



Aetna Student Health

Plan Design and Benefits Summary

Preferred Provider Organization (PPO)

American University

Policy Year: 2025–2026

Policy Number: 186133

<https://www.aetnastudenthealth.com>

(877) 373-2708



AMERICAN UNIVERSITY
WASHINGTON, DC



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

AMERICAN UNIVERSITY STUDENT HEALTH CENTER

The student health center is the University's on-campus health facility. The Student Health Center staff consists of both clinical and administrative staff. The clinical staff is an interdisciplinary team of physicians, physician assistants, nurse practitioners, nurses, and medical assistants. All students enrolled in credit-bearing courses at AU, regardless of the type of insurance coverage they carry, are eligible for care in the student health center.

The student health center is open for regular business hours Monday through Thursday from 9:00 a.m. to 8:00 p.m. and Tuesday, Wednesday, Friday from 9:00 a.m. to 6:00 p.m. During the summer and semester breaks, the student health center is open Monday through Friday from 9:00 a.m. to 4:30 p.m. For more information or to make an appointment, call the student health center at 202-885-3380. In the event of an emergency, call 911 or contact campus police.

Who is eligible?

All full-time degree, resident and international students with F-1 and J-1 visas are required to have health insurance each school year. Students will automatically be enrolled in the Student Health Insurance Plan if they are required to have insurance and the annual premium will be charged to their student account. Domestic students may waive out of the plan with an approved waiver by the appropriate deadline.

Part-time students enrolled in at least 6 credit hours are able to voluntarily enroll in the student health insurance plan and have the premium assessed to their student account by completing the Voluntary Enrollment Form with the school.

Insured students are eligible to enroll dependents including their spouse, domestic partner, and/or dependent children.

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.

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.

Coverage Periods

Coverage for all insured students 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.

Rates

The rates below include premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna), as well as \$8 for the annual Travel Assistance Program. This is prorated for other periods of enrollment.

| | Annual 08/01/2025- 07/31/2026 | Spring/Summer 01/01/2026- 07/31/2026 |
|----------|-------------------------------------|--|
| Student | \$2,506.00 | \$1,456.00 |
| Spouse | \$2,506.00 | \$1,456.00 |
| Child | \$2,506.00 | \$1,456.00 |
| Children | \$5,012.00 | \$2,912.00 |

Waiver deadlines: Fall 09/08/2025, Spring/Summer 01/31/2026

Waive

To waive, log on to <https://american.myahpcare.com/waiver>.

Enrollment

To enroll, log on to <https://american.myahpcare.com/enrollment>.

American University Home Page

To visit, log on to <https://american.myahpcare.com/>.

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

A newborn child - Your newborn child is covered on your health plan for the first 60 days from the moment of birth.

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

An adopted child or a child legally placed with you for adoption - A child that you, or you and your spouse, civil union partner or domestic partner adopts or is placed with you for adoption, is covered on your plan for the first 60 days after the adoption or the placement is complete.

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

Dependent coverage due to a court order

If you must provide coverage to a dependent because of a court order, your dependent is covered on your health plan for the first 60 days from the court order.

- To keep your dependent covered, we must receive your completed enrollment information within 60 days of the court order.
- You must still enroll the dependent within 60 days of the court order even when coverage does not require payment of an additional premium contribution for the dependent.
- If you miss this deadline, your dependent will not have health benefits after the first 60 days.
- If your coverage ends during this 60 day period, then your dependent's coverage will end on the same date as your coverage. This applies even if the 60 day period has not ended.

If you need information or have general questions on dependent enrollment, call Member Services at (877) 373-2708.

Medicare Eligibility Notice

You are not eligible to enroll in the student health plan if you have Medicare at the time of enrollment in this student plan. The plan does not provide coverage for people who have Medicare.

Termination and Refunds

Withdrawal from Classes – Leave of Absence

If you withdraw from classes under a school-approved leave of absence, your coverage will remain in force through the end of the period for which premium payment has been received. No premiums will be refunded.

