Aetna Student Health℠
Plan Design and Benefits Summary
Preferred Provider Organization (PPO)

Pacific University
Policy Year: 2021 – 2022
Policy Number: 686193
www.aetnastudenthealth.com
1-888-834-4704
This is a brief description of the Student Health Plan. The plan is available for Pacific University students. The plan is insured by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Certificate issued to you and may be viewed online at www.aetnastudenthealth.com. If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

HEALTH SERVICES

Pacific University has a student health center that provides services to students on a fee schedule. For students who have chosen the University Student Health Plan, the yearly deductible is waived, and coverage is 100% for charges at the student health center.

Health Clinic Locations - Students May Use Clinic Services at Either Location:
Forest Grove Clinic: 2142 College Way, Forest Grove, OR 97116 (next to admissions office)
Hillsboro Clinic: 730 SE Oak Street, Suite D, Hillsboro, OR (3 blocks from campus)

All services are by appointment. Students may be seen at either the Forest Grove or Hillsboro clinic. Call 503-352-2269 to make an appointment.

Who is eligible?
All students enrolled in 3 or more credit hours and Psychology Graduate students enrolled in 1 or more credit hours are required to participate in the Student Health Insurance Plan. The premium is automatically billed on the tuition billing statement. If a student has comparable coverage, a waiver may be completed online prior to the deadline.

You must actively attend classes for at least the first 31 days after the date your coverage becomes effective.

Enrolling after the Initial Enrollment Period

Special Enrollment Periods
You may decline coverage during your initial enrollment period. To do so, you must submit a completed qualifying waiver provided by your school before your school’s required deadline. You may enroll in this plan later if you qualify under the Special Enrollment Rules below.

- Special Enrollment Rule #1
  If you declined enrollment for yourself because of other health insurance coverage, you may enroll in the plan later if the other coverage ends involuntarily. To do so, you must request enrollment within 31 days after the other health insurance coverage ends (or within 60 days after the other health insurance coverages ends if the other coverage is through Medicaid or a State Children’s Health Insurance Program). Coverage will begin on the day after the other coverage ends.

- Special Enrollment Rule #2
  If you be eligible for a premium assistance subsidy under Medicaid or a state Children’s Health Insurance Program (CHIP), you may be able to enroll yourself at that time. To do so, you must request enrollment within 60 days of the date you become eligible for such assistance. Coverage will begin on the first day of the month after becoming eligible for such assistance.

Effective Date of Coverage
Coverage for each student who enrolls is effective on the first day of the period in which you are eligible, and premium has been paid. See Policyholder for premium payment requirements for you to enroll in this plan.
**Coverage Dates and Rates**

Coverage for all insured students 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.

### Students

<table>
<thead>
<tr>
<th>Program</th>
<th>Coverage Dates</th>
<th>Waiver Deadline</th>
<th>Student Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall Annual (Domestic/International)</td>
<td>08/01/2021 – 07/31/2022</td>
<td>07/06/2021 – 08/13/2021</td>
<td>$3,275.00</td>
</tr>
<tr>
<td>Education - Hybrid Programs</td>
<td>06/01/2021 – 07/31/2021</td>
<td>04/15/2021 – 06/01/2021</td>
<td>$610.00</td>
</tr>
<tr>
<td>MBA (Graduating)</td>
<td>08/01/2021 – 12/31/2021</td>
<td>07/06/2021 – 08/13/2021</td>
<td>$1,417.00</td>
</tr>
<tr>
<td>Physician Asst. 1 yr, 2 yr</td>
<td>05/01/2021 – 04/30/2022</td>
<td>04/15/2021 – 05/15/2021</td>
<td>$3,275.00</td>
</tr>
<tr>
<td>Physician Asst. (Graduating)</td>
<td>05/01/2021 – 12/31/2021</td>
<td>04/15/2021 – 05/15/2021</td>
<td>$2,222.00</td>
</tr>
<tr>
<td>Physician Asst. (Spring Starts)</td>
<td>01/01/2022 – 04/30/2022</td>
<td>12/01/2021 – 01/13/2022</td>
<td>$1,128.00</td>
</tr>
<tr>
<td>Spring New Starts</td>
<td>01/01/2022 – 07/31/2022</td>
<td>12/01/2021 – 01/13/2022</td>
<td>$1,933.00</td>
</tr>
</tbody>
</table>

