share (your deductible and 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. Please send Aetna the bill at the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.	After a $150 Copay per visit (waived if admitted), 80% of the Negotiated Charge	After a $150 Deductible per visit (waived if admitted), 80% of the Recognized Charge

OUTPATIENT EXPENSES (continued)	Preferred Care	Non-Preferred Care
Durable Medical and Surgical Equipment Expense Durable medical and surgical equipment would include: Artificial arms and legs; including accessories; • Arm, back, neck braces, leg braces; including attached shoes (but not corrective shoes); • Surgical supports; • Scalp hair prostheses required as the result of hair loss due to injury; sickness; or treatment of sickness; and • Head halters.	80% of the Negotiated Charge	50% of the Recognized Charge

PREVENTIVE CARE EXPENSES

Preventive Care is services provided for a reason other than to diagnose or treat a suspected or identified sickness or injury and rendered in accordance with the guidelines provided by the following agencies:

- 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 **uspreventiveservicestaskforce.org**.
- Services as recommended in the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents **http://brightfutures.aap.org/**.
- For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration **http://www.hrsa.gov/index.html**.

PREVENTIVE CARE EXPENSES	Preferred Care	Non-Preferred Care
Routine Physical Exam Includes routine vision & hearing screenings given as part of the routine physical exam.	100% of the Negotiated Charge*	50% of the Recognized Charge
Preventive Care Immunizations Includes charges made by a physician or a facility for: • Immunizations for infectious diseases; and • The materials for administration of immunizations; that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. Not covered under this Preventive Care Expense benefit are charges incurred for: • Immunizations that are not considered Preventive Care such as those required due to employment or travel; and • If applicable and currently excluded by the Policy, services and supplies furnished by a non-preferred care provider.	100% of the Negotiated Charge*	50% of the Recognized Charge *Payable at 100% of the Recognized Charge from birth up to age Six.
Well Woman Preventive Visits Routine well woman preventive exam office visit, including Pap smears. Coverage includes at a minimum, a conventional pap smear screening or a screening using liquid based cytology methods, alone or in combination with another test approved by US FDA for detection of HPV.	100% of the Negotiated Charge*	50% of the Recognized Charge
Preventive Care Screening and Counseling Services for Sexually Transmitted Infections Includes the counseling services to help a covered person prevent or reduce sexually transmitted infections.	100% of the Negotiated Charge*	50% of the Recognized Charge

PREVENTIVE CARE EXPENSES (continued)	Preferred Care	Non-Preferred Care
Preventive Care Screening and Counseling Services for Obesity and/or Healthy Diet Screening and counseling services to aid in weight reduction due to obesity. Coverage includes: • Preventive counseling visits and/or risk factor reduction intervention; • Nutritional counseling; and • Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.	100% of the Negotiated Charge*	50% of the Recognized Charge
Preventive Care Screening and Counseling Services for Misuse of Alcohol and/or Drugs Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.	100% of the Negotiated Charge*	50% of the Recognized Charge
Preventive Care Screening and Counseling Services for Use of Tobacco Products Screening and counseling services to aid a covered person to stop the use of tobacco products. Coverage includes: • Preventive counseling visits; • Treatment visits; and • Class visits; to aid a covered person to stop the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: • Cigarettes; • Cigars; • Smoking tobacco; • Snuff; • Smokeless tobacco; and • Candy-like products that contain tobacco.	100% of the Negotiated Charge*	50% of the Recognized Charge
Preventive Care Screening and Counseling Services for Depression Screening Screening or test to determine if depression is present.	100% of the Negotiated Charge*	50% of the Recognized Charge
Preventive Care Routine Cancer Screenings Covered expenses include but are not limited to: Pap smears; Mammograms; Fecal occult blood tests; Digital rectal exams; Prostate specific antigen (PSA) tests; Sigmoidoscopies; Double contrast barium enemas (DCBE); Colonoscopies. Includes: • Bowel preparation medications • Anesthesia • Removal of polyps performed during a screening procedure • - Pathology exam on any removed polyps); and Lung cancer screenings.	100% of the Negotiated Charge*	50% of the Recognized Charge

PREVENTIVE CARE EXPENSES (continued)	Preferred Care	Non-Preferred Care
Preventive Care Screening and Counseling Services for Genetic Risk for Breast and Ovarian Cancer Covered medical expenses include the counseling and evaluation services to help assess a covered person's risk of breast and ovarian cancer susceptibility.	100% of the Negotiated Charge*	50% of the Recognized Charge
Preventive Care Prenatal Care Coverage for prenatal care under this Preventive Care Expense benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check, and fundal height). Refer to the Maternity Expense benefit for more information on coverage for maternity expenses under the Policy, including other prenatal care, delivery and postnatal care office visits.	100% of the Negotiated Charge*	50% of the Recognized Charge
Preventive Care Lactation Counseling Services Lactation support and lactation counseling services are covered medical expenses when provided in either a group or individual setting.	100% of the Negotiated Charge*	50% of the Recognized Charge
Preventive Care Breast Pumps and Supplies	100% of the Negotiated Charge*	50% of the Recognized Charge
Preventive Care Female Contraceptive Counseling Services, Preventive Care Female Contraceptive Generic, Brand Name, Biosimilar Prescription Drugs and Devices provided, administered, or removed, by a Physician during an Office Visit, Preventive Care Female Voluntary Sterilization (Inpatient), Preventive Care Female Voluntary Sterilization (Outpatient) Includes counseling services on contraceptive methods provided by a physician, obstetrician or gynecologist. Such counseling services are covered medical expenses when provided in either a group or individual setting. **Voluntary Sterilization** Includes charges billed separately by the provider for female voluntary sterilization procedures & related services & supplies including, but not limited to, tubal ligation and sterilization implants. Covered medical expenses under this benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement. **Contraceptive**s can be paid either under this benefit or the prescribed medicines expense depending on the type of expense and how and where the expense is incurred. Benefits are paid under this benefit for female contraceptive prescription drugs and devices (including any related services and supplies) when they are provided, administered, or removed, by a physician during an office visit.	100% of the Negotiated Charge*	50% of the Recognized Charge

