



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

Michigan State University – Graduate Assistant Plan

Policy Year: 2026–2027

Policy Number: 246796

<https://www.aetnastudenthealth.com>

(800) 859-8452



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

Olin Health Center

Services and Benefits at Campus Health Services, Olin Health Center

Campus Health Services at Olin Health Center is the preferred place for students enrolled in the Student Health Insurance Plan to go for medical care. When you get care at Olin Health Center, you do not have to pay copays, coinsurance, or meet a deductible the way that you would for other services under the insurance plan. When referred outside of Olin, copays, coinsurance, and deductibles will apply.

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

Services at Olin Health Center:

Medical Care

- All primary medical care
- Illness and Injury
- STI screening/treatment
- Physical Exams
- Vaccinations
- Mental Health treatment (depression, anxiety, ADHD)
- Chronic disease management

Nutrition Services

- Expert consultations with registered dietitians

Laboratory & X-Ray

- Full-service lab testing
- Plain film x-ray in-house, with outside referrals available for advanced imaging tests

Psychiatry

- Referral-based psychiatric care

Sexual and Reproductive Health

- All primary gynecologic care
- Annual exams
- Pap smears
- STI screening/treatment
- Contraception care, including IUD insertion
- Gynecologic symptoms and concerns

Physical Therapy

- Offered by MSU Health Care located at: 4660 Hagadorn Rd, Suite 400 (adjacent to campus)

These services are offered at OLIN HEALTH SERVICES, but not covered by the Student Insurance Plan:

- Spartan Fit fitness assessments
- Travel Clinic visits

Who is eligible?

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

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

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

For further details regarding Graduate Assistant appointments, review the Assistantships Frequently Asked Questions (FAQs) online at [Assistantships FAQs](#).

Dependent Coverage Eligibility

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

Eligible dependents include:

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

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

Coverage Dates and Rates

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

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

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

Graduate Assistant and Eligible Dependents:

Term	FALL	SPRING I	SPRING II	SPRING III
Effective Dates	8/16/26 – 2/15/27	1/01/27 – 8/15/27	2/16/27 – 8/15/27	5/17/27 – 8/15/27
Graduate Assistant	\$0	\$0	\$0	\$0
One Dependent (Spouse / Other Eligible Individual or Child)	\$293	\$342	\$293	\$146
Two or More Dependents	\$1,254	\$1,463	\$1,254	\$625

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

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

Enrollment

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

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

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

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

Newborn child

- Your newborn child is covered on your health plan for the first 60 days from the moment of birth.
 - To keep your newborn covered, you must notify us (or our agent) of the birth and pay any required premium contribution during that 60-day period.
 - You must still enroll the child within 60 days of birth even when coverage does not require payment of an additional premium contribution for the newborn.
 - If you miss this deadline, your newborn will not have health benefits after the first 60 days.
 - If your coverage ends during this 60 day period, then your newborn's coverage will end on the same date as your coverage. This applies even if the 60-day period has not ended.

Adopted child or a child legally placed with you for adoption

- A child that you, or you and your spouse, civil union partner or domestic partner adopt, or that is placed with you for adoption, is covered on your plan for the first 60 days after the adoption or the placement is complete.
 - To keep your child covered, we must receive your completed enrollment information within 60 days after the adoption or placement for adoption.
 - You must still enroll the child within 60 days of the adoption or placement for adoption even when coverage does not require payment of an additional premium contribution for the child.
 - If you miss this deadline, your adopted child or child placed with you for adoption will not have health benefits after the first 60 days.
 - If your coverage ends during this 60-day period, then coverage for your adopted child or child placed with you for adoption will end on the same date as your coverage. This applies even if the 60-day period has not ended.

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

Qualifying Life Events

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

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

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

Medicare Eligibility Notice

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

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

Termination and Refunds

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

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

In-network Provider Network

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

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

Precertification

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

Precertification Call

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

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

An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.