### Education Students

<table>
<thead>
<tr>
<th>Program</th>
<th>Coverage Dates</th>
<th>Waiver Deadline</th>
<th>Student Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall Annual (Domestic/International)</td>
<td>08/01/2021 – 07/31/2022</td>
<td>07/06/2021 – 08/13/2021</td>
<td>$3,275.00</td>
</tr>
<tr>
<td>EDUC (Early Entry)</td>
<td>05/01/2021 – 07/31/2021</td>
<td>04/15/2021 – 05/15/2021</td>
<td>$882.00</td>
</tr>
<tr>
<td>EDUC (Spring Only)</td>
<td>01/01/2022 – 07/31/2022</td>
<td>12/01/2021 – 01/13/2022</td>
<td>$1,933.00</td>
</tr>
<tr>
<td>MAT SPED EUG (Graduating)</td>
<td>05/01/2020 – 08/31/2021</td>
<td>04/15/2021 – 05/15/2021</td>
<td>$1,009.00</td>
</tr>
<tr>
<td>MAT5Y EUG/Flex EUG (Graduating)</td>
<td>08/01/2021 – 01/31/2022</td>
<td>07/06/2021 – 08/13/2021</td>
<td>$1,688.00</td>
</tr>
<tr>
<td>MAT5Y WB (New Starts)</td>
<td>06/28/2021 – 06/27/2022</td>
<td>04/15/2021 - 06/28/2021</td>
<td>$3,275.00</td>
</tr>
<tr>
<td>MAT5Y (New Starts)</td>
<td>06/28/2021 – 06/27/2022</td>
<td>04/15/2021 - 06/28/2021</td>
<td>$3,275.00</td>
</tr>
</tbody>
</table>

### Master of Fine Arts

<table>
<thead>
<tr>
<th>Program</th>
<th>Coverage Dates</th>
<th>Waiver Deadline</th>
<th>Student Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>MFA</td>
<td>06/01/2021 – 05/31/2022</td>
<td>04/15/2021 – 06/01/2021</td>
<td>$3,275.00</td>
</tr>
<tr>
<td>MFA (Graduating)</td>
<td>06/01/2021 – 06/30/2021</td>
<td>N/A</td>
<td>$267.00</td>
</tr>
<tr>
<td>MFA (Spring Starts)</td>
<td>01/01/2022 – 05/31/2022</td>
<td>12/01/2021 – 01/13/2022</td>
<td>$1,399.00</td>
</tr>
</tbody>
</table>

### Enrollment

To enroll online please visit [pacificu.myahpcare.com](http://pacificu.myahpcare.com), click on Enrollment tab and then select the appropriate enrollment link.

If you withdraw from school within the first 31 days of a coverage period, you will not be covered under the Policy and the full premium will be refunded, less any claims paid. After 31 days, you will be covered for the full period that you have paid the premium for, and no refund will be allowed. (This refund policy will not apply if you withdraw due to a covered Accident or Sickness.)
Medicare Eligibility Notice
You are not eligible to enroll in the student health plan if you have Medicare at the time of enrollment in this student plan. The plan does not provide coverage for people who have Medicare.

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

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

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

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

Precertification
You need pre-approval from us for some eligible health services. Pre-approval is also called precertification. Your in-network physician is responsible for obtaining any necessary precertification before you get the care. When you go to an out-of-network provider, it is your responsibility to obtain precertification from us for any services and supplies on the precertification list. If you do not precertify when required, there is a $500 penalty for each type of eligible health service that was not precertified. Precertification does not apply to prescription drugs and over-the-counter drugs that are considered preventive care. For a current listing of the health services or prescription drugs that require precertification, contact Member Services or go to www.aetnastudenthealth.com.

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

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-emergency admissions:</td>
<td>You, your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.</td>
</tr>
<tr>
<td>An emergency admission:</td>
<td>You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.</td>
</tr>
<tr>
<td>An urgent admission:</td>
<td>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.</td>
</tr>
<tr>
<td>Outpatient non-emergency services requiring precertification:</td>
<td>You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.</td>
</tr>
</tbody>
</table>
We will provide a written notification to you and your physician of the precertification decision, where required by state law. If your precertified services are approved, the approval is valid for 30 days as long as you remain enrolled in the plan.

**Coordination of Benefits (COB)**

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB). A complete description of the Coordination of Benefits provision is contained in the certificate issued to you.

**Description of Benefits**

The Plan excludes coverage for certain services and has limitations on the amounts it will pay. While this Plan Summary document will tell you about some of the important features of the Plan, other features that may be important to you are defined in the Certificate. To look at the full Plan description, which is contained in the Certificate issued to you, go to [www.aetnastudenthealth.com](http://www.aetnastudenthealth.com).