Withdrawal from Classes – Other than Leave of Absence

If you withdraw from classes within 31 days after the policy effective date, you will be considered ineligible for coverage. Your coverage will be terminated retroactively, and any premium paid will be refunded.

If you withdraw from classes more than 31 days after the policy effective date, your coverage will remain in force through the end of the period for which premium payment has been received. No premium will be refunded.

If you withdraw from classes to enter the armed forces of any country, your coverage will end as of the date of such entry. We will refund your premium, on a pro-rata basis, if you submit a written request within 90 days from the date you withdraw.

In-network Provider Network

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

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

Precertification

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

Precertification Call

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

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

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

We will provide a written notification to you and your physician of the precertification decision, where required by state law and within the timeframe specified by state law. If your pre-certified services are approved, the approval is valid for 60 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 <https://www.aetnastudenthealth.com>.

This Plan will pay benefits in accordance with any applicable **District of Columbia** Insurance Law(s).

| 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 | \$200 per policy year | \$500 per policy year |
| Spouse | \$200 per policy year | \$500 per policy year |
| Each child | \$200 per policy year | \$500 per policy year |
| Family | \$400 per policy year | \$1,000 per policy year |

Policy year deductible waiver

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

- In-network care for Pediatric Dental Type A services, Pediatric Vision Care Services, Abortion-physician or specialist surgical services and Voluntary sterilization for males-physician or specialist surgical services
- In-network care and out-of-network care for Preventive care and wellness, Well newborn nursery care, Routine Mammography, and Outpatient prescription drugs

Individual

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

Family

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

To satisfy this family policy year deductible limit for the rest of the policy year, the following must happen:

- The combined eligible health services that you and each of your covered dependents incur towards the individual policy year deductibles must reach this family policy year deductible limit in a policy year.
- Two covered person(s) must individually meet their policy year deductible in a policy year.

When this occurs in a policy year, the individual policy year deductibles for you and your covered dependents will be considered to be met for the rest of the policy year.

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

Maximum out-of-pocket limit per policy year

| | | |
|-------------------|--------------------------|--------------------------|
| Student | \$8,000 per policy year | \$25,000 per policy year |
| Spouse | \$8,000 per policy year | \$25,000 per policy year |
| Each child | \$8,000 per policy year | \$25,000 per policy year |
| Family | \$16,000 per policy year | \$40,000 per policy year |

| Eligible health services | In-network coverage | Out-of-network coverage |
|---|--|--|
| Preventive care and wellness | | |
| Routine physical exam | | |
| Performed at a physician's office | | |
| Routine physical exam | 100% (of the negotiated charge) per visit No copayment or policy year deductible applies | 100% (of the recognized charge) per visit No policy year deductible applies |
| Routine physical exam limits for covered persons through age 21: maximum age and visit limits per policy year | Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents. | |
| Routine physical exam limits for covered persons age 22 and over: maximum visits per policy year | | 1 visit |
| Preventive care immunizations | | |
| Performed in a facility or at a physician's office | | |
| Preventive care immunizations | 100% (of the negotiated charge) per visit No copayment or policy year deductible applies | 100% (of the recognized charge) per visit No policy year deductible applies |
| Preventive care immunization maximums | Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention | |
| The following is not covered under this benefit: | | |
| <ul style="list-style-type: none"> Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment or travel | | |
| Well woman preventive visits | | |
| Routine gynecological exams (including Pap smears and cytology tests) | | |
| Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office | 100% (of the negotiated charge) per visit No copayment or policy year deductible applies | 100% (of the recognized charge) per visit No policy year deductible applies |
| Maximum visits per policy year | | 1 visit |

