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

Postdoctoral Trainees

Vanderbilt University

VANDERBILT UNIVERSITY

Policy Year: 2021–2022
Policy Number: 175136
www.aetnastudenthealth.com
877-480-4168

This is a brief description of the Student Health Plan. The plan is available for Vanderbilt University Postdoctoral Trainees and their eligible dependents. The plan is insured by Aetna Health and Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Certificate issued to you and may be viewed online at **www.aetnastudenthealth.com.** If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

Who is eligible?

Non-employee postdocs (i.e., VU Postdoctoral Scholar, Trainee) on training and fellowship grants (for whom no FICA is withheld) are eligible for the VU Postdoctoral Trainee Health Insurance Plan.

Dependent Coverage Eligibility

Covered Postdoctoral Trainees may also enroll their eligible dependents for an additional cost. It is the member's responsibility to enroll eligible Dependents each year. Dependents are not automatically enrolled. Members need to purchase coverage for their eligible dependent(s) at the same time of their initial plan enrollment and must purchase the same period of coverage for which the student is enrolled.

Who can be on your plan (who can be your dependent)
Your plan includes dependent coverage, so you can enroll the following family members on your plan. They are referred to in this certificate of coverage as your "covered dependents" or "dependents".)

- Your legal spouse that resides with you
- Your dependent children – your own or those of your spouse. The children must be under 26 years of age, and they include: biological children, stepchildren, legally adopted children, or a child legally placed with you for adoption.

Coverage Dates and Rates

Coverage for all insured members and eligible dependents will become effective at 12:01 AM on the Coverage Start Date indicated below, and will terminate at 11:59 PM on the Coverage End Date indicated. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Certificate of Coverage.

Coverage Periods

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	08/12/2021	08/11/2022	08/01/2021

Rates

All rate information can be found by visiting vanderbilt.myahpcare.com.

Enrollment

Eligible Postdoctoral Trainees will be automatically enrolled in this Plan, unless the completed waiver application has been received by Vanderbilt University by the specified enrollment deadline dates listed in the Coverage Periods section of this Plan Design and Benefits Summary. Eligible Postdoctoral Trainees may also insure their Dependents. Eligible Dependents are the Postdoctoral Trainee's legal spouse and dependent children under 26 years of age.

To enroll online for voluntary dependent coverage, log on to vanderbilt.myahpcare.com then click on Enrollment tab to enroll.

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 remainder of the plan year providing plan premiums are paid, and no refund will be allowed. (This refund policy will not apply if you withdraw due to a covered Accident or Sickness.)

Graduating within 31 days of the start of the coverage period shall not be considered a withdrawal from school.

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

A newborn child will automatically be covered for the first 31 days following the child's birth. To extend coverage for a newborn child past the 31 day period, the covered member must: 1) enroll the child within 31 days of birth, and 2) pay any required additional premium.

To keep your newborn covered, you must notify us (or our agent) of the birth and pay any required premium contribution during that 31 day period, retroactive to date of birth.

Special times you and your dependents can join the plan

You can enroll in these situations:

- When you did not enroll in this plan before because:
  - You were covered by another health plan, and now that other coverage has ended.
  - You had COBRA, and now that coverage has ended.
  - You have added a dependent because of marriage, birth, adoption, placement for adoption. See the *Enrollment* section above for more information.
- You or your dependents become eligible for State premium assistance under Medicaid or an S-CHIP plan for the payment of your **premium** contribution for coverage under this plan.
- When a court orders that you cover a current spouse or a minor child on your health plan.
- When you are a victim of domestic abuse or spousal abandonment and you don't want to be enrolled in the perpetrator's health plan.

We must receive your completed enrollment information from you within 31 days of that date on which you no longer have the other coverage mentioned above.

Three-Month Continuation Option for Expiring 2021-2022 Insurance

Postdoctoral Trainees graduating or otherwise leaving school whose 2021-2022 health insurance coverage is terminating may elect to purchase a continuation option that will provide an additional three months of coverage based on the 2022-2023 Policy year benefits. Please note you can only enroll one time into the continuation option plan.

