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Aetna Student Health

Plan Design and Benefits Summary

Preferred Provider Organization (PPO)

St. Mary's University

Policy Year: 2019 - 2020
Policy Number: 686167
stmarytx.myahpcare.com
1-855-357-0238
Enrollment/Wavier

This is a brief description of the Student Health Plan. The Plan is available for St. Mary's University students and their eligible dependents. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Certificate of Coverage issued to you and may be viewed online at https://stmarytx.myahpcare.com/**.** If there is a difference between this Benefit Summary and the Certificate of Coverage, the Certificate will control. If you would like to obtain information about coverage under the Plan, please contact us at 1-877-480-4161, or call the Member Services number on the back of your ID card, or write to us at:

Aetna, Student Health
151 Farmington Avenue
Hartford, CT 06156

STUDENT HEALTH SERVICES (SHC)

The medical staff of the Student Health Center provides high quality primary health care services that are cost-effective and accessible to enrolled students of St. Mary's University. The provision of timely health care services on campus serves to minimize the academic interruptions that students may experience from an illness or injury. The Student Health Center staff offer services that are nondiscriminatory and nonjudgmental. Significant importance is placed in respecting the rights to privacy and confidentiality of each patient. It is through personalized evaluation; treatment and health education that students learn to make positive, long-lasting lifestyle choices. The SHC is staffed by a doctor and a physician's assistant. There is a copayment per visit and deductible is waived. Services not covered by the health plan will be charged to the student business account. If you carry the St. Mary's University Health Insurance and are treated for a covered benefit, a claim will be generated. Copayments are not reimbursable.

For more information, call the Health Services at (210) 436-3506 located on the 1st floor of Charles Francis Hall. In the event of an emergency, call 911 or the Campus Police.

Coverage Periods

Students: Coverage for all insured students enrolled for coverage in the Plan for the following Coverage Periods. Coverage will become effective at 12:01 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicated.

Eligible Dependents: Coverage for dependents eligible under the Plan for the following Coverage Periods. Coverage will, will become effective at 12:01 AM on the Coverage Start Date indicated below August 02, 2019, and will terminate at 11:59 PM on the Coverage End Date indicated August 09, 2020. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Certificate of Coverage.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment Deadline	Waiver Deadline
Annual	08/02/2019	08/01/2020	09/13/2019	09/06/2019
Fall	08/02/2019	12/31/2019	09/13/2019	09/06/2019
Spring	01/01/2020	08/01/2020	02/03/2020	02/03/2020
Summer 1	05/26/2020	08/01/2020	06/08/2020	06/05/2020
Summer 2	06/26/2020	08/01/2020	07/13/2020	

Rates

The rates below reflect premiums for the Plan underwritten by Aetna Health and Life Insurance Company (Aetna), as well as the St. Mary's University administrative fee.

Rates
Undergraduates and Graduate Students

	Annual	Fall Semester	Spring Semester	Summer 1	Summer 2
Student	$2,230.00	$1,115.00	$1,115.00	$414.00	$225.00
Spouse	$2,230.00	$1,115.00	$1,115.00	$414.00	$225.00
Child	$2,230.00	$1,115.00	$1,115.00	$414.00	$225.00
2 + Children	$4,460.00	$2,230.00	$2,230.00	$828.00	$450.00

Student Coverage

Who is eligible?

All registered students residing on campus and all intercollegiate athletes will be automatically enrolled in the Student Health Insurance Plan at registration and premium will be added to your tuition bill unless proof of comparable coverage is provided.

All other registered undergraduate, graduate and doctoral students taking six (6) or more credit hours are eligible to participate in the Plan and may enroll online at https://stmarytx.myahpcare.com/ or request to add premium to their tuition bill by the 12th class day. Graduate students completing thesis or dissertation and enrolled in their last semester are eligible to participate in the Plan. All registered "F", "J", and "H" International students, including "J" and "F" visa Intensive English Program (IEP) students, will be automatically enrolled in the Student Health Insurance Plan.

International students may submit an online waiver to remove the health insurance premium from their business accounts by the deadline. There are strict requirements that must be met before a waiver is granted, including demonstration of medical evacuation and repatriation benefits. AHP reserves the right to deny waiver requests.

Deadline for online waiver requests at https://stmarytx.myahpcare.com/waiver is the 12th class day of the semester the student is entering. Please visit Gateway for more information.

You must actively attend classes for at least the first 31 days after the date your coverage becomes effective. You cannot meet this eligibility requirement if you take courses through:

- Home study
- Correspondence
- The internet
- Television (TV)

If we find out that you do not meet this eligibility requirement, we are only required to refund any premium contribution minus any claims that we have paid.

Enrollment

To enroll online or obtain an enrollment application for voluntary coverage, log on to https://stmarytx.myahpcare.com/.

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

Dependent Coverage

Eligibility

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

Enrollment

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

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

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

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

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

- To keep your child covered, we must receive your completed enrollment information within 31 days after the adoption or placement for adoption.
- You must still enroll the child within 31 days of the adoption or placement for adoption even when coverage does not require payment of an additional premium contribution for the child.
- If you miss this deadline, your adopted child or child placed with you for adoption will not have health benefits after the first 31 days.
- If your coverage ends during this 31-day period, then coverage for your adopted child or child placed with you for adoption will end on the same date as your coverage. This applies even if the 31-day period has not ended.

