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Aetna Student Health

Major Medical Outline of Coverage
Lincoln University

Policy Year: 2018 - 2019
Policy Number: 686171

lincoln.myahpcare.com
1-855-850-4297
Enrollment/Wavier

This is a brief description of the Student Health Plan. The Plan is available for Lincoln University and their eligible dependents. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Certificate of Coverage issued to you and may be viewed online at lincoln.myahpcare.com**.** If there is a difference between this Benefit Summary and the Certificate of Coverage, the Certificate will control.

STUDENT HEALTH SERVICES (SHC)

The University Health Services is the University's on-campus health facility. Staffed by registered nurses, it is open weekdays from 9:00 a.m. to 4:00 p.m., (closing for 1 hour between 12 noon- 1:00 p.m. for lunch) during the Fall and Spring semesters. A Physician is on duty for morning clinics three days during the week.

For more information, call the Student Health Services at (484) 365-7338. In the event of an emergency, call 911 or the Campus Police.

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.

Eligible Dependents: Coverage for dependents eligible under the Plan for the following Coverage Periods. Coverage will, will become effective at 12:01 AM on the Coverage Start Date indicated below August 11, 2018, and will terminate at 11:59 PM on the Coverage End Date indicated August 10, 2019. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Certificate of Coverage.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	08/11/2018	08/10/2019	09/24/2018/ 09/17/2018
Spring/Summer	01/10/2019	08/10/2019	02/04/2019/ 1/28/2019

Rates

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

	Annual	Spring/Summer Semester
Student	$829	$484
Spouse	$829	$484
Child	$829	$484
2 or more children	$1,658	$968

Student Coverage

Who is eligible?

All currently enrolled full time students are required to enroll. Full time students are defined as Undergraduate students taking 9 or more credit hours and Graduate students taking 3 or more credit hours. The applicable premium will be charged to the student's tuition bill. Students who waive out of the plan are required to submit proof of other comparable coverage. Once proof of other coverage is received and accepted the applicable premium will be removed from the bill. International students may not waive out of the plan. Part time students are not eligible.

Enrollment

To enroll online or obtain an enrollment application for voluntary coverage, log on to lincoln.myahpcare.com.

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

Dependent Coverage

Eligibility

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

Enrollment

To enroll the dependent(s) of a covered student, please complete the Enrollment Form by visiting lincoln.myahpcare.com. Please refer to the Coverage Periods section of this document for coverage dates and deadline dates. Dependent enrollment applications will not be accepted after the enrollment deadline, unless there is a significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage under another health plan.) This form can be found on lincoln.myahpcare.com.

Important note regarding coverage for a newborn infant or newly adopted child:

Your newborn child is covered on your health plan for the first 31 days from the moment of birth.

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

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

- To keep your child covered, we must receive your completed enrollment information within 31 days after the adoption or placement for adoption.
- You must still enroll the child within 31 days of the adoption or placement for adoption even when coverage does not require payment of an additional premium contribution for the child.
- If you miss this deadline, your adopted child or child placed with you for adoption will not have health benefits after the first 31 days.

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

If you need information or have general questions on dependent enrollment, call Member Services at 877-480-4161.

Medicare Eligibility Notice

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

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

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

In-network Provider Network

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

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

Pre-certification

You need pre-approval from us for some eligible health services. Pre-approval is also called pre-certification.

Pre-certification for medical services and supplies

In-network care

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

Out-of-network care

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

Pre-certification call

Pre-certification should be secured within the timeframes specified below. To obtain pre-certification, call Member Services at the toll-free number on your ID card. This call must be made:

Non-emergency admissions:	You, your physician or the facility will need to call and request pre-certification at least 14 days before the date you are scheduled to be admitted.
An emergency admission:	You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
An urgent admission:	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.
Outpatient non-emergency services requiring pre-certification:	You or your physician must call at least 14 before the outpatient care is provided, or the treatment or procedure is scheduled.
Delivery:	You, your physician, or the facility must call within 48 hours of the birth or as soon thereafter as possible. No penalty will be applied for the first 48 hours after delivery for a routine delivery and 96 hours for a cesarean delivery.