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

<table>
<thead>
<tr>
<th></th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Policy year deductibles</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You have to meet your policy year deductible before this plan pays for benefits.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student</td>
<td>$300 per policy year</td>
<td>$550 per policy year</td>
</tr>
</tbody>
</table>

**Policy year deductible waiver**

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

- In-network care for Physician, specialist including Consultants Office visits, Walk-in clinic visits, Urgent Care, Pediatric Dental Type A services, Family planning services, Outpatient mental health and substance abuse treatment office visits, Chiropractic services, Hearing aid exams, and Pediatric Vision Care
- In-network care and out-of-network care for Preventive care and wellness, Hospital emergency room, Well newborn nursery care, and outpatient prescription drugs

This is the amount you owe for in-network and out-of-network eligible health services each policy year before the plan begins to pay for eligible health services. After the amount you pay for eligible health services reaches the policy year deductible, this plan will begin to pay for eligible health services for the rest of the policy year.

Eligible health services applied to the out-of-network policy year deductibles will not be applied to satisfy the in-network policy year deductibles. Eligible health services applied to the in-network policy year deductibles will not be applied to satisfy the out-of-network policy year deductibles.

**Maximum out-of-pocket limits**

<table>
<thead>
<tr>
<th></th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student</td>
<td>$5,000 per policy year</td>
<td>$10,000 per policy year</td>
</tr>
</tbody>
</table>

Eligible health services applied to the out-of-network maximum out-of-pocket limit will not be applied to satisfy the in-network maximum out-of-pocket limit and eligible health services applied to the in-network maximum out-of-pocket limit will not be applied to satisfy the out-of-network maximum out-of-pocket limit.
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine physical exams</strong></td>
<td>100% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Performed at a physician’s office</td>
<td>No copayment or policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Maximum age and visit limits per policy year through age 21</td>
<td>Subject to any age and visit limits provided for in the comprehensive guidelines</td>
<td>Subject to any age and visit limits provided for in the comprehensive guidelines</td>
</tr>
<tr>
<td></td>
<td>supported by the American Academy of Pediatrics/Bright Futures/Health Resources</td>
<td>supported by the American Academy of Pediatrics/Bright Futures/Health Resources</td>
</tr>
<tr>
<td></td>
<td>and Services Administration guidelines for children and adolescents.</td>
<td>and Services Administration guidelines for children and adolescents.</td>
</tr>
<tr>
<td>Covered persons age 22 and over: Maximum visits per policy year</td>
<td>1 visit</td>
<td></td>
</tr>
<tr>
<td><strong>Preventive care immunizations</strong></td>
<td>100% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Performed in a facility or at a physician’s office</td>
<td>No copayment or policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Maximums</td>
<td>Subject to any age limits provided for in the comprehensive guidelines supported</td>
<td>Subject to any age limits provided for in the comprehensive guidelines supported</td>
</tr>
<tr>
<td></td>
<td>by Advisory Committee on Immunization Practices of the Centers for Disease Control</td>
<td>by Advisory Committee on Immunization Practices of the Centers for Disease Control and</td>
</tr>
<tr>
<td></td>
<td>and Prevention</td>
<td>Prevention</td>
</tr>
<tr>
<td><strong>Routine gynecological exams (including Pap smears and cytology tests)</strong></td>
<td>100% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Performed at a physician’s, obstetrician (OB), gynecologist (GYN) or OB/GYN office</td>
<td>No copayment or policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td>1 visit</td>
<td></td>
</tr>
<tr>
<td><strong>Preventive screening and counseling services</strong></td>
<td>100% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Preventive screening and counseling services for Obesity and/or healthy diet counseling,</td>
<td>No copayment or policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Misuse of alcohol &amp; drugs, Tobacco Products, Depression Screening, Sexually transmitted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>infection counseling &amp; Genetic risk counseling for breast and ovarian cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Obesity and/or healthy diet counseling Maximum visits</td>
<td>Age 0-22: unlimited visits. Age 22 and older: 26 visits per 12 months, of which up</td>
<td></td>
</tr>
<tr>
<td></td>
<td>to 10 visits may be used for healthy diet counseling.</td>
<td></td>
</tr>
<tr>
<td>Misuse of alcohol and/or drugs counseling Maximum visits per policy year</td>
<td>5 visits</td>
<td></td>
</tr>
<tr>
<td>Use of tobacco products counseling Maximum visits per policy year</td>
<td>8 visits</td>
<td></td>
</tr>
<tr>
<td>Depression screening counseling Maximum visits per policy year</td>
<td>1 visit</td>
<td></td>
</tr>
<tr>
<td>Sexually transmitted infection counseling Maximum visits per policy year</td>
<td>2 visits</td>
<td></td>
</tr>
<tr>
<td>Eligible health services</td>
<td>In-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Genetic risk counseling for breast and ovarian cancer limitations</td>
<td>Not subject to any age or frequency limitations</td>
<td></td>
</tr>
<tr>
<td>Routine cancer screenings</td>
<td>100% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Maximum:</td>
<td>Subject to any age; family history; and frequency guidelines as set forth in the most current:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- 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</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- The comprehensive guidelines supported by the Health Resources and Services Administration.</td>
<td></td>
</tr>
<tr>
<td>Lung cancer screening maximums</td>
<td>1 screening every 12 months*</td>
<td></td>
</tr>
<tr>
<td>Prenatal care services (Preventive care services only)</td>
<td>100% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Lactation support and counseling services - facility or office visits</td>
<td>100% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Lactation counseling services maximum visits per policy year either in a group or individual setting</td>
<td>6 visits</td>
<td></td>
</tr>
<tr>
<td>Breast pump supplies and accessories</td>
<td>100% (of the negotiated charge) per item</td>
<td>60% (of the recognized charge) per item</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Family planning services — female contraceptives</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female contraceptive counseling services office visit</td>
<td>100% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Contraceptive counseling services maximum visits per policy year either in a group or individual setting</td>
<td>2 visits</td>
<td></td>
</tr>
<tr>
<td>Female contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit</td>
<td>100% (of the negotiated charge) per item</td>
<td>60% (of the recognized charge) per item</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Eligible health services</td>
<td>In-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td>-----------------------------------------------------------</td>
<td>---------------------------------------------------------</td>
</tr>
<tr>
<td>Female Voluntary sterilization-Inpatient &amp; Outpatient provider services</td>
<td>100% (of the negotiated charge)</td>
<td>60% (of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td>No copayment or policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
</tbody>
</table>

