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

West Virginia University

Policy Year: 2025 – 2026
Policy Number: 474957
https://www.aetnastudenthealth.com
(866) 654-2338

This is a brief description of the Student Health Plan. The plan is available for West Virginia 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 **https://www.aetnastudenthealth.com.** If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

Coverage Periods

Coverage will become effective at 12:01 AM (EST) on the Coverage Start Date indicated and will terminate at 12:00 AM (EST) on the Coverage End Date indicated.

Coverage Period	Coverage Start Date	Coverage End Date	Waiver Deadline
Fall Term	08/11/2025	12/31/2025	07/25/2025
Spring Term	01/01/2026	08/10/2026	Please monitor student insurance website for updates.
Summer Only Term	05/11/2026	08/10/2026	Please monitor student insurance website for updates.

Please visit **wvu.myahpcare.com** for updated Spring and Summer waiver deadlines when available.

Rates

2025-2026 Rates

Fall Term	Spring/Summer Term	Summer Only Term
$1,196	$1,854	$769

Student Coverage

Who is eligible?

All domestic students who are enrolled in six or more credit hours and all international students enrolled in one or more credit hours at West Virginia University or West Virginia University Institute of Technology, including WVU students enrolled in fully online programs. Please Note: Dependents of students are not eligible to purchase the 2025/2026 West Virginia University Student Health Insurance Plan.

Students who fall below the credit hour requirement prior to the end of the add/drop period will be dis-enrolled from the plan and refunded the premium for that term. Students who fall below the credit hour requirement after the end of the add/drop period will remain enrolled in the plan and will not be refunded the premium.

Enrollment

Eligible students will be automatically enrolled in this Plan, unless the completed waiver application has been received and approved by the specified waiver deadline published online at wvu.myahpcare.com.

Students who fall below the credit hour requirement prior to the end of the add/drop period will be dis-enrolled from the plan and refunded the premium for that term. Students who fall below the credit hour requirement after the end of the add/drop period will remain enrolled in the plan and will not be refunded the premium.

Exception: A Covered Person entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro rata refund of premium will be made for such person upon written request received by Aetna within 90 days of withdrawal from school.

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 premium payment has been received. No premium will be refunded.

Withdrawal from Classes – Other than Leave of Absence: If you withdraw from classes within 31 days after the policy effective date, you will be considered ineligible for coverage. Your coverage will be terminated retroactively, and any premium paid will be refunded. If you withdraw from classes more than 31 days after the policy effective date, your coverage will remain in force through the end of the period for which premium payment has been received. No premium will be refunded. If you withdraw from classes to enter the armed forces of any country, your coverage will end as of the date of such entry. We will refund your premium, on a pro-rata basis, if you submit a written request within 90 days from the date you withdraw.

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. For a current listing of the health services or prescription drugs that require precertification, contact Member Services or go to www.aetna.com.

Precertification information

Precertification should be secured within the timeframes specified below. To obtain precertification, submit a request through the link to the electronic portal [found on your ID card]. You, your physician or the facility must submit your request to us within these timelines:

Non-emergency admissions	Submit your request at least 14 days before the date you are scheduled to be admitted.
Emergency admission	Submit your request within 48 hours or as soon as reasonably possible after you have been admitted.
Urgent admission	Submit your request before you are scheduled to be admitted.
Outpatient non-emergency medical services	Submit your request 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 an electronic notification to you and your physician of the precertification decision within five business days of receipt of the request if all information as required is provided, or within two business days:

- after receipt of the additional information submitted by your provider if the information as required was not provided
- if the request is for medical care or other service(s) that could seriously jeopardize your or others life, health, or safety due to your psychological condition
- if your provider with knowledge of your medical condition determines you will have adverse health consequences without the requested care or treatment

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 **https://www.aetnastudenthealth.com.**