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

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

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

What if you don't obtain the required pre-certification?

If you don't obtain the required pre-certification:

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

What types of services and supplies require pre-certification?

Pre-certification is required for the following types of services and supplies:

Inpatient services and supplies
Obesity (bariatric) surgery
Stays in a **hospice** facility
Stays in a **hospital**
Stays in a **rehabilitation facility**
Stays in a **residential treatment facility** for treatment of **mental disorders** and **substance abuse**
Stays in a **skilled nursing facility**

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

Coordination of Benefits (COB)

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

Here's how COB works

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

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

Description of Benefits

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

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

Metallic Level: Gold, Tested at: 83.72%.

Policy year deductible	**In-network coverage**	**Out-of-network coverage**
You have to meet your policy year deductible before this plan pays for benefits.		
Student	$250 per Policy Year	$600 per Policy Year
Spouse	$250 per Policy Year	$600 per Policy Year
Each child	$250 per Policy Year	$600 per Policy Year
Family	None	None
Policy year deductible waiver		
The policy year deductible is waived for all of the following eligible health services: • In-network care for Preventive care and wellness, and Pediatric preventive dental care services • In-network and Out-of-network care for Pediatric vision care services, Outpatient prescription drugs, and Well newborn nursery care		
Maximum out-of-pocket limit per **policy year**		
Student	$6,250 per Policy Year	$12,700 per Policy Year
Spouse	$6,250 per Policy Year	$12,700 per Policy Year
Each child	$6,250 per Policy Year	$12,700 per Policy Year
Family	None	None

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

Eligible health services	In-network coverage	Out-of-network coverage
Preventive care and wellness		
Routine physical exams		
Performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Covered persons through age 21: Maximum age and visit limits per policy year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Aetna Navigator® secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Covered persons age 22 and over: Maximum visits per policy year	1 visit	
Preventive care immunizations		
Performed in a facility or at a physician's office	100% (of the negotiated charge) per visit. No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician or Member Services by logging onto your Aetna Navigator® secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Well woman preventive visits **Routine gynecological exams (including Pap smears and cytology tests)**		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	

Eligible health services	In-network coverage	Out-of-network coverage
Preventive screening and counseling services		
Obesity and/or healthy diet counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)	
Misuse of alcohol and/or drugs counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year	5 visits	
Use of tobacco products counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year	8 visits	
Depression screening counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year	1 visit	
Sexually transmitted infection counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year	2 visits	

Eligible health services	In-network coverage	Out-of-network coverage
Genetic risk counseling for breast and ovarian cancer counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Routine cancer screenings performed at a physician's office, specialist's office or facility.		
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician or Member Services by logging onto your Aetna Navigator® secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Lung cancer screening maximums	1 screening every 12 months*	
***Important note:** Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.		
Prenatal care services (provided by a physician, an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)		
Preventive care services only	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Important note: You should review the *Maternity care and Well newborn nursery care* sections. They will give you more information on coverage levels for maternity care under this plan.		
Comprehensive lactation support and counseling services		
Lactation counseling services - facility or office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits	