| Eligible health services | In-network coverage | Out-of-network coverage |
|---|---|--|
| Preventive screening and counseling services | | |
| Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer | 100% (of the negotiated charge) per visit No copayment or policy year deductible applies | 100% (of the recognized charge) per visit No policy year deductible applies |
| Obesity and/or healthy diet counseling Maximum visits | Age 0-22: unlimited visits. Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling. | |
| Misuse of alcohol and/or drugs counseling Maximum visits per policy year | | 5 visits |
| Use of tobacco products counseling Maximum visits per policy year | | 8 visits |
| Sexually transmitted infection counseling Maximum visits per policy year | | 2 visits |
| Genetic risk counseling for breast and ovarian cancer limitations | | Not subject to any age or frequency limitations |
| Genetic risk counseling for breast and ovarian cancer Maximum visits per policy year | | 1 visit |
| Routine cancer screenings Deductible does not apply to routine mammography | 100% (of the negotiated charge) per visit No copayment or policy year deductible applies | 100% (of the recognized charge) per visit No policy year deductible applies |
| Maximum: | Subject to any age; family history; and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. | |
| Lung cancer screening maximums | 1 screening every 12 months | |

| Eligible health services | In-network coverage | Out-of-network coverage |
|--|---|--|
| Prenatal care services (Preventive care services only) | 100% (of the negotiated charge) per visit No copayment or policy year deductible applies | 100% (of the recognized charge) per visit No policy year deductible applies |
| Lactation counseling services | 100% (of the negotiated charge) per visit No copayment or policy year deductible applies | 100% (of the recognized charge) per visit No policy year deductible applies |
| 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 recognized charge) per item No policy year deductible applies |
| Family planning services – female contraceptives | | |
| Counseling services | | |
| Female contraceptive counseling services office visit | 100% (of the negotiated charge) per visit No copayment or policy year deductible applies | 100% (of the recognized charge) per visit No policy year deductible applies |
| Contraceptive counseling services maximum visits per policy year either in a group or individual setting | | 2 visits |
| Female contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit | 100% (of the negotiated charge) per item No copayment or policy year deductible applies | 100% (of the recognized charge) per item No policy year deductible applies |
| Female Voluntary sterilization | | |
| Inpatient provider services | 100% (of the negotiated charge) per visit No copayment or policy year deductible applies | 100% (of the recognized charge) per visit No policy year deductible applies |

| Eligible health services | In-network coverage | Out-of-network coverage |
|---|---|--|
| Outpatient provider services | 100% (of the negotiated charge) per visit No copayment or policy year deductible applies | 100% (of the recognized charge) per visit No policy year deductible applies |
| The following are not covered under this benefit: | | |
| <ul style="list-style-type: none"> Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA Male contraceptive methods, sterilization procedures or devices, except for male condoms prescribed by a provider | | |
| Physicians and other health professionals | | |
| Physician, specialist including Consultants Office visits (non-surgical/ non-preventive care by a physician and specialist, includes telemedicine consultations) | \$20 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit | 60% (of the recognized charge) per visit |
| Allergy testing and treatment | | |
| Allergy testing performed at a physician's or specialist's office | 80% (of the negotiated charge) per visit | 60% (of the recognized charge) per visit |
| Allergy injections treatment including Allergy sera and extracts administered via injection performed at a physician's or specialist's office | 80% (of the negotiated charge) per visit | 60% (of the recognized charge) per visit |
| Physician and specialist surgical services | | |
| Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses) | 80% (of the negotiated charge) | 60% (of the recognized charge) |
| The following are not covered under this benefit: | | |
| <ul style="list-style-type: none"> A stay in a hospital (Hospital stays are covered in the <i>Eligible health services and exclusions – Hospital and other facility care</i> section) Services of another physician for the administration of a local anesthetic | | |