In-network Provider Network

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

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

Precertification

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

Precertification Call

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

Non-emergency admissions:	You, your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.
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 precertification:	You or your physician must call at least 14 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 precertification decision, where required by state law. If your precertified services are approved, the approval is valid for 30 days as long as you remain enrolled in the plan.

Coordination of Benefits (COB)

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

Description of Benefits

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

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

Plan features	Designated network	In-network coverage	Out-of-network coverage
Policy year deductibles			
You have to meet your policy year deductible before this plan pays for benefits.			
Postdoctoral Trainee	$250 per policy year (Combined)		$500 per policy year
Spouse	$250 per policy year (Combined)		$500 per policy year
Each child	$250 per policy year (Combined)		$500 per policy year
Policy year deductible waiver			
The policy year deductible is waived for all of the following eligible health services: • Designated care and In-network care for Preventive care and wellness, Physician, specialist including Consultants Office visits, Walk-in clinic visits, Pediatric Dental Type A services, Voluntary sterilization for males, Pediatric Vision care services, Mental Health and Substance Abuse Outpatient Office Visits, and Outpatient prescription drugs • Designated care, in-network care, and out-of-network care for Blood and body fluid exposure, Hospital emergency room and Well newborn nursery care			

Maximum out-of-pocket limits		
Maximum out-of-pocket limit per **policy year**		
Postdoctoral Trainee	$5,000 per policy year (Combined)	$10,000 per policy year
Spouse	$5,000 per policy year (Combined)	$10,000 per policy year
Each child	$5,000 per policy year (Combined)	$10,000 per policy year
Family	$10,000 per policy year (Combined)	$20,000 per policy year

Coinsurance listed in the schedule of benefits

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**.

Eligible health services	Designated network	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	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
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 in to your Aetna website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.			
Covered persons age 22 and over: Maximum visits per policy year: 1 visit			
Preventive care immunizations Performed in a facility or at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximums: Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. For details, contact your physician or Member Services by logging in to your Aetna website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.			
The following is not covered under this benefit: • Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment or travel			
Well woman Routine gynecological exams (including Pap smears)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximums: Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.			
Maximum visits per policy year: 1 visit			
Preventive screening and counseling services			
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Depression Screening, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit

Eligible health services	Designated network	In-network coverage	Out-of-network coverage
Obesity and/or healthy diet counseling Maximum visits: Age 0-22: unlimited visits. Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.			
Misuse of alcohol and/or drugs counseling Maximum visits per policy year: 5 visits			
Use of tobacco products counseling Maximum visits per policy year: 8 visits			
Depression screening counseling Maximum visits per policy year: 1 visit			
Sexually transmitted infection counseling Maximum visits per policy year: 2 visits			
Genetic risk counseling for breast and ovarian cancer limitations: Not subject to any age or frequency limitations			
Routine cancer screenings Performed at a physician's office, specialist's office or facility	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
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 in to your Aetna website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.			
Lung cancer screening maximums: 1-2 screenings 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 -Preventive care services only	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	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 counseling services - facility or office visits	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Lactation counseling services maximum visits per policy year either in a group or individual setting: 6 visits			
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	100% (of the negotiated charge) per item No copayment or policy year deductible applies	60% (of the recognized charge) per item
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Contraceptive counseling services maximum visits per policy year either in a group or individual setting: 2 visits			

Eligible health services	Designated network	In-network coverage	Out-of-network coverage
Female contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit	100% (of the negotiated charge) per item No copayment or policy year deductible applies	100% (of the negotiated charge) per item No copayment or policy year deductible applies	60% (of the recognized charge) per item
Voluntary sterilization-Inpatient & Outpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
The following are not covered under this benefit: • Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care • Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA			
Physicians and other health professionals			
Physician, specialist including Consultants Office visits (non-surgical/ non-preventive care by a physician and specialist, includes telemedicine consultations)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$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
Allergy testing and treatment			
Allergy testing & Allergy injections treatment (including Allergy sera and extracts administered via injection) performed at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received.		
Physician and specialist surgical services			
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	90% (of the negotiated charge)	80% (of the negotiated charge)	60% (of the recognized charge)
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • Services of another physician for the administration of a local anesthetic			
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