The following are not covered under this benefit:
- 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

<table>
<thead>
<tr>
<th>Physicians and other health professionals</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist), includes telemedicine consultations</td>
<td>$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Allergy testing and treatment</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy testing &amp; Allergy injections treatment performed at a physician’s or specialist’s office</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

The following are not covered under this benefit:
- Allergy sera and extracts administered via injection

<table>
<thead>
<tr>
<th>Physician and specialist surgical services</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)</td>
<td>80% (of the negotiated charge)</td>
<td>60% (of the recognized charge)</td>
</tr>
</tbody>
</table>

The following are not covered under this benefit:
- 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 and exclusions – Hospital and other facility care section)
- Services of another physician for the administration of a local anesthetic

| Outpatient surgery performed at a physician’s or specialist’s office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses) | 80% (of the negotiated charge) per visit | 60% (of the recognized charge) per visit |

The following are not covered under this benefit:
- 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 and exclusions – 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
## Eligible health services

### Alternatives to physician office visits

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walk-in clinic visits (non-emergency visit)</td>
<td>$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

### Hospital and other facility care

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient hospital (room and board) and other miscellaneous services and supplies</td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>In-hospital non-surgical physician services</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

### Alternatives to hospital stays

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

### The following are not covered under this benefit:

- The services of any other physician who helps the operating physician
- A stay in a hospital (See the Hospital care – facility charges 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

### Home health care - Outpatient

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

### The following are not covered under this benefit:

- 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-Inpatient facility

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
</tbody>
</table>

### Hospice-Outpatient

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
</tbody>
</table>

### Respite care-maximum number of days per 30 day period

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>30</td>
<td></td>
</tr>
</tbody>
</table>

### Bereavement counseling-maximum number of sessions per policy year

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>30</td>
<td></td>
</tr>
</tbody>
</table>

### Bereavement counseling-maximum per session per policy year

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$50-unlimited</td>
<td></td>
</tr>
</tbody>
</table>

### The following are not covered under this benefit:

- Funeral arrangements
- Pastoral 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

### Eligible health services

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled nursing facility-Inpatient facility</td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Maximum days of confinement per policy year</td>
<td></td>
<td>60</td>
</tr>
<tr>
<td>Hospital emergency room</td>
<td>$50 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit</td>
<td>Paid the same as in-network coverage</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Non-emergency care in a hospital emergency room</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### 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, 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.

### The following are not covered under this benefit:
- Non-emergency services in a hospital emergency room facility, freestanding emergency medical care facility or comparable emergency facility

<table>
<thead>
<tr>
<th>Service</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent care</td>
<td>$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Non-urgent use of an urgent care provider</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
The following is not covered under this benefit:
- Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)

<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage*</th>
<th>Out-of-network coverage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type A services</td>
<td>100% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No copayment or deductible applies</td>
<td></td>
</tr>
<tr>
<td>Type B services</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Type C services</td>
<td>50% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Orthodontic services</td>
<td>50% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Dental emergency services</td>
<td>Covered according to the type of benefit and the place where the service is received</td>
<td>Covered according to the type of benefit and the place where the service is received</td>
</tr>
</tbody>
</table>

**Pediatric dental care exclusions**

The following are not covered under this benefit:
- 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 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 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 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
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered 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

<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetic services and supplies (including equipment and training)</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Podiatric (foot care) treatment Physician and specialist non-routine foot care treatment</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