Eligible health services	In-network coverage	Out-of-network coverage
Important note: Any visits that exceed the lactation counseling services maximum are covered under the *Physicians and other health professionals* section.		
Breast pump supplies and accessories	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximums	An electric breast pump (non-hospital grade, cost is covered by your plan once every three years) or A manual breast pump (cost is covered by your plan once per pregnancy) If an electric breast pump was purchased within the previous three year period, the purchase of another electric breast pump will not be covered until a three year period has elapsed since the last purchase.	
Family planning services – female contraceptives		
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Contraceptives (prescription drugs and devices)		
Female contraceptive prescription drugs and devices provided, administered, or removed, by a physician during an office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Female voluntary sterilization		
Inpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Outpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Physicians and other health professionals		
Physician and specialist services		
Office hours visits (non-surgical and non-preventive care by a physician and specialist)	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter	60% (of the recognized charge) per visit
Telemedicine consultation By a physician or specialist	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
Allergy testing and treatment		
Allergy testing performed at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Allergy injections treatment performed at a physician's, or specialist office when you see the physician	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Allergy sera and extracts administered via injection at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Physician and specialist - inpatient surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge)	60% (of the recognized charge)
Anesthetist	80% (of the negotiated charge)	60% (of the recognized charge)
Surgical assistant	80% (of the negotiated charge)	60% (of the recognized charge)
Physician and specialist - outpatient surgical services		
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
In-hospital non-surgical physician services		
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Consultant services (non-surgical and non-preventive)		
Office hours visits (non-surgical and non-preventive care)	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter	60% (of the recognized charge) per visit
Telemedicine consultation by a consultant	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Second surgical opinion	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Alternatives to physician office visits		
Walk-in clinic visits(non-emergency visit)	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter	60% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Hospital and other facility care		
Inpatient hospital (room and board) and other miscellaneous services and supplies) Subject to semi-private room rate unless intensive care unit required Room and board includes intensive care For physician charges, refer to the *Physician and specialist – inpatient surgical services* benefit	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Preadmission testing	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Alternatives to hospital stays		
Outpatient surgery (facility charges)		
Facility charges for surgery performed in the outpatient department of a hospital or surgery center For physician charges, refer to the *Physician and specialist - outpatient surgical services* benefit	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Home health care		
Outpatient	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum visits per policy year	120 days per policy year	
Outpatient private duty nursing	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Hospice care		
Inpatient facility (room and board and other miscellaneous services and supplies)	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Maximum days per confinement per policy year	Unlimited	
Outpatient	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum visits per policy year	Unlimited	
Respite care-maximum number of days per 6 month period	30	
Bereavement counseling-maximum number of sessions per policy year	30	

Eligible health services	In-network coverage	Out-of-network coverage
Skilled nursing facility		
Inpatient facility (room and board and miscellaneous inpatient care services and supplies) Subject to semi-private room rate unless intensive care unit is required Room and board includes intensive care	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Maximum days of confinement per policy year	120 days per policy year	
Emergency services and urgent care		
Emergency services		
Hospital emergency room *Includes complex imaging services, lab work and radiological services performed during a hospital emergency room visit, and any surgery which results from the hospital emergency room visit	$250 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not Covered	Not Covered

Important note:

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

Eligible health services	In-network coverage	Out-of-network coverage
Urgent care		
Urgent medical care provided by an urgent care provider Does not include complex imaging services, lab work and radiological services performed during an urgent medical care visit	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Non-urgent use of urgent care provider Examples of non-urgent care are: • Routine or preventive care (this includes immunizations) • Follow-up care • Physical therapy • Elective treatment • Any diagnostic lab work and radiological services which are not related to the treatment of the urgent condition.	Not covered	Not covered
Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19)		
Type A services	100% (of the negotiated charge) per visit No copayment or deductible applies	100% (of the recognized charge) per visit
Type B services	70% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit
Type C services	50% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit
Orthodontic services	50% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit
Dental emergency treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received.
Specific conditions		
Birthing center (facility charges)		
Inpatient (room and board and other miscellaneous services and supplies)	Paid at the same cost-sharing as hospital care.	Paid at the same cost-sharing as hospital care.
Diabetic services and supplies (including equipment and training)		
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Eligible health services	In-network coverage	Out-of-network coverage
Impacted wisdom teeth		
Impacted wisdom teeth	80% (of the negotiated charge)	80% (of the recognized charge)
Accidental injury to sound natural teeth		
Accidental injury to sound natural teeth	80% (of the negotiated charge)	80% (of the recognized charge)
Anesthesia and related facility charges for dental care		
Anesthesia and related facility charges for oral surgery a dental care Coverage is subject to certain conditions. See the benefit description in the certificate of coverage for details.	80% (of the negotiated charge)	60% (of the recognized charge)
Blood and body fluid exposure		
Blood and body fluid exposure	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment		
TMJ and **CMJ** treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Dermatological treatment		
Dermatological treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maternity care		
Maternity care (includes delivery and postpartum care services in a hospital or birthing center)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
Note: *The per admission copayment amount and/or policy year deductible for newborns will be waived for nursery charges for the duration of the newborn's initial routine facility stay. The nursery charges waiver will not apply for non-routine facility stays.*		
Pregnancy complications		
Inpatient (room and board and other miscellaneous services and supplies) Subject to semi-private room rate unless intensive care unit required Room and board includes intensive care	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
Family planning services – other		
Voluntary sterilization for males Inpatient physician or specialist surgical services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Voluntary sterilization for males Outpatient physician or specialist surgical services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Abortion Inpatient physician or specialist surgical services	80% (of the negotiated charge)	60% (of the recognized charge)
Abortion Outpatient physician or specialist surgical services	80% (of the negotiated charge)	60% (of the recognized charge)
Gender reassignment (sex change) treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Important Note: Just log into your Aetna Navigator® secure website at www.aetnastudenthealth.com for detailed information about this covered benefit, including eligibility requirements in Aetna's clinical policy bulletin #0615. You can also call *Member Services* at the toll-free number on the back of your ID card.		
Autism spectrum disorder		
Autism spectrum disorder treatment (includes physician and specialist office visits, diagnosis and testing)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Applied behavior analysis*	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
***Important note**: Applied behavior analysis requires pre-certification by Aetna. Your in-network provider is responsible for obtaining pre-certification. You are responsible for obtaining pre-certification when you use an out-of-network provider.		