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

Coordination of Benefits (COB)

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

Description of Benefits

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

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

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Preventive care and wellness Routine physical exams Performed at a physician's office			
Routine physical exam	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) after deductible per visit
Routine physical exam limits for covered persons through age 21: maximum age and visit limits per policy year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.		
Covered persons age 22 and over: Maximum visits per policy year	1 visit		

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Preventive care immunizations Performed in a facility or at a physician's office			
Preventive care immunizations	100% (of the negotiated charge) per visit No copayment or policy year deductible applies Travel immunizations not available	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) after deductible per visit
Preventive care immunization Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention		
The following is not covered under this benefit: Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment			
Well woman preventive visits Routine gynecological exams (including Pap smears and cytology tests)			
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) after deductible per visit
Maximum visits per policy year	1 visit		
Preventive screening and counseling services			
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) after deductible per visit
Obesity and/or healthy diet counseling Maximum visits	Age 0-22: unlimited visits. Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.		
Misuse of alcohol and/or drugs counseling Maximum visits per policy year	5 visits		

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Use of tobacco products counseling Maximum visits per policy year	8 visits		
Sexually transmitted infection counseling Maximum visits per policy year	2 visits		
Genetic risk counseling for breast and ovarian cancer limitations	Not subject to any age or frequency limitations		
Routine cancer screenings	Available for Consult and Referral	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) after deductible per visit
Routine cancer screening maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: - Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and - The comprehensive guidelines supported by the Health Resources and Services Administration.		
Lung cancer screening maximums	1 screening every 12 months		
Prenatal care services (Preventive care services only)	Available for Consult and Referral	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) after deductible per visit
Lactation counseling services	Available for Consult and Referral	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) after deductible per visit
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits		

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Breast pump supplies and accessories (Must be obtained from a participating DME provider)	Available for Consult and Referral	100% (of the negotiated charge) per item No copayment or policy year deductible applies	80% (of the recognized charge) after deductible per item
Family planning services – female contraceptives			
Counseling services			
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) after deductible per visit
Contraceptive counseling services maximum visits per policy year either in a group or individual setting	2 visits		
Female contraceptive preferred generic prescription drugs and devices provided, administered, or removed, by a provider during an office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) after deductible per visit
Female voluntary sterilization			
Inpatient provider services	Available for Consult and Referral	100% (of the negotiated charge) No copayment or policy year deductible applies	80% (of the recognized charge) after deductible
Outpatient provider services	Available for Consult and Referral	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	80% (of the recognized charge) after deductible per visit
The following are not preventive covered services: • Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care • Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA • Male contraceptive methods, sterilization procedures or devices, except for male condoms prescribed by a provider			

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Physicians and other health professionals			
Physician & specialist visits including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist, includes telemedicine consultations)	\$15 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit Telemedicine not available	\$15 copayment then the plan pays 100% (of the balance of the negotiated charge) after deductible per visit	80% (of the recognized charge) after deductible per visit
Allergy testing and treatment			
Allergy testing performed at a physician's or specialist's office	Available for Consult and Referral	95% (of the negotiated charge) after deductible per visit. Office visit copay may apply.	80% (of the recognized charge) after deductible per visit
Allergy injections treatment performed at a physician's, or specialist office	100% (of the negotiated charge) per visit	95% (of the negotiated charge) after deductible per visit. Office visit copay may apply.	80% (of the recognized charge) after deductible per visit
Allergy sera and extracts administered via injection at a physician's or specialist's office	100% (of the negotiated charge)	95% (of the negotiated charge) after deductible. Office visit copay may apply.	80% (of the recognized charge) after deductible
Physician and specialist surgical services			
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	Available for Consult and Referral	95% (of the negotiated charge) after deductible	80% (of the recognized charge) after deductible
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the <i>Covered services and exclusions – Hospital and other facility care</i> section) • Services of another physician for the administration of a local anesthetic			