OTHER FAMILY PLANNING SERVICES EXPENSE	Preferred Care	Non-Preferred Care
Voluntary Sterilization for Males (Outpatient) Covered medical expenses include charges for certain family planning services, even though not provided to treat a sickness or injury as follows. • Voluntary sterilization for males	80% of the Negotiated Charge	50% of the Recognized Charge
AMBULANCE EXPENSE	**Preferred Care**	**Non-Preferred Care**
Ground, Air, Water and Non-Emergency Ambulance Includes charges incurred by a covered person for the use of a professional ambulance in an emergency. Covered medical expenses for the service are limited to charges for ground transportation to the nearest hospital equipped to render treatment for the condition. Air transportation is covered only when medically necessary.	80% of the Negotiated Charge	80% of the Recognized Charge
ADDITIONAL BENEFITS	**Preferred Care**	**Non-Preferred Care**
Allergy Testing and Treatment Expense Includes charges incurred by a covered person for diagnostic testing and treatment of allergies and immunology services.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Diagnostic Testing For Learning Disabilities Expense Covered medical expenses include charges incurred by a covered person for diagnostic testing for: • Attention deficit disorder; or • Attention deficit hyperactive disorder.	Payable in accordance with the type of expense incurred and the place where service is provided.	
High Cost Procedures Expense Includes charges incurred by a covered person as a result of certain high cost procedures provided on an outpatient basis. Covered medical expenses for high cost procedures include; but are not limited to; charges for the following procedures and services: • Computerized Axial Tomography (CAT) scans; • Magnetic Resonance Imaging (MRI); and • Positron Emission Tomography (PET) Scans.	80% of the Negotiated Charge	50% of the Recognized Charge
Urgent Care Expense	After a $15 Copay per visit, 80% of the Negotiated Charge	After a $15 Deductible per visit, 50% of the Recognized Charge
Dental Expense for Impacted Wisdom Teeth Includes charges incurred by a covered person for services of a dentist or dental surgeon for removal of one or more impacted wisdom teeth. Not more than the Maximum Benefit will be paid. Includes expenses for the treatment of: the mouth; teeth; and jaws; but only those for services rendered and supplies needed for the following treatment of; or related to conditions; of the: • mouth; jaws; jaw joints; or • supporting tissues; (this includes: bones; muscles; and nerves).	80% of the Negotiated Charge	80% of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Accidental Injury to Sound Natural Teeth Expense Covered medical expenses include charges incurred by a covered person for services of a dentist or dental surgeon as a result of an injury to sound natural teeth.	80% of the Negotiated Charge	80% of the Recognized Charge
Non-Elective Second Surgical Opinion Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Consultant Expense Includes the charges incurred by covered person in connection with the services of a consultant. The services must be requested by the attending physician to confirm or determine a diagnosis. Coverage may be extended to include treatment by the consultant.	After a $15 Copay per visit, 80% of the Negotiated Charge	After a $15 Deductible per visit, 50% of the Recognized Charge
Skilled Nursing Facility Expense Benefits limited to 25 days per policy year.	80% of the Negotiated Charge	50% of the Recognized Charge
Rehabilitation Facility Expense Includes charges incurred by a covered person for confinement as a full time inpatient in a rehabilitation facility.	80% of the Negotiated Charge	50% of the Recognized Charge
Home Health Care Expense Covered medical expenses will not include: • Services by a person who resides in the covered person's home, or is a member of the covered person's immediate family • Homemaker or housekeeper services; • Maintenance therapy; • Dialysis treatment; • Purchase or rental of dialysis equipment; • Food or home delivered services; or • Custodial care. Benefits limited to 60 visits per Policy Year.	80% of the Negotiated Charge	50% of the Recognized Charge
Temporomandibular Joint Dysfunction Expense Covered medical expenses include physician's charges incurred by a covered person for diagnostic, surgical, and non-surgical treatment of Temporomandibular Joint (TMJ) Dysfunction resulting from: • An accident or trauma • Congenital defect • Developmental defect • A pathology.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Dermatological Expense Includes physician's charges incurred by a covered person for the diagnosis and treatment of skin disorders. Related laboratory expenses are covered under the Lab and X-ray Expense benefit. Unless specified above, not covered under this benefit are charges incurred for: • Cosmetic treatment and procedures; and Laboratory fees.	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Prosthetic Devices Expense Includes charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by sickness, injury or congenital defect. The plan covers the first prosthesis a covered person need that temporarily or permanently replaces all or part of an body part lost or impaired as a result of sickness or injury or congenital defects as described in the list of covered devices below for an: • Internal body part or organ; or • External body part. **Limitations:** Unless specified above, not covered under this benefit are charges for: • Eye exams; • Eyeglasses; • Vision aids; • Hearing aids; • Communication aids.	80% of the Negotiated Charge	50% of the Recognized Charge
Podiatric Expense Includes charges incurred by a covered person for podiatric services; provided on an outpatient basis following an injury. Not covered under this benefit are charges incurred for routine foot care, such as trimming of corns, calluses, and nails.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Hypodermic Needles Expense Includes expenses incurred by a covered person for hypodermic needles and syringes.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Maternity Expense Covered medical expenses include charges made by a physician for pregnancy and childbirth services and supplies. This includes prenatal visits (non-preventive care), delivery, and postnatal visits. For inpatient care of the mother and newborn child, covered medical expenses include charges made by a hospital for a minimum of: a) 48 hours following an uncomplicated vaginal delivery; b) 96 hours following an uncomplicated cesarean section; and c) a shorter stay, if the attending physician, with the consent of the mother, discharges the mother or newborn earlier. If the mother is discharged earlier, the plan will pay for 2 post-delivery home visits by a health care provider. During the initial 48 or 96 hours; no pre-certification is required for the mother or her newly born child. Pre-certification is required after the 48 or 96 hours. Any decision to shorten such minimum coverage shall be made by the attending physician and in consultation with the mother. In such cases; covered services may include parent education. Pregnancy Complications shall be treated as any other covered medical expenses.	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Non-Prescription Enteral Formula Expense Includes charges incurred by a covered person, for non-prescription enteral formulas for which a physician has issued a written order, and are for the treatment of malabsorption caused by: • Crohn's Disease; • Ulcerative colitis; • Gastroesophageal reflux; • Gastrointestinal motility; • Chronic intestinal pseudo obstruction; and • Inherited diseases of amino acids and organic acids. Covered medical expenses for inherited diseases of amino acids; and organic acids; will also include food products modified to be low protein.	Paid according to the tier of drug on the Schedule of Benefits for Prescription Drugs.	
Acupuncture in Lieu of Anesthesia Expense Includes charges incurred by a covered person for acupuncture therapy when acupuncture is used in lieu of other anesthesia for a surgical or dental procedure covered under this Plan. The acupuncture must be administered by a health care provider who is a legally qualified physician; practicing within the scope of their license.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Transfusion or Kidney Dialysis of Blood Expense Includes charges incurred by a covered person for the transfusion or kidney dialysis of blood, including the cost of: Whole blood; blood components; and the administration of whole blood and blood components.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Hospice Expense	80% of the Negotiated Charge	50% of the Recognized Charge