**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, running, working or wearing shoes
  - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
  - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet

<table>
<thead>
<tr>
<th>Impacted wisdom teeth</th>
<th>80% (of the negotiated charge)</th>
<th>60% (of the recognized charge)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental injury to sound natural teeth</td>
<td>80% (of the negotiated charge)</td>
<td>60% (of the recognized charge)</td>
</tr>
<tr>
<td>Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

**The following are not covered under this benefit:**
- Dental implants

<table>
<thead>
<tr>
<th>Clinical trial (routine patient costs)</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
</tr>
</thead>
</table>

**The following are not covered under this benefit:**
- 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)

| 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. |
The following are not covered under this benefit:
• Cosmetic treatment and procedures

<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity care (includes delivery and postpartum care services in a hospital or birthing center)</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Well newborn nursery care in a hospital or birthing center</td>
<td>80% (of the negotiated charge) No policy year deductible applies</td>
<td>60% (of the recognized charge) No policy year deductible applies</td>
</tr>
<tr>
<td>Family planning services – other</td>
<td>100% (of the negotiated charge) No policy year deductible applies</td>
<td>60% (of the recognized charge) No policy year deductible applies</td>
</tr>
<tr>
<td>Voluntary sterilization for males-surgical services</td>
<td>100% (of the negotiated charge) No policy year deductible applies</td>
<td>60% (of the recognized charge) No policy year deductible applies</td>
</tr>
<tr>
<td>Abortion</td>
<td>100% (of the negotiated charge) No policy year deductible applies</td>
<td>60% (of the recognized charge) No policy year deductible applies</td>
</tr>
<tr>
<td>Gender affirming treatment</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

All other cosmetic services and supplies not listed under eligible health services above are not covered under this benefit. This includes, but is not limited to the following:
• Rhinoplasty
• Face-lifting
• Lip enhancement
• Facial bone reduction
• Blepharoplasty
• Liposuction of the waist (body contouring)
• Reduction thyroid chondroplasty (tracheal shave)
• Nipple reconstruction
• 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
• Voice and communication therapy
• Chest binders
• Chin implants, nose implants, and lip reduction, which are used to assist masculinization, are considered cosmetic
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Autism spectrum disorder</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autism spectrum disorder treatment, diagnosis and testing and Applied behavior analysis</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Pervasive development disorders</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Behavioral Health Mental Health &amp; Substance Abuse Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient hospital treatment (room and board and other miscellaneous hospital)</td>
<td>80% (of the negotiated charge) per admission</td>
<td>60% (of the recognized charge) per admission</td>
</tr>
<tr>
<td>Outpatient treatment office visits to a physician or behavioral health provider (includes telemedicine cognitive behavioral therapy consultations)</td>
<td>$10 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td><strong>Eligible health services</strong> In-network coverage (IOE facility)*</td>
<td></td>
<td>Out-of-network coverage*</td>
</tr>
<tr>
<td>(Includes providers who are otherwise part of Aetna’s network but are non-IOE providers)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Transplant services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient and outpatient transplant facility services</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Inpatient and outpatient transplant physician and specialist services</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Transplant services-travel and lodging</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Lifetime Maximum payable for Travel and Lodging Expenses for any one transplant, including tandem transplants</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Maximum payable for Lodging Expenses per IOE patient</td>
<td>$50 per night</td>
<td>$50 per night</td>
</tr>
<tr>
<td>Maximum payable for Lodging Expenses per companion</td>
<td>$50 per night</td>
<td>$50 per night</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Treatment of infertility</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic infertility services Inpatient and outpatient care</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

The following are not covered services under the infertility treatment benefit:

- Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.
- All charges associated with:
  - Surrogacy for you or the surrogate, except for covered benefits for maternity care as described in the *Eligible health services under your plan-Maternity care* section. 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

### Specific therapies and tests

<table>
<thead>
<tr>
<th>Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility</th>
<th>80% (of the negotiated charge)</th>
<th>60% (of the recognized charge)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic lab work and radiological services performed in a physician’s office, the outpatient department of a hospital or other facility</td>
<td>80% (of the negotiated charge)</td>
<td>60% (of the recognized charge)</td>
</tr>
<tr>
<td>Outpatient Chemotherapy, Radiation, Infusion &amp; Respiratory Therapy</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy)</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Combined for short-term rehabilitation services and habilitation therapy services</td>
<td>80% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Eligible health services</td>
<td>In-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>-----------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting</td>
<td>Covered according to the type of benefit or the place where the service is received.</td>
<td>Covered according to the type of benefit or the place where the service is received.</td>
</tr>
</tbody>
</table>

**Other services and supplies**

| Emergency ground, air, and water ambulance (includes non-emergency ambulance)          | 80% (of the negotiated charge) per trip                                              | Paid the same in-network coverage                |