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)	Available for Consult and Referral	95% (of the negotiated charge) per visit after deductible	80% (of the recognized charge) after deductible per visit
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the <i>Covered services and exclusions – Hospital and other facility care</i> section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic			
Alternatives to physician office visits			
Walk-in clinic visits (non-emergency visit)	Not available	\$15 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	80% (of the recognized charge) after deductible per visit
Hospital and other facility care			
Inpatient hospital (room and board) and other miscellaneous services and supplies	Not available	95% (of the negotiated charge) after deductible per admission	80% (of the recognized charge) after deductible per admission
Includes birthing center facility charges			
The following are not covered services: • All services and supplies provided in: - Rest homes - Any place considered a person's main residence or providing mainly custodial or rest care - Health resorts - Spas - Schools or camps			
Preadmission testing	Not available	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
In-hospital non-surgical physician services	Not available	95% (of the negotiated charge) after deductible per visit	80% (of the recognized charge) after deductible per visit

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Alternatives to hospital stays			
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	Not available	95% (of the negotiated charge) after deductible	80% (of the recognized charge) after deductible
The following are not covered under this benefit: • A stay in a hospital (See the <i>Hospital care – facility charges</i> benefit in this section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic			
Home health Care	Not available	95% (of the negotiated charge) after deductible per visit	80% (of the recognized charge) after deductible per visit
The following are not covered under this benefit: • Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities) • Transportation • Homemaker or housekeeper services • Food or home delivered services • Maintenance therapy			
Hospice care-Inpatient facility (room and board and other miscellaneous services and supplies)	Not available	95% (of the negotiated charge) after deductible per admission	80% (of the recognized charge) after deductible per admission
Hospice care-Outpatient	Not available	95% (of the negotiated charge) after deductible per visit	80% (of the recognized charge) after deductible per visit
The following are not covered under this benefit: • Funeral arrangements • Pastoral counseling • Bereavement counseling • Financial or legal counseling which includes estate planning and the drafting of a will • Homemaker or caretaker services that are services which are not solely related to your care and may include: - Sitter or companion services for either you or other family members - Transportation - Maintenance of the house			
Skilled nursing facility-Inpatient Must meet medical necessity guidelines for skilled care	Not available	95% (of the negotiated charge) after deductible per admission	80% (of the recognized charge) after deductible per admission

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Emergency room Copay waived when admitted at inpatient.	Not available	\$50 copayment then the plan pays 95% (of the balance of the negotiated charge) per visit No policy year deductible applies	Paid the same as in-network coverage
Non-emergency care in an emergency room	Not available	95% (of the balance of the negotiated charge) per visit No policy year deductible applies	Paid the same as in-network coverage
Important note: - 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 may not be 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 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 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 emergency room copayment/coinsurance. - Separate copayment/coinsurance amounts may apply for certain services given to you in the emergency room that are not part of the emergency room benefit. These copayment/coinsurance amounts may be different from the emergency room copayment/coinsurance. They are based on the specific service given to you. - Services given to you in the emergency room that are not part of the emergency room benefit may be subject to copayment/coinsurance amounts that are different from the emergency room copayment/coinsurance amounts.			
Urgent care services	Not available	95% (of the negotiated charge) after deductible per visit	80% (of the recognized charge) after deductible per visit

