



**Aetna Student Health Plan
Plan Design and Benefits Summary
Administrative Services by Aetna Student Health**



Michigan State University – Graduate Assistant Plan

Policy Year: 2024–2025

Policy Number: 246796

<https://www.aetnastudenthealth.com>

(800) 859-8452



This is a brief description of the Michigan State University Graduate Assistant Health Insurance Plan. The plan is available for Michigan State University Graduate Assistant's and their eligible dependents. Aetna Life Insurance Company (Aetna) is the plan administrator. The exact provisions, including definitions, governing this insurance are contained in the Michigan State University Wrap Plan Document plan document. You may request a copy of the plan document by contacting the MSU HR Solution Center at 517-353-4434 or SolutionsCenter@hr.msu.edu. If there is a difference between this Plan Summary and the plan document, the plan document will control.

Olin Health Center

Olin Health Center is the University's on-campus health facility. Staffed by MD (allopathic) and DO (osteopathic) physicians as well as certified Nurse Practitioners and Physician Assistants, it is open weekdays from 8:00 a.m. to 11:45 a.m. and 12:45 p.m. to 4:50 p.m. A 24-hour Phone Information Nurse line is available to answer health-related questions, call 517-353-5557. For more information, call Olin Health Center at 517-884-6546 or email Olin@msu.edu. In the event of an emergency, call 911 or the Campus Police at 517-355-2222, www.police.msu.edu.

Who is eligible?

All Graduate Assistants who meet the following eligibility criteria are automatically enrolled in the health insurance plan, unless the waiver has been completed by the specified enrollment deadline dates.

- Graduate Assistant with 1/4, 1/2, or 3/4 appointments (eligible for tuition waiver); AND
- Who have worked at least 53 calendar days during their Fall or Spring appointment, or 46 calendar days during their Summer appointment.

If a Graduate Assistant has comparable coverage in a different health plan, a waiver can be requested (within the established deadlines) by visiting <https://msu.myahpcare.com/waiver>.

For further details regarding Graduate Assistant appointments, review the [Assistantships Frequently Asked Questions \(FAQs\)](https://hr.msu.edu/employment/graduate-assistants/faqs.html) online at <https://hr.msu.edu/employment/graduate-assistants/faqs.html>.

Dependent Coverage Eligibility

Covered Graduate Assistants may also enroll their lawful spouse, OEI, and children up to age 26. To enroll, please go to msu.myahpcare.com/enrollment, click on the "Click Here to Enroll" button under the "Student and Graduate Assistant" drop down.

Eligible dependents include:

- The insured Graduate Assistant's spouse residing with the Graduate Assistant;
- The insured Graduate Assistant's Other Eligible Individual (OEI); and
- The insured Graduate Assistant's children and stepchildren (must be under the age of 26).

A person who is eligible for Medicare at the time of enrollment under this plan is not eligible for medical expense coverage and prescribed medicines expense coverage. If a covered person becomes eligible for Medicare after he or she is enrolled in this plan, such Medicare eligibility will not result in the termination of medical expense coverage and prescribed medicines expense coverage under this plan. As used within this provision, persons are "eligible for Medicare" if they are entitled to benefits under Part A (receiving free Part A) or enrolled in Part B or Premium Part A.

Coverage Dates and Rates

Michigan State University will cover the cost of the health plan for the Graduate Assistant. The premium for spouses/other eligible individuals and eligible dependents of Graduate Assistants are partially funded by MSU.

Coverage for Graduate Assistants and their eligible dependents will become effective at 12:01 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicated. Coverage for insured dependents terminates in accordance with the Termination Provisions, described in the Wrap Plan Document plan document.

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

Graduate Assistant and Eligible Dependents:

Term	FALL	SPRING I	SPRING II	SPRING III	MONTHLY
Effective Dates	8/16/24 – 2/15/25	1/01/25 – 8/15/25	2/16/25 – 8/15/25	5/12/25 – 8/15/25	
Graduate Assistant	\$0	\$0	\$0	\$0	\$0
One Dependent (Spouse / Other Eligible Individual or Child)	\$235	\$296	\$235	\$118	\$39
Two or More Dependents	\$1,008	\$1,271	\$1,008	\$504	\$168

Note: Dependents can't be enrolled in this plan beyond the Graduate Assistant coverage period.

To view all enrollment and coverage periods available, please visit msu.myahpcare.com.

Enrollment

To enroll your covered dependents online, visit msu.myahpcare.com and click "Begin Enrollment". From there, navigate to your student category, and click on Enroll. You will be directed to Academic HealthPlan (AHP) Care26 to make your elections.

Dependent enrollment applications will not be accepted after the enrollment deadline, unless there is a qualified life event change that directly affects their insurance coverage. (An example of a qualified life change would be loss of health coverage under another health plan.) If you need assistance with enrollment, you can call AHP customer service at 855-904-1740.

Detailed plan information can be found at msu.myahpcare.com/benefits. Should you have any questions or need support with enrollment, you may call, chat or email AHP. Complete contact information can be found at msu.myahpcare.com/contact.