**The following are not covered under this benefit:**
- Non-emergency fixed wing air ambulance from an out-of-network provider
- Ambulance services for routine transportation to receive outpatient or inpatient care

| Durable medical and surgical equipment                                                 | 80% (of the negotiated charge) per item                                              | 60% (of the recognized charge) per item          |

**The following are not covered under this benefit:**
- 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                                                                    | 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. |

**The following are not covered under this benefit:**
- 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

| Prosthetic Devices & Orthotics Includes Cranial prosthetics *(Medical wigs)*           | 80% (of the negotiated charge) per item                                              | 60% (of the recognized charge) per item          |

Coverage includes one wig per policy year following chemotherapy or radiation therapy

**The following are not covered under this benefit:**
- 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

<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing aids and Exams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing exam</td>
<td>$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Hearing exam maximum</td>
<td>One hearing exam every policy year</td>
<td></td>
</tr>
</tbody>
</table>

**The following are not covered under this benefit:**

- Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay

<table>
<thead>
<tr>
<th>Hearing Aids</th>
<th>80% (of the negotiated charge) per item</th>
<th>60% (of the recognized charge) per item</th>
</tr>
</thead>
</table>

| Hearing aids maximum per ear | One hearing aid per ear policy year |                         |

**The following are not covered under this benefit:**

- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 6-60 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

<table>
<thead>
<tr>
<th>Tobacco cessation</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage includes</td>
<td>Physician services, outpatient prescription drugs and over-the-counter medications</td>
<td>Physician services, outpatient prescription drugs and over-the-counter medications</td>
</tr>
<tr>
<td></td>
<td>prescribed by physician</td>
<td>prescribed by physician</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Podiatric (foot care) treatment -Physician and specialist non-routine foot care treatment</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
<th>Covered according to the type of benefit and the place where the service is received.</th>
</tr>
</thead>
</table>

**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, running, working or wearing shoes
  - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
  - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed by a legally qualified ophthalmologist or optometrist (includes comprehensive low vision evaluations)</td>
<td>100% (of the negotiated charge) per visit</td>
<td>60% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td></td>
<td>1 visit</td>
</tr>
<tr>
<td>Low vision Maximum</td>
<td>One comprehensive low vision evaluation every policy year</td>
<td></td>
</tr>
<tr>
<td>Fitting of contact Maximum</td>
<td>1 visit</td>
<td></td>
</tr>
<tr>
<td>Pediatric vision care services &amp; supplies- Eyeglass frames, prescription lenses or prescription contact lenses</td>
<td>100% (of the negotiated charge) per item</td>
<td>60% (of the recognized charge) per item</td>
</tr>
<tr>
<td>Maximum number Per year: Eyeglass frames</td>
<td>One set of eyeglass frames</td>
<td></td>
</tr>
<tr>
<td>Prescription lenses</td>
<td>One pair of prescription lenses</td>
<td></td>
</tr>
<tr>
<td>Contact lenses (includes non-conventional prescription contact lenses &amp; aphakic lenses prescribed after cataract surgery)</td>
<td>Daily disposables: up to 3 month supply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Extended wear disposable: up to 6 month supply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-disposable lenses: one set</td>
<td></td>
</tr>
<tr>
<td>Optical devices</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td></td>
</tr>
<tr>
<td>Maximum number of optical devices per policy year</td>
<td>One optical device</td>
<td></td>
</tr>
</tbody>
</table>

*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.

**The following are not covered under this benefit:**
- 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

<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient prescription drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Copayment/coinsurance waiver for risk reducing breast cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>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%.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient prescription drug copayment waiver for tobacco cessation prescription and over-the-counter drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The outpatient prescription drug copayment will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a retail or mail order select care, in-network and out-of-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any prescription drug copayment will apply after those two regimens per policy year have been exhausted.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Outpatient prescription copayment waiver for contraceptives

The prescription drug copayment will not apply to female contraceptive methods when obtained at in-network pharmacy.

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

- 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 cost-sharing that applies to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at a in-network pharmacy will continue to apply unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.