Blood and Body Fluid Exposure/ Needle Stick Coverage Expense Limited to those charges related to a clinical related injury. Any expense related to the treatment of any sickness resulting from a clinical related injury is not covered under this benefit. Incidents include, but are not limited to needle sticks, unprotected exposure to blood and body fluid, and unprotected exposure to highly contagious pathogens.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Diabetes Benefit Expense Includes charges for services, supplies, equipment, & training for the treatment of insulin and non-insulin dependent diabetes &elevated blood glucose levels during pregnancy. Self-management training provided by a licensed health care provider certified in diabetes self-management training.	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Mastectomy and Reconstructive Surgery Expense Covered medical expenses include expenses for charges incurred in connection with a mastectomy and lymph node dissection. Coverage includes reconstructive surgery by your provider and related supplies provided in an inpatient or outpatient setting only in the following circumstances: • Your surgery reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of the mastectomy, including lymphedema. • Your surgery corrects an accidental injury that happened no more than 24 months before your surgery. For a covered person under age 18, the time period for coverage may be extended through age 18. Injuries that occur during surgical procedures or medical treatments are not considered accidental injuries, even if unplanned or unexpected. • Your surgery is to implant or attach a covered prosthetic device. Your surgery corrects a gross anatomical defect present at birth. The surgery will be covered if: • The defect results in severe facial disfigurement or major functional impairment of a body part. • The purpose of the surgery is to improve function. • Your surgery is needed because treatment of your [illness] resulted in severe facial disfigurement or major functional impairment of a body part, and your surgery will improve function.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Autism Spectrum Disorder Expense Includes charges incurred for services and supplies required for the diagnosis and treatment of autism spectrum disorder when ordered by a physician or behavioral health provider as part of a treatment plan. Includes early intensive behavioral interventions such as Applied Behavior Analysis (ABA). Applied Behavior Analysis is an educational service that is the process of applying interventions that: • Systematically change behavior; and • Are responsible for the observable improvement in behavior.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Reconstructive Surgery for Craniofacial Abnormalities Expense Includes coverage for reconstructive surgery for craniofacial abnormalities. Reconstructive surgery for craniofacial abnormalities means surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Orthotic Devices Expense Includes coverage for orthotic devices, including custom-fitted or custom-fabricated medical devices that are applied to a part of the human body to correct a deformity, improve function, or relieve symptoms of a disease. The coverage includes the professional services related to the fitting and use of the devices, as well as repair and replacement unless due to misuse by the covered person. Coverage is limited to the most appropriate model orthotic device that adequately meets the medical needs of the covered person as determined by the covered person's treating physician, podiatrist or orthotist, and the covered person as applicable.	80% of the Negotiated Charge	50% of the Recognized Charge
Anesthesia and Hospital Charges for Dental Care Includes anesthesia for dental care only if the covered person: • Has a disability or a physical, mental, or medical condition that requires that a dental procedure be done in a hospital or outpatient surgery center; • Is developmentally disabled; and • Is in poor health and have a medical need for general anesthesia.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Amino Acid-Based Elemental Formulas Coverage will be provided for amino acid-based elemental formulas, if the covered person's physician has issued a written order stating that an amino acid-based elemental formula is medically necessary for the covered person's treatment after the covered person has been diagnosed with any of the following diseases or disorders: 1. immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins; 2. Severe food protein-induced enterocolitis syndrome; 3. Eosinophilic disorders, as evidenced by the results of a biopsy; and 4. Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract. Coverage is provided regardless of the formula delivery method. Coverage includes any medically necessary services associated with the administration of the formula.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Acquired Brain Injury Coverage An "acquired brain injury" is a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Newborn Hearing Screening Expense Although not incurred in connection with the treatment of a disease or injury, covered medial expense includes charges for: • A screening test for hearing loss from birth through the date a child is 30 days old • Medically necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old. • Covered medical expenses are not subject to deductible or copay.	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Basic Infertility Expense Covered medical expenses include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Bariatric Surgery Expense Covered medical expenses for the treatment of morbid obesity include one bariatric surgical procedure including related outpatient services, within a two-year period, beginning with the date of the first bariatric surgical procedure, unless a multi-stage procedure is planned.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Clinical Trials Expense (Experimental or Investigational Treatment) Includes charges made by a provider for experimental or investigational drugs, devices, treatments or procedures “under an approved clinical trial” only when a covered person has cancer or a terminal illness.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Clinical Trials Expense Routine Patient Costs Covered Percentage Includes charges made by a provider for "routine patient costs" furnished in connection with a covered person’s participation in an "approved clinical trial” for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Gender Reassignment (Sex Change) Treatment Expense Includes charges made in connection with a medically necessary gender reassignment surgery (sometimes called sex change surgery) as long the covered student or their covered dependent has obtained pre-certification from Aetna. The covered student or their covered dependent must be at least 18 years of age or older to be eligible for this benefit. Covered medical expenses include: • Charges made by a physician for: o Performing the surgical procedure; and o Pre-operative and post-operative hospital and office visits. • Charges made by a hospital for inpatient and outpatient services (including outpatient surgery). • Charges made by a Skilled Nursing Facility for inpatient services and supplies. • Charges made for the administration of anesthetics. • Charges for outpatient diagnostic laboratory and x-rays. • Charges for blood transfusion and the cost of unreplaced blood and blood products. • Charges made by a behavioral health provider for gender reassignment counseling. No benefits will be paid for covered medical expenses under this benefit unless they have been pre-certified by Aetna. Refer to the Pre-certification section for more information.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Chiropractic Treatment Expense Covered medical expenses include charges made by a physician on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.	80% of the Negotiated Charge	50% of the Recognized Charge