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Pediatric dental care (Limited to covered dependent through the end of the policy year in which the dependent turns age 19.)			
Pediatric dental deductible	Not applicable	Not applicable	\$50 per individual \$150 per contract
Deductible per policy year			
Pediatric dental out-of-pocket maximum	Not applicable	\$350 per individual \$700 per contract per policy year	Not applicable
Type A services – Diagnostic and preventive services such as oral exams, cleanings, X-rays	Available for Consult and Referral	100% (of the negotiated charge) per visit No deductible applies	70% (of the recognized charge) per visit
Type B services – Basic services such as fillings, endodontic treatments and oral surgery	Available for Consult and Referral	70% (of the negotiated charge) per visit	50% (of the recognized charge) after deductible per visit
Type C services – Major services such as crowns and bridges	Available for Consult and Referral	50% (of the negotiated charge) per visit	50% (of the recognized charge) after deductible per visit
Dental emergency services	Not available	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received.
Pediatric dental care exclusions These dental exclusions are in addition to the exclusions that apply to health coverage. The following are not covered under this benefit: - Any instruction for diet, plaque control and oral hygiene - Cosmetic services and supplies including: - Plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance - Augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the <i>Covered services and exclusions</i> section - Facings on molar crowns and pontics will always be considered cosmetic - Crown, inlays, onlays, and veneers unless: - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material - The tooth is an abutment to a covered partial denture or fixed bridge - Mouth guards, and other devices to protect, replace or reposition teeth - Dental implants except when part of an approved treatment plan for a covered service described in <i>Covered services and exclusions - Reconstructive surgery and supplies</i> - 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 *Covered services and exclusions – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another covered service
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered above and in the Orthodontic treatment rule 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
 - Services and supplies provided for your personal comfort or convenience or the convenience of another person, including a provider
 - Services and supplies provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a dental provider that is legally qualified to furnish dental services and supplies
- Orthodontic services

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

Diabetic services and supplies (including equipment and training)

Covered services include:

- Services and supplies
 - Foot care to minimize the risk of infection
 - Insulin preparations
 - Hypodermic needles and syringes used for the treatment of diabetes
 - Injection aids for the blind

- Diabetic test agents
- Lancets/lancing devices
- Prescribed oral medications whose primary purpose is to influence blood sugar
- Alcohol swabs
- Injectable glucagons
- Glucagon emergency kits
- Equipment
 - External insulin pumps
 - Blood glucose meters without special features, unless required due to blindness
- Training
 - Self-management training provided by a health care **provider** certified in diabetes self-management training

The following are not covered under this benefit:

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

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
<u>Temporomandibular Joint Dysfunction</u> Covered medical expenses include physician's charges incurred by a covered person for surgical and non-surgical treatment of Temporomandibular Joint (TMJ) Dysfunction.	Available for Consult and Referral	95% (of the negotiated charge) after deductible per visit	80% (of the recognized charge) after deductible per visit

The following are not covered under this benefit:

- Dental implants

Clinical trials

Experimental or investigational therapies	Available for Consult and Referral	Not covered	Not covered
Routine patient costs	Available for Consult and Referral	Not covered	Not covered

The following are not covered services:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies)

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Dermatological treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: Cosmetic treatment and procedures			
Obesity Surgery inpatient and outpatient facility and physician services	Available for Consult and Referral	Covered according to the type of benefit and the place where the service is received. Medical necessity is required.	Covered according to the type of benefit and the place where the service is received. Medical necessity is required.
The following are not covered services: - Weight management treatment. - Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the certificate. - Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes: - 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.			
Maternity care (includes delivery and postpartum care services in a hospital or birthing center) See Prenatal care services under the Preventive care and wellness section above.	Available for Consult and Referral	95% (of the negotiated charges) after deductible	80% (of the recognized charge) after deductible
The following are not covered under this benefit: Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries			
Well newborn nursery care in a hospital or birthing center	Available for Consult and Referral	95% (of the negotiated charge) after deductible	80% (of the recognized charge) after deductible
Voluntary sterilization for males			
Inpatient physician or specialist surgical services	Available for Consult and Referral	95% (of the negotiated charge) after deductible	80% (of the recognized charge) after deductible
Outpatient physician or specialist surgical services	Available for Consult and Referral	95% (of the negotiated charge) after deductible	80% (of the recognized charge) after deductible