Eligible health services	Designated network	In-network coverage	Out-of-network coverage
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic			
Alternatives to physician office visits			
Walk-in clinic (non-emergency visit)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$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
Important note: Some walk-in clinics can provide preventive care and wellness services. The types of services offered will vary by the provider and location of the clinic. *If you get preventive care and wellness benefits at a walk-in clinic, they are paid at the cost-sharing shown in the Preventive care and wellness section.*			
Hospital and other facility care			
Inpatient hospital (room and board) and other miscellaneous services and supplies) Includes birthing center facility charges	90% (of the negotiated charge) per admission	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
In-hospital non-surgical physician services	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Alternatives to hospital stays			
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	90% (of the negotiated charge)	80% (of the negotiated charge)	60% (of the recognized charge)
The following are not covered under this benefit: • The services of any other physician who helps the operating physician • A stay in a hospital (See the *Hospital care – facility charges* benefit in this section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic			
Home health care	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	80% (of the recognized charge) per visit
The following are not covered under this benefit: • Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities) • Transportation • 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 - Inpatient	90% (of the negotiated charge) per admission	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Hospice care -Outpatient	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

Eligible health services	Designated network	In-network coverage	Out-of-network coverage
The following are not covered under this benefit: • 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			
Skilled nursing facility-Inpatient	90% (of the negotiated charge) per admission	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Emergency services and urgent care			
Hospital emergency room	$100 copayment then the plan pays 90% (of the balance of the negotiated charge) per visit	Paid the same as designated care coverage	Paid the same as designated care coverage
Important note: • As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment and coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on your ID card, or call Member Services for an address at 1-877-480-4168 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 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 will be waived and your inpatient copayment will apply. • Covered benefits that are applied to the hospital emergency room copayment cannot be applied to any other copayment under the plan. Likewise, a copayment that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment**.** • Separate copayment 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 amounts may be different from the hospital emergency room copayment. 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 amounts that are different from the hospital emergency room copayment amounts.			
Non-emergency care in a hospital emergency room	Not covered	Not covered	Not covered
The following are not covered under this benefit: • Non-emergency services in a hospital emergency room facility			
Urgent medical care provided by an urgent care provider	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Non-urgent use of urgent care provider	Not covered	Not covered	Not covered
The following is not covered under this benefit: • Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)			
Pediatric dental care Limited to covered persons through the end of the month in which the person turns age 19.			
Type A services	100% (of the negotiated charge) per visit No copayment or deductible applies	100% (of the negotiated charge) per visit No copayment or deductible applies	60% (of the recognized charge) per visit
Type B services	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

Eligible health services	Designated network	In-network coverage	Out-of-network coverage
Type C services	50% (of the negotiated charge) per visit	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 negotiated charge) per visit	50% (of the recognized charge) per visit
Dental emergency services	Covered according to the type of benefit and the place where the service is received.		

Pediatric dental care exclusions

The following are not covered under this benefit:

- Any instruction for diet, plaque control and oral hygiene
- Asynchronous dental treatment
- Cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically provided in the *Eligible health services and exclusions* section. Facings on molar crowns and pontics will always be considered cosmetic.
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material or
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants and braces (that are determined not to be medically necessary mouth guards, and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) and craniomandibular joint dysfunction disorder (CMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services and exclusions – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another eligible health service
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered in the *Pediatric dental care* section of the schedule of benefits
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication or analgesia (nitrous oxide)
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically provided in the *Pediatric dental care* section of the schedule of benefits
- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a provider
  - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a dental provider