| Eligible health services | In-network coverage | Out-of-network coverage |
|--|---|---|
| Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses) | 80% (of the negotiated charge) per visit | 60% (of the recognized charge) per visit |
| The following are not covered under this benefit: | | |
| <ul style="list-style-type: none"> • A stay in a hospital (Hospital stays are covered in the <i>Eligible health services and exclusions – Hospital and other facility care</i> section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic | | |
| Alternatives to physician office visits | | |
| Walk-in clinic visits (non-emergency visit) | \$20 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit | 60% (of the recognized charge) per visit |
| Hospital and other facility care | | |
| Inpatient hospital (room and board, including intensive care) and other miscellaneous services and supplies) | 80% (of the negotiated charge) per admission | 60% (of the recognized charge) per admission |
| Includes birthing center facility charges | | |
| Includes birthing center facility charges | | |
| The following are not eligible health services: | | |
| <ul style="list-style-type: none"> • All services and supplies provided in: <ul style="list-style-type: none"> - Rest homes - Any place considered a person's main residence or providing mainly custodial or rest care - Health resorts - Spas - Schools or camps | | |
| Preadmission testing | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| In-hospital non-surgical physician services | 80% (of the negotiated charge) per visit | 60% (of the recognized charge) per visit |

| Eligible health services | In-network coverage | Out-of-network coverage |
|--|---|--|
| Alternatives to hospital stays | | |
| Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center | 80% (of the negotiated charge) | 60% (of the recognized charge) |
| The following are not covered under this benefit: | | |
| | <ul style="list-style-type: none"> • A stay in a hospital (See the <i>Hospital care – facility charges</i> benefit in this section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic | |
| Home health Care | 80% (of the negotiated charge) per visit | 60% (of the recognized charge) per visit |
| Maximum visits per episode per policy year | 90 | |
| The following are not covered under this benefit: | | |
| | <ul style="list-style-type: none"> • Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities) • Transportation • Homemaker or housekeeper services • Food or home delivered services • Maintenance therapy | |
| Hospice-Inpatient facility | 80% (of the negotiated charge) per admission | 60% (of the recognized charge) per admission |
| Maximum days per confinement per policy year | 180 | |
| Hospice-Outpatient | 80% (of the negotiated charge) per visit | 60% (of the recognized charge) per visit |
| Maximum outpatient hospice visits per policy year | 180 | |
| The following are not covered under this benefit: | | |
| | <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> - Sitter or companion services for either you or other family members - Transportation - Maintenance of the house | |

| Eligible health services | In-network coverage | Out-of-network coverage |
|---|--|---|
| Skilled nursing facility- Inpatient facility | 80% (of the negotiated charge) per admission | 60% (of the recognized charge) per admission |
| Maximum days of confinement per policy year | | 60 |
| Emergency room | \$250 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit | Paid the same as in-network coverage |
| Non-emergency care in an 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, or call Member Services for an address at 1-877-480-4161 and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill.
- A separate emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived and your inpatient copayment/coinsurance will apply.
- Covered benefits that are applied to the emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the emergency room copayment/coinsurance.
- Separate copayment/coinsurance amounts may apply for certain services given to you in the emergency room that are not part of the emergency room benefit. These copayment/coinsurance amounts may be different from the emergency room copayment/coinsurance. They are based on the specific service given to you.
- Services given to you in the emergency room that are not part of the emergency room benefit may be subject to copayment/coinsurance amounts.

The following are not covered under this benefit:

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

| | | |
|--|---|--|
| Urgent care | 80% (of the negotiated charge) per visit | 60% (of the recognized charge) per visit |
| Non-urgent use of an urgent care provider | 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)

| Eligible health services | In-network coverage | Out-of-network coverage |
|---|--|--|
| 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 | 60% (of the recognized charge) per visit |
| Type B services | 80% (of the negotiated charge) per visit | 60% (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 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 |

Pediatric dental care exclusions

The following are not covered under this benefit:

- Any instruction for diet, plaque control and oral hygiene
 - Cosmetic services and supplies including:
 - Plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
 - Augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the *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
 - 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) 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 above and in the *Pediatric dental care* section of Policy
- 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
- 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 | In-network coverage | Out-of-network coverage |
|---|--|--|
| Diabetic services and supplies (including equipment and training) | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| Podiatric (foot care) treatment Physician and specialist non-routine foot care treatment | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |

The following are not covered under this benefit:

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

| | | |
|--|--------------------------------|--------------------------------|
| Accidental injury to sound natural teeth | 80% (of the negotiated charge) | 60% (of the recognized charge) |
|--|--------------------------------|--------------------------------|