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Abortion Inpatient physician or specialist surgical services	Not available	95% (of the negotiated charge) after deductible	80% (of the recognized charge) after deductible
Abortion Outpatient physician or specialist surgical services	Not available	95% (of the negotiated charge) after deductible	80% (of the recognized charge) after deductible
Maximum number of procedures per policy year	Not available	1	
Gender affirming treatment			
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Autism spectrum disorder			
Autism spectrum disorder treatment, diagnosis and testing includes Applied behavior analysis and Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Available for Consult and Referral	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Behavioral health			
Mental Health and Substance Abuse Treatment			
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	Not available	95% (of the negotiated charge) after deductible per admission	80% (of the recognized charge) after deductible per admission
Outpatient office visits (includes telemedicine consultations)	\$15 copayment then the plan pays 100% (of the balance of the negotiated charge per visit Telemedicine not available	Office visits: \$15 copayment then the plan pays 100% (of the balance of the negotiated charge per visit All other outpatient services: 95% (of the negotiated charge) after deductible per visit	Mental health & behavioral health office visits: \$15 copayment after deductible All other outpatient services to include substance abuse services: 80% (of the recognized charge) after deductible per visit
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	Available for Consult and Referral	95% (of the negotiated charge) after deductible per visit	80% (of the recognized charge) after deductible per visit

Description	MSU Student Health Services at Olin Health Center	In-network coverage (IOE facility]	Out-of-network coverage (Includes providers who are otherwise part of Aetna's network but are non-IOE providers)
Transplant services			
Inpatient and outpatient transplant facility services	Available for Consult and Referral	95% (of the negotiated charge) after deductible per visit	80% (of the recognized charge) after deductible per visit
Inpatient and outpatient transplant physician and specialist services	Not available	95% (of the negotiated charge) after deductible per visit	80% (of the recognized charge) after deductible per visit
Inpatient and outpatient transplant physician and specialist services	Not available	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following services for transplant donors are covered by Aetna GA health plan <i>when billed to the transplant recipient</i>. The <i>transplant recipient must be covered under the Aetna GA health plan for these services to be covered</i>: • Compatibility testing of prospective organ/tissue from donors who are members of the immediate family (first degree relatives, such as, parents, siblings, and children) of a member selected for an organ transplant • Live organ/tissue donor fees • Cadaveric organ/tissue procurement preservation, storage and transportation fees as billed by the Organ Procurement Organization (OPO) • Charges for activating the donor search process for donors in the registry, HLA-DR sample procurement and typing, donor physical examinations and laboratory tests as well as bone marrow/stem cell procurement The following are not covered under this benefit: • Services and supplies furnished to a donor when billed directly to the recipient and/or the recipient is not a covered person • Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness • Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness			
Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Infertility services			
Treatment of basic infertility	Available for Consult and Referral	95% (of the negotiated charge) after deductible per visit. Office visit copay may apply.	80% (of the allowed amount) after deductible per visit

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Limited infertility services			
Inpatient and outpatient care	Available for Consult and Referral	95% (of the negotiated charge) after deductible per visit. Office visit copay may apply.	80% (of the allowed amount) after deductible per visit
Maximum number of ovulation induction cycles with menotropins per lifetime	Not available	6	6
Maximum number of Intrauterine insemination cycles per lifetime	Not available	6	6
Infertility services exclusions: The following are not covered under the infertility services benefit: - All infertility services associated with or in support of an Advanced Reproductive Technology (ART) cycle. These include, but are not limited to: - Imaging, laboratory services, and professional services - In vitro fertilization (IVF) - Zygote intrafallopian transfer (ZIFT) - Gamete intrafallopian transfer (GIFT) - Cryopreserved embryo transfers - Gestational carrier cycles - Any related services, products or procedures (such as intracytoplasmic sperm injection (ICSI) or ovum microsurgery). - Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue. - Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue. - All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father. - Home ovulation prediction kits or home pregnancy tests. - The purchase of donor embryos, donor eggs or donor sperm. - Obtaining sperm from a person not covered under this plan. - Infertility treatment when a successful pregnancy could have been obtained through less costly treatment. Infertility treatment when either partner has had voluntary sterilization surgery, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization. - Infertility treatment when infertility is due to a natural physiologic process such as age related ovarian insufficiency (e.g., perimenopause, menopause). - Treatment for dependent children.			