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

Medicare Eligibility Notice

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

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

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

Coordination of Benefits (COB)

The Coordination of Benefits ("COB") provision applies when a person has health care coverage under more than one 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).

The order of benefit determination rules tell you the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms. Payment is made without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

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

In-network Provider Network

Under your plan, you can choose to receive care from an in-network provider or an out-of-network provider. An in-network provider is a provider who is listed in the directory for your plan and provides services at negotiated/reduced rates as agreed to with Aetna. An out-of-network provider is not an in-network provider, is not listed in the directory for your plan, and does not provide negotiated/reduced rates for their services.

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 a situation where there is are an inadequate number of network providers, Aetna may issue a pre-approval for you to receive the care from an Out-of-network Provider at the same benefit level that is provided for care received from In-network Providers.

Pre-authorization

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

Preauthorization for medical services and supplies

In-network care

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

Out-of-network care

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

Preauthorization call

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

Non-emergency admissions:	You, your physician or the facility will need to call and request preauthorization at least 3 days before the date you are scheduled to be admitted.
An emergency admission:	You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
An urgent admission:	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.
Outpatient non-emergency services requiring preauthorization:	You or your physician must call at least 3 days before the outpatient care is provided, or the treatment or procedure is scheduled.

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

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

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

What if you don't obtain the required preauthorization?

If you don't obtain the required preauthorization:

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

What types of services and supplies require pre-authorization?

Preauthorization is required for the following types of services and supplies:

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

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

Description of the Coordination of Benefits provision is contained in the Policy issued to St Mary's University, and may be viewed online at www.aetnastudenthealth.com.

Description of Benefits

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

Aetna's network of providers

Aetna's network of **physicians**, **hospitals** and other health care **providers** is there to give you the care that you need. You can find **in-network providers** and see important information about them most easily on our online **provider directory**. Just log into your **Aetna** secure website at www.aetnastudenthealth.com.

If you can't find an **in-network provider** for a service or supply that you need, call Member Services at the toll-free number on your ID card. We will help you find an **in-network provider**. If we can't find one, we may give you a pre-approval to get the service or supply from an **out-of-network provider**. When you get a pre-approval for an **out-of-network provider**, **covered benefits** are paid at the in-network coverage level of benefits. This Plan will pay benefits in accordance with any applicable Texas Insurance Law(s).

Metallic Level: Gold, Tested at 83.24%.

Policy year deductible	In-network coverage	Out-of-network coverage
You have to meet your policy year deductible before this plan pays for benefits.		
Student	$500 per policy year	$500 per policy year
Spouse	$500 per policy year	$500 per policy year
Each child	$500 per policy year	$500 per policy year
Family	None	None
Policy year deductible waiver		
The policy year deductible is waived for all of the following eligible health services: • In-network care for Preventive care and wellness, Physician and specialist Office Visit, Consultant Services Office Visit, Walk-in Clinic Office Visit, Hospital Emergency Room, Urgent Care, Mental Health Treatment Outpatient Office Visit, Substance Abuse Treatment Outpatient Office Visit • In-network care, and out-of-network care for Well newborn nursery care and outpatient prescription drugs		
Maximum out-of-pocket limits **Maximum out-of-pocket limit** per **policy year**		
Student	$7,350 per policy year	$14,700 per policy year
Spouse	$7,350 per policy year	$14,700 per policy year
Each child	$7,350 per policy year	$14,700 per policy year
Family	$14,700 per policy year	$38,100 per policy year
Pre-authorization covered benefit penalty		
This only applies to out-of-network coverage: The certificate of coverage contains a complete description of the pre-authorization program. You will find details on pre-authorization requirements in the *Medical necessity and pre-authorization requirements* section. Failure to pre-certify your eligible health services when required will result in the following benefit penalties: • A **$500** benefit penalty will be applied separately to each type of eligible health services. The additional percentage or dollar amount of the recognized charge which you may pay as a penalty for failure to obtain pre-authorization is not a covered benefit and will not be applied to the policy year deductible amount or the maximum out-of-pocket limit, if any.		

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

The reimbursement percentage, copayment, deductible or no charge amount, for services rendered by a **dentist** of an **out-of-network** dental provider will be reimbursed the same as an **in-network** dental provider.