Eligible health services	Designated network	In-network coverage	Out-of-network coverage
Specific conditions			
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received.		
Family planning services – other			
Voluntary sterilization for males -surgical services	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
The following are not covered under this benefit: • Reversal of voluntary sterilization procedures, including related follow-up care			
Abortion	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
TMJ and CMJ treatment	Covered according to the type of benefit and the place where the service is received.		
The following are not covered under this benefit: • Dental implants			
Impacted wisdom teeth	90% (of the negotiated charge) per visit	90% (of the negotiated charge) per visit	90% (of the recognized charge) per visit
Accidental injury to sound natural teeth	90% (of the negotiated charge) per visit	90% (of the negotiated charge) per visit	90% (of the recognized charge) per visit
The following are not covered under this benefit: • The care, filling, removal or replacement of teeth and treatment of diseases of the teeth • Dental services related to the gums • Apicoectomy (dental root resection) • Orthodontics • Root canal treatment • Soft tissue impactions • Bony impacted teeth • Alveolectomy • Augmentation and vestibuloplasty treatment of periodontal disease • False teeth • Prosthetic restoration of dental implants • Dental implants			
Blood and body fluid exposure	100% (of the negotiated charge) No policy year deductible applies	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
Dermatological treatment	Covered according to the type of benefit and the place where the service is received.		
The following are not covered under this benefit: • Cosmetic treatment and procedures			
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.		
The following are not covered under this benefit: • Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries			

Eligible health services	Designated network	In-network coverage	Out-of-network coverage
Well newborn nursery care in a hospital or birthing center	90% (of the negotiated charge) per visit No policy year deductible applies	80% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit No policy year deductible applies
Note: If applicable, the per admission copayment and/or policy year deductible amounts 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.			
Gender affirming treatment			
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received.		
Tracheal shave	Covered according to the type of benefit and the place where the service is received.		
Nipple reconstruction	Covered according to the type of benefit and the place where the service is received.		
Electrolysis of face and neck	Covered according to the type of benefit and the place where the service is received.		
Voice and communication therapy	Covered according to the type of benefit and the place where the service is received.		
Chest binders	Covered according to the type of benefit and the place where the service is received.		
The following is not covered under this benefit: • Liposuction of the waist (body contouring)			
Autism spectrum disorder			
Autism spectrum disorder treatment, diagnosis & testing and Applied behavior analysis	Covered according to the type of benefit and the place where the service is received.		
Mental Health & Substance Abuse Treatment			
Inpatient hospital (room &board and other miscellaneous hospital services and supplies)	90% (of the negotiated charge) per admission	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Outpatient office visits (includes telemedicine consultations)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$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
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Obesity surgery- inpatient and outpatient facility and physician services	Covered according to the type of benefit and the place where the service is received.		
The following are not covered under this benefit: • Weight management treatment or drugs intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity except as described above and in the *Eligible health services and exclusions – Preventive care and wellness* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are: - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications - Hypnosis or other forms of therapy - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement		

Eligible health services	Designated network	In-network coverage	Out-of-network coverage
Reconstructive surgery and supplies (includes reconstructive breast surgery)	Covered according to the type of benefit and the place where the service is received.		
Eligible health services	**Select care coverage***	**In-network coverage (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.		
Transplant services-travel and lodging	Covered	Covered	Covered
Lifetime Maximum payable for Travel and Lodging Expenses for any one transplant, including tandem transplants	$10,000	$10,000	$10,000
Maximum payable for Lodging Expenses per IOE patient	$50 per night	$50 per night	$50 per night
Maximum payable for Lodging Expenses per companion	$50 per night	$50 per night	$50 per night

The following are not covered under this benefit:

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

Eligible health services	Designated network	In-network coverage	Out-of-network coverage
Treatment of infertility			
Basic infertility services Inpatient and outpatient care	Covered according to the type of benefit and the place where the service is received.		