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

	Designated care	In-network coverage	Out-of-network coverage
Policy year deductibles			
You have to meet your policy year deductible before this plan pays for benefits.			
Student	$500 per policy year (Combined)		$5,000 per policy year
Policy year deductible waiver			
The policy year deductible is waived for all of the following eligible health services: • Designated and In-network care for Preventive care and wellness, Physician, specialist including Consultants Office visits, Walk-in clinic visits, Diagnostic complex imaging services, Diagnostic lab work and radiological services, Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy), and Chiropractic Services • Designated, In-network, and out-of-network care for Immunizations up to age 16, Pediatric Dental Care Services, Well newborn nursery care, Pediatric Vision Services, and outpatient prescription drugs			
Individual 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. This policy year deductible applies separately to you. 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.			
Maximum out-of-pocket limits			
	Designated care	**In-network coverage**	**Out-of-network coverage**
Student	$8,350 per policy year (Combined)		None

Referral penalty

You must get a referral from school health services for off-campus care.

If you do not get a referral, then we will pay covered benefits at the out-of-network coverage cost sharing.

Exceptions

- Care is provided by Designated Care Providers: WVU Healthcare, University Health Associates, Gateway Health Services Corp, WVU-Dental Corp., Berkeley Medical Center, Jefferson Memorial Hospital and University Medical Labs,
- Treatment is for an Emergency Medical Condition (a referral is required for follow up care),
- Obstetric and Gynecological Treatment,
- Pediatric Care,
- Preventive/Routine Services (services considered preventive according to Health Care Reform and/or services rendered not to diagnose or treat an Accident or Sickness)
- Physical Therapy
- The student is more than 20 miles away from WVU Student Health Services,
- Student Health Services is closed,
- Services rendered at another facility during vacation or break periods,
- Medical Care received when the student is no longer eligible to use WVU Student Health Services due to a change in Student Status,
- Maternity,
- Mental Health,
- Laboratory and X-Ray Expenses,
- Hospice Expense,
- Skilled Nursing Facility Expense,
- Rehabilitation Facility Expense,
- Private Duty Expense,
- and Licensed Nurse Expense.

The additional percentage or dollar amount which you may pay as a penalty for failure to obtain a referral is not a covered benefit and will not be applied to a policy year deductible amount or the maximum out-of-pocket limit, if any.

Eligible health services	Designated care	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 policy year deductible applies	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) 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.		
Routine physical exam limits for covered persons age 22 and over: maximum visits per policy year	1 visit		
Preventive care immunizations **Performed in a facility or at a physician's office**			
Preventive care immunizations	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) 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 or travel			
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 policy year deductible applies	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Well woman routine gynecological exam maximums	1 visit		

Eligible health services	Designated care	In-network coverage	Out-of-network coverage
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 policy year deductible applies	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) 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		
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	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Maximum:	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)	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit

Eligible health services	Designated care	In-network coverage	Out-of-network coverage
Lactation counseling services	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits		
Breast pump supplies and accessories	100% (of the negotiated charge) per item No policy year deductible applies	100% (of the negotiated charge) per item No policy year deductible applies	50% (of the recognized charge) per item
Family planning services – female contraceptives **Counseling services**			
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Contraceptive counseling services maximum visits per policy year either in a group or individual setting	2 visits		
Female contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit	100% (of the negotiated charge) per item No policy year deductible applies	100% (of the negotiated charge) per item No policy year deductible applies	50% (of the recognized charge) per item
Female Voluntary sterilization			
Inpatient provider services	100% (of the negotiated charge) No policy year deductible applies	100% (of the negotiated charge) No policy year deductible applies	50% (of the recognized charge)
Outpatient provider services	100% (of the negotiated charge) No policy year deductible applies	100% (of the negotiated charge) No policy year deductible applies	50% (of the recognized charge)
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, except for male condoms prescribed by a provider