The following are not covered under this benefit:

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

| Eligible health services | In-network coverage | Out-of-network coverage |
|--|--|--|
| Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| Clinical trials | | |
| Experimental or investigational therapies | 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 |
| 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 |

The following are not eligible health services:

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

| | | |
|--------------------------|--|--|
| Dermatological treatment | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
|--------------------------|--|--|

The following are not covered under this benefit:

- Acne treatment
- Cosmetic treatment and procedures

| | | |
|--|--|--|
| 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 |
|--|--|--|

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 | In-network coverage | Out-of-network coverage |
|--|---|--|
| 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 |
| Voluntary sterilization for males | | |
| Inpatient Physician or specialist surgical services | 100% (of the negotiated charge) No policy year deductible applies | 60% (of the recognized charge) |
| Outpatient Physician or specialist surgical services | 100% (of the negotiated charge) per visit No policy year deductible applies | 60% (of the recognized charge) per visit |
| Abortion | | |
| Inpatient physician or specialist surgical services | 100% (of the negotiated charge) No policy year deductible applies | 60% (of the recognized charge) |
| Outpatient physician or specialist surgical services | 100% (of the negotiated charge) No policy year deductible applies | 60% (of the recognized charge) |
| Gender affirming treatment | | |
| Surgical, hormone replacement therapy, and counseling treatment | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| Autism spectrum disorder | | |
| Autism spectrum disorder treatment, diagnosis and testing. Includes Applied behavior analysis and Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| Behavioral health | | |
| Inpatient hospital (room and board and other miscellaneous hospital services and supplies) | 80% (of the negotiated charge) per admission | 60% (of the recognized charge) per admission |
| Outpatient treatment office visits (includes telemedicine [cognitive behavioral therapy] consultations) | \$20 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit | 60% (of the recognized charge) per visit |

| Eligible health services | In-network coverage | Out-of-network coverage |
|--|--|--|
| Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program) | 80% (of the negotiated charge) per visit | 60% (of the recognized charge) per visit |

| Eligible health services | In-network coverage (IOE facility) | Out-of-network coverage (Includes providers who are otherwise part of Aetna's network but are non-IOE providers) |
|---|--|---|
| Transplant services | | |
| Inpatient and outpatient transplant facility services | Covered according to the type of benefit and the place where the service is received | 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 | Covered according to the type of benefit and the place where the service is received |
| Transplant services-travel and lodging | Covered | Covered |
| Lifetime Maximum payable for Travel and Lodging Expenses for any one transplant, including tandem transplants | \$10,000 | \$10,000 |
| Maximum payable for Lodging Expenses per IOE patient | \$50 per night | \$50 per night |
| Maximum payable for Lodging Expenses per companion | \$50 per night | \$50 per night |
| <p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> • 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 <p>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</p> | | |

| Eligible health services | In-network coverage | Out-of-network coverage |
|--|--|--|
| Infertility services | | |
| Treatment of basic infertility | Covered according to the type of benefit and the place where the service is received | Covered according to the type of benefit and the place where the service is received |
| Limited Infertility services | | |
| Inpatient and outpatient 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 |
| Advanced reproductive technology (ART) | | |
| Inpatient and outpatient 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 |
| Fertility preservation | 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 |
| For treatment that includes oocyte retrieval, maximum number of retrievals | 3, with unlimited embryo transfers from those oocyte retrievals | 3, with unlimited embryo transfers from those oocyte retrievals |
| Infertility services exclusions | | |
| The following are not covered under the infertility services benefit: | | |
| <ul style="list-style-type: none"> The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers. A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person. All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father. Home ovulation prediction kits or home pregnancy tests. The purchase of donor embryos, donor eggs or donor sperm. Obtaining sperm from a person not covered under this plan. Infertility treatment when a successful pregnancy could have been obtained through less costly treatment. Infertility treatment when either partner has had voluntary sterilization surgery, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization. Infertility treatment when infertility is due to a natural physiologic process such as age related ovarian insufficiency (e.g., perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period [or other abnormal testing results as outlined in Aetna's infertility clinical policy.. Treatment for dependent children, except for fertility preservation as described above. | | |

