Quality Health Plans & Benefits
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Aetna Student Health
Plan Design and Benefits Summary

Arizona State University

Policy Year: 2017 - 2018
Policy Number: 697443

www.aetnastudenthealth.com
(866) 378-0178

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

15.06.311.1 A

This is a brief description of the Arizona Board of Regents Student Health Insurance Plan for Arizona State University. The Plan is available for Arizona State University students. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions governing this insurance, including definitions, are contained in the Master Policy issued to Arizona State University and may be viewed online at **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Policy, the Master Policy will govern and control the payment of benefits.

ASU HEALTH SERVICES

When you need care, make one of the ASU Health Services or Counseling Services locations your first stop. They can provide many of the routine health services you need. If you need care they can't provide, they'll refer you to a doctor or other health care provider who belongs to Aetna's Preferred Provider* network. If a referral is not obtained, you will be subject to a benefit reduction and claims will be paid at the Non-Preferred level of care.

You also may visit any licensed health care provider directly for covered services in Aetna's Preferred Provider* network (doctors, specialists, facilities except that specific Plan restrictions on certain services may apply). However, when you visit ASU Health Services or Counseling Services first, you'll generally pay less out of your own pocket for your care.

To learn more about Preferred Providers, visit **www.aetnastudenthealth.com.**

*Providers are independent contractors and are not agents of Aetna. Provider participation may change without notice. Aetna does not provide care or guarantee access to health services.

ASU Health Services/Counseling Services Costs

Services Offered	Your Responsibility
General Medicine	$15 Copay per visit
Well-Woman Care	No Copay Applied
Specialist Care	$25 Copay per visit
Lab	$10 Copay per day
X-ray	$10 Copay per day
Chiropractic Care	$25 Copay per visit
Psychiatric Services**	$15 Copay per visit
Initial Counseling Assessment	No Copay Applied
Brief Counseling Treatment	$15 Copay per visit

**In the event that psychiatric services provided by ASU Counseling staff are unavailable, the ASU Counseling Service will provide referrals to community-based Aetna Student Health providers. Preferred rates would apply.

In case of an emergency, call 911 or your local emergency hotline, or go directly to an emergency care facility. For non-emergency situations please visit or call:

<u>Tempe Campus</u>

ASU Health Services
451 E. University Drive, Tempe, AZ 85281-2104
Phone: (480) 965-3346 ASU On-Call After Hours Medical Advice: (800) 293-5775
Fall/Spring Hours: Monday – Friday, 8 a.m. – 6 p.m. Last appointment at 5:30 p.m.
Saturday, 10 a.m. – 4 p.m. Last appointment 1:30 p.m.
Summer Hours: Monday – Friday, 8 a.m. – 5 p.m. Last appointment 4:30 p.m.

Counseling & Consultation
451 E. University Drive Student Services Bldg., Room 334, 150 S. Forest Avenue, Tempe, AZ 85287-1012
Phone: (480) 965-6146
Hours: Monday – Friday, 8 a.m. – 5 p.m.

ASU Health Services – SRC
ASU Health Services – SRC Student Recreation Complex, Apache Blvd & Palm Walk, Tempe, AZ
Phone: (480) 965-3346
Fall/Spring Hours: Monday – Friday.
Visit **www.students.asu.edu/health** for hours of operation.

<u>Polytechnic Campus</u>

ASU Health Services-Polytechnic
7332 Sun Devil Mall Mesa, AZ 85212
Phone: (480) 727-1500
Hours: Monday – Friday, 9 a.m. – 12:30 p.m. 1 p.m. – 4:30 p.m.
Counseling Services 6049 S. Backus Mall, Sutton Hall, Suite 240, Mesa, AZ 85212
Phone: (480) 727-1255
Hours: Monday – Friday, 9 a.m. – 4:30 p.m.

<u>West Campus</u>

ASU Health Services-West
University Center Building, Room 190 4701 W. Thunderbird Road Glendale, AZ 85306
Phone: (602) 543-8019
Hours: Monday – Friday, 9 a.m. – 1 p.m. 1:30 p.m. – 5 p.m.

Counseling Center
University Center Building, Room 2214701 W. Thunderbird Road, Glendale, AZ 85306
Phone: (602) 543-8125
Hours: Monday – Friday, 8 a.m. – 5 p.m.

<u>Phoenix Campus</u>

ASU Health Services-Downtown
NP Healthcare Phoenix Nursing & Health Innovation Building 500 N. 3rd Street, Suite 155 Phoenix, AZ 85004
Phone: (602) 496-0721
Hours: Monday – Friday, 8 a.m. – 1 p.m. 2 p.m. – 5 p.m.

Counseling Services
NP Healthcare Phoenix, Nursing & Health, Innovation Building, 500 N. 3rd Street, Suite 155, Phoenix, AZ 85004
Phone: (602) 496-0721
Hours: Monday – Friday, 8 a.m. – 1 p.m. 2 p.m. – 5 p.m.

Coverage Periods

Coverage will become effective at 12:00 AM on the Coverage Start Date indicated below, and will terminate at 11:59 PM on the Coverage End Date indicated.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment Deadline
Fall C (Full Fall Semester)	08/16/2017	01/03/2018	08/31/2017
Fall Session A	08/16/2017	10/09/2017	08/31/2017
Fall Session B	10/10/2017	01/03/2018	10/23/2017
Spring C (Full Spring Semester)	01/04/2018	08/15/2018	01/24/2018
Spring Session A	01/04/2018	03/07/2018	01/24/2018
Spring Session B	03/08/2018	08/15/2018	03/27/2018
Summer C (Full Summer Semester)	05/16/2018	08/15/2018	06/02/2018
Summer Session A	05/16/2018	08/15/2018	06/02/2018
Summer Session B	06/28/2018	08/15/2018	07/13/2018

Rates

Coverage Period	Rate
Fall C (Full Fall Semester)	$724.00
Fall Session A	$282.00
Fall Session B	$442.00
Spring C (Full Spring Semester)	$1151.00
Spring Session A	$324.00
Spring Session B	$827.00
Summer C (Full Summer Semester)	$473.00
Summer Session A	$473.00
Summer Session B	$252.00

Student Coverage

Eligibility

The following groups of students are eligible for coverage:

- Undergraduate students if they are enrolled in a program of study and a) taking at least six units, b) have a consortium agreement to take courses at a qualified college with an overall credit hour total of at least six units.
- Seniors may enroll with less than seven units if they are in their last semester to achieve their final graduation requirements and had the insurance coverage in the prior semester.

- Graduate students if they are enrolled in a graduate degree or certificate program and taking at least three units or one dissertation/thesis unit.
- Graduate non-degree students must have applied to a degree program and be taking at least six transferable units, be in a certificate program, or be a full-time student taking at least nine units.
- Graduate assistants or associates who are officially hired, with a signed and filed notice of appointment, and taking at least six units of graduate credit.
- Post-Doctoral Fellows, J1 Visiting Scholars or J1 Student Interns.
- International students on non-immigrant visas, regardless of his or her fitting into one of the above classifications and regardless of the number of units being taken, are automatically enrolled in the Plan.

Please make sure you understand your school's credit hour and other requirements for enrolling in this plan. Aetna Student Health reserves the right to review, at any time, your eligibility to enroll in this plan. If it is determined that you did not meet