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Specific therapies and tests			
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility – Requires preauthorization	Available for Consult and Referral	95% (of the negotiated charge) after deductible	80% (of the recognized charge) after deductible
Diagnostic lab work performed in a physician's office, the outpatient department of a hospital or other facility	100% (of the negotiated charge) Some services are not available at Olin Health Center	95% (of the negotiated charge) after deductible	80% (of the recognized charge) after deductible
Diagnostic radiological services performed in a physician's office, the outpatient department of a hospital or other facility	100% (of the negotiated charge) some services are not provided at Olin	95% (of the negotiated charge) after deductible	80% (of the recognized charge) after deductible
Outpatient Chemotherapy, Radiation & Respiratory Therapy	Available for Consult and Referral	95% (of the negotiated charge) per visit after deductible	80% (of the recognized charge) after deductible per visit
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	Available for Consult and Referral	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan • Enteral nutrition • Blood transfusions and blood products • Dialysis			
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for short-term rehabilitation services and habilitation therapy services Unlimited visits; Medical necessity required	\$15 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit (Physical therapy is offered at MSU MCI. ST and OT not available at Olin Health Center.)	\$15 copayment then the plan pays 90% (of the balance of the negotiated charge) after deductible per visit	80% (of the recognized charge) after deductible per visit

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
Chiropractic services	Available for Consult and Referral	\$15 copayment then the plan pays 90% (of the balance of the negotiated charge) after deductible per visit	80% (of the recognized charge) after deductible per visit
Maximum chiropractic visits per policy year	30		
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
Other services			
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	Not available	95% (of the negotiated charge) after deductible per trip No policy year deductible applies	Paid the same as in-network coverage No policy year deductible applies
The following are not covered under this benefit: Ambulance services for routine transportation to receive outpatient or inpatient care			
Durable medical and surgical equipment Preauthorization may be required	90% (of the negotiated charge) per item Certain item available	95% (of the negotiated charge) after deductible per item	95% (of the recognized charge) after deductible per item
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 - parenteral and enteral	Available for Consult and Referral	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
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, except as described above			

Description	MSU Student Health Services at Olin Health Center	In-network coverage	Out-of-network coverage
All other prosthetic Devices (including breast prosthetic devices) & Orthotics	90% (of the negotiated charge) per item Certain item available	95% (of the negotiated charge) after deductible per item	95% (of the recognized charge) after deductible per item
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 • Cochlear implants			
Pediatric vision care (Limited to covered dependents through the end of the policy year in which the dependent turns age 19)			
Performed by a legally qualified ophthalmologist or optometrist (includes comprehensive low vision evaluations and office visit for fitting of contact lenses)	Available for Consult and Referral	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the recognized charge) per visit No policy year deductible applies
Maximum visits per policy year Low vision Maximum Fitting of contact Maximum	1 visit One comprehensive low vision evaluation every policy year 1 visit		
Pediatric vision care services & supplies-Eyeglass frames and prescription lenses	Available for Consult and Referral	100% (of the negotiated charge) per item No policy year deductible applies	100% (of the recognized charge) per item No policy year deductible applies
Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	One set of eyeglass frames (Frames - chosen from a select collection) One pair of prescription lenses Daily disposables: Not covered Extended wear disposable: Not covered Non-disposable lenses: Not covered		
Optical devices	Not available	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum number of optical devices per policy year	One optical device		
The following is not covered under this benefit: • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes • Prescription contact lenses			

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

Outpatient prescription drug copayment waiver for tobacco cessation prescription and over-the-counter drugs		
The outpatient prescription copayment will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a retail in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%. Any prescription drug copayment will apply after those two regimens per policy year have been exhausted.		
Outpatient prescription drug copayment waiver for contraceptives		
The outpatient prescription drug copayment will not apply to female contraceptive methods when obtained at an in-network pharmacy. This means that such contraceptive methods are paid at 100% for: - Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. - If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug or device for that method paid at 100%. The prescription drug copayment continues to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at an in-network pharmacy unless you are granted a medical exception from the pharmacy benefit manager, CVS Caremark.		