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

- Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists.
- All charges associated with:
  - Surrogacy for you or the surrogate. 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

Eligible health services	Designated network	In-network coverage	Out-of-network coverage
Specific therapies and tests			
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	90% (of the negotiated charge) per visit	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	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Outpatient Chemotherapy, Radiation & Respiratory Therapy	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Infusion Therapy	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	Covered according to the type of benefit and the place where the service is received.		
Transfusion or kidney dialysis of blood	Covered according to the type of benefit and the place where the service is received.		
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for short-term rehabilitation services and habilitation therapy services	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Acupuncture therapy	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Chiropractic services	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Diagnostic testing for learning disabilities	Covered according to the type of benefit and the place where the service is received.		
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	100% (of the negotiated charge) per trip	Paid the same as Designated care coverage	Paid the same as Designated care coverage
The following are not covered under this benefit: • Non-emergency fixed wing air ambulance from an out-of-network provider • Ambulance services for routine transportation to receive outpatient or inpatient care			
Clinical trial therapies	Covered according to the type of benefit and the place where the service is received.		

Eligible health services	Designated network	In-network coverage	Out-of-network coverage
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received.		
The following are not covered under this benefit: • Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs) • Services and supplies provided by the trial sponsor without charge to you • The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental and investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna's claim policies)			
Durable medical equipment	80% (of the negotiated charge) per item	80% (of the negotiated charge) per item	80% (of the recognized charge) per item
The following are not covered under this benefit: • Whirlpools • Portable whirlpool pumps • Sauna baths • Massage devices • Over bed tables • Elevators • Communication aids • Vision aids • Telephone alert systems • Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician			
Nutritional support	Covered according to the type of benefit and the place where the service is received.		
The following are not covered under this benefit: • Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as described above			
Prosthetic Devices & Orthotics	90% (of the negotiated charge) per item	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
The following are not covered under this benefit: • Services covered under any other benefit • Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace • Trusses, corsets, and other support items • Repair and replacement due to loss, misuse, abuse or theft			
Cochlear implants	90% (of the negotiated charge) per item	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Hearing aids	90% (of the negotiated charge) per item	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Hearing aids maximum per ear: One hearing aid per ear every 36 month consecutive period			
The following are not covered under this benefit: • A replacement of: - A hearing aid that is lost, stolen or broken - A hearing aid installed within the prior 24 month period • Replacement parts or repairs for a hearing aid • Batteries or cords • Cochlear implants • A hearing aid that does not meet the specifications prescribed for correction of hearing loss • Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist			
Hearing exams	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

Eligible health services	Designated network	In-network coverage	Out-of-network coverage
Hearing exam maximum: 1 hearing exams every policy year			
The following are not covered under this benefit: • Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay			
Podiatric (foot care) treatment			
Podiatric (foot care) treatment non-routine foot care treatment	Covered according to the type of benefit and the place where the service is received.		
The following are not covered under this benefit: • Services and supplies for: - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet			
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 or optometrist (includes comprehensive low vision evaluations)	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year: 1 visit **Low vision Maximum:** One comprehensive low vision evaluation every policy year **Fitting of contact Maximum:** 1 visit			
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item No policy year deductible applies	100% (of the negotiated charge) per item No policy year deductible applies	60% (of the recognized charge) per item
Maximum number Per year **Eyeglass frames**: One set of eyeglass frames **Prescription lenses:** One pair of prescription lenses **Contact lenses (includes non-conventional prescription contact lenses & 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			
Optical devices	Covered according to the type of benefit and the place where the service is received.		
Maximum number of optical devices per policy year: One optical device			
The following are not covered under this benefit: • Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes			
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.			