Eligible health services	In-network coverage	Out-of-network coverage
Preventive care and wellness		
Routine physical exams		
Performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Routine physical exams for covered persons age 18 or more Maximum age and visit limits per policy year:		
Screening for abdominal aortic aneurysm	1 time for adults aged 65-75 who have ever smoked	
Screening for cholesterol at increased risk for coronary heart disease	Men age 35 and older Men under age 35 who have heart disease or risk factors for heart disease Women who have heart disease or risk factors for heart disease	
Colorectal cancer screening	For adults over 50	
Screening for aspirin use for the primary prevention of cardiovascular disease and colorectal cancer as recommended by their physician	For adults age 50-59 years of age who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years	
Routine physical exams for covered persons from birth to age 18: Maximum age and visits per policy year		
Autism screening	At intervals of 18 and 24 months	
Developmental screening	Under age 3 and surveillance throughout childhood	
Blood pressure screenings at certain intervals	0-11 months 1-4 years 5-10 years 11-14 years 15-17 years	
Covered persons through age 21: Maximum age and visit limits per policy year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Aetna secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Covered persons age 22-27 and over: Maximum visits per policy year	1 visit	

Eligible health services	In-network coverage	Out-of-network coverage
Preventive care immunizations		
Performed in a facility or at a physician's office No policy year deductible or copayment applies for children from birth through age 6	100% (of the negotiated charge) per visit. No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Limited to:		
Routine physical exams for adults age 18 or more	As shown in the certificate of coverage	
Routine physical exams for children from birth to age 18	As shown in the certificate of coverage	
Additional maximums per policy year	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician or Member Services by logging onto your Aetna secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Well woman preventive visits **Routine gynecological exams (including Pap smears and cytology tests)**		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Pap smear or screening using liquid based cytology methods	1 Pap smear every 12 months for women age 18 and older	
Gynecological exam that includes a rectovaginal pelvic exam	1 exam every 12 months for women over age 25 who are at risk for ovarian cancer	
Diagnostic exam for the early detection of ovarian cancer, cervical cancer, and the CA 125 blood test	1 exam every 12 months for women age 18 and older	
Screening for osteoporosis	For women over age 60 depending on risk factors	
Additional maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	
Additional maximum visits per policy year	1 visit	

Eligible health services	In-network coverage	Out-of-network coverage
Preventive screening and counseling services		
Obesity and/or healthy diet counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)	
Misuse of alcohol and/or drugs counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year	5 visits	
Use of tobacco products counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year	8 visits	
Depression screening counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year	1 visit	
Sexually transmitted infection counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year	2 visits	
Genetic risk counseling for breast and ovarian cancer counseling office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Age and frequency limitations	Not subject to any age or frequency limitations	
Routine cancer screenings performed at a physician's office, specialist's office or facility.		
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Mammogram maximums	1 low-dose mammogram every 12 months for covered persons age 35 or older For covered persons of any age, 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 • The comprehensive guidelines supported by the Health Resources and Services Administration	

Routine cancer screenings performed at a physician's office, specialist's office or facility. (Continued)		
Prostate specific antigen (PSA) tests maximums	1 PSA test every 12 months for covered persons age 50 and older 1 PSA test every 12 months for covered persons age 40 and older with a family history of prostate cancer, or other risk factor	
Fecal occult blood tests maximums	1 occult test every 12 months for covered persons age 50 or older	
Sigmoidoscopies maximums	1 flexible sigmoidoscopy every 5 years for covered persons age 50 or older	
Colonoscopies maximums	1 colonoscopy every 10 years for covered persons age 50 or older	
Additional maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician or Member Services by logging onto your Aetna secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card in the *How to contact us for help* section.	
Lung cancer screening maximums	1 screening every 12 months*	
***Important note:** Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.		
Prenatal care services (provided by a physician, an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)		
Preventive care services only	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Important note: You should review the *Maternity care and Well newborn nursery care* sections. They will give you more information on coverage levels for maternity care under this plan.		
Comprehensive lactation support and counseling services		
Lactation counseling services - facility or office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits	
Important note: Any visits that exceed the lactation counseling services maximum are covered under the *Physicians and other health professionals* section.		

Eligible health services	In-network coverage	Out-of-network coverage
Comprehensive lactation support and counseling services (Continued)		
Breast pump supplies and accessories	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Important note: See the *Breast feeding durable medical equipment* section of the certificate of coverage for limitations on breast pump and supplies.		
Family planning services – female contraceptives		
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Contraceptive counseling services maximum visits per policy year either in a group or individual setting	2 visits	
Contraceptives (prescription drugs and devices)		
Female contraceptive prescription drugs and devices provided, administered, or removed, by a physician during an office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Female voluntary sterilization		
Inpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Outpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Physicians and other health professionals		
Physician and specialist services		
Office hours visits (non- surgical and non-preventive care by a physician and specialist, includes telemedicine or telehealth consultations)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	60% (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.	Covered according to the type of benefit and the place where the service is received.
Allergy injections treatment performed at a physician's, or specialist office when you see the physician	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
Physician and specialist - inpatient surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge)	60% (of the recognized charge)
Anesthetist	80% (of the negotiated charge)	60% (of the recognized charge)
Surgical assistant	80% (of the negotiated charge)	60% (of the recognized charge)
Physician and specialist - outpatient surgical services		
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon. (includes anesthetist and surgical assistant expenses	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
In-hospital non-surgical physician services		
In-hospital non-surgical physician services	80% (of the negotiated charge)	60% (of the recognized charge)
Consultant services (non-surgical and non-preventive)		
Office hours visits (non-surgical and non-preventive care), includes telemedicine or telehealth consultations	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	60% (of the recognized charge) per visit
Second surgical opinion	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	60% (of the recognized charge) per visit