| Eligible health services | 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 | 80% (of the negotiated charge) | 60% (of the recognized charge) |
| Diagnostic lab work performed in a physician's office, the outpatient department of a hospital or other facility | 80% (of the negotiated charge) | 60% (of the recognized charge) |
| Diagnostic radiological services performed in a physician's office, the outpatient department of a hospital or other facility | 80% (of the negotiated charge) | 60% (of the recognized charge) |
| Outpatient Chemotherapy, Radiation & Respiratory Therapy | 80% (of the negotiated charge) per visit | 60% (of the recognized charge) per visit |
| Hormone replacement 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 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 |
| <p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan Enteral nutrition Blood transfusions and blood products Dialysis | | |
| Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) | 80% (of the negotiated charge) per visit | 60% (of the recognized charge) per visit |
| Combined for short-term rehabilitation services and habilitation therapy services | | |
| Cardiac and Pulmonary Maximum visits per policy year | Treatment over a 90 consecutive day period per incident of illness or injury beginning with the first day of treatment. | |
| Chiropractic services | 80% (of the negotiated charge) per visit | 60% (of the recognized charge) per visit |

| Eligible health services | In-network coverage | Out-of-network coverage |
|---|---|--|
| 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 | Covered according to the type of benefit and the place where the service is received |
| Other services | | |
| Acupuncture | 80% (of the negotiated charge) per visit | 60% (of the recognized charge) per visit |
| The following is not covered under this benefit: | | |
| <ul style="list-style-type: none"> • Acupressure | | |
| Emergency ground, air, and water ambulance (includes non-emergency ambulance) | \$250 copayment then the plan pays 80% (of the balance of the negotiated charge) per trip | Paid the same as in-network coverage |
| The following are not eligible health services: | | |
| <ul style="list-style-type: none"> • Ambulance services for routine transportation to receive outpatient or inpatient care | | |
| Durable medical and surgical equipment | 80% (of the negotiated charge) per item | 60% (of the recognized charge) per item |
| The following are not covered under this benefit: | | |
| <ul style="list-style-type: none"> • 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 | 80% (of the negotiated charge) per item | 60% (of the recognized charge) per item |
| The following are not covered under this benefit: | | |
| <ul style="list-style-type: none"> • 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 | | |
| Osteoporosis (non-preventive care) Physician's or specialist's 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 |
| Prosthetic Devices & Orthotics Includes Cranial prosthetics (<i>Medical wigs</i>) | 80% (of the negotiated charge) per item | 60% (of the recognized charge) per item |
| Wig maximum | \$250 | |

The following are not covered under this benefit:

- Services covered under any other benefit
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft
- Communication aids

| Eligible health services | In-network coverage | Out-of-network coverage | | |
|--|--|--|--|--|
| Hearing aids and Exams | | | | |
| Hearing exam | 80% (of the negotiated charge) per visit | 60% (of the recognized charge) per visit | | |
| Hearing exam maximum | 1 hearing exams every 36 month consecutive period | | | |
| The following are not covered under this benefit: | | | | |
| <ul style="list-style-type: none"> • Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay | | | | |
| Hearing Aids | 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: | | | | |
| <ul style="list-style-type: none"> • A replacement of: <ul style="list-style-type: none"> - A hearing aid that is lost, stolen or broken - A hearing aid installed within the prior 36 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 | | | | |
| Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19) | | | | |
| 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 | 60% (of the recognized charge) per visit | | |
| 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 | | |

| Eligible health services | In-network coverage | Out-of-network coverage |
|---|---|--|
| Maximum visits per policy year Low vision Maximum Fitting of contact Maximum | | 1 visit One comprehensive low vision evaluation every policy year 1 visit |
| Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses | 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 Prescription lenses Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery) | | One set of eyeglass frames One pair of prescription lenses Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set |
| Optical devices | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| Maximum number of optical devices per policy year | One optical device | |

***Important note:**

Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies.