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

Description	In-network coverage	Out-of-network coverage
Preventive care drugs and supplements filled at a retail pharmacy For each 30-day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Preventive care drugs and supplements maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by calling the toll-free number on your ID card	
Risk reducing breast cancer prescription drugs filled at a pharmacy For each 30-day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits above
Risk reducing breast cancer prescription drugs maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered risk reducing breast cancer prescription drugs, contact Member Service by calling the toll-free number on your ID card	
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each 30-day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits above
Tobacco cessation prescription drugs and OTC drugs maximums	Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits.	
Contraceptives (birth control)		
For each fill up to a 30-day supply of generic and OTC drugs and devices filled at a retail pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
For each fill up to a 30-day supply of brand name prescription drugs and devices filled at a retail pharmacy	Paid according to the type of drug per the schedule of benefits above	Paid according to the type of drug per the schedule of benefits above
Outpatient prescription drug exclusions The following are not covered services: - Any services related to providing, injecting or application of a drug - Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones unless we have approved a medical exception - Cosmetic drugs including medication and preparations used for cosmetic purposes - Devices, products and appliances unless listed as a covered service		

- Dietary supplements including medical foods
- Drugs or medications:
 - Administered or entirely consumed at the time and place they are prescribed or provided unless we have approved a medical exception
 - Which do not require a prescription by law, even if a prescription is written, unless listed as a covered service or we have approved a medical exception
 - That are therapeutically the same or an alternative to a covered prescription drug, unless we approve a medical exception
 - Not approved by the FDA or not proven safe or effective
 - Provided under your medical plan while inpatient at a healthcare facility
 - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
 - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
 - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as a covered service
 - That are indicated or used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, non-prescription appetite suppressants or other medications unless listed as a covered service
- Duplicative drug therapy; for example, two antihistamines for the same condition
- Genetic care including:
 - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as a covered service
- Immunizations related to work
- Immunization or immunological agents unless listed as a covered service
- Implantable drugs and associated devices unless listed as a covered service
- Infertility:
 - Prescription drugs used primarily for the treatment of infertility
- Injectables including:
 - Any charges for the administration or injection of prescription drugs
 - Needles and syringes except for those used for insulin administration
 - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception unless listed in the drug guide or we have approved a medical exception
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- Prescription drugs:
 - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or prescription drugs for the treatment of a dental condition
 - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's drug guide
 - That are used for the purpose of improving visual acuity or field of vision
 - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card
- Prescription drugs indicated for the purpose of weight loss.
- Replacement of lost or stolen prescriptions
- Test agents except diabetic test agents
- Tobacco cessation drugs, unless recommended by the USPSTF

- We reserve the right to exclude:
 - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's drug guide
 - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's drug guide

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

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

Out of Country claims

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

General Exclusions

The following are not covered services under your plan:

Acupuncture

- Acupuncture
- Acupressure

Blood and blood products

- Blood, blood products, and related services that are supplied to your provider free of charge

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, including cosmetic drugs, medications, and preparations used for cosmetic purposes, except where described in the *Covered services and exclusions* section

Court-ordered services and supplies

This includes court-ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding, unless they are a covered service under your plan

Custodial care

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

Examples of these are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter, including emptying or 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 including room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- For behavioral health (mental health treatment and substance related disorders treatment):
 - Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
 - Services given mainly to:
 - Maintain, not improve, a level of function
 - Provide a place free from conditions that could make your physical or mental state worse