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

Eligible health services	In-network coverage	Out-of-network coverage
Skilled nursing facility		
Inpatient facility (room and board and miscellaneous inpatient care services and supplies) Subject to semi-private room rate unless intensive care unit is required Room and board includes intensive care	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Maximum days of confinement per policy year	25	
Emergency services and urgent care		
Emergency services		
Hospital emergency room	$200 copayment then the plan pays 80% (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 a hospital emergency room	Not covered	Not covered

Important note:

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

Eligible health services	In-network coverage	Out-of-network coverage
Urgent care		
Urgent medical care provided by an urgent care provider	$50 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies	60% (of the recognized charge) per visit
Non-urgent use of urgent care provider	Not covered	Not covered
Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19) The reimbursement percentage, copayment, deductible or no charge amount, for services rendered by a non-contracting dental provider will be reimbursed the same as a contracting dental provider.		
Type A services	100% (of the negotiated charge) per visit No copayment or deductible applies	80% (of the recognized charge) per visit
Type B services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Type C services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Orthodontic services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Dental emergency treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received.
Specific conditions		
Birthing center (facility charges)		
Inpatient (room and board and other miscellaneous services and supplies)	Paid at the same cost-sharing as hospital care.	Paid at the same cost-sharing as hospital care.
Diabetic services and supplies (including equipment and training)		
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Impacted wisdom teeth		
Impacted wisdom teeth	80% (of the negotiated charge)	80% (of the recognized charge)
Accidental injury to sound natural teeth		
Accidental injury to sound natural teeth	80% (of the negotiated charge)	80% (of the recognized charge)
Anesthesia and related facility charges for oral surgery a dental procedure ***Coverage is subject to certain conditions. See the benefit description in the certificate of coverage for details.***		
Anesthesia and related facility charges for oral surgery a dental procedure	80% (of the negotiated charge)	60% (of the recognized charge)

Eligible health services	In-network coverage	Out-of-network coverage
Blood and body fluid exposure		
Blood and body fluid exposure	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment		
TMJ and **CMJ** treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Dermatological treatment		
Dermatological treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maternity care		
Maternity care (includes delivery and postpartum Care services in a hospital or birthing center)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Well newborn nursery care In a hospital or birthing center	80% (of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
Note: *The per admission copayment amount and/or policy year deductible for newborns will be waived for nursery charges for the duration of the newborn's initial routine facility stay. The nursery charges waiver will not apply for non-routine facility stays.*		
Pregnancy complications		
Inpatient (room and board and other miscellaneous services and supplies) Subject to semi-private room rate unless intensive care unit required Room and board includes intensive care	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Family planning services – other		
Voluntary sterilization for Males Inpatient physician or specialist surgical services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Voluntary sterilization for males Outpatient physician or specialist surgical services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Gender reassignment (sex change) treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
Autism spectrum disorder		
Autism spectrum disorder diagnosis and testing	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Autism spectrum disorder treatment (includes physician and specialist office visits)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Services for children with developmental delays	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
Mental health treatment		
Mental health treatment – inpatient		
Inpatient hospital mental disorders treatment (room and board and other miscella hospital services and supplies) Inpatient residential treatment facility mental disorders treatment (room and board and other miscellaneous residential treatment facility services and supplies) Subject to semi-private room rate unless intensive care unit is required Mental disorder room and board intensive care	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Mental health treatment - outpatient		
Outpatient mental disorders treatment office visits to a physician or behavioral health provider (includes telemedicine or telehealth consultation)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Mental health treatment – outpatient (continued)		
Other outpatient mental disorders treatment (includes skilled behavioral health services in the home) Partial hospitalization treatment Intensive Outpatient Program	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Important note: **All mental health treatment coverage is provided under the same terms and conditions as any other illness.**		
Substance abuse related disorders treatment-inpatient		
Inpatient hospital substance abuse detoxification (room and board and other miscellaneous hospital services and supplies) Inpatient hospital substance abuse rehabilitation (room and board and other miscellaneous hospital services and supplies) Inpatient residential treatment facility substance abuse (room and board and other miscellaneous residential treatment facility services and supplies) Subject to semi-private room rate unless intensive care unit is required Substance abuse room and board intensive care	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Substance abuse related disorders treatment-outpatient: detoxification and rehabilitation		
Outpatient substance abuse office visits to a physician or behavioral health provider (includes telemedicine or telehealth consultations)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Substance abuse related disorders treatment-outpatient: detoxification and rehabilitation (continued)		
Other outpatient substance abuse services Partial hospitalization treatment Intensive Outpatient Program	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Oral and maxillofacial treatment (mouth, jaws, and teeth)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Reconstructive surgery and supplies		
Reconstructive surgery and supplies (includes reconstructive breast surgery)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage (IOE facility)	In-network coverage (Non-IOE facility)	Out-of-network coverage
Transplant services			
Inpatient and outpatient transplant facility services	Covered according to the type of benefit and the place where the service is received.		
Inpatient and outpatient transplant physician and specialist services	Covered according to the type of benefit and the place where the service is received.		
Treatment of infertility			
Basic infertility services Inpatient and outpatient care - basic infertility	Covered according to the type of benefit and the place where the service is received.		Covered according to the type of benefit and the place where the service is received.
Specific therapies and tests			
Outpatient diagnostic testing			
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit		60% (of the recognized charge) per visit
Diagnostic lab work and radiological services performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit		60% (of the recognized charge) per visit
Diagnostic follow-up care related to newborn hearing screening	80% (of the negotiated charge) per visit		60% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient diagnostic testing (continued)		
Cardiovascular disease testing	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum visits per policy year	1 screening every 5 years Limited to: Men age 45 and over but less than 76 and women age 55 and over but less than 76	
Chemotherapy		
Chemotherapy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Oral anti-cancer prescription drugs	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient infusion therapy		
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient radiation therapy		
Outpatient radiation therapy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient respiratory therapy		
Respiratory therapy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Transfusion or kidney dialysis of blood		
Transfusion or kidney dialysis of blood	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Short-term cardiac and pulmonary rehabilitation services		
Cardiac rehabilitation	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Pulmonary rehabilitation	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
Short-term rehabilitation and habilitation therapy services		
Outpatient physical, occupational, speech, and cognitive therapies Combined for short-term rehabilitation services and habilitation therapy services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum visits per policy year	Unlimited	
Acquired brain injury	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.
Speech or hearing loss or impairment	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.
Alzheimer's disease	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.
Chiropractic services		
Chiropractic services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum visits per policy year	35	
Evaluation and therapy for learning and developmental disabilities		
Evaluation and therapy for learning and developmental disabilities	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Specialty prescription drugs (Purchased and injected or infused by your provider in an outpatient setting)		
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
Other services and supplies		
Acupuncture in lieu of anesthesia	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	80% (of the negotiated charge) per trip	Paid the same as in-network coverage
Clinical trial therapies (experimental or investigational)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
Other services and supplies (continued)		
Durable medical and surgical equipment	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Enteral formulas and nutritional supplements	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum per item	Unlimited	
Osteoporosis (non-preventive care)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Prosthetic devices		
Cranial prosthetics *(Medical wigs)*	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Prosthetic devices	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Orthotic devices	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Hearing aids and exams		
Hearing aid exams	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Hearing aids and cochlear implants and related services		
Hearing aids and cochlear implants and related services	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Hearing aids maximum per ear	One per ear every three years	
Replacement of cochlear implant external speech processor and controller components	Unlimited	
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.
Vision care		
Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)		
Pediatric routine vision exams (including refraction)		
Performed by a legally qualified ophthalmologist, optometrist, therapeutic optometrist, or any other provider**s** acting within the scope of their license	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year	1 visit	