### Preferred Generic prescription drugs

<table>
<thead>
<tr>
<th>For each fill up to a 30 day supply filled at a retail pharmacy</th>
<th>$20 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</th>
<th>$20 copayment per supply then the plan pays 50% (of the balance of the recognized charge)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy</th>
<th>$60 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

### Preferred brand-name prescription drugs

<table>
<thead>
<tr>
<th>For each fill up to a 30 day supply filled at a retail pharmacy</th>
<th>$40 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</th>
<th>$40 copayment per supply then the plan pays 50% (of the balance of the recognized charge)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy</th>
<th>$120 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>

### Non-preferred Generic prescription drugs

<table>
<thead>
<tr>
<th>For each fill up to a 30 day supply filled at a retail pharmacy</th>
<th>$65 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</th>
<th>$65 copayment per supply then the plan pays 50% (of the balance of the recognized charge)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy</th>
<th>$195 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td></td>
</tr>
</tbody>
</table>
### Non-preferred brand-name prescription drugs

<table>
<thead>
<tr>
<th>Description</th>
<th>Copayment Per Supply</th>
<th>Plan Coverage</th>
<th>Deductible Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each fill up to a 30 day supply filled at a retail pharmacy</td>
<td>$65</td>
<td>$65 copayment per supply then the plan pays 100% (of the balance of the</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>negotiated charge)</td>
<td></td>
</tr>
<tr>
<td>More than a 30 day supply but less than a 90 day supply filled at a mail</td>
<td>$195</td>
<td>$195 copayment per supply then the plan pays 100% (of the balance of the</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>order pharmacy</td>
<td></td>
<td>negotiated charge)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>$65 copayment per supply then the plan pays 50% (of the balance of the</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>recognized charge)</td>
<td></td>
</tr>
</tbody>
</table>

### Specialty drugs

<table>
<thead>
<tr>
<th>Description</th>
<th>Copayment Per Supply</th>
<th>Plan Coverage</th>
<th>Deductible Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each fill up to a 30 day supply filled at a retail pharmacy</td>
<td>$65</td>
<td>$65 copayment per supply then the plan pays 100% (of the balance of the</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td></td>
<td></td>
<td>negotiated charge)</td>
<td></td>
</tr>
<tr>
<td>Orally administered anti-cancer prescription drugs- For each fill up to a</td>
<td>100%</td>
<td>100% (of the recognized charge)</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>30 day supply filled at a retail pharmacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive care drugs and supplements filled at a retail pharmacy</td>
<td>100%</td>
<td>Paid according to the type of drug per the schedule of benefits, above</td>
<td></td>
</tr>
<tr>
<td>For each 30 day supply</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Risk reducing breast cancer prescription drugs filled at a pharmacy</td>
<td>100%</td>
<td>Paid according to the type of drug per the schedule of benefits, above</td>
<td></td>
</tr>
<tr>
<td>For each 30 day supply</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 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.

### Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy

<table>
<thead>
<tr>
<th>Description</th>
<th>Copayment Per Supply</th>
<th>Plan Coverage</th>
<th>Deductible Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>For each 30 day supply</td>
<td>100%</td>
<td>Paid according to the type of drug per the schedule of benefits, above</td>
<td></td>
</tr>
</tbody>
</table>

### 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.

### Outpatient prescription drugs exclusions

The following are not covered under the outpatient prescription drugs benefit:

- Allergy sera and extracts administered via injection
- Any services related to the dispensing, injecting or application of a drug
- Biological sera
• Compounded prescriptions containing bulk chemicals not approved by the U.S. Food and Drug Administration (FDA) including compounded bioidentical hormones
• Cosmetic drugs including medications and 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 provided
  - 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 above
  - That include the same active ingredient or a modified version of an active ingredient as a covered prescription drug (unless a medical exception is approved)
  - That are therapeutically equivalent or therapeutically alternative to a covered prescription drug (unless a medical exception is approved)
  - That are 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 or 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 our Pharmacy and Therapeutics Committee
  - That include 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 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 except when medically necessary to treat gender dysphoria
  - 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 covered person meets one or more clinical criteria detailed in our precertification and clinical policies. This does not apply to growth hormone injections or treatment to treat documented growth hormone deficiencies.
• 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 except as specifically stated in the schedule of benefits or the certificate
• Implantable drugs and associated devices except as specifically provided above
• 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.
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 a 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 and 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 to 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 person identified on the ID card.
- 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 products unless recommended by the United States Preventive Services Task Force (USPSTF)
- We reserve the right to exclude:
  - A manufacturer’s product when the 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