SHORT-TERM CARDIAC AND PULMONARY REHABILITATION THERAPY SERVICES EXPENSE

Inpatient rehabilitation benefits for the services listed will be paid as part of the Hospital Expense and Skilled Nursing Facility Expense benefits.

Cardiac Rehabilitation Benefits

Cardiac rehabilitation benefits received at a hospital, skilled nursing facility, or physician's office. This Plan will cover charges in accordance with a treatment plan as determined by a covered person's risk level when recommended by a physician.

Pulmonary Rehabilitation Benefits

Pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states.

ADDITIONAL BENEFITS	Preferred Care	Non-Preferred Care
Cardiac Rehabilitation	80% of the Negotiated Charge	50% of the Recognized Charge
Pulmonary Rehabilitation	80% of the Negotiated Charge	50% of the Recognized Charge

SHORT-TERM REHABILITATION EXPENSE

Includes charges for short-term rehabilitation services, as described below, when prescribed by a physician. Short-term rehabilitation services must follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration;
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate; and
- Allows therapy services, provided in a covered person's home, if the covered person is homebound.

Inpatient rehabilitation benefits for the services listed will be paid as part of the inpatient hospital and skilled nursing facility benefits.

Short-Term Rehabilitation Expense Outpatient Physical, Occupational and Speech Rehabilitation and Habilitation Therapy Services (combined)	80% of the Negotiated Charge	50% of the Recognized Charge
Habilitation Therapy Includes charges for habilitation therapy services, as described below, when prescribed by a physician. Habilitation services must follow a specific treatment plan that: • Details the treatment, and specifies frequency and duration; • Provides for ongoing reviews and is renewed only if continued therapy is appropriate; and • Allows therapy services, provided in a covered person's home, if a covered person is homebound. • Inpatient habilitation benefits for the services listed will be paid as part of the inpatient hospital and skilled nursing facility benefits. • Physical therapy (except for services provided in an educational or training setting) is covered provided that the therapy is expected to develop any impaired function. • Occupational therapy, (except for vocational rehabilitation, employment counseling, and services provided in an educational or training setting), is covered provided that the therapy is expected to develop any impaired function; Speech therapy is covered provided that the therapy is expected to develop speech function as a result of delayed development. Speech function is the ability to express thoughts, speak words, and form sentences.	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Therapy for Children with Development Delays Include coverage for rehabilitative and habilitative therapies, including: (1) occupational therapy evaluations and services; (2) physical therapy evaluations and services; (3) speech therapy evaluations and services; and (4) dietary or nutritional evaluations, determined to be necessary to and provided in accordance with an individualized family service plan issued by the Interagency Council on Early Childhood Intervention under Chapter 73, Texas Human Resources Code, for a covered person under three years of age who is documented as having developmental delay or has medically diagnosed physical or mental condition that has a high probability of resulting in developmental delay in one or more of the following areas: (A) cognitive development; (B) physical development; (C) communication development; (D) social or emotional development; or (E) adaptive development.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Early Detection of Cardiovascular Disease Includes coverage for certain tests for the early detection of cardiovascular disease for any covered person who is: 1. male and older than 45 years of age and younger than 76 years of age; or 2. female and older than 55 years of age and younger than 76 years of age; and who is: • Diabetic; or • Has a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher. If performed by a laboratory that is certified by a national organization recognized by Texas for the purposes of this section, coverage will be provided for one of the following non-invasive screening tests for atherosclerosis and abnormal artery structure and function: • computed tomography (CT) scanning measuring coronary artery calcification; or • ultrasonography measuring carotid intima-media thickness and plaque. Any reference in the plan to the exclusion or limitation of any of the above covered services and supplies, unless expressly outlined in this section, shall not apply.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Loss or Impairment of Speech or Hearing Includes expenses incurred by a covered person for medically necessary care and treatment of loss or impairment of speech or hearing on the same basis any other physical illness.	Payable in accordance with the type of expense incurred and the place where service is provided.	
HEARING AIDS	**Preferred Care**	**Non-Preferred Care**
Hearing Aid Expenses Covered medical expenses for hearing care includes charges for hearing exams, prescribed hearing aids and hearing aid expenses.	80% of the Negotiated Charge	50% of the Recognized Charge