Eligible health services	Designated care	In-network coverage	Out-of-network coverage
Physicians and other health professionals			
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist) includes telemedicine Consultations)	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit No policy year deductible applies	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit No policy year deductible applies	$70 copayment then the plan pays 50% (of the balance of the recognized charge) per visit
Allergy testing and treatment			
Allergy testing performed at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received.		
Allergy injections treatment performed at a physician's, or specialist office	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Allergy sera and extracts administered via injection at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received.		
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)	80% (of the negotiated charge)	80% (of the negotiated charge)	50% (of the recognized charge)
The following are not covered under this benefit: • 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	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
The following are not covered under this benefit: • 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	Designated care	In-network coverage	Out-of-network coverage
Alternatives to physician office visits			
Walk-in clinic visits (non-emergency visit)	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit No policy year deductible applies	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit No policy year deductible applies	$70 copayment then the plan pays 50% (of the balance of the recognized charge) per visit
Hospital and other facility care			
Inpatient hospital (room and board) and other miscellaneous services and supplies) Includes birthing center facility charges	$300 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission	$300 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission	$300 copayment then the plan pays 50% (of the balance of the recognized charge) per admission
The following are not eligible health 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	Covered according to the type of benefit and the place where the service is received.		
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Alternatives to hospital stays			
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	80% (of the negotiated charge)	80% (of the negotiated charge)	50% (of the recognized charge)
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	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Maximum visits per policy year	100		
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

Eligible health services	Designated care	In-network coverage	Out-of-network coverage
Hospice-Inpatient	80% (of the negotiated charge) per admission	80% (of the negotiated charge) per admission	50% (of the recognized charge) per admission
Maximum days per Confinement per policy year	Unlimited		
Hospice-Outpatient	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Respite care-maximum number of days per 30 day period	30		

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

Outpatient private duty nursing	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Skilled nursing facility-Inpatient	$300 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission	$300 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission	$300 copayment then the plan pays 50% (of the balance of the recognized charge) per admission
Maximum days of confinement per policy year	100		
Emergency room	$300 copayment (waived if admitted) then the plan pays 80% (of the balance of the negotiated charge) per admission	$300 copayment (waived if admitted) then the plan pays 80% (of the balance of the negotiated charge) per admission	Paid the same as in-network coverage
Non-emergency care in an emergency room	Not covered	Not covered	Not covered

Emergency services 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 your ID

card and we will resolve any payment issue with the provider. Make sure the member ID 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.

The following are not covered under this benefit:

- Non-emergency services in a hospital emergency room or an independent freestanding emergency department

Eligible health services	Designated care	In-network coverage	Out-of-network coverage
Urgent care - Urgent medical care provided by an urgent care provider	$50 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	$50 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	$50 copayment then the plan pays 50% (of the balance of the recognized charge) per visit
Non-urgent use of an urgent care provider	Not covered	Not covered	Not covered
The following is not covered under this benefit: • Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)			
Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19			
Type A services	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit No policy year deductible applies
Type B services	75% (of the negotiated charge) per visit No policy year deductible applies	75% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit No policy year deductible applies
Type C services	75% (of the negotiated charge) per visit No policy year deductible applies	75% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit No policy year deductible applies

Eligible health services	Designated care	In-network coverage	Out-of-network coverage
Orthodontic services	75% (of the negotiated charge) per visit No policy year deductible applies	75% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit No policy year deductible applies
Dental emergency services	Covered according to the type of benefit and the place where the service is received.		

Pediatric dental care exclusions

The following are not covered under this benefit:

- Any instruction for diet, plaque control and oral hygiene
- 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 the purpose of splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) and craniomandibular joint dysfunction disorder (CMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services 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

Eligible health services	Designated care	In-network coverage	Out-of-network coverage
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received.		
Impacted wisdom teeth	100% (of the negotiated charge)	100% (of the negotiated charge)	50% (of the recognized charge)
Accidental injury to sound natural teeth	100% (of the negotiated charge)	100% (of the negotiated charge)	100% (of the recognized charge)
The following are not covered under this benefit: • The care, filling, removal or replacement of teeth and treatment of diseases of the teeth • Dental services related to the gums • Apicoectomy (dental root resection) • Orthodontics • Root canal treatment • Soft tissue impactions • Bony impacted teeth • Alveolectomy • Augmentation and vestibuloplasty treatment of periodontal disease • False teeth • Prosthetic restoration of dental implants • Dental implants			
Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment	Covered according to the type of benefit and the place where the service is received.		
The following are not covered under this benefit: Dental implants			
Clinical trials			
Experimental or investigational therapies	Covered according to the type of benefit and the place where the service is received.		
Routine patient costs	Covered according to the type of benefit and the place where the service is received.		
The following are not eligible health 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)			
Dermatological treatment	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 and services	Covered according to the type of benefit and the place where the service is received.		
Obesity surgery and services The following are not eligible health 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