Eligible health services	In-network coverage	Out-of-network coverage
Mental health treatment		
Mental health treatment – inpatient		
Inpatient hospital mental disorders treatment (room and board and other miscellaneous hospital services and supplies) Inpatient residential treatment facility mental disorders treatment (room and board and other miscellaneous residential treatment facility services and supplies) Subject to semi-private room rate unless intensive care unit is required Mental disorder room and board intensive care	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Mental health treatment - outpatient		
Outpatient mental disorders treatment office visits to a physician or behavioral health provider (includes telemedicine cognitive behavioral therapy consultations)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Other outpatient mental disorders treatment (includes skilled behavioral health services in the home) Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical treatment) Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Substance abuse related disorders treatment-inpatient		
Inpatient hospital substance abuse detoxification (room and board and other miscellaneous hospital services and supplies) Inpatient hospital substance abuse rehabilitation (room and board and other miscellaneous hospital services and supplies) Inpatient residential treatment facility substance abuse (room and board and other miscellaneous residential treatment facility services and supplies) Subject to semi-private room rate unless intensive care unit is required Substance abuse room and board intensive care	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Substance abuse related disorders treatment-outpatient: detoxification and rehabilitation		
Outpatient substance abuse office visits to a physician or behavioral health provider (includes telemedicine cognitive behavioral therapy consultations)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Other outpatient substance abuse services (includes skilled behavioral health services in the home) Partial hospitalization treatment (at least 4 hours, but less than 24 hours per day of clinical treatment) Intensive Outpatient Program (at least 2 hours per day and at least 6 hours per week of clinical treatment)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Obesity (bariatric) Surgery		
Inpatient and outpatient facility and physician services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
Reconstructive surgery and supplies		
Reconstructive surgery and supplies (includes reconstructive breast surgery)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