As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.

The following are not covered under this benefit:

- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

Adult vision care Limited to covered persons age 19 and over

| Eligible health services | In-network coverage | Out-of-network coverage |
|---|--|--|
| Adult routine vision exams (including refraction) Performed by a legally qualified ophthalmologist or therapeutic optometrist, or any other providers acting within the scope of their license Includes fitting of prescription contact lenses | 100% (of the negotiated charge) per visit No policy year deductible applies | 60% (of the recognized charge) per visit |
| Maximum visits per policy year Maximum per policy year Fitting of Contact maximum | | 1 visit \$50 1 visit |

The following are not covered under this benefit:

Adult vision care

- Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes

Adult vision care services and supplies

- 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

Policy year deductible and copayment waiver for risk reducing breast cancer

The policy year deductible and the per prescription copayment will not apply to risk reducing breast cancer prescription drugs 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 waiver for tobacco cessation prescription and over-the-counter drugs

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

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

Outpatient prescription drug copayment waiver for contraceptives

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

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

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

The prescription drug copayment continues to apply to prescription drugs that have a generic equivalent, 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 |
|---|--|--|
| Outpatient prescription drugs | | |
| Preferred and Non-Preferred generic prescription drugs | | |
| For each fill up to a 30 day supply filled at a retail pharmacy | \$15 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies | \$15 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies |
| More than a 30 day supply but less than a 91 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 | Not covered |

| Eligible health services | In-network coverage | Out-of-network coverage |
|--|---|--|
| Preferred brand-name prescription drugs | | |
| For each fill up to a 30 day supply filled at a retail pharmacy | \$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 recognized charge) No policy year deductible applies |
| More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy | \$90 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies | Not covered |
| Non-preferred brand-name prescription drugs | | |
| For each fill up to a 30 day supply filled at a retail pharmacy | \$70 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies | \$70 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies |
| More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy | \$140 copayment per supply then the plan pays 100% (of the balance 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 specialty pharmacy or a retail pharmacy | Copayment per supply of 20% of the negotiated charge No policy year deductible applies | Not covered |
| <p>Important note: Your cost share will not exceed \$150 per 30 day supply of a covered specialty drug.</p> | | |

| Eligible health services | In-network coverage | Out-of-network coverage |
|---|---|--|
| Anti-cancer drugs taken by mouth- For each fill up to a 30 day supply | 100% (of the negotiated charge) No policy year deductible applies | 100% (of the recognized charge) No policy year deductible applies |
| Diabetic insulin & supplies | | |
| 30 day supply at retail pharmacy | Paid according to the type of drug per the schedule of benefits, above | Paid according to the type of drug per the schedule of benefits, above |
| 90 day supply at mail order pharmacy | Paid according to the type of drug per the schedule of benefits, above | Paid according to the type of drug per the schedule of benefits, above |
| Diabetic insulin important note: Your cost share will not exceed \$25 per 30 day supply of a covered prescription insulin drug filled at a network pharmacy. No deductible applies for preferred insulin. | | |
| Contraceptives (birth control) Brand-name prescription drugs and devices are covered at 100% at an in-network pharmacy when a generic is not available | | |
| For each fill up to a 12 month supply of generic and OTC drugs and devices filled at a retail pharmacy | 100% (of the negotiated charge) No policy year deductible applies | 100% (of the recognized charge) No policy year deductible applies |
| For each fill up to a 12 month supply of brand name prescription drugs and devices filled at a retail pharmacy | Paid according to the type of drug per the schedule of benefits, above | Paid according to the type of drug per the schedule of benefits, above |
| Preventive care drugs and supplements filled at a retail pharmacy | 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 |
| For each 30 day supply | | |
| Risk reducing breast cancer prescription drugs filled at a pharmacy | 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 |
| For each 30 day supply | | |
| Maximums: | Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. | |