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 therapy
- Maintenance treatment
- Acupuncture when provided for the following conditions:
  - Acute low back pain
  - Addiction
  - AIDS
  - Amblyopia
  - Allergic rhinitis
  - Asthma
  - Autism spectrum disorders
  - Bell’s Palsy
  - Burning mouth syndrome
  - Cancer-related dyspnea
  - Carpal tunnel syndrome
  - Chemotherapy-induced leukopenia
  - Chemotherapy-induced neuropathic pain
  - Chronic pain syndrome (e.g., RSD, facial pain)
  - Chronic obstructive pulmonary disease
  - Diabetic peripheral neuropathy
  - Dry eyes
  - Erectile dysfunction
  - Facial spasm
  - Fetal breech presentation
  - Fibromyalgia
  - Fibrotic contractures
  - Glaucoma
  - Hypertension
  - Induction of labor
  - Infertility (e.g., to assist oocyte retrieval and embryo transfer during IVF treatment cycle)
  - Insomnia
  - Irritable bowel syndrome
  - Menstrual cramps/dysmenorrhea
  - Mumps
  - Myofascial pain
  - Myopia
  - Neck pain/cervical spondylosis
  - Obesity
  - Painful neuropathies
  - Parkinson’s disease
  - Peripheral arterial disease (e.g., intermittent claudication)
  - Phantom leg pain
- Polycystic ovary syndrome
- Post-herpetic neuralgia
- Psoriasis
- Psychiatric disorders (e.g., depression)
- Raynaud’s disease pain
- Respiratory disorders
- Rheumatoid arthritis
- Rhinitis
- Sensorineural deafness
- Shoulder pain (e.g., bursitis)
- Stroke rehabilitation (e.g., dysphagia)
- Tennis elbow/ epicondylitis
- Tension headache
- Tinnitus
- Tobacco Cessation
- Urinary incontinence
- Uterine fibroids
- Xerostomia
- Whiplash

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

This exclusion does not apply if:
- You are traveling solely as a fare-paying passenger
- You are traveling on a licensed, commercial, regularly scheduled non-military aircraft
- You are traveling solely in a civil aircraft with a current valid “Standard Federal Aviation Agency Airworthiness Certificate” and:
  - 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 for gender identity disorders
- Tobacco use disorders except as described in the Eligible health services and exclusions – Preventive care and wellness section
- Pathological gambling, kleptomania, pyromania
- Specific developmental disorders of scholastic skills (learning disorders/learning disabilities)
- Specific developmental disorder of motor functions
- Specific developmental disorders of speech and language
- Other disorders of psychological development

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

Blood, blood plasma, synthetic blood, blood derivatives or substitutes
Examples of these are:
- The provision of blood to the hospital, other than blood derived clotting factors
- Any related services including processing, storage or replacement expenses
- The services of blood donors, apheresis or plasmapheresis
- For autologous blood donations, only administration and processing expenses are covered

Breasts
- Services and supplies given by a provider for breast reduction or gynecomastia (swelling of the breast tissue in boys or men, caused by an imbalance of the hormones estrogen and testosterone), except when medically necessary to treat gender dysphoria.

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 and exclusions- Clinical trial therapies (experimental or investigational) section in the certificate

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

Cosmetic services and plastic surgery
- Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons.

This 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.)
- Coverage that may be provided under the Eligible health services and exclusions- Gender affirming treatment section.
Court-ordered services and supplies
- This includes court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding, unless they are a covered benefit under your plan.

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

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) section in the certificate. 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.

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

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

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

**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:
- 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.

**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

This exclusion does not apply to growth hormone injections or treatments to treat documented growth hormone deficiencies.
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 and exclusions – Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment section in the certificate.

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 and exclusions – Habilitation therapy services section in the certificate

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-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 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:
  - 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

Other primary payer

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

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

Personal care, comfort or convenience items

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

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 and exclusions 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

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

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
  - 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, except as specifically provided in the Eligible health services and exclusions – Preventive care and wellness section in the certificate
  - Hypnosis and other therapies
  - Medications, except as specifically provided in the Eligible health services and exclusions – Outpatient prescription drugs section in the certificate
  - 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

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 Pacific 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 Aetna Health and 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](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

አማርኛ ይግባብ ከማይמכስ ከማይጋብ ከማይጋብ. ይግባብ ከማይጋብ ከማይጋብ. ይግባብ ከማይጋብ ከማይጋብ. ይግባብ ከማይጋብ ከማይጋብ. ይግባብ ከማይጋብ ከማይጋብ. ይግባብ ከማይጋብ ከማይጋብ. ይግባብ ከማይጋብ ከማይጋብ. ይግባብ ከማይጋብ ከማይጋብ. ይግባብ ከማይጋብ ከማይጋብ. ይግባብ ከማይጋብ ከማይጋብ. ይግባብ ከማይጋብ ከማይጋブ (የማስቀን ከማይጋብ: 711).

العربية/Arabic

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

Ɓàsɔ́ɔ̀ Wùɖù/Bassa


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 می گردد، 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


Kreyòl Ayisyen/Haitian Creole


Igbo


한국어/Korean

**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)**.

**Urdu**

توجه دين: آگر آپ اردو بولیں ہوئے تو آپ کو زیان کی مدد کی خدمات مفت دستیاب بھی (TTY: 711) **1-877-480-4161** 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)**.

**Yoruba/Yoruba**

Àkíyèsí: Bí o bá nṣò èdè Yorùbá, ìrànòwọ̀ lórí èdè, lófèé, wà fún ọ̀. 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).*