Eligible health services	Designated network	In-network coverage	Out-of-network coverage
Outpatient prescription drugs			
Copayment/coinsurance waiver for risk reducing breast cancer			
The per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network, pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.			
Outpatient prescription drug copayment waiver for tobacco cessation prescription and over-the-counter drugs			
The outpatient prescription drug copayment will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%. Your outpatient prescription drug copayment will apply after those two regimens per policy year have been exhausted.			
Outpatient prescription drug copayment waiver for contraceptives			
The outpatient prescription drug copayment will not apply to female contraceptive methods when obtained at a in-network pharmacy. This means that such contraceptive methods are paid at 100% for: • Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. • If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug or device for that method paid at 100%. The prescription drug copayment will continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at a in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.			
Preferred generic prescription drugs (including specialty drugs)			
For each fill up to a 30 day supply filled at a **retail pharmacy**	$15 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$15 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
For each fill up to a 90 day supply filled at a **retail pharmacy**	$45 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$45 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
More than a 30 day supply but less than a 90 day supply filled at a **mail order pharmacy**	$30 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$30 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
Preferred brand-name prescription drugs (including specialty drugs)			
For each fill up to a 30 day supply filled at a **retail pharmacy**	$50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
For each fill up to a 90 day supply filled at a **retail pharmacy**	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered

Eligible health services	Designated network	In-network coverage	Out-of-network coverage
More than a 30 day supply but less than a 90 day supply filled at a **mail order pharmacy**	$100 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$100 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
Non-preferred generic prescription drugs (including specialty drugs)			
For each fill up to a 30 day supply filled at a **retail pharmacy**	$75 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$75 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
For each fill up to a 90 day supply filled at a **retail pharmacy**	$225 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$225 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
More than a 30 day supply but less than a 90 day supply filled at a **mail order pharmacy**	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
Non-preferred brand-name prescription drugs (including specialty drugs)			
For each fill up to a 30 day supply filled at a **retail pharmacy**	$75 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$75 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
For each fill up to a 90 day supply filled at a **retail pharmacy**	$225 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$225 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
More than a 30 day supply but less than a 90 day supply filled at a **mail order pharmacy**	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not Covered
Orally administered anti-cancer prescription drugs- For each fill up to a 30 day supply filled at a retail pharmacy	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Not Covered
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	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Not Covered
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	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Not Covered

Eligible health services	Designated network	In-network coverage	Out-of-network coverage
Maximums: Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.			
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each 30 day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Not Covered
Maximums: Coverage is permitted for two 90-day treatment regimens only. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.			

Outpatient prescription drugs exclusions

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

- Any services related to the dispensing, injecting or application of a drug
- Biological sera
- Compounded prescriptions containing bulk chemicals not approved by the U.S. Food and Drug Administration (FDA) including compounded bioidentical hormones
- Cosmetic drugs including medications and preparations used for cosmetic purposes
- Devices, products and appliances, except those that are specially covered
- Dietary supplements including medical foods
- Drugs or medications
  - Administered or entirely consumed at the time and place it is prescribed or provided
  - Which do not, by federal or state law, require a **prescription** order i.e. over-the-counter (OTC) drugs), even if a **prescription** is written except as specifically provided above
  - That include the same active ingredient or a modified version of an active ingredient as a covered **prescription drug** (unless a medical exception is approved)
  - That are therapeutically equivalent or therapeutically alternative to a covered **prescription drug** (unless a medical exception is approved)
  - That are therapeutically equivalent or therapeutically alternative to an over-the-counter (OTC) product (unless a medical exception is approved
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while an inpatient of a healthcare facility
  - Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by our Pharmacy and Therapeutics Committee
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration)
  - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - That are used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the **covered person** meets one or more clinical criteria detailed in our **precertification** and clinical policies
- Duplicative drug therapy (e.g. two antihistamine drugs)
- Genetic care
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects
- Immunizations related to travel or work
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
- Implantable drugs and associated devices except as specifically provided above
- **Infertility**
  - **Injectable prescription drugs** used primarily for the treatment of **infertility**
- Injectables
  - Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by us.