Eligible health services	Designated care	In-network coverage	Out-of-network coverage
Maternity care (includes delivery and postpartum care services in a hospital or birthing center)	Covered according to the type of benefit and the place where the service is received.		
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	80% of the negotiated charge No policy year deductible applies	80% (of the negotiated charge No policy year deductible applies	50% of the recognized charge No policy year deductible applies
Voluntary sterilization for males			
Inpatient surgical services	Covered according to the type of benefit and the place where the service is received.		
Outpatient surgical services	Covered according to the type of benefit and the place where the service is received.		
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.		
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	Covered according to the type of benefit and the place where the service is received.		

Important note:

Your cost share for services provided by a licensed occupational therapist or occupational therapist assistant, licensed speech-language pathologist or speech-language pathologist assistant, licensed physical therapist or physical therapist assistant will not exceed the copayment, coinsurance, or office visit deductible amount charged for services provided by an osteopathic or primary care physician.

Eligible health services	Designated care	In-network coverage	Out-of-network coverage
Behavioral health			
Mental health treatment			
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	$300 copayment then the plan pays 80% (of the balance of the negotiated charge)	$300 copayment then the plan pays 80% (of the balance of the negotiated charge)	$300 copayment then the plan pays 50% (of the balance of the recognized charge)
Outpatient office visits (includes telemedicine consultations)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	$70 copayment then the plan pays 50% (of the balance of the recognized charge) per visit thereafter
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	80% of the negotiated charge No policy year deductible applies	80% of the negotiated charge No policy year deductible applies	50% of the recognized charge
Eligible health services	**Select care coverage***	**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	Covered according to the type of benefit and the place where the service is received.		
Inpatient and outpatient transplant physician and specialist services	Covered according to the type of benefit and the place where the service is received.		
Transplant services-travel and lodging	Covered	Covered	Covered
Lifetime Maximum payable for Travel and Lodging Expenses for any one transplant, including tandem transplants	$10,000	$10,000	$10,000
Maximum payable for Lodging Expenses per **IOE** patient	$50 per night	$50 per night	$50 per night
Maximum payable for Lodging Expenses per companion	$50 per night	$50 per night	$50 per night

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	Designated care	In-network coverage	Out-of-network coverage
Infertility services			
Treatment of basic infertility	Covered according to the type of benefit and the place where the service is received.		

Infertility services exclusions

The following are not covered under the infertility services benefit:

- All infertility services associated with or in support of an ovulation induction cycle while on medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services.
- Infertility medication. See the *Eligible health services and exclusions-Outpatient prescription drugs* section for information on coverage of infertility prescription drugs.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- Obtaining sperm from a person not covered under this plan.
- Infertility treatment when a successful pregnancy could have been obtained through less costly treatment.
- Infertility treatment when either partner has had voluntary sterilization surgery, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- Infertility treatment when infertility is due to a natural physiologic process such as age related ovarian insufficiency (e.g., perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period or other abnormal testing results as outlined in Aetna's infertility clinical policy.