| | | | | |
|--|--|---|--|--|
| Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each 30 day supply | 100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies | Paid according to the type of drug per the schedule of benefits, above | | |
| Maximums: | Coverage is permitted for two 90-day treatment regimens only. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. | | | |
| Outpatient prescription drugs exclusions | | | | |
| The following are not eligible health services: <ul style="list-style-type: none"> • Any services related to providing, injecting or application of a drug • Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones • Cosmetic drugs including medication and preparations used for cosmetic purposes • Devices, products and appliances unless listed as an eligible health service • Dietary supplements including medical foods • Drugs or medications: <ul style="list-style-type: none"> - Administered or entirely consumed at the time and place they are prescribed or provided - Which do not require a prescription by law, even if a prescription is written, unless we have approved a medical exception - That are therapeutically the same or an alternative to a covered prescription drug, unless we approve a medical exception - Not approved by the FDA or not proven safe or effective - Provided under your medical plan while inpatient at a healthcare facility - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF) - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as an eligible health service - That are indicated or used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, non-prescription appetite suppressants or other medications except as described in the certificate - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature, unless there is evidence that the covered person meets one or more clinical criteria detailed in our precertification and clinical policies • Duplicative drug therapy; for example, two antihistamines for the same condition • Genetic care including: <ul style="list-style-type: none"> - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as an eligible health service • Immunizations related to travel or work | | | | |

- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
- Implantable drugs and associated devices except as specifically stated in the schedule of benefits or the certificate
- Injectables including:
 - Any charges for the administration or injection of prescription drugs
 - Needles and syringes except for those used for insulin administration
 - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- Prescription drugs:
 - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or prescription drugs for the treatment of a dental condition
 - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's drug guide
 - That are used for the purpose of improving visual acuity or field of vision
 - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card
- Prescription drugs indicated for the purpose of weight loss.
- Replacement of lost or stolen prescriptions
- Test agents except diabetic test agents
- Tobacco cessation drugs, unless recommended by the USPSTF
- We reserve the right to exclude:
 - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's drug guide
 - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's drug guide

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

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

Out of Country claims

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

General Exclusions

The following are not eligible health services under your plan:

Behavioral health treatment

- Services for the following based on categories, conditions, diagnoses or equivalent terms as listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association:
 - School and/or education service including special education, remedial education, wilderness treatment programs, or any such related or similar programs
 - Services provided in conjunction with school, vocation, work or recreational activities
 - Transportation

Blood and blood products

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

Cosmetic services and plastic surgery

- Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body except where described in the *Eligible health services and exclusions* section

Court-ordered testing

- Court-ordered testing or care unless medically necessary

Custodial care

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

Examples of these are:

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

Dental care for adults

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

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

Educational services

Examples of these are:

- Any service or supply for education, training or retraining services or testing. This includes:
 - Special education
 - Remedial education
 - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
 - Job training
 - Job hardening programs

- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Examinations

Any health or dental examinations needed:

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

Experimental, investigational, or unproven

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

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

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

Jaw joint disorder

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

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

Maintenance care

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

Medical supplies – outpatient disposable

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

Obesity surgery and services

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

Other primary payer

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

Personal care, comfort or convenience items

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

Private duty nursing

Routine exams and preventive services and supplies

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

Services not permitted by law

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

Services provided by a family member

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

Sexual dysfunction and enhancement

- Except as required by law, any treatment, prescription drug, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
 - Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape of a sex organ
 - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Sports

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

Strength and performance

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

Students in mental health field

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

Telemedicine

- Services including:
 - Telephone calls
 - Telemedicine kiosks
 - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

Therapies and tests

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

Tobacco cessation

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

Treatment in a federal, state, or governmental entity

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

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.

Important Note:

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

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

Sanctioned Countries

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

Assistive Technology

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

Smartphone or Tablet

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

Non-Discrimination

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

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

These aids and services include:

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

If you need these services, contact the number on your ID card. Not an Aetna member? Call us at 1-877-480-4161.

If you have questions about our nondiscrimination policy or have a discrimination-related concern that you would like to discuss, please call us at 1-877-480-4161.

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