- Needles and syringes, except for those used for self-administration of an injectable drug.
- Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

- **Prescription drugs**:
  - For which there is an over-the-counter (OTC) product which has the same active ingredient and strength even I a **prescription** is written.
  - Packaged in a unit dose form.
  - Filled prior to the effective date or after the termination date of coverage under this plan.
  - Dispensed by a **mail order pharmacy** and include **prescription drugs** that cannot be shipped by mail due to state or federal laws or regulations, or when the plan considers shipment through the mail to be unsafe. Examples of these types of drugs include, but are not limited to, narcotics, amphetamines, DEA controlled substances and anticoagulants.
  - That include an active metabolite, stereoisomer, prodrug (precursor) or altered formulation of another drug and are not clinically superior to that drug as determined by the plan.
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth, or **prescription** drugs for the treatment to a dental condition.
  - That are considered oral dental preparations and fluoride rinses, except pediatric fluoride tablets or drops as specified on the **preferred drug guide**.
  - That are **non-preferred drugs** unless **non-preferred drugs** are specifically covered as described in your schedule of benefits. However, a **non-preferred drug** will be covered if in the judgment of the **prescriber** there is no equivalent **prescription drug** on the **preferred drug guide** or the product on the **preferred drug guide** is ineffective in treating your disease or condition or has caused or is likely to cause an adverse reaction or harm you.
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, the use of or intended use of which would be illegal, unethical, imprudent, abusive, not **medically necessary** or otherwise improper, and drugs obtained for use by anyone other than the person identified on the ID card.
- Refills dispensed more than one year from the date the latest **prescription** order was written
- Replacement of lost or stolen **prescriptions**
- Test agents except diabetic test agents
- Tobacco cessation products unless recommended by the United States Preventive Services Task Force (USPSTF)
- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (that is, a drug with the same active ingredient or same therapeutic effect), supply or equipment is on the **preferred drug guide**
  - Any dosage or form of a drug when the same drug (that is, a drug with the same active ingredient or same therapeutic effect) is available in a different dosage or form on our **preferred drug guide**

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

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

Out of Country claims

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

General Exclusions

Air or space travel

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

  This exclusion does not apply if:
  - You are traveling solely as a fare-paying passenger
  - You are traveling on a licensed, commercial, regularly scheduled non-military aircraft
  - You are traveling solely in a civil aircraft with a current valid "Standard Federal Aviation Agency Airworthiness Certificate" and:
    - The civil aircraft is piloted by a person with a current valid pilot's certificate with proper ratings for the type of flight and aircraft involved
    - You are as a passenger with no duties at all on an aircraft used only to carry passengers or you are a pilot or a part of the flight crew on an aircraft owned or leased by the policyholder performing duties for the policyholder

Alternative health care

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

Armed forces

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

Behavioral health treatment

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

Beyond legal authority

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

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

Examples of these are:

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

Breasts

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

Clinical trial therapies (experimental or investigational)

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

Cosmetic services and plastic surgery

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

This exclusion does not apply to:

- Surgery after an accidental injury when performed as soon as medically feasible. (Injuries that occur during medical treatments are not considered accidental injuries even if unplanned or unexpected.)
- Coverage that may be provided under the *Eligible health services and exclusions - Gender affirming treatment* section.

Court-ordered services and supplies

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

Custodial care

Examples are:

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

Dental care for adults

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

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

Educational services

Examples of these services are:

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

Elective treatment or elective surgery

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

Examinations

Any health or dental examinations needed:

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

Experimental or investigational

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

Facility charges
For care, services or supplies provided in:

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

Felony

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

Gene-based, cellular and other innovative therapies (GCIT)
The following are not eligible health services unless you receive prior written approval from us:

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

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

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

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, *as determined by Aetna's Clinical Policy Bulletins, please contact 877-480-4168 with any questions.*

Jaw joint disorder

- Surgical treatment of jaw joint disorders
- Non-surgical treatment of jaw joint disorders
- Jaw joint disorder treatment performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to jaw joint disorders including associated myofascial pain

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

Judgment or settlement

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

Mandatory no-fault laws

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

Maintenance care

- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services. See the *Eligible health services and exclusions – Habilitation therapy service*s section

Medical supplies – outpatient disposable

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

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 within the covered person's home country but only if the home country has a socialized medicine program

Other primary payer

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

Outpatient prescription or non-prescription drugs and medicines

- Outpatient prescription drugs or non-prescription drugs and medicines provided by the policyholder

Personal care, comfort or convenience items

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

Private duty nursing

Riot

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

Routine exams

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

School health services

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

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

  the policyholder.