Specific therapies and tests			
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit No policy year deductible applies	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit No policy year deductible applies	$70 copayment then the plan pays 50% (of the balance of the recognized charge) per visit
Diagnostic lab work performed in a physician's office, the outpatient department of a hospital or other facility	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit No policy year deductible applies	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit No policy year deductible applies	$70 copayment then the plan pays 50% (of the balance of the recognized charge) per visit

Eligible health services	Designated care	In-network coverage	Out-of-network coverage
Diagnostic radiological services performed in a physician's office, the outpatient department of a hospital or other facility	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit No policy year deductible applies	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit No policy year deductible applies	$70 copayment then the plan pays 50% (of the balance of the recognized charge) per visit
Outpatient Chemotherapy, Radiation & Respiratory Therapy	Covered according to the type of benefit and the place where the service is received.		
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	Covered according to the type of benefit and the place where the service is received		
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	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit No policy year deductible applies	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit No policy year deductible applies	$70 copayment then the plan pays 50% (of the balance of the recognized charge) per visit
Important note: Your cost share for services provided by a licensed occupational therapist or occupational therapist assistant, licensed speech-language pathologist or speech-language pathologist assistant, licensed physical therapist or physical therapist assistant will not exceed the copayment, coinsurance, or office visit deductible amount charged for services provided by an osteopathic or primary care physician.			
Chiropractic services	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit No policy year deductible applies	$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit No policy year deductible applies	$70 copayment then the plan pays 50% (of the balance of the recognized charge) per visit
Maximum 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.		

<table>
<tr><th colspan="4">Other services</th></tr>
<tr><th>Eligible health services</th><th>Designated care</th><th>In-network coverage</th><th>Out-of-network coverage</th></tr>
<tr><td>Emergency ground, air, and water ambulance

(includes non-emergency ambulance)</td><td>100% (of the negotiated charge) per trip</td><td>100% (of the negotiated charge) per trip</td><td>Paid the same as in-network coverage</td></tr>
<tr><td colspan="4">The following are not covered under this benefit:
Ambulance services for routine transportation to receive outpatient or inpatient services</td></tr>
<tr><td>Durable medical and surgical equipment</td><td>80% (of the negotiated charge) per item</td><td>80% (of the negotiated charge) per item</td><td>50% (of the recognized charge) per item</td></tr>
<tr><td colspan="4">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</td></tr>
<tr><td>Nutritional support</td><td colspan="3">Covered according to the type of benefit and the place where the service is received.</td></tr>
<tr><td colspan="4">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</td></tr>
<tr><td>Prosthetic Devices & Orthotics</td><td>80% (of the negotiated charge) per item</td><td>80% (of the negotiated charge) per item</td><td>50% (of the recognized charge) per item</td></tr>
<tr><td colspan="4">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</td></tr>
</table>

Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)			
Eligible health services	**Select care coverage**	**In-network coverage**	**Out-of-network coverage**
Performed by a legally qualified ophthalmologist or optometrist (includes comprehensive low vision evaluations)	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit No policy year deductible applies
Office visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the negotiated charge) per visit No policy year deductible applies	50% (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 2 visits		
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item No policy year deductible applies	100% (of the negotiated charge) per item No policy year deductible applies	50% (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 One pair of prescription lenses Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set		
Optical devices	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		
***Important note**: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both. Coverage does not include the office visit for the fitting of prescription contact lenses.			
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			

Policy year deductible and copayment waiver for risk reducing breast cancer

The policy year deductible and the per prescription copayment 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 policy year deductible and copayment waiver for tobacco cessation prescription and over-the-counter drugs

The outpatient prescription drug policy year deductible and the 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, in-network and out-of-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%.

Your policy year deductible outpatient prescription drug policy year deductible and any prescription drug copayment will apply after those two regimens per policy year have been exhausted.

Outpatient prescription drug policy year deductible and copayment waiver for contraceptives

The outpatient prescription drug policy year deductible and the prescription drug copayment will not apply to female contraceptive methods when obtained at an in-network and out-of-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 outpatient prescription drug policy year deductible and the prescription drug copayment continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at a select care pharmacy or in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.