Eligible health services	In-network coverage	Out-of-network coverage
Pediatric comprehensive low vision evaluations		
Performed by a legally qualified ophthalmologist optometrist, therapeutic optometrist, or any other providers acting within the scope of their license	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum	One comprehensive low vision evaluation every policy year	
Pediatric vision care services and supplies		
Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Maximum number of eyeglass frames per policy year Maximum number of prescription lenses per policy year	One set of eyeglass frames One pair of prescription lenses	
Maximum number of prescription contact lenses per policy year (includes non-conventional prescription contact lenses and aphakic lenses prescribed after cataract surgery)	Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set	
Office visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Optical devices	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	
Maximum benefit per policy year per device	$5,000	
*__Important note__: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both. Coverage does not include the office visit for the fitting of prescription contact lenses.		
Outpatient prescription drugs		
Policy year deductible and copayment/coinsurance waiver for risk reducing breast cancer		
The policy year deductible and the per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network, pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.		

Policy year deductible and copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs

The policy year deductible and the per prescription copayment/coinsurance will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a retail in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%.

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

Policy year deductible and copayment/coinsurance waiver for contraceptives

The policy year deductible and the per prescription copayment/coinsurance will not apply to female contraceptive methods when obtained at an in-network pharmacy.

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

- Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%.
- If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug or device for that method paid at 100%.

The policy year deductible prescription drug policy year deductible and the per prescription copayment/coinsurance continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at an in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.

Eligible health services	In-network coverage	Out-of-network coverage
Preferred Generic prescription drugs		
Per prescription copayment/coinsurance		
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 negotiated charge) No policy year deductible applies	$15 copayment per supply then the plan pays 60% (of the recognized charge) No policy year deductible applies
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	$45 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	Not covered
Preferred brand-name prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	$30 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$30 copayment per supply then the plan pays 60% (of the recognized charge) No policy year deductible applies
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	$90 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	Not covered

Eligible health services	In-network coverage	Out-of-network coverage
Non-preferred generic prescription drugs		
Per prescription copayment/coinsurance		
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 negotiated charge) No policy year deductible applies	$60 copayment per supply then the plan pays 60% (of the recognized charge) No policy year deductible applies
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	$180 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	Not covered
Non-preferred brand-name prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	$60 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$60 copayment per supply then the plan pays 60% (of the recognized charge) No policy year deductible applies
More than a 30 day supply but less than a 90 day supply filled at a mail order pharmacy	$180 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	Not covered
Specialty Drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	80% (of the negotiated charge) No policy year deductible applies	80% (of the recognized charge) No policy year deductible applies
Orally administered anti-cancer prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a retail pharmacy For each 30 day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card.	