Cochlear Implants	80% of the Negotiated Charge	50% of the Recognized Charge
TREATMENT OF MENTAL DISORDER EXPENSE	**Preferred Care**	**Non-Preferred Care**
Inpatient Mental Health Expense & Residential Mental Health Treatment Facility Expense Covered medical expenses include charges made by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider for the treatment of mental disorders for Inpatient room and board at the semi-private room rate, and other services and supplies related to a covered person's condition that are provided during a covered person's stay in a hospital, psychiatric hospital, or residential treatment facility.	80% of the Negotiated Charge	50% of the Recognized Charge
Inpatient Mental Health Physician Services per Admission Expense	80% of the Negotiated Charge	50% of the Recognized Charge
Outpatient Mental Health Expense	After a $15 Copay per visit, 80% of the Negotiated Charge	After a $15 Deductible per visit, 50% of the Recognized Charge
Outpatient Mental Health Partial Hospitalization Expense	80% of the Negotiated Charge	50% of the Recognized Charge
Residential Mental Health Treatment Facility Expense	80% of the Negotiated Charge	50% of the Recognized Charge
ALCOHOLISM AND DRUG ADDICTION TREATMENT	**Preferred Care**	**Non-Preferred Care**
Inpatient Substance Abuse Treatment Covered medical expenses include charges made by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider for the treatment of mental disorders for Inpatient room and board at the semi-private room rate, and other services and supplies related to a covered person's condition that are provided during a covered person's stay in a hospital, psychiatric hospital, or residential treatment facility.	80% of the Negotiated Charge	50% of the Recognized Charge
Inpatient Substance Abuse Physician Services per Admission Expense	80% of the Negotiated Charge	50% of the Recognized Charge
Outpatient Substance Abuse Treatment	After a $15 Copay per visit, 80% of the Negotiated Charge	After a $15 Deductible per visit, 50% of the Recognized Charge
TRANSPLANT SERVICE EXPENSE	**Preferred Care**	**Non-Preferred Care**
Transplant Services Expense Benefits may vary if an Institute of Excellence™ (IOE) facility or non-IOE or non-preferred care provider is used. Through the IOE network, the covered person will have access to a provider network that specializes in transplants. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure the covered person requires. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.	Payable in accordance with the type of expense incurred and the place where service is provided.	

Transplant Travel and Lodging Expense The plan will reimburse a covered person for some of the cost of their travel and lodging expenses.	$50 per night Maximum Benefit for Lodging Expenses per IOE patient & $50 per night Maximum Benefit for Lodging Expenses per companion up to 10,000 per transplant.	
PEDIATRIC DENTAL SERVICES EXPENSE (Coverage is limited to covered persons until the end of the month in which the covered person turns 19)	**Preferred Care**	**Non-Preferred Care**
Type A Expense (Pediatric Routine Dental Exam Expense)	100% of the Negotiated Charge*	50% of the Recognized Charge
Type B Expense (Pediatric Basic Dental Care Expense)	70% of the Negotiated Charge*	50% of the Recognized Charge
Type C Expense (Pediatric Major Dental Care Expense)	50% of the Negotiated Charge*	50% of the Recognized Charge
Pediatric Orthodontia Expense Orthodontics Medically necessary comprehensive treatment • Replacement of retainer (limit one per lifetime).	50% of the Negotiated Charge*	50% of the Recognized Charge
PEDIATRIC ROUTINE VISION (Coverage is limited to covered persons until the end of the month in which the covered person turns 19)	**Preferred Care**	**Non-Preferred Care**
Pediatric Routine Vision Exams (including refractions) Includes charges made by a legally qualified ophthalmologist or optometrist for a routine vision exam. The exam will include refraction & glaucoma testing.	100% of the Negotiated Charge*	60% of the Recognized Charge*
Pediatric Visit for the fitting of Prescription Contact Lenses Covered medical expenses include charges for the following vision care services and supplies: • Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses.	100% of the Negotiated Charge *	60% of the Recognized Charge*
Pediatric Eyeglass Frames, Prescription Lenses or Prescription Contact Lenses, Preferred Optical Devices, Non-Preferred Optical Devices Covered medical expenses include charges for the following vision care services and supplies: • Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a preferred care provider. • Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a non-preferred care provider. Coverage includes charges incurred for: • Non-conventional prescription contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses. Aphakic prescription lenses prescribed after cataract surgery has been performed.	100% of the Negotiated Charge *	60% of the Recognized Charge*

PEDIATRIC ROUTINE VISION (continued) (Coverage is limited to covered persons until the end of the month in which the covered person turns 19)	Preferred Care	Non-Preferred Care
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. **Limitations:** Unless specified above, not covered under this benefit are charges incurred for services and supplies: • Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses. Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes.	100% of the Negotiated Charge *	60% of the Recognized Charge*
Comprehensive Low Vision Evaluations Coverage includes charges incurred for: Low vision services including comprehensive low vision evaluations and prescribed optical devices, such as high-power spectacles, magnifiers, and telescopes.	Payable in accordance with the type of expense incurred and the place where service is provided.	

PRESCRIBED MEDICINES EXPENSE

Covered Percentage*	Preferred Care	Non-Preferred Care
Preventive Care Drugs and Supplements 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		
Risk Reducing Breast Cancer Prescription Drugs For each 30 day supply filled at a retail pharmacy.	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits.	100% of the Recognized Charge
Tobacco Cessation Prescription Drugs and Over-the-Counter Drugs. **(**for two 90-day treatment regimens only)	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits.	100% of the Recognized Charge
Other preventive care drugs and supplements For each 30 day supply filled at a retail pharmacy.	100% per supply	100% of the Recognized Charge
CONTRACEPTIVES	**Preferred Care**	**Non-Preferred Care**
FDA-Approved Female Generic Over-the-Counter Contraceptives **(**Non-Emergency) For each 30 day Supply	100% per supply	100% of the Recognized Charge
FDA-Approved Female Generic Emergency Contraceptives	100% per supply	100% of the Recognized Charge
All OTHER PRESCRIPTION DRUGS	**Preferred Care**	**Non-Preferred Care**
For each 30 day supply filled at a retail pharmacy.	100% of the Negotiated Charge	100% of the Recognized Charge

*The prescription drug plan covered percentage is the percentage of prescription drug covered medical expenses that the plan pays after any applicable deductibles and copays have been met.