Eligible health services	Designated Care	In-network coverage	Out-of-network coverage
Preferred generic prescription drugs			
For each fill up to a 30 day supply filled at a retail pharmacy	$15 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$15 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$15 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
More than a 30 day supply but less than a 91 day supply filled at a retail or mail order 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 negotiated charge) No policy year deductible applies	Not Covered

Eligible health services	Designated care	In-network coverage	Out-of-network coverage
Preferred brand-name prescription drugs			
For each fill up to a 30 day supply filled at a retail pharmacy	$40 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$40 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$40 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
More than a 30 day supply but less than a 91 day supply filled at a retail or mail order pharmacy	$80 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$80 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
Non-preferred generic prescription 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	$75 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$75 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
More than a 30 day supply but less than a 91 day supply filled at a retail or mail order pharmacy	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
Non-preferred brand-name prescription 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	$75 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$75 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
More than a 30 day supply but less than a 91 day supply filled at a retail or mail order pharmacy	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered

Eligible health services	Designated care	In-network coverage	Out-of-network coverage
Specialty drugs			
For each fill up to a 30 day supply filled at a specialty pharmacy or a retail pharmacy	Copayment per supply of 20% of the negotiated charge then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Copayment per supply of 20% of the negotiated charge then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Copayment per supply of 20% of the recognized charge then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
Diabetic supplies and insulin important note: Your cost share per 30 day supply of a covered diabetic prescription filled at an in-network pharmacy will not exceed: • $35 for preferred prescription insulin • $100 for other prescription diabetic supplies			
Anti-cancer prescription drugs taken by mouth- For each fill up to a 30 day supply	100% (of the negotiated charge) No policy year deductible applies		100% (of the recognized charge) No policy year deductible applies
Preventive care drugs and supplements filled at a retail pharmacy For each 30 day supply	100% (of the negotiated charge) per prescription or refill		Paid according to the type of drug per the schedule of benefits, above
Risk reducing breast cancer prescription drugs filled at a pharmacy For each 30 day supply	100% (of the negotiated charge) per prescription or refill		Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.		
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each 30 day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies		Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.		

Contraceptives (birth control)	
For each fill up to a 12 month supply of generic and OTC drugs and devices filled at a retail pharmacy or mail order pharmacy	100% (of the negotiated charge)
For each fill up to a 12 month supply of brand name prescription drugs and devices filled at a retail pharmacy or mail order pharmacy	Paid according to the type of drug per the schedule of benefits, above

Dispense As Written (DAW)
If a provider prescribes a covered brand-name prescription drug when a generic prescription drug equivalent is available and specifies "Dispense As Written" (DAW), you will pay the cost share for the brand-name drug. If a provider does not specify DAW and you request a covered brand-name prescription drug, you will be responsible for the cost share that applies to the brand-name drug plus the cost difference between the generic drug and the brand-name drug. The cost difference related to a prescription not specified as DAW does not apply toward your policy year deductible or maximum out-of-pocket limit.

Outpatient prescription drug exclusions
The following are not eligible health services:

- Abortion drugs used for elective termination of pregnancy except when the pregnancy [is the result of rape or incest or if it places the woman's life in serious danger
- Any services related to providing, injecting or application of a drug
- Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as an eligible health service
- Dietary supplements including medical foods
- Drugs or medications:
  - Administered or entirely consumed at the time and place they are prescribed or provided
  - Which do not require a prescription by law, even if a prescription is written, unless we have approved a medical exception
  - That are therapeutically the same or an alternative to a covered prescription drug, unless we approve a medical exception
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility
  - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as an eligible health service
  - That are 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 except as described in the certificate]
  - 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
- Duplicative drug therapy; for example, two antihistamines for the same condition

• Genetic care including:
- Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as an eligible health service
• Immunizations related to 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 stated in the schedule of benefits or the certificate
• Infertility:
- Prescription drugs used primarily for the treatment of infertility
• Injectables including:
- Any charges for the administration or injection of prescription drugs
- Needles and syringes except for those used for insulin administration
- Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception
• Off-label drug use except for indications recognized through peer-reviewed medical literature
• Prescription drugs:
- That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or prescription drugs for the treatment of a dental condition
- That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's drug guide
- That are used for the purpose of improving visual acuity or field of vision
- That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card
• 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 In-network level of benefits.