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

Eligible health services	In-network coverage	Out-of-network coverage
Treatment of infertility		
Basic infertility services Inpatient and outpatient care - basic infertility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Comprehensive infertility services Inpatient and outpatient care - comprehensive infertility services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Specific therapies and tests		
Outpatient diagnostic testing		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	$15 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter	60% (of the recognized charge) per visit
Diagnostic lab work and radiological services performed in a physician's office, the outpatient department of a hospital or other facility	$15 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter	60% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Chemotherapy		
Chemotherapy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient infusion therapy		
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient radiation therapy		
Outpatient radiation therapy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient respiratory therapy		
Respiratory therapy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Transfusion or kidney dialysis of blood		
Transfusion or kidney dialysis of blood	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Short-term cardiac and pulmonary rehabilitation services		
Cardiac rehabilitation	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Pulmonary rehabilitation	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Short-term rehabilitation and habilitation therapy services		
Outpatient physical, occupational, speech, and cognitive therapies Combined for short-term rehabilitation services and habilitation therapy services	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter	60% (of the recognized charge) per visit
Chiropractic services		
Chiropractic services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum visits per policy year	20	
Diagnostic testing for learning disabilities		
Diagnostic testing for learning disabilities	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
Specialty prescription drugs (Purchased and injected or infused by your provider in an outpatient setting)		
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
Other services and supplies		
Acupuncture in lieu of anesthesia	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	80% (of the negotiated charge) per trip	Paid the same as in-network coverage
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Durable medical and surgical equipment	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Enteral formulas and nutritional supplements	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Osteoporosis (non-preventive care)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Prosthetic devices		
All other prosthetic devices Includes Cranial prosthetics *(Medical wigs)*	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Orthotic devices	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Cochlear implants Coverage is limited to covered persons age 18 and over	80% (of the negotiated charge) per item	60% (of the recognized charge) per item

Eligible health services	In-network coverage	Out-of-network coverage
Hearing aids and exams		
Hearing aid exams	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter	60% (of the recognized charge) per visit
Hearing aids	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Hearing aids maximum per ear	One hearing aid per ear every policy year	
Podiatric (foot care) treatment		
Physician and Specialist non-routine foot care treatment (includes routine foot care)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Vision care		
Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)		
Pediatric routine vision exams (including refraction)		
Performed by a legally qualified ophthalmologist or optometrist	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year	1 visit	
Pediatric comprehensive low vision evaluations		
Performed by a legally qualified ophthalmologist or optometrist	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum	One comprehensive low vision evaluation every policy year	
Pediatric vision care services and supplies		
Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Maximum number of eyeglass frames per policy year Maximum number of prescription lenses per policy year	One set of eyeglass frames One pair of prescription lenses	
Maximum number of prescription contact lenses per policy year (includes non-conventional prescription contact lenses and aphakic lenses prescribed after cataract surgery)	Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set	
Office visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Optical devices Maximum number of optical devices per policy year One optical device	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
*__Important note__: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both. Coverage does not include the office visit for the fitting of prescription contact lenses.		
Outpatient prescription drugs		
Policy year deductible and copayment/coinsurance waiver for risk reducing breast cancer		
The policy year deductible and the per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network, pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.		
Policy year deductible and copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs		
The policy year deductible and the per prescription copayment/coinsurance will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a retail in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%. Your policy year deductible and any prescription copayment/coinsurance will apply after those two regimens per policy year have been exhausted.		
Policy year deductible and copayment/coinsurance waiver for contraceptives		
The policy year deductible and the per prescription copayment/coinsurance will not apply to female contraceptive methods when obtained at an in-network pharmacy. This means that such contraceptive methods are paid at 100% for: • Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. • If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug or device for that method paid at 100%. The policy year deductible prescription drug policy year deductible and the per prescription copayment/coinsurance continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at an in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.		
Preferred Generic prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	$10 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$10 copayment per supply then the plan pays 100% (of the recognized charge) No policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	$20 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	Not covered
Preferred brand-name prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	$30 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$30 copayment per supply then the plan pays 100% (of the recognized charge) No policy year deductible applies
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	$60 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	Not Covered
Non-preferred generic prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	$50 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$50 copayment per supply then the plan pays 100% (of the recognized charge) No policy year deductible applies
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	$100 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	Not Covered
Non-preferred brand-name prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	$50 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$50 copayment per supply then the plan pays 100% (of the recognized charge) No policy year deductible applies
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	$100 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	Not Covered

Eligible health services	In-network coverage	Out-of-network coverage
Orally administered anti-cancer prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a retail pharmacy For each 30 day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna Navigator® secure website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card.	
Risk reducing breast cancer prescription drugs		
Risk reducing breast cancer prescription drugs filled at a pharmacy For each 30 day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna Navigator® secure website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card.	
Tobacco cessation prescription and over-the-counter drugs		
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each 30 day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card.	

A covered person, a covered person's designee or a covered person's prescriber may seek an expedited medical exception process to obtain coverage for non-covered drugs in exigent circumstances. An "exigent circumstance" exists when a covered person is suffering from a health condition that may seriously jeopardize a covered person's life, health, or ability to regain maximum function or when a covered person is undergoing a current course of treatment using a non-formulary drug.

The request for an expedited review of an exigent circumstance may be submitted by contacting Aetna's *Pre-certification Department* at **1-855-240-0535**, faxing the request to **1-877-269-9916**, or submitting the request in writing to:

CVS Health
ATTN: Aetna PA
1300 E. Campbell Road
Richardson, TX 75081

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

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

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

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

General exceptions and exclusions

Acupuncture therapy

- Maintenance treatment
- Acupuncture when provided for the following conditions:
  - Acute low back pain
  - Addiction
  - AIDS
  - Amblyopia
  - Allergic rehinitis
  - Asthma
  - Autism spectrum disorders
  - Bell's Palsy
  - Burning mouth syndrome
  - Cancer-related dyspnea
  - Carpal tunnel syndrome
  - Chemotherapy-induced leukopenia
  - Chemotherapy-induced neuopathic pain
  - Chronic pain syndrome (e.g., RSD, facial pain)
  - Chronic obstructive pulmonary disease
  - Diabetic peripheral neuropathy
  - Dry eyes
  - Erectile dysfunction
  - Facial spasm
  - Fetal breech presentation
  - Fibromyalgia

- Fibrotic contractures
- Glaucoma
- Hypertension
- Induction of labor
- Infertility(e.g., to assist oocyte retrieval and embryo transfer during IVF treatment cycle)
- Insomnia
- Irritable bowel syndrome
- Menstrual cramps/dysmenorrhea
- Mumps
- Myofascial pain
- Myopia
- Neck pain/cervical spondylosis
- Obesity
- Painful neuropathies
- Parkinson's disease
- Peripheral arterial disease (e.g., intermittent claudication)
- Phantom leg pain
- Polycystic ovary syndrome
- Post-herpetic neuralgia
- Psoriasis
- Psychiatric disorders (e.g., depression)
- Raynaud's disease pain
- Respiratory disorders
- Rheumatoid arthritis
- Rhinitis
- Sensorineural deafness
- Shoulder pain (e.g., bursitis)
- Stroke rehabilitation (e.g., dysphagia)
- Tennis elbow/ epicondylitis
- Tension headache
- Tinnitus
- Tobacco Cessation
- Urinary incontinence
- Uterine fibroids
- Xerostomia
- Whiplash

Air or space travel

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

  This exclusion does not apply if:
  - You are traveling solely as a fare-paying passenger
  - You are traveling on a licensed, commercial, regularly scheduled non-military aircraft
  - You are traveling solely in a civil aircraft with a current valid "Standard Federal Aviation Agency Airworthiness Certificate" and:
    - The civil aircraft is piloted by a person with a current valid pilot's certificate with proper ratings for the type of flight and aircraft involved

- You are as a passenger with no duties at all on an aircraft used only to carry passengers or you are a pilot or a part of the flight crew on an aircraft owned or leased by the policyholder performing duties for the policyholder

Alternative health care

- Services and supplies given by a provider for alternative health care. This includes but is not limited to aromatherapy, naturopathic medicine, herbal remedies, homeopathy, energy medicine, Christian faith-healing medicine, Ayurvedic medicine, yoga, hypnotherapy, and traditional Chinese medicine.

Ambulance services

- Non-emergency fixed wing air ambulance from an out-of-network provider
- Non-emergency ambulance transports except as covered under the *Eligible health services under your plan* section of this certificate of coverage

Armed forces

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

Artificial organs

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

Beyond legal authority

- Services and supplies provided by a health professional or other provider that is acting beyond the scope of its legal authority

Blood and body fluid exposure

- Services and supplies provided for the treatment of an illness that results from your clinical related injury as these are covered elsewhere in the student policy

Blood (synthetic or substitutes)

Examples of these are:

- The provision of blood to the hospital, other than blood derived clotting factors
- Any related services including processing, storage or replacement expenses
- The services of blood donors, apheresis or plasmapheresis
- For autologous blood donations, including drawing, storage and transfusion, only administration and processing expenses are covered

Breasts

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

Clinical trial therapies (experimental or investigational)

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

Clinical trial therapies (routine patient costs)

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except medically necessary Category B investigational devices and

promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna's claim policies)
- Select care or in-network coverage limited to benefits for routine patient services provided within the network

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

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

This exclusion does not apply to:
- Surgery after an accidental injury when performed as soon as medically feasible
- Coverage that may be provided under the *Eligible health services under your plan - Gender reassignment (sex change) treatment* section.

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

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

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

Dermatological treatment
- Cosmetic treatment and procedures

Dental care for adults
- Dental services for adults including services related to:
  - The care, filling, removal or replacement of teeth and treatment of **injuries** to or diseases of the teeth
  - Dental services related to the gums
  - Apicoectomy (dental root resection)
  - Orthodontics
  - Root canal treatment

- Soft tissue impactions
- Alveolectomy
- Augmentation and vestibuloplasty treatment of periodontal disease
- False teeth
- Prosthetic restoration of dental implants
- Dental implants

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

Durable medical equipment (DME)
Examples of these items are:

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

Early intensive behavioral interventions
Examples of these services are:

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

Educational services
Examples of these services are:

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

Elective treatment or elective surgery

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

Enteral formulas and nutritional supplements

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

Examinations
Any health or dental examinations needed:

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

Experimental or investigational

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

Emergency services and urgent care

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

Facility charges
For care, services or supplies provided in:

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

Family planning services - other

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

Felony

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

Foot care

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

Gender reassignment (sex change) treatment

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

Genetic care

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

Growth/Height care

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

Hearing aids and exams

The following services or supplies:

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

Home health care

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

Hospice care

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

Incidental surgeries

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

Jaw joint disorder

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

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

Judgment or settlement

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

Mandatory no-fault laws

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

Maintenance care

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

Maternity and related newborn care

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

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. Examples of these are:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans

- Syringes
- Blood or urine testing supplies
- Other home test kits
- Splints
- Neck braces
- Compresses
- Other devices not intended for reuse by another patient

Medicare

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

Mental health treatment

- Mental health services for the following categories (or equivalent terms as listed in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association):
  - Stays in a facility for treatment of dementias and amnesia without a behavioral disturbance that necessitates mental health treatment
  - Sexual deviations and disorders except for gender identity disorders
  - Tobacco use disorders except as described in the *Eligible health services under your plan – Preventive care and wellness* section
  - Pathological gambling, kleptomania, pyromania
  - School and/or education service including special educational, remedial education, wilderness treatment programs, or any such related or similar programs
  - Services provided in conjunction with school, vocation, work or recreational activities
  - Transportation

Motor vehicle accidents

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

Non-medically necessary services and supplies

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

Non-U.S .citizen

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

Obesity (bariatric) surgery

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

- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery
- Surgical procedures, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity
- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
- Hypnosis or other forms of therapy
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Organ removal

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

Other primary payer

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

Outpatient infusion therapy

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

Outpatient prescription or non-prescription drugs and medicines

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

Outpatient surgery

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

Pediatric dental care

- Any instruction for diet, plaque control and oral hygiene
- Asynchronous dental treatment
- Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *Eligible health services under your plan* section. Facings on molar crowns and pontics will always be considered cosmetic.
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material or
  - The tooth is an abutment to a covered partial denture or fixed bridge

- Dental implants and braces(that are determined not to be medically necessary mouth guards, and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of:
  - splinting
  - to alter vertical dimension
  - to restore occlusion
  - for correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) and craniomandibular joint dysfunction disorder (CMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services under your plan – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another eligible health service except as specifically described in the *Eligible health services* under your plan – *Pediatric dental care* section
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered in the Orthodontic Treatment Rule section of the Policy
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication or analgesia (nitrous oxide)
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically provided in the Eligible health services under your plan —Pediatric dental care section
- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a provider
  - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a dental provider

Personal care, comfort or convenience items

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

Preventive care and wellness

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

Prosthetic devices

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

Riot

- Services and supplies that you receive from providers as a result of an injury from your "participation in a riot". This means when you take part in a riot in any way such as inciting, or conspiring to incite, the riot. It does not include actions that you take in self-defense as long as they are not against people who are trying to restore law and order.

Routine exams

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

School health services

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

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

Services provided by a family member

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

Services, supplies and drugs received outside of the United States

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

Sexual dysfunction and enhancement

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

Sinus surgery

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

Sleep apnea

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

Specialty prescription drugs

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

Sports

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

Strength and performance

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

Students in mental health field

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

Telemedicine

- Services given when you are not present at the same time as the **provider**
- Services including:
  - Telephone calls for behavioral health services
  - Telemedicine kiosks
  - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

Temporomandibular joint dysfunction treatment (TMJ) and craniomandibular joint dysfunction treatment (CMJ)

- Dental implants

Therapies and tests

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

Tobacco cessation

- Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:

- Counseling, except as specifically provided in the Eligible health services under your plan – Preventive care and wellness section
- Hypnosis and other therapies
- Medications, except as specifically provided in the Eligible health services under your plan – Outpatient prescription drugs section
- Nicotine patches
- Gum

Transplant services

- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
- Harvesting and/or storage of bone marrow, or hematopoietic stem cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness
- Travel and lodging expenses for transplants that are not obtained at an IOE facility

Treatment in a federal, state, or governmental entity

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

Treatment of infertility

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

Use of drugs, alcohol or intoxicants

- Services and supplies to treat an injury resulting from the use of:
  - Drugs (except as prescribed by a physician)
  - Alcohol
  - Intoxicants

Valid and collectable insurance

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

Vision Care

Pediatric vision care services and supplies

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

Adult vision care

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

Adult vision care services and supplies

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

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

Wilderness Treatment Programs

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

Work related illness or injuries

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

Exceptions and exclusions that apply to outpatient prescription drugs

Allergy sera and extracts administered via injection

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

Biological sera

Compounded prescriptions

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

Cosmetic drugs

- Medications or preparations used for cosmetic purposes

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

Dietary supplements including medical foods

Drugs or medications

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

Duplicative drug therapy (e.g. two antihistamine drugs)

Genetic care

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

Immunizations related to travel or work

Immunization or immunological agents

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

Infertility

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

Injectables

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

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

Prescription drugs:

- For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a prescription is written.
- Packaged in unit dose form.
- Filled prior to the effective date or after the termination date of coverage under this plan.
- Dispensed by a mail order pharmacy that include prescription drugs that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.
- That include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and are not clinically superior to that drug as determined by the plan.
- That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or prescription drugs for the treatment of a dental condition.
- That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the preferred drug guide.
- That are non-preferred drugs, unless non-preferred drugs are specifically covered as described in your schedule of benefits. However, a non-preferred drug will be covered if in the judgment of the prescriber there is no equivalent prescription drug on the preferred drug guide or the product on the preferred drug guide is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.
- That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not medically

necessary, or otherwise improper, and drugs obtained for use by anyone other than the identified on the ID card.

Refills

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

Replacement of lost or stolen prescriptions

Test agents except diabetic test agents

Tobacco cessation

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

We reserve the right to exclude:

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

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

Sanctioned Countries

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

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

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

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

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

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

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 (877) 480-4161

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

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

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

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

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

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

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

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero (877) 480-4161. (Italian) 言語サービスを無料でご利用いただくには、(877) 480-4161までお電話ください。(Japanese) 무료 언어 서비스를 이용하려면 (877) 480-4161번으로 전화해 주십시오. (Korean)

(877) 480-4161 تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć (877) 480-4161. (Polish) Para acessar os serviços de idiomas sem custo para você, ligue para (877) 480-4161. (Portuguese)

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

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