Generic Prescription Drugs	Preferred Care	Non-Preferred Care
For each 30 day supply filled at a retail pharmacy.	$20 Copay per supply	$20 Deductible per supply
Preferred Brand-Name Prescription Drug	**Preferred Care**	**Non-Preferred Care**
For each 30 day supply filled at a retail pharmacy.	$40 Copay per supply	$40 Deductible per supply
Non-Preferred Brand-Name Prescription Drugs	**Preferred Care**	**Non-Preferred Care**
For each 30 day supply filled at a retail pharmacy.	$80 Copay per supply	$80 Deductible per supply
Orally Administered Anti-Cancer Prescription Drugs (including Chemotherapy Drugs)	Payable on the same basis as covered cancer chemotherapy medications that are administered intravenously or by injection.	
Risk Reducing Breast Cancer Prescription Drugs For each 30 day supply filled at a retail pharmacy.	100% per supply	100% of the Recognized Charge
Tobacco Cessation Prescription Drugs and Over-the-Counter Drugs. (for two 90-day treatment regimens only)	100% per supply	100% of the Recognized Charge
Other preventive care drugs and supplements For each 30 day supply filled at a retail pharmacy.	100% per supply	100% of the Recognized Charge
CONTRACEPTIVES	**Preferred Care**	**Non-Preferred Care**
FDA-Approved Female Generic Over-the-Counter Contraceptives (Non-Emergency) **For each 30 day Supply**	100% per supply	100% of the Recognized Charge
FDA-Approved Female Generic Emergency Contraceptives	100% per supply	100% of the Recognized Charge

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

Aetna will make a coverage determination within 24 hours after receipt of the request and will notify the covered person, the covered person's designee or the covered person's prescriber of Aetna's decision.

Copay and Deductible Waiver

Waiver for Risk-Reducing Breast Cancer Prescription Drugs

The per prescription copay/deductible and policy year deductible will not apply to risk-reducing breast cancer generic, prescription drugs when obtained at a preferred care pharmacy. This means that such risk-reducing breast cancer generic prescription drugs will be paid at 100%.

Waiver for Prescription Drug Contraceptives

The per prescription copay/deductible and policy year deductible will not apply to:

- Female contraceptives that are:
  - Oral prescription drugs that are generic prescription drugs.
  - Injectable prescription drugs that are generic prescription drugs.
  - Vaginal ring prescription drugs that are generic prescription drugs, brand-name prescription drugs and biosimilar prescription drugs.
  - Transdermal contraceptive patch prescription drugs that are generic prescription drugs, brand-name prescription drugs, and biosimilar prescription drugs.
- Female contraceptive devices.
- FDA-approved female:
  - generic emergency contraceptives; and
  - generic over-the-counter (OTC) emergency contraceptives.

when obtained at a preferred care pharmacy. This means that such contraceptive methods will be paid at 100%.

The per prescription copay/deductible and policy year deductible continue to apply:

- When the contraceptive methods listed above are obtained at a non-preferred pharmacy.
- To female contraceptives that are:
  - Oral prescription drugs that are brand-name prescription drugs and biosimilar prescription drugs.
  - Injectable prescription drugs that are brand-name prescription drugs and biosimilar prescription drugs.
  - Vaginal ring prescription drugs that are brand-name prescription drugs and biosimilar prescription drugs.
  - Transdermal contraceptive patch prescription drugs that are brand-name prescription drugs and biosimilar prescription drugs.
- To female contraceptive devices that are brand-name devices.
- To FDA-approved female:
  - brand-name and biosimilar emergency contraceptives; and
  - brand-name over-the-counter (OTC) emergency contraceptives.
- To FDA-approved female brand-name over-the-counter (OTC) contraceptives.
- To FDA-approved male brand-name over-the-counter (OTC) contraceptives.

However, the per prescription copay/deductible and policy year deductible will not apply to such contraceptive methods if:

- A generic equivalent, biosimilar or generic alternative, within the same therapeutic drug class is not available; or
- A covered person is granted a medical exception; or
- A physician specifies “Dispense as Written” (DAW).

A covered person's prescriber may seek a medical exception by submitting a request to Aetna's Pre-certification Department. Any waiver granted as a result of a medical exception shall be based upon an individual, case by case medically necessary determination and coverage will not apply or extend to other covered persons.

To the extent:

- FDA-approved female generic prescription drugs are not available, brand name prescription drugs will be covered;
- FDA-approved female generic vaginal rings are not available, brand name vaginal rings will be covered.
- FDA-approved female generic devices are not available, brand name devices will be covered.
- One of the FDA-approved female emergency contraceptive methods are not available as generic, a brand name emergency contraceptive will be covered.

Exclusions

This Plan does not cover nor provide benefits for:

1. Expense incurred for services normally provided without charge by the Policyholder's school health services; infirmary or hospital; or by health care providers employed by the Policyholder.

2. Expense incurred as a result of injury due to participation in a riot. "Participation in a riot" means taking part in a riot in any way; including inciting the riot or conspiring to incite it. It does not include actions taken in self-defense; so long as they are not taken against persons who are trying to restore law and order.

3. Expense incurred as a result of an accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation; except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.

4. Expense incurred as a result of an injury or sickness due to working for wage or profit or for which benefits are payable under any Workers' Compensation or Occupational Disease Law.

5. Expense incurred as a result of an injury sustained or sickness contracted while in the service of the Armed Forces of any country. Upon the covered person entering the Armed Forces of any country; the unearned pro rata premium will be refunded to the Policyholder.

6. Expense incurred for treatment provided in a governmental hospital unless there is a legal or regulatory obligation to pay such charges in the absence of insurance.

7. Expense incurred for elective treatment or elective surgery except as specifically covered under the Policy and provided while the Policy is in effect.

8. Expense incurred for cosmetic surgery; reconstructive surgery; or other services and supplies which improve; alter; or enhance appearance; whether or not for psychological or emotional reasons; except to the extent needed to:
   - Improve the function of a part of the body that: is not a tooth or structure that supports the teeth; and is malformed.
   - Repair an injury which occurs while the covered person is covered under the Policy. Surgery must be performed:
     i. in the policy year of the accident which causes the injury; or - in the next policy year.
     This exclusion will not apply to reconstructive surgery for craniofacial abnormalities. As used here, "reconstructive surgery for craniofacial abnormalities" means reconstructive surgery:
     1. To improve the function of; or
     2. To attempt to create a normal appearance of;
        a. An abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections or disease; or as a result of a severe birth defect; including harelip; webbed fingers; or toes; or as direct result of: disease; or surgery performed to treat a disease or injury.