General Exclusions

The following are not eligible health services under your plan:

Abortion

- Services and supplies provided for an abortion except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger

Abortion drugs

- Drugs used for elective termination of pregnancy except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger

Acupuncture

- Acupuncture
- Acupressure

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:
  - 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

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, except where described in the *Eligible health services and exclusions* section

Court-ordered services and testing

- Court-ordered testing or care unless medically necessary

Custodial care

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

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying 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 an eligible health service described in the *Eligible health 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
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Examinations
Any health or dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job, or 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, or 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)

Growth/Height care

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

Hearing aids
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.

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

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

Personal care, comfort or convenience items

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

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 *Eligible health services and exclusions* section.

School health services

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

- Services and supplies provided by health professionals who the policyholder:
  - Employs
  - Is affiliated with
  - Has an agreement or arrangement with
  - Otherwise designates

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

- 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 to 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 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 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, 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, 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

See *Educational services* in 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.

Important Note:

A source of coverage or reimbursement is 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.

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

Sanctioned Countries

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

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-654-2338.

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

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 **1-866-654-2338** (TTY: **711**).

Español/Spanish

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-866-654-2338** (TTY: **711**).

አማርኛ**/Amharic**

ልብ ይበሉ: ኣማርኛ ቋንቋ የሚናገሩ ከሆነ፣ የትርጉም ድጋፍ ሰጪ ድርጅቶች፣ ያለምንም ክፍያ እርስዎን ለማገልገል ተዘጋጅተዋል። የሚከተለው ቁጥር ላይ ይደውሉ **1-866-654-2338** (መስማት ለተሳናቸው: **711**).

العربية**/Arabic**

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-654-2338(رقم الهاتف النصي: **711**).**1-866-654-2338**

Bàsɔ̀ɔ̀ Wùɖù/Bassa

Dè dɛ nìà kɛ dyeɖeˈ gbo: ɔ juˇ keˈ m̀ dyi Bàsɔ̀ɔ̀-wùɖù-po-nyɔ̀ juˇ niˈ, nìiˈ à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ m̀ gbo kpaˈa. Ɗaˈ **1-866-654-2338** (TTY: **711**).

中文/Chinese

注意：如果您说中文，我们可为您提供免费的语言协助服务。请致电 **1-866-654-2338** (TTY: **711**)。

فارسی**/Farsi**

توجه: اگر به زبان فارسی صحبت می کنید، خدمات زبانی رایگان به شما ارایه میگردد، با شماره **1-866-654-2338** (TTY: **711**) تماس بگیرید.

Français/French

Attention : Si vous parlez français, vous pouvez disposer d'une assistance gratuite dans votre langue en composant le **1-866-654-2338** (TTY: **711**).

ગુજરાતી**/Gujarati**

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો ભાષાકીય સહાયતા સેવા તમને નિ:શુલ્ક ઉપલબ્ધ છે. કૉલ કરો **1-866-654-2338** (TTY: **711**).

Kreyòl Ayisyen/Haitian Creole

Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-866-654-2338** (TTY: **711**).

Igbo

Nrụbama: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-866-654-2338** (TTY: **711**).

한국어/Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스가 무료로 제공됩니다. **1-866-654-2338** (TTY: **711**)번으로 전화해 주십시오.

Português/Portuguese

Atenção: a ajuda está disponível em português por meio do número **1-866-654-2338** (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 **1-866-654-2338** (TTY: **711**).

Tagalog

Paunawa: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-866-654-2338** (TTY: **711**).

Urdu/اردو

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت دستیاب ہیں ۔ (**711** :TTY) **1-866-654-2338** 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 **1-866-654-2338** (TTY: **711**).

Yorùbá/Yoruba

Àkíyèsí: Bí o bá nsọ èdè Yorùbá, ìrànlọ́wọ́ lórí èdè, lófẹ̀ẹ́, wà fún ọ. Pe **1-866-654-2338** (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).