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

Academic Emergency Services

To ensure immediate access to assistance if you experience a crisis while traveling over 100 miles from home, or outside your home country, Academic HealthPlans has included Academic Emergency Services (AES) benefits in your Student Health Plan coverage. AES offers a wide range of services and benefits to provide everything you need to prepare for your international experience, as well as get the help or information you need in a crisis, no matter how large or small. For more details, go to stmarytx.myahpcare.com.

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-authorization Department* at **1-855-240-0535**, faxing the request to **1-877-269-9916**, or submitting the request in writing to:

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

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

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

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

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

Exclusions:

Acupuncture therapy

- Maintenance treatment
- Acupuncture when provided for the following conditions:
  - Acute low back pain
  - Addiction
  - AIDS
  - Amblyopia
  - Allergic rehinitis
  - Asthma
  - Autism spectrum disorders
  - Bell's Palsy
  - Burning mouth syndrome
  - Cancer-related dyspnea
  - Carpal tunnel syndrome
  - Chemotherapy-induced leukopenia
  - Chemotherapy-induced neuopathic pain
  - Chronic pain syndrome (e.g., RSD, facial pain)
  - Chronic obstructive pulmonary disease
    Diabetic peripheral neuropathy
    Dry eyes
  - Erectile dysfunction
  - Facial spasm
  - Fetal breech presentation
  - Fibromyalgia
  - Fibrotic contractures
  - Glaucoma
  - Hypertension
  - Induction of labor
  - Infertility(e.g., to assist oocyte retrieval and embryo transfer during IVF treatment cycle)
  - Insomnia
  - Irritable bowel syndrome
  - Menstrual cramps/dysmenorrhea
  - Mumps
  - Myofascial pain
  - Myopia
  - Neck pain/cervical spondylosis
  - Obesity
  - Painful neuropathies
  - Parkinson's disease

- Peripheral arterial disease (e.g., intermittent claudication)
- Phantom leg pain
- Polycystic ovary syndrome
- Post-herpetic neuralgia
- Psoriasis
- Psychiatric disorders (e.g., depression)
- Raynaud's disease pain
- Respiratory disorders
- Rheumatoid arthritis
- Rhinitis
- Sensorineural deafness
- Shoulder pain (e.g., bursitis)
- Stroke rehabilitation (e.g., dysphagia)
- Tennis elbow/ epicondylitis
- Tension headache
- Tinnitus
- Tobacco Cessation
- Urinary incontinence
- Uterine fibroids
- Xerostomia
- Whiplash

Air or space travel

- Traveling in, on or descending from any aircraft, including a hang glider, while the aircraft is in flight. This includes descending by a parachute, wingsuit or any other similar device.
  This exclusion does not apply if:
  - You are traveling solely as a fare-paying passenger
  - You are traveling on a licensed, commercial, regularly scheduled non-military aircraft
  - You are traveling solely in a civil aircraft with a current valid "Standard Federal Aviation Agency Airworthiness Certificate" and:
    - The civil aircraft is piloted by a person with a current valid pilot's certificate with proper ratings for the type of flight and aircraft involved
    - You are as a passenger with no duties at all on an aircraft used only to carry passengers or you are a pilot or a part of the flight crew on an aircraft owned or leased by the policyholder performing duties for the policyholder
  - You are enrolled in the policyholder's "Bachelor of Science in Aviation" program

Alternative health care

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

Ambulance services

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

Armed forces

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

Artificial organs

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

Beyond legal authority

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

Blood and body fluid exposure

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

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

Examples of these are:

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

Breasts

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

Clinical trial therapies (experimental or investigational)

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

Clinical trial therapies (routine patient costs)

- Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)
- Services and supplies provided by the trial sponsor without charge to you
- The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna's claim policies)
- Select care or in-network coverage limited to benefits for routine patient services provided within the network

Cornea or cartilage transplants

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

Cosmetic services and plastic surgery

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

Counseling

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

Court-ordered services and supplies

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

Custodial care

Examples are:

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

Dermatological treatment

- Cosmetic treatment and procedures

Dental care for adults

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

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

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

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

Early intensive behavioral interventions
Examples of these services are:

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

Educational services
Examples of these services are:

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

Elective treatment or elective surgery

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

Enteral formulas and nutritional supplements

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

Examinations
Any health or dental examinations needed:

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

Experimental or investigational

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

Emergency services and urgent care

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

Facility charges

For care, services or supplies provided in:

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

Family planning services - other

- Services and supplies provided for an abortion except as described in the *Pregnancy complications* section and except when the pregnancy places the woman's life in serious danger or at serious risk of substantial impairment of a major bodily function
- Reversal of voluntary sterilization procedures, including related follow-up care
- Family planning services received while confined as an inpatient in a hospital or other facility
- Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care