Services provided by a family member

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

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

Sports

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

Strength and performance

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

Students in mental health field

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

Therapies and tests

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

Tobacco cessation

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

Treatment in a federal, state, or governmental entity

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

Vision care for adults

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

Wilderness treatment programs

See *Educational services* within this section

Work related illness or injuries

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

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

Sanctioned Countries

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

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-877-480-4168.

Smartphone or Tablet

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

Non-Discrimination

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

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

These aids and services include:

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

If you need these services, contact the number on your ID card. Not an Aetna member? Call us at 1-877-480-4168.

If you have questions about our nondiscrimination policy or have a discrimination-related concern that you would like to discuss, please call us at 1-877-480-4168.

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

Language accessibility statement

Interpreter services are available for free.

Attention: If you speak English, language assistance service, free of charge, are available to you. Call **1-877-480-4168** (TTY: **711**).

Español/Spanish

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-480-4168** (TTY: **711**).

አማርኛ/Amharic

ልብ ይበሉ: አማርኛ ቋንቋ የሚናገሩ ከሆነ፥ የትርጉም ድጋፍ ሰጪ ድርጅቶች፣ ያለምንም ክፍያ እርስዎን ለማገልገል ተዘጋጅተዋል። የሚከተለው ቁጥር ላይ ይደውሉ **1-877-480-4168** (መስማት ለተሳናቸው: **711**).

العربية/Arabic

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-480-4168** (رقم الهاتف النصي: **711**).

Bàsɔ̀ɔ̀ Wùɖù/Bassa

Dè dɛ nìà kɛ dyéɖé gbo: Ɔ jǔ ké m̀ dyi Bàsɔ̀ɔ̀-wùɖù-po-nyɔ̀ jǔ ní, nìí à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ m̀ gbo kpáa. Ɖá **1-877-480-4168** (TTY: **711**).

中文/Chinese

注意：如果您说中文，我们可为您提供免费的语言协助服务。请致电 **1-877-480-4168** (TTY: **711**)。

فارسی/Farsi

توجه: اگر به زبان فارسی صحبت می کنید، خدمات زبانی رایگان به شما ارایه میگردد، با شماره **1-877-480-4168** (TTY: **711**) تماس بگیرید.

Français/French

Attention : Si vous parlez français, vous pouvez disposer d’une assistance gratuite dans votre langue en composant le **1-877-480-4168** (TTY: **711**).

ગુજરાતી/Gujarati

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો ભાષાકીય સહાયતા સેવા તમને નિ:શુલ્ક ઉપલબ્ધ છે. કૉલ કરો **1-877-480-4168** (TTY: **711**).

Kreyòl Ayisyen/Haitian Creole

Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-877-480-4168** (TTY: **711**).

Igbo

Nrụbama: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-877-480-4168** (TTY: **711**).

한국어/Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스가 무료로 제공됩니다. **1-877-480-4168**(TTY: **711**)번으로 전화해 주십시오.

Português/Portuguese

Atenção: a ajuda está disponível em português por meio do número **1-877-480-4168** (TTY: **711**). Estes serviços são oferecidos gratuitamente.

Русский/Russian

Внимание: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Звоните по телефону **1-877-480-4168** (TTY: **711**).

Tagalog

Paunawa: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-480-4168** (TTY: **711**).

اردو/Urdu

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت دستیاب ہیں ۔ (TTY: **711**) **1-877-480-4168** پر کال کریں.

Tiếng Việt/Vietnamese

Lưu ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Gọi số **1-877-480-4168** (TTY: **711**).

Yorùbá/Yoruba

Àkíyèsí: Bí o bá nsọ èdè Yorùbá, ìrànlọ́wọ́ lórí èdè, lófẹ̀ẹ́, wà fún ọ. Pe **1-877-480-4168** (TTY: **711**).

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