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

Newborn child

- Your newborn child is covered on your health plan for the first 60 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 60-day period.
 - You must still enroll the child within 60 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 60 days.
 - If your coverage ends during this 60 day period, then your newborn's coverage will end on the same date as your coverage. This applies even if the 60-day period has not ended.

Adopted child or a child legally placed with you for adoption

- A child that you, or you and your spouse, civil union partner or domestic partner adopt, or that is placed with you for adoption, is covered on your plan for the first 60 days after the adoption or the placement is complete.
 - To keep your child covered, we must receive your completed enrollment information within 60 days after the adoption or placement for adoption.
 - You must still enroll the child within 60 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 60 days.
 - If your coverage ends during this 60-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 60-day period has not ended.

If you need information or have general questions on dependent enrollment, call AHP Member Services at 855-904-1740.

Qualifying Life Events

A Qualifying Life Event (QLE) is a change in your situation – like getting married, having a baby, or an involuntary loss of health coverage – that can make you eligible for a Special Enrollment Period, allowing you to enroll in health insurance outside the plan's scheduled Open Enrollment Period(s). Examples:

- Loss of other coverage (e.g. student "aging off" parents' plan, loss of coverage through employer, Medicaid)
- Marriage
- Divorce
- Birth of a Child
- Adoption of a Child
- Spouse/dependent entering the United States

Enrollment Deadline: Notice of the qualifying event enrollment must be received within 30 days from the qualifying event date. Graduate Assistants who miss the enrollment deadline to enroll themselves or their dependents must wait for the next enrollment period, unless they experience another Qualifying Life Event.

Medicare Eligibility Notice

The Graduate Assistant health insurance plan does not provide coverage for people who have Medicare. Students are not eligible to enroll in this student health insurance plan if they have Medicare at the time of enrollment in this plan.

The Graduate Assistant health insurance plan is considered individual health insurance under federal law. The Medicare anti-duplication rules make it illegal for an insurer to knowingly sell an individual policy to a person enrolled in Medicare (whether Part A or B or both). If a student enrolls in the student health plan and later becomes enrolled in Medicare (mid-year), Aetna will not automatically terminate coverage.

Termination and Refunds

If you withdraw or are dismissed from classes within the first 31 days of a coverage period, you will not be covered under the health insurance plan 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.)

If you wish to withdraw or are dismissed from classes, please contact MSU HR at SolutionsCenter@hr.msu.edu or 517-353-4434 for information regarding the impact to your insurance enrollment and continuation option.

In-network Provider Network

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

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

Precertification

You need pre-approval from us for some eligible health services. Pre-approval is also called precertification. Your in-network physician is responsible for obtaining any necessary precertification before you get the care. When you go to an out-of-network provider, it is your responsibility to obtain precertification from us for any services and supplies on the precertification list. For a current listing of the health services or prescription drugs that require precertification, contact Member Services or go to <https://www.aetnastudenthealth.com>.

Precertification Call

Precertification should be secured within the timeframes specified below. To obtain precertification, call Member Services at the toll-free number on your ID card. You, your physician or the facility must call us within these timelines:

Type of care	Timeframe
Non-emergency admissions	Call at least 14 days before the date you are scheduled to be admitted.
Emergency admission	Call within 48 hours or as soon as reasonably possible after you have been admitted.
Urgent admission	Call before you are scheduled to be admitted.
Outpatient non-emergency medical services	Call at least 14 days before the care is provided, or the treatment is scheduled

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.

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

Coordination of Benefits (COB)

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

Description of Benefits

The Plan excludes coverage for certain services and has limitations on the amounts it will pay. While this Plan Summary document will tell you about some of the important features of the Plan, other features that may be important to you are defined in the MSU Wrap Benefit Plan plan document.

	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Policy year deductibles			
Individual	None	\$125 per policy year	\$250 per policy year
Family	None	\$250 per policy year	\$500 per policy year
Policy year deductible waiver			
The policy year deductible is waived for all of the following eligible health services: <ul style="list-style-type: none"> In-network care for Preventive care and wellness and Pediatric Dental Type A services In-network care and out-of-network care for Well newborn nursery care, Hospital Emergency Room, Ambulance, Pediatric Vision Care Services and Outpatient prescription drugs 			
Maximum out-of-pocket limits			
	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Individual	\$1,500 per policy year (combined)		\$2,300 per policy year
Family	\$3,000 per policy year (combined)		\$4,600 per policy year
Maximum out-of-pocket limit applies to deductibles, copays and coinsurance amounts for all covered services, including prescription drug copays.			
Not included in the maximum out-of-pocket limits: Balance-billed charges, Health care this plan doesn't cover, Non-referred or nonauthorized services, Pediatric dental and vision.			

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Preventive care and wellness			
Routine physical exams			
Routine physical exam	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) after deductible per visit
Routine physical exam limits for 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.		
Covered persons age 22 and over: Maximum visits per policy year	1 visit		

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Preventive care immunizations Performed in a facility or at a physician's office			
Preventive care immunizations	100% (of the negotiated charge) per visit No copayment or policy year deductible applies Travel immunizations not available	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) after deductible per visit
Preventive care immunization 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		
The following is not covered under this benefit: <ul style="list-style-type: none"> Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment 			
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	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) after deductible per visit
Maximum visits per policy year	1 visit		
Preventive screening and counseling services			
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) after deductible per visit
Obesity and/or healthy diet counseling Maximum visits	Age 0-22: unlimited visits. Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.		
Misuse of alcohol and/or drugs counseling Maximum visits per policy year	5 visits		

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Use of tobacco products counseling Maximum visits per policy year	8 visits		
Sexually transmitted infection counseling Maximum visits per policy year	2 visits		
Genetic risk counseling for breast and ovarian cancer limitations	Not subject to any age or frequency limitations		
Routine cancer screenings	Available for Consult and Referral	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) after deductible per visit
Routine cancer screening maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> • 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. 		
Lung cancer screening maximums	1 screening every 12 months		
Prenatal care services (Preventive care services only)	Available for Consult and Referral	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) after deductible per visit
Lactation counseling services	Available for Consult and Referral	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) after deductible per visit
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits		

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Breast pump supplies and accessories (Must be obtained from a participating DME provider)	Available for Consult and Referral	100% (of the negotiated charge) per item No copayment or policy year deductible applies	80% (of the recognized charge) after deductible per item
Family planning services – female contraceptives			
Counseling services			
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) after deductible per visit
Contraceptive counseling services maximum visits per policy year either in a group or individual setting	2 visits		
Female contraceptive preferred generic prescription drugs and devices provided, administered, or removed, by a provider during an office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) after deductible per visit
Female voluntary sterilization			
Inpatient provider services	Available for Consult and Referral	100% (of the negotiated charge) No copayment or policy year deductible applies	80% (of the recognized charge) after deductible
Outpatient provider services	Available for Consult and Referral	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) after deductible per visit
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> • 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, sterilization procedures or devices, except for male condoms prescribed by a provider 			

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Physicians and other health professionals			
Physician & specialist visits including Consultants Office visits (non-surgical/ non-preventive care by a physician and specialist, includes telemedicine consultations)	\$15 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit Telemedicine not available	\$15 copayment then the plan pays 100% (of the balance of the negotiated charge) after deductible per visit	80% (of the recognized charge) after deductible per visit
Allergy testing and treatment			
Allergy testing performed at a physician's or specialist's office	Available for Consult and Referral	95% (of the negotiated charge) after deductible per visit. Office visit copay may apply.	80% (of the recognized charge) after deductible per visit
Allergy injections treatment performed at a physician's, or specialist office	100% (of the negotiated charge) per visit	95% (of the negotiated charge) after deductible per visit. Office visit copay may apply.	80% (of the recognized charge) after deductible per visit
Allergy sera and extracts administered via injection at a physician's or specialist's office	100% (of the negotiated charge)	95% (of the negotiated charge) after deductible. Office visit copay may apply.	80% (of the recognized charge) after deductible
Physician and specialist surgical services			
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	Available for Consult and Referral	95% (of the negotiated charge) after deductible	80% (of the recognized charge) after deductible
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> • A stay in a hospital (Hospital stays are covered in the <i>Eligible health services and exclusions – Hospital and other facility care</i> section) • Services of another physician for the administration of a local anesthetic 			

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)	Available for Consult and Referral	95% (of the negotiated charge) per visit after deductible	80% (of the recognized charge) after deductible per visit
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> • A stay in a hospital (Hospital stays are covered in the <i>Eligible health services and exclusions – Hospital and other facility care</i> section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic 			
Alternatives to physician office visits			
Walk-in clinic visits (non-emergency visit)	Not available	\$15 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	80% (of the recognized charge) after deductible per visit
Hospital and other facility care			
Inpatient hospital (room and board) and other miscellaneous services and supplies Includes birthing center facility charges	Not available	95% (of the negotiated charge) after deductible per admission	80% (of the recognized charge) after deductible per admission
Preadmission testing	Not available	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.
In-hospital non-surgical physician services	Not available	95% (of the negotiated charge) after deductible per visit	80% (of the recognized charge) after deductible per visit
Alternatives to hospital stays			
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	Not available	95% (of the negotiated charge) after deductible	80% (of the recognized charge) after deductible
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> • A stay in a hospital (See the <i>Hospital care – facility charges</i> benefit in this section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic 			

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Home health Care	Not available	95% (of the negotiated charge) after deductible per visit	80% (of the recognized charge) after deductible per visit
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> • 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 • Homemaker or housekeeper services • Food or home delivered services • Maintenance therapy 			
Hospice care-Inpatient facility (room and board and other miscellaneous services and supplies)	Not available	95% (of the negotiated charge) after deductible per admission	80% (of the recognized charge) after deductible per admission
Hospice care-Outpatient	Not available	95% (of the negotiated charge) after deductible per visit	80% (of the recognized charge) after deductible per visit
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> - Sitter or companion services for either you or other family members - Transportation - Maintenance of the house 			
Skilled nursing facility-Inpatient Must meet medical necessity guidelines for skilled care	Not available	95% (of the negotiated charge) after deductible per admission	80% (of the recognized charge) after deductible per admission
Hospital emergency room Copay waived when admitted at inpatient.	Not available	\$50 copayment then the plan pays 95% (of the balance of the negotiated charge) per visit No policy year deductible applies	Paid the same as in-network coverage

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Non-emergency care in a hospital emergency room	Not available	95% (of the balance of the negotiated charge) per visit No policy year deductible applies	Paid the same as in-network coverage
Important note: <ul style="list-style-type: none"> 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, [or call Member Services for an address at 1-877-480-4161 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. 			
Urgent care services	Not available	95% (of the negotiated charge) after deductible per visit	80% (of the recognized charge) after deductible per visit
Pediatric dental care (Limited to covered dependent through the end of the policyyear in which the dependent turns age 19.)			
Pediatric dental deductible	Not applicable	Not applicable	\$50 per individual \$150 per contract
Deductible per policy year			
Pediatric dental out-of-pocket maximum	Not applicable	\$350 per individual \$700 per contract per policy year	Not applicable
Type A services – Diagnostic and preventive services such as oral exams, cleanings, X-rays	Available for Consult and Referral	100% (of the negotiated charge) per visit No deductible applies	70% (of the recognized charge) per visit

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Type B services – Basic services such as fillings, endodontic treatments and oral surgery	Available for Consult and Referral	70% (of the negotiated charge) per visit	50% (of the recognized charge) after deductible per visit
Type C services – Major services such as crowns and bridges	Available for Consult and Referral	50% (of the negotiated charge) per visit	50% (of the recognized charge) after deductible per visit
Dental emergency services	Not available	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received.

Pediatric dental care exclusions

The following are not covered under this benefit:

- Any instruction for diet, plaque control and oral hygiene
- Cosmetic services and supplies including:
 - Plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
 - Augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the *Eligible health services and exclusions* section
 - Facings on molar crowns and pontics will always be considered cosmetic
- Crown, inlays, onlays, and veneers unless:
 - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material
 - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants and braces (that are determined not to be medically necessary), mouth guards, and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
 - For splinting
 - To alter vertical dimension
 - To restore occlusion
 - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) and craniomandibular joint dysfunction disorder (CMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services and exclusions – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another eligible health service
- Orthodontic treatment except as covered above and in the *Pediatric dental care* section of the schedule of benefits
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication or analgesia (nitrous oxide)
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures

- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically provided in the *Pediatric dental care* section of the schedule of benefits
- Services and supplies:
 - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
 - Provided for your personal comfort or convenience or the convenience of another person, including a provider
 - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a dental provider that is legally qualified to furnish dental services and supplies
- Orthodontic services

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Diabetic services and supplies (see below)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Podiatric (foot care) treatment Physician and specialist non-routine foot care treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Diabetic services and supplies (including equipment and training)

Eligible health services include:

- Services and supplies
 - Foot care to minimize the risk of infection
 - Insulin preparations
 - Hypodermic needles and syringes used for the treatment of diabetes
 - Injection aids for the blind
 - Diabetic test agents
 - Lancets/lancing devices
 - Prescribed oral medications whose primary purpose is to influence blood sugar
 - Alcohol swabs
 - Injectable glucagons
 - Glucagon emergency kits
- Equipment
 - External insulin pumps
 - Blood glucose meters without special features, unless required due to blindness
- Training
 - Self-management training provided by a health care **provider** certified in diabetes self-management training

The following are not covered under this benefit:

- 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,

<p>running, working or wearing shoes</p> <ul style="list-style-type: none"> - Supplies (including orthopedic shoes), 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 			
Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
<p><u>Temporomandibular Joint Dysfunction</u></p> <p>Covered medical expenses include physician’s charges incurred by a covered person for surgical and non-surgical treatment of Temporomandibular Joint (TMJ) Dysfunction.</p>	Available for Consult and Referral	95% (of the negotiated charge) after deductible per visit	80% (of the recognized charge) after deductible per visit
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> • Dental implants 			
Clinical trial (routine patient costs)	Available for Consult and Referral	Not covered	Not covered
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> • 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 or investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna’s claim policies) 			
Dermatological treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> • Cosmetic treatment and procedures 			
Obesity bariatric Surgery inpatient and outpatient facility and physician services	Available for Consult and Referral	<p>Covered according to the type of benefit and the place where the service is received.</p> <p>Medical necessity is required.</p>	<p>Covered according to the type of benefit and the place where the service is received.</p> <p>Medical necessity is required.</p>
<p>The following are not covered under this benefit:</p> <p>Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described above and in the <i>Eligible health services and exclusions – Preventive care and wellness</i> section, including preventive services for obesity screening and weight management</p>			

interventions. This is regardless of the existence of other medical conditions. Examples of these are:

- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
- Hypnosis or other forms of therapy
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Description	MSU Student Health Services Health Center	In-network coverage	Out-of-network coverage
Maternity care (includes delivery and postpartum care services in a hospital or birthing center) See Prenatal care services under the Preventive care and wellness section above.	Available for Consult and Referral	95% (of the negotiated charges) after deductible	80% (of the recognized charge) after deductible
The following are not covered under this benefit: <ul style="list-style-type: none"> • Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries 			
Well newborn nursery care in a hospital or birthing center	Available for Consult and Referral	95% (of the negotiated charge) after deductible	80% (of the recognized charge) after deductible
Voluntary sterilization for males-Inpatient physician or specialist surgical services	Available for Consult and Referral	95% (of the negotiated charge) after deductible	80% (of the recognized charge) after deductible
Voluntary sterilization for males-Outpatient physician or specialist surgical services	Available for Consult and Referral	95% (of the negotiated charge) after deductible	80% (of the recognized charge) after deductible
Abortion Inpatient physician or specialist surgical services	Not available	95% (of the negotiated charge) after deductible	80% (of the recognized charge) after deductible
Abortion Outpatient physician or specialist surgical services	Not available	95% (of the negotiated charge) after deductible	80% (of the recognized charge) after deductible
Maximum number of procedures per policy year	Not available	1	
Gender affirming treatment			
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Autism spectrum disorder			
Autism spectrum disorder treatment, diagnosis and testing includes Applied behavior analysis and Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Available for Consult and Referral	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Behavioral health			
Mental Health and Substance Abuse Treatment			
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	Not available	95% (of the negotiated charge) after deductible per admission	80% (of the recognized charge) after deductible per admission
Outpatient office visits (includes telemedicine consultations)	\$15 copayment then the plan pays 100% (of the balance of the negotiated charge per visit Telemedicine not available	Office visits: \$15 copayment then the plan pays 100% (of the balance of the negotiated charge per visit All other outpatient services: 95% (of the negotiated charge) after deductible per visit	Mental health & behavioral health office visits: \$15 copayment after deductible All other outpatient services to include substance abuse services: 80% (of the recognized charge) after deductible per visit
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	Available for Consult and Referral	95% (of the negotiated charge) after deductible per visit	80% (of the recognized charge) after deductible per visit
Description	MSU Student Health Services at Olin Health Center	In-network coverage (IOE facility)	Out-of-network coverage (Includes providers who are otherwise part of Aetna's network but are non-IOE providers)
Transplant services			
Inpatient and outpatient transplant facility services	Available for Consult and Referral	95% (of the negotiated charge) after deductible per visit	80% (of the recognized charge) after deductible per visit
Inpatient and outpatient transplant physician and specialist services	Not available	95% (of the negotiated charge) after deductible per visit	80% (of the recognized charge) after deductible per visit

Inpatient and outpatient transplant physician and specialist services	Not available	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<p>The following services for transplant donors are covered by Aetna GA health plan <i>when billed to the transplant recipient</i>. The <i>transplant recipient must be covered under the Aetna GA health plan for these services to be covered</i>:</p> <ul style="list-style-type: none"> • Compatibility testing of prospective organ/tissue from donors who are members of the immediate family (first degree relatives, such as, parents, siblings, and children) of a member selected for an organ transplant • Live organ/tissue donor fees • Cadaveric organ/tissue procurement preservation, storage and transportation fees as billed by the Organ Procurement Organization (OPO) • Charges for activating the donor search process for donors in the registry, HLA-DR sample procurement and typing, donor physical examinations and laboratory tests as well as bone marrow/stem cell procurement <p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> • Services and supplies furnished to a donor when billed directly to the recipient and/or the recipient is not a covered person • Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness • Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness 			
Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Infertility services			
Basic infertility services Inpatient and outpatient care	Available for Consult and Referral	95% (of the negotiated charge) after deductible per visit. Office visit copay may apply.	80% (of the allowed amount) after deductible per visit
Comprehensive infertility services			
Comprehensive infertility services Inpatient and outpatient care	Available for Consult and Referral	95% (of the negotiated charge) after deductible per visit. Office visit copay may apply.	80% (of the allowed amount) after deductible per visit
Maximum number of ovulation induction cycles with menotropins per lifetime	Not available	6	6
Maximum number of Intrauterine insemination cycles per lifetime	Not available	6	6
<p>Infertility services exclusions: The following are not covered under the infertility services benefit:</p> <ul style="list-style-type: none"> • All infertility services associated with or in support of an Advanced Reproductive Technology (ART) cycle. These include, but are not limited to: <ul style="list-style-type: none"> - Imaging, laboratory services, and professional services 			

- In vitro fertilization (IVF)
- Zygote intrafallopian transfer (ZIFT)
- Gamete intrafallopian transfer (GIFT)
- Cryopreserved embryo transfers
- Gestational carrier cycles
- Any related services, products or procedures (such as intracytoplasmic sperm injection (ICSI) or ovum microsurgery).
- Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue.
- Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- Obtaining sperm from a person not covered under this plan.
- Infertility treatment when a successful pregnancy could have been obtained through less costly treatment.
- Infertility treatment when either partner has had voluntary sterilization surgery, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- Infertility treatment when infertility is due to a natural physiologic process such as age related ovarian insufficiency (e.g., perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period or other abnormal testing results as outlined in Aetna’s infertility clinical policy.
- Treatment for dependent children

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Specific therapies and tests			
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility – Requires preauthorization	Available for Consult and Referral	95% (of the negotiated charge) after deductible	80% (of the recognized charge) after deductible
Diagnostic lab work performed in a physician’s office, the outpatient department of a hospital or other facility	100% (of the negotiated charge) Some services are not available at Olin Health Center	95% (of the negotiated charge) after deductible	80% (of the recognized charge) after deductible
Diagnostic radiological services performed in a physician’s office, the outpatient department of a hospital or other facility	100% (of the negotiated charge) some services are not provided at Olin	95% (of the negotiated charge) after deductible	80% (of the recognized charge) after deductible
Outpatient Chemotherapy, Radiation & Respiratory Therapy	Available for Consult and Referral	95% (of the negotiated charge) per visit after deductible	80% (of the recognized charge) after deductible per visit

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	Available for Consult and Referral	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> • 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 physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for short-term rehabilitation services and habilitation therapy services Unlimited visits; Medical necessity required	\$15 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit (Physical therapy only. ST and OT not available at Olin Health Center.)	\$15 copayment then the plan pays 90% (of the balance of the negotiated charge) after deductible per visit	80% (of the recognized charge) after deductible per visit
Chiropractic services	Available for Consult and Referral	\$15 copayment then the plan pays 90% (of the balance of the negotiated charge) after deductible per visit	80% (of the recognized charge) after deductible per visit
Maximum chiropractic visits per policy year	30		
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.	Covered according to the type of benefit or the place where the service is received.
Other services			
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	Not available	95% (of the negotiated charge) after deductible per trip No policy year deductible applies	Paid the same as in-network coverage
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> • Ambulance services for routine transportation to receive outpatient or inpatient care 			

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Durable medical and surgical equipment Preauthorization may be required	90% (of the negotiated charge) per item Certain item available	95% (of the negotiated charge) after deductible per item	95% (of the recognized charge) after deductible per item
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> 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 			
Nutritional support - parenteral and enteral	Available for Consult and Referral	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as described above 			
All other prosthetic Devices (including breast prosthetic devices) & Orthotics	90% (of the negotiated charge) per item Certain item available	95% (of the negotiated charge) after deductible per item	95% (of the recognized charge) after deductible per item
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> 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 			
<p>Pediatric vision care (Limited to covered dependents through the end of the policy year in which the dependent turns age 19)</p>			
Performed by a legally qualified ophthalmologist or optometrist (includes comprehensive low vision evaluations and office visit for fitting of contact lenses)	Available for Consult and Referral	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the recognized charge) per visit No policy year deductible applies

Maximum visits per policy year Low vision Maximum Fitting of contact Maximum	1 visit One comprehensive low vision evaluation every policy year 1 visit		
Pediatric vision care services & supplies-Eyeglass frames and prescription lenses	Available for Consult and Referral	100% (of the negotiated charge) per item No policy year deductible applies	100% (of the recognized charge) per item No policy year deductible applies
Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	One set of eyeglass frames (Frames - chosen from a select collection) One pair of prescription lenses Daily disposables: Not covered Extended wear disposable: Not covered Non-disposable lenses: Not covered		
Optical devices	Not available	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum number of optical devices per policy year	One optical device		
The following is not covered under this benefit: <ul style="list-style-type: none"> • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes • Prescription contact lenses 			

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs		
Copayment/coinsurance waiver for risk reducing breast cancer		
The per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs filled at a retail in-network, pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.		

Outpatient prescription drug copayment waiver for tobacco cessation prescription and over-the-counter drugs
The outpatient prescription copayment will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a retail in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%. Any prescription drug copayment will apply after those two regimens per policy year have been exhausted.
Outpatient prescription drug copayment waiver for contraceptives
The outpatient prescription drug copayment will not apply to female contraceptive methods when obtained at an in-network pharmacy. This means that such contraceptive methods are paid at 100% for:

- 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 prescription drug copayment continues 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 from the pharmacy benefit manager, CVS Caremark.

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs		
Preferred and non-preferred generic prescription drugs		
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 balance of the negotiated charge) No policy year deductible applies	\$10 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
Preferred brand-name prescription drugs		
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 balance of the negotiated charge) No policy year deductible applies	\$30 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
Non-preferred brand-name prescription drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	\$60 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	\$60 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
Preferred Specialty drugs		
For each fill up to a 30-day supply filled at a retail pharmacy	\$75 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
Non-Preferred Specialty drugs		
For each fill up to a 30-day supply filled at a retail pharmacy	\$75 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
Anti-cancer prescription drugs taken by mouth- For each fill up to a 30-day supply	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
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
Preventive care drugs and supplements maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by calling the toll-free number on your ID card	
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
Risk reducing breast cancer prescription drugs maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered risk reducing breast cancer prescription drugs, contact Member Service by calling the toll-free number on your ID card	
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
Tobacco cessation prescription drugs and OTC drugs maximums	Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits.	
Contraceptives (birth control)		
For each fill up to a 30-day supply of generic and OTC drugs and devices 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
For each fill up to a 30-day supply of brand name prescription drugs and devices filled at a retail pharmacy	Paid according to the type of drug per the schedule of benefits above	Paid according to the type of drug per the schedule of benefits above
Outpatient prescription drug exclusions The following are not eligible health services: <ul style="list-style-type: none"> • Any services related to providing, injecting or application of a drug • Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones • Cosmetic drugs including medication and preparations used for cosmetic purposes • Devices, products and appliances unless listed as an eligible health service 		

- Dietary supplements including medical foods
- Drugs or medications:
 - Administered or entirely consumed at the time and place they are prescribed or provided
 - Which do not require a prescription by law, even if a prescription is written, unless we have approved a medical exception
 - That are therapeutically the same or an alternative to a covered prescription drug, unless we approve a medical exception
 - Not approved by the FDA or not proven safe or effective
 - Provided under your medical plan while inpatient at a healthcare facility
 - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
 - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
 - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as an eligible health service
 - That are used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications
- Duplicative drug therapy; for example, two antihistamines for the same condition
- Genetic care including:
 - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as an eligible health service
- Immunizations related to work
- Immunization or immunological agents except as specifically stated in the schedule of benefits
- Implantable drugs and associated devices except as specifically stated in the schedule of benefits
- Infertility:
 - Prescription drugs used primarily for the treatment of infertility
- Injectables including:
 - Any charges for the administration or injection of prescription drugs
 - Needles and syringes except for those used for insulin administration
 - 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 with the exception of Depo Provera and other injectable drugs for contraception
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- Prescription drugs:
 - 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 plan's drug guide
 - That are used for the purpose of improving visual acuity or field of vision
 - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card
- Replacement of lost or stolen prescriptions
- Test agents except diabetic test agents
- Tobacco cessation drugs, unless recommended by the USPSTF
- We reserve the right to exclude:
 - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's drug guide

- Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's drug guide

A covered person, a covered person's designee or a covered person's prescriber may seek an expedited medical exception process to obtain coverage for non-covered drugs in exigent circumstances. An "exigent circumstance" exists when a covered person is suffering from a health condition that may seriously jeopardize a covered person's life, health, or ability to regain maximum function or when a covered person is undergoing a current course of treatment using a non-formulary drug. The request for an expedited review of an exigent circumstance may be submitted by contacting Aetna's *Pre-certification Department* at **1-855-240-0535**, faxing the request to **1-877-269-9916**, or submitting the request in writing to:

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

Out of Country claims

Out of Country claims should be submitted with appropriate medical service and payment information from the provider of service. Covered services received outside the United States will be considered at the Out-of-network level of benefits.

General Exclusions

Acupuncture

- Acupuncture
- Acupressure

Air or space travel

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

This exclusion does not apply if:

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

Alternative health care

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

Armed forces

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

Behavioral health treatment

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

Beyond legal authority

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

Blood, blood plasma, synthetic blood, blood derivatives or substitutes

Examples of these are:

- The provision of donated blood to the hospital, other than blood derived clotting factors
- Any related services for donated blood including processing, storage or replacement expenses
- The services of blood donors, including yourself, apheresis or plasmapheresis
- The blood you donate for your own use, excluding administration and processing expenses and except where described in the *Eligible health services and exclusions – Transplant services* section

Clinical trial therapies (experimental or investigational)

- Your plan does not cover clinical trial therapies (experimental or investigational)

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

This exclusion does not apply to:

- Surgery after an accidental injury when performed as soon as medically feasible. (Injuries that occur during medical treatments are not considered accidental injuries even if unplanned or unexpected.)
- Medically necessary plastic surgery for:
 - Blepharoplasty of upper lids
 - Breast reduction
 - Surgical treatment of male gynecomastia
 - Panniculectomy
 - Rhinoplasty or septorhinoplasty for sleep apnea
- Coverage that may be provided under the *Eligible health services -and exclusions. Gender affirming treatment* section.

Court-ordered testing

- Court-ordered testing or care unless medically necessary

Custodial care

Services and supplies meant to help you with activities of daily living or other personal needs.

Examples of these are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care except in connection with hospice care, adult (or child) day care, or convalescent care

- Institutional care. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training
- For behavioral health (mental health treatment and substance related disorders treatment):
 - Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
 - Services given mainly to:
 - Maintain, not improve, a level of function
 - Provide a place free from conditions that could make your physical or mental state worse

Dental care for adults

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

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

Educational services

Examples of these services are:

- Any service or supply for education, training or retraining services or testing, except where described in the *Eligible health services and exclusions– Diabetic services and supplies (including equipment and training)* and *Educational services for chronic disease* sections. This includes:
 - Special education
 - Remedial education
 - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
 - Job training
 - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

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).

Facility charges

For care, services or supplies provided in:

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

Felony

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

Gene-based, cellular and other innovative therapies (GCIT)

The following are not eligible health services unless you receive prior written approval from us:

- GCIT services received at a facility or with a provider that is not a GCIT-designated facility/provider.
- All associated services when GCIT services are not covered. Examples include infusion, laboratory, radiology, anesthesia, and nursing services.

Please refer to the *Medical necessity, referral and precertification requirements* section.

Gene-based, cellular and other innovative therapies (GCIT)

Therapies and treatments including:

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

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

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

Genetic care

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

Growth/Height care

- A treatment, device, 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

Any tests, appliances and devices to:

- Improve your hearing
- Enhance other forms of communication to make up for hearing loss or devices that simulate speech

Hearing exams

- Hearing exams performed for the evaluation and treatment of illness, injury or hearing loss.

Illegal occupation or criminal activity

Services and supplies you receive in which the contributing cause was your:

- Commission of or attempt to commit a felony
- Engagement in an illegal occupation or other willful criminal activity.

A "willful criminal activity" includes, but is not limited to, either of the following:

- Operating a vehicle while intoxicated
- Operating a methamphetamine laboratory.

"Willful criminal activity" does not include a civil infraction or other activity that does not rise to the level of a misdemeanor or felony

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.

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

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.

Medical supplies – outpatient disposable

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

Medicare

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

Non-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 and services

- 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 and exclusions – Preventive care and wellness* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
 - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
 - Hypnosis or other forms of therapy
 - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Other primary payer

- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer
- Health care services for which other coverage is required by federal, state or local law to be bought or provided through other arrangements

- Health care services arising from injuries sustained as a result of a motor vehicle accident, to the extent the services are payable under an automobile insurance policy, medical payment, personal injury protection or no-fault coverage

Personal care, comfort or convenience items

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

Private duty nursing

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 and exclusions* section

Services not permitted by law

- Some laws restrict the range of health care services a provider may perform under certain circumstances or in a particular state. When this happens, the services are not covered by the plan.

Services provided by a family member

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

Sexual dysfunction and enhancement

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

Sinus surgery

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

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:
 - Telemedicine kiosks
 - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

Therapies and tests

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

Tobacco cessation

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

Treatment in a federal, state, or governmental entity

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

Vision care for adults

- Routine vision exam provided by an ophthalmologist or optometrist, including refraction and glaucoma testing
- Vision care services and supplies

Voluntary sterilization

- Reversal of voluntary sterilization procedures, including related follow-up care

Wilderness treatment programs

See *Educational services* within this section

Work related illness or injuries

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

that illness or injury will be considered “non-occupational” regardless of cause.

The Michigan State University Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student HealthSM 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>.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-877-480-4161.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna is committed to being an inclusive health care company. Aetna does not discriminate on the basis of ancestry, race, ethnicity, color, religion, sex/gender (including pregnancy), national origin, sexual orientation, gender identity or expression, physical or mental disability, medical condition, age, veteran status, military status, marital status, genetic information, citizenship status, unemployment status, political affiliation, or on any other basis or characteristic prohibited by applicable federal, state or local law.

Aetna provides free aids and services to people with disabilities and free language services to people whose primary language is not English.

These aids and services include:

- Qualified language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Qualified interpreters
- Information written in other languages

If you need these services, contact the number on your ID card. Not an Aetna member? Call us at 1-877-480-4161.

If you have questions about our nondiscrimination policy or have a discrimination-related concern that you would like to discuss, please call us at 1-877-480-4161.

Please note, Aetna covers health services in compliance with applicable federal and state laws. Not all health services are covered. See plan documents for a complete description of benefits, exclusions, limitations, and conditions of coverage.

Language accessibility statement

Interpreter services are available for free.

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

Español/Spanish

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

አማርኛ/Amharic

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

العربية/Arabic

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

Bàsòò Wùdù/Bassa

Dè dè nià kè dyédé gbo: ɔ jù ké n̄ dyi Bàsòò-wùdù-po-nyò jù ni, niì à wuɖu kà kò d̄ò po-poò b̄é n̄ gbo kpáa. Ɖà **1-877-480-4161** (TTY: **711**).

中文/Chinese

注意：如果您说中文，我们可为您提供免费的语言协助服务。请致电 **1-877-480-4161** (TTY: **711**)。

فارسی/Farsi

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

Français/French

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

ગુજરાતી/Gujarati

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો ભાષાકીય સહાયતા સેવા તમને નિ:શુલ્ક ઉપલબ્ધ છે.
કોલ કરો **1-877-480-4161** (TTY: **711**).

Kreyòl Ayisyen/Haitian Creole

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

Igbo

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

한국어/Korean

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

Português/Portuguese

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

Русский/Russian

Внимание: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Звоните по телефону **1-877-480-4161** (TTY: **711**).

Tagalog

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

اردو/Urdu

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

Tiếng Việt/Vietnamese

Lưu ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số **1-877-480-4161** (TTY: **711**).

Yorùbá/Yoruba

Àkíyèsí: Bí o bá nsọ èdè Yorùbá, ìrànlọ́wọ́ lórí èdè, lófẹ́ẹ̀, wà fún ọ. Pe **1-877-480-4161** (TTY: **711**).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).