Felony

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

Gender reassignment (sex change) treatment

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

Genetic care

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

Growth/Height care

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

Hearing aids and exams, except as provided in the Hearing aids and cochlear implants and other services section of the Eligible health services section

Home health care

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

Hospice care

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

Incidental surgeries

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

Jaw joint disorder

- Non-surgical treatment of Temporomandibular joint dysfunction disorder (TMJ)

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

Judgment or settlement

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

Mandatory no-fault laws

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

Maintenance care

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

Maternity care

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

Medical supplies – outpatient disposable

- Any outpatient disposable supply or device. These items are usually included in the cost of other services and are not billed separately. Examples of these are:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Syringes, except for treatment of diabetes
  - Blood or urine testing supplies, except for treatment of diabetes
  - Other home test kits
  - Splints
  - Neck braces
  - Compresses
  - Other devices not intended for reuse by another patient

Medicare

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

Mental health treatment

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

Motor vehicle accidents

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

Non-medically necessary services and supplies

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

Non-U.S. citizen

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

Obesity (bariatric) surgery

- Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described in the *Eligible health services under your plan – Preventive care and wellness* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery
  - Surgical procedures, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Organ removal

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

Other primary payer

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

Outpatient infusion therapy

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

Outpatient prescription or non-prescription drugs and medicines

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

Outpatient surgery

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

Personal care, comfort or convenience items

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

Preventive care and wellness

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

Private duty nursing (outpatient only)

Prosthetic devices

- Services covered under any other benefit
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace
- Repair and replacement due to loss, misuse, abuse or theft
- Communication aids
- Cochlear implants except as provided in the *Eligible health services under your plan - Hearing aids and cochlear implants and related services--Other services* section

Riot

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

Routine exams

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

School health services

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

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

Services provided by a family member

- Services provided by a spouse, domestic partner parent, child, stepchild, brother, sister, in-law or any household member, except when that family member is a dentist who is licensed in the State of Texas to provide the service rendered

Services, supplies and drugs received outside of the United States

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

Sexual dysfunction and enhancement

- Any treatment, prescription drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services
- Not eligible for coverage are prescription drugs in 30 day supplies

Sinus surgery

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

Sleep apnea

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

Specialty prescription drugs

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

Strength and performance

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

Students in mental health field

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

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

- Dental implants

Therapies and tests

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

Tobacco cessation

- Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including, medications, nicotine patches and gum unless recommended by the United States Preventive Services Task Force (USPSTF). This also includes:
  - Counseling, except as specifically provided in the *Eligible health services under your plan – Preventive care and wellness* section
  - Hypnosis and other therapies
  - Medications, except as specifically provided in the *Eligible health services under your plan – Outpatient prescription drugs* section
  - Nicotine patches
  - Gum

Transplant services

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

Treatment in a federal, state, or governmental entity

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

Treatment of infertility

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

Use of drugs, alcohol or intoxicants

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

Vision Care

Pediatric vision care services and supplies

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

Adult vision care

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

Adult vision care services and supplies

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

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

Wilderness Treatment Programs

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

Work related illness or injuries

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

Exceptions and exclusions that apply to outpatient prescription drugs

Abortion drugs

Allergy sera and extracts administered via injection

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

Biological sera

Compounded prescriptions

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

Cosmetic drugs

- Medications or preparations used for cosmetic purposes

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

Dietary supplements including medical foods

Drugs or medications

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

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

Genetic care

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

Immunizations related to travel or work

Immunization or immunological agents

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

Infertility

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

Injectables

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

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

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

Prescription drugs:

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

Refills

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

Replacement of lost or stolen prescriptions

Test agents except diabetic test agents

Tobacco cessation

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

We reserve the right to exclude:

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

In case of a medical emergency

When you experience an emergency medical condition, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance assistance. If possible, call your physician but only if a delay will not harm your health.

After-hours care — available 24/7

Call your doctor when you have medical questions or concerns. Your doctor should have an answering service if you call after the office closes. You can also go to an urgent care center, which may have limited hours. To find a center near you, log in at https://myaetna.com and search our list of doctors and other health care providers. Check your plan documents to see how much you must pay for urgent care services.

Out-of-area services and benefits

You may not have access to an in-network provider when you are traveling outside of the plan's service area. If you must receive medically necessary services or supplies when traveling outside of the plan's service area, we will reimburse you as shown in the table below.

Type of provider	Your cost share
In-network provider	• You pay the copayment/coinsurance.
Out-of-network provider	• You pay the pharmacy directly for the cost of the prescription. Then you fill out and send a prescription drug refund form to us, including all itemized pharmacy receipts. • Submission of a claim doesn't guarantee payment. If your claim is approved, you will be reimbursed the cost of your prescription less your copayment/coinsurance.

Keeping a provider, you go to now (continuity of care)

You may have to find a new provider when:

- You join the plan and the provider you have now is not in the network
- You are already covered under another Aetna plan and your provider stops being in our network

However, in some cases, you may be able to keep going to your current provider to complete a treatment or to have treatment that was already scheduled. This is called continuity of care.