9. Expense incurred as a result of commission of a felony.

10. Expense incurred after the date insurance terminates for a covered person except as may be specifically provided in the Extension of Benefits provision.

11. Expense incurred for any services rendered by a member of the covered person's immediate family or a person who lives in the covered person's home.

12. Expenses for treatment of injury or sickness to the extent that payment is made; as a judgment or settlement; by any person deemed responsible for the injury or sickness (or their insurers).

13. Expense incurred for which no member of the covered person's immediate family has any legal obligation for payment.

14. Expense incurred for custodial care.

15. Expense incurred for the removal of an organ from a covered person for the purpose of donating or selling the organ to any person or organization except as specifically covered in the Policy. This limitation does not apply to a donation by a covered person to a spouse; child; brother; sister; or parent.

16. Expenses incurred for blood or blood plasma; except charges made by a hospital for the processing or administration of blood.

17. Expenses incurred for the repair or replacement of existing artificial limbs; orthopedic braces; or orthotic devices except as specifically covered in the Policy.

18. Expense incurred for, or in connection with, drugs, devices, procedures, or treatments that are, as determined by Aetna to be, experimental or investigational except as specifically covered under the Policy.

19. Expenses incurred for breast reduction/mammoplasty.

20. Expenses incurred for gynecomastia (male breasts).

21. Expense incurred by a covered person; not a United States citizen; for services performed within the covered person's home country; if the covered person's home country has a socialized medicine program.

22. Expense incurred for acupuncture except as specifically covered under the Policy.

23. Expense incurred for alternative; holistic medicine; and/or therapy; including but not limited to; yoga and hypnotherapy unless specifically covered under the Policy.

24. Expense incurred when the person or individual is acting beyond the scope of his/her/its legal authority.

25. Expense incurred for hearing exams, hearing aids; the fitting; or prescription of hearing aids except as specifically covered under the Policy. Not covered are: Any hearing service or supply that does not meet professionally accepted standards;
    - Hearing exams given during a stay in a hospital or other facility;
    - Any tests, appliances, and devices for the improvement of hearing, including aids, hearing aids and amplifiers, or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech; and
    - Routine hearing exams, except for routine hearing screenings as specifically described under Preventive Care Benefits.

26. Expense for services or supplies used to treat conditions related to autism; pervasive development disorder; hyperkinetic syndromes; learning disabilities; behavioral problems; mental retardation; or senile deterioration; beyond the period necessary to diagnose the condition except for services listed as specifically covered in the Policy.

27. Expense for charges for failure to keep a scheduled visit; or charges for completion of a claim form.

28. Expense for personal hygiene and convenience items; such as air conditioners; humidifiers; hot tubs; whirlpools; or physical exercise equipment; even if such items are prescribed by a physician.

29. Expense incurred for any non-emergency charges incurred outside of the United States: 1) if you traveled to such location to obtain prescription drugs, or supplies, even if otherwise covered under this Policy; or 2) such drugs or supplies are unavailable or illegal in the United States; or 3) the purchase of such prescription drugs or supplies outside the United States is considered illegal.

30. Expense for services or supplies provided for the treatment of obesity and/or weight control except screening and counseling services as specifically covered under the Policy. Not covered is any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions, including but not limited to:
    - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery;
    - surgical procedures, medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including morbid obesity;
    - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
    - Counseling, coaching, training, hypnosis, or other forms of therapy; and
    - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy, or other forms of activity or activity enhancement.

31. Expense incurred for 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 counseling, hypnosis and other therapies; medications; nicotine patches; and gum; unless recommended by the United States Preventive Services Task Force (USPTSTF).

32. Expense for services and supplies for or related to gamete intrafallopian transfer; artificial insemination; in-vitro fertilization (except as required by the state law); or embryo transfer procedures; male elective sterilization; male or female elective sterilization reversal; or elective abortion; unless specifically covered in the Policy.

33. Expense incurred for injury resulting from the plan or practice of intercollegiate sports (participating in sports clubs; or intramural athletic activities; is not excluded).

34. Expenses incurred for massage therapy.

35. Expense incurred for non-preferred care charges that are above the recognized charges.

36. Expense for treatment of covered students who specialize in the mental health care field; and who receive treatment as a part of their training in that field.

37. Expense incurred for routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically covered in the Policy.

38. Expense incurred for a treatment; service; prescription drug, or supply; which is not medically necessary; as determined by Aetna; for the diagnosis, care, or treatment of the sickness or injury involved, the restoration of physiological functions, or covered preventive services. This includes behavioral health services that are not primarily aimed at treatment of sickness, 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 the person's attending physician, dentist, or vision provider.

39. Expenses incurred for vision-related services and supplies, except as specifically covered in the Policy. In addition, the plan does not cover:
    - Special supplies such as non-prescription sunglasses;
    - Vision service or supply which does not meet professionally accepted standards;
    - Special vision procedures, such as orthoptics or vision training;
    - Eye exams during a 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; and
    - Services to treat errors of refraction.

40. Expense incurred for behavioral health services for the following categories (or equivalent terms as listed in the most recent version of the International Classification of Diseases (ICD)) except as specifically covered in the Policy:
    - Dementias and amnesias without behavioral disturbances;
    - Sexual deviations and disorders except for gender identity disorders;
    - Tobacco use disorders;
    - Specific disorders of sleep;
    - Antisocial or dissocial personality disorder;
    - Pathological gambling, kleptomania, pyromania;

- Specific delays in development (learning disorders, academic underachievement); and
- Mental retardation.