Dental care for adults

- Dental services for adults including services related to:
 - The care, filling, removal or replacement of teeth and treatment of injuries to or diseases of the teeth
 - Dental services related to the gums
 - Apicoectomy (dental root resection)
 - Orthodontics
 - Root canal treatment
 - Soft tissue impactions
 - Alveolectomy
 - Augmentation and vestibuloplasty treatment of periodontal disease
 - False teeth
 - Prosthetic restoration of dental implants
 - Dental implants except when part of an approved treatment plan for a covered service described in the *Covered services and exclusions – Reconstructive surgery and supplies* section.

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

Educational services

Examples of these are:

- Any service or supply for education, training or retraining services or testing. 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
- Any services that are schooling related or similar programs
- Therapeutic programs within a school, vocational, work, or recreational setting.

Examinations

Any health or dental examinations needed:

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

Experimental, investigational, or unproven

- Experimental, investigational, or unproven drugs, devices, treatments or procedures unless otherwise covered under clinical trials

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

All services and supplies associated with GCIT including, but not limited to:

- The cost of the GCIT product.
- Any medical, surgical, professional, and facility charges directly related to GCIT. Examples include:
 - Anesthesia
 - Infusion
 - Lab and radiology
 - Nursing
 - Physician or specialist services

Growth/Height care

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

This exclusion does not apply to drugs and growth hormones as described in the *Outpatient prescription drugs – Other covered services* section.

Hearing aids

Any tests, appliances and devices to:

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

Hearing exams

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

Illegal occupation or criminal activity

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

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

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

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

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

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.

Maintenance care

- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services.

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. Examples of these include:
 - Sheaths
 - Bags
 - Elastic garments
 - Support hose
 - Bandages
 - Bedpans
 - Home test kits not related to diabetic testing
 - Splints
 - Neck braces
 - Compresses
 - Other devices not intended for reuse by another patient

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

Other primary payer

- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer
- Health care services for which other coverage is required by federal, state or local law to be bought or provided through other arrangements
- Health care services arising from injuries sustained as a result of a motor vehicle accident, to the extent the services are payable under an automobile insurance policy, medical payment, personal injury protection or no-fault coverage

Personal care, comfort or convenience items

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

Private duty nursing**Routine exams and preventive services and supplies**

- Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Covered services and exclusions* section

Services not permitted by law

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

Services provided by a family member

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

Sexual dysfunction and enhancement

- Except where described in the Covered services and exclusions section, any treatment, prescription drug, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
 - Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape of a sex organ
 - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Sports

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

Strength and performance

- Services, devices and supplies such as drugs or preparations designed primarily enhance your strength, physical condition, endurance or physical performance

Students in mental health field

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

Telemedicine

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

Therapies and tests

- Full body CT scans
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment
- Sensory or hearing and sound integration therapy

Tobacco cessation

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

Treatment in a federal, state, or governmental entity

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

Vision care for adults

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

Voluntary sterilization

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

Wilderness treatment programs

Wilderness treatment programs, whether or not the program is part of a residential treatment facility or otherwise licensed institution

Work related illness or injuries

- Coverage available to you under worker's compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.

Important Note:

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

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

Sanctioned Countries

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

Assistive Technology

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

Smartphone or Tablet

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

Discrimination is Against the Law

Aetna Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with 45 CFR § 92.101(a)(2)). Aetna Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Aetna Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
 - Qualified interpreters
 - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 1-877-480-4161 (TTY: 711) or the number on the back of your ID card.

If you believe that Aetna Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator

Attn: 1557 Coordinator
CVS Pharmacy, Inc.
1 CVS Drive, MC 2332,
Woonsocket, RI 02895

Phone: 1-800-648-7817, TTY: 711

Email: CRCoordinator@aetna.com

You can file a grievance in person, by mail, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

This notice is available at Aetna Inc.'s website: <https://www.aetnastudenthealth.com>