	If you are a new enrollee and your provider is an out-of-network provider	If you are a current enrollee and your provider stops participation with Aetna
Request for approval	You need to complete a [Transition Coverage Request] form and send it to us. You can get this form by contacting [Member Services] at the toll-free number on the back of your ID card.	You or your provider should call Aetna for approval to continue any care.

Length of transitional period	Care will continue during a transitional period, usually 90 days, but this may vary based on your condition.	Care will continue during a transitional period, usually 90 days, This date is based on the date the provider terminated their participation with Aetna.

	If you have a terminal illness and your provider stops participation with Aetna
Request for approval	Your provider should call us for approval to continue any care. You can call Member Services at the toll-free number on the back of your ID card for information on continuity of care.
Length of transitional period	Care will continue during a transitional period for up to nine (9) months. This date is based on the date the provider terminated their participation with Aetna.
How claim is paid	Your claim will be paid at not less than the negotiated charge during the transitional period.

	If you are pregnant and have entered your second trimester and your provider stops participation with Aetna
Request for approval	Your provider should call us for approval to continue any care. You can call [Member Services] at the toll-free number on the back of your ID card for information on continuity of care.
Length of transitional period	Care will continue during a transitional period through delivery, including the time required for postpartum care directly related to the delivery. This includes a post-delivery checkup within six weeks.
How claim is paid	Your claim will be paid at not less than the negotiated charge during the transitional period.

We will authorize coverage for the transitional period only if the provider agrees to our usual terms and conditions for contracting providers.

Complaints and Appeals

If you are dissatisfied with the service you receive from the Plan or you want to complain about a preferred care provider, you may call the Member Services telephone number shown on your ID card or write to Aetna at:

Aetna Life Insurance Company
Appeals Resolution Team
PO Box 14464
Lexington, KY 40512

The complaint must include a detailed description of the matter and include copies of any records or documents that you think are relevant to the matter. You may submit an appeal if Aetna gives notice of an adverse benefit determination. A final adverse benefit determination notice may also provide an option to request an External Review (if available).

For more information about the Complaints and Appeals Procedure or External Review processes, you may call the Member Services telephone number shown on your ID card. A complete description of the Complaints and Appeals Procedure and External Review processes are contained in the Master Policy/Certificate of Coverage issued to [St. Mary's University, and may be viewed online at www.aetnastudenthealth.com.

Directory

The list of in-network providers, which includes complete descriptions of the providers' networks and a disclosure of which PPOs will not accept new patients for your plan appears at www.aetnastudenthealth.com under the DocFind® label. When searching DocFind®, you need to make sure that you are searching for providers that participate in your specific plan. In-network providers may only be considered for certain Aetna plans. When searching for in-network dental providers, you need to make sure you are searching under Pediatric Dental plan. Upon your request, we will send you a non-electronic version of the directory at no cost to you. Please contact us at 877-480-4161, or call the Member Services number on the back of your ID card, or write to us at:

Aetna, Student Health
151 Farmington Avenue
Hartford, CT 06156

St. Mary's 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).

Texas Department of Insurance Notice

You have the right to an adequate network of preferred providers (also known as "network providers"). If you believe the network is inadequate, you may file a complaint with the Texas Department of Insurance. If you relied on materially inaccurate directory information, you may be entitled to have an out-of-network claim paid at the in-network percentage level of reimbursement and your out-of-pocket expenses counted toward your in-network deductible and out-of-pocket maximum. You have the right, in most cases, to obtain estimates in advance:

- From out-of-network providers of what they will charge for their services; and
- From your insurer of what it will pay for the services.

You may obtain a current directory of preferred providers at the following website: **www.aetna.com/docfind** or by calling the number on your Aetna ID card (if you're not yet enrolled, call **1-888-982-3862**) for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits. If you are treated by a provider or hospital that is not a preferred provider, you may be billed for anything not paid by the insurer.

If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, assistant surgeon or neonatologist is greater than $500 (not including your copayment, coinsurance and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you.

You can learn more about mediation at the Texas Department of Insurance website: **www.tdi.texas.gov/consumer/cpmmediation.html**.

Sanctioned Countries

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

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

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

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

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

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).

TTY: 711

To access language services at no cost to you, call (877) 480-4161.
Para acceder a los servicios de idiomas sin costo, llame al (877) 480-4161. (Spanish)
如欲使用免費語言服務，請致電 (877) 480-4161。(Chinese)
Afin d'accéder aux services langagiers sans frais, composez le (877) 480-4161 (French)
Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa (877) 480-4161. (Tagalog)
Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie (877) 480-4161 an. (German)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 480-4161 (877). (Arabic)
Pou jwenn sèvis lang gratis, rele (877) 480-4161. (French Creole-Haitian)
Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero (877) 480-4161. (Italian)

言語サービスを無料でご利用いただくには、(877) 480-4161 までお電話ください。(Japanese)

무료 언어 서비스를 이용하려면 (877) 480-4161 번으로 전화해 주십시오. (Korean)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 480-4161 (877) تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć (877) 480-4161. (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para (877) 480-4161. (Portuguese)

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

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