41. Expense incurred in a facility for care, services or supplies provided in:
    - Rest homes;
    - Assisted living facilities (this does not apply to assisted living facilities for the treatment of Acquired Brain Injuries);
    - Similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
    - Health resorts;
    - Spas, sanitariums;
    - Infirmaries at schools, colleges or camps; and
    - Wilderness Treatment Programs or any such related or similar program, school and/or education service.

42. 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).

43. Expense incurred for contraception except as specifically covered in the Policy.

44. Expense incurred for disposable outpatient supplies (except as specifically covered in the Policy). Any outpatient disposable supply or device, including but not limited to sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.

45. Expense incurred for drugs, medications and supplies, except as specifically covered in the Policy. Not covered are:
    - Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a prescription including vitamins;
    - Services related to the dispensing, injection or application of a drug;
    - A prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
    - Immunizations related to travel or work;
    - Needles, syringes and other injectable aids, except as covered for diabetic supplies, and for a covered drug;
    - Drugs related to the treatment of non-covered medical expenses;
    - Performance enhancing steroids;
    - Implantable drugs and associated devices;
    - Injectable drugs if an alternative oral drug is available, unless medically necessary;
    - Any expenses for prescription drugs, and supplies covered under the Pharmacy Plan will not be covered under this medical expense plan. prescription drug exclusions that apply to the Aetna Pharmacy plan will apply to the medical expense coverage; and
    - Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy whether functional or organic.

46. Expense incurred for educational services:
    - Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
    - Evaluation or treatment of learning disabilities, attention deficit disorder, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause;
    - Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills; and

- Services eligible under the Individuals with Disabilities in Education Act (IDEA).

47. Expenses incurred for food items except as specifically covered under the Policy: Any food item, including infant formulas, nutritional supplements, vitamins, including prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.

48. Expense incurred in relation to genetics: Except as specifically covered in the Policy, the plan does not cover 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.

49. Expense incurred for any treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth, including surgical procedures, devices to stimulate growth, and growth hormones except as specifically covered in the Policy.

50. Expense incurred for outpatient cognitive therapy, physical therapy, and occupational therapy, except as specifically covered in the Policy. Not covered under the Policy are charges for:
    - Educational services;
    - Any services unless provided in accordance with a specific treatment plan;
    - Services provided during a stay in a hospital, skilled nursing facility or hospice facility except as specifically covered in Policy section;
    - Services provided by a home health care agency;
    - Services provided by a physician or treatment covered as part of Chiropractic Treatment. This applies whether or not benefits have been paid under the Chiropractic Treatment benefit;
    - Services not performed by a physician, occupational or physical therapist or under the direct supervision of a physician;
    - Services provided by a physician or physical or occupational therapist who resides in your home; or who is a member of your family, or a member of your spouse's or your domestic partner's family; and
    - Special education to instruct a person to function. This includes lessons in sign language.

51. Expense incurred for outpatient speech therapy. Except as specifically covered in the Policy, not covered are charges for:
    - Any services unless provided in accordance with a specific treatment plan;
    - Services provided during a stay in a hospital, skilled nursing facility or hospice facility except as specifically covered in the Policy;
    - Services provided by a home health care agency;
    - Services not performed by a physician, or speech therapist or under the direct supervision of a physician;
    - Services provided by a physician or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's or your domestic partner's family; and
    - Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

52. Expense incurred for therapies and tests: Any of the following treatments or procedures including but not limited to:
    - Aromatherapy;
    - Bio-feedback and bioenergetic therapy except this does not apply to the treatment of acquired brain injury;
    - Carbon dioxide therapy;
    - Chelation therapy (except for heavy metal poisoning);
    - Computer-aided tomography (CAT) scanning of the entire body;
    - Early intensive behavioral interventions (including Applied Behavior Analysis, Denver, LEAP, TEACHH, Rutgers programs) except as specifically covered in the What the Medical Plan Covers Section;

- Educational therapy;
- Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography

53. Expense incurred for contraceptive methods or supplies for contraceptive purposes as elected by the Policyholder who is a Religious Policyholder.

Additional Pediatric Dental Services Exclusions and Limitations

54. Expenses incurred for any instruction for diet, plaque control and oral hygiene.

55. Expenses incurred for 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 covered in the Policy. Facings on molar crowns and pontics will always be considered cosmetic.

56. Expenses incurred for crown, inlays and 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.

57. Expenses incurred for dental examinations that are:
    - Required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
    - Required by any law of a government, securing insurance or school admissions, or professional or other licenses;
    - Required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
    - Any special medical reports not directly related to treatment except when provided as part of a covered service.

58. Expenses incurred for dental implants, braces (that are not determined to be medically necessary), mouth guards, and other devices to protect, replace or reposition teeth and removal of implants.

59. Expenses incurred for dental services and supplies that are covered in whole or in part under any other part of this plan.

60. Expenses incurred for dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, abfraction or erosion.

61. Expenses incurred for general anesthesia and intravenous sedation, except as specifically covered in the Policy and only when done in connection with another medically necessary covered service or supply.

62. Expenses incurred for jaw joint disorder treatment, services and supplies, except as specifically covered in the Policy, to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

63. Expenses incurred for orthodontic treatment except as specifically covered in the Orthodontic Treatment Rule section of the Policy.

64. Expenses incurred for pontics, crowns, cast or processed restorations made with high noble metals (gold).

65. Expenses incurred for prescribed drugs; pre-medication; or analgesia.

66. Expenses incurred for 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.

67. Expenses incurred for replacement of teeth beyond the normal complement of 32.

68. Expenses incurred for routine dental exams and other preventive services and supplies, except as specifically covered in the Policy.

69. Expenses incurred for space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.

70. Expenses incurred for the surgical removal of impacted wisdom teeth only for orthodontic reasons.

71. Expenses incurred for treatment by other than a dentist or dental provider that is legally qualified to furnish dental services or supplies.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

The Houston Community College Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health℠ is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).

IMPORTANT NOTICES:

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 **1-877-480-4161**.

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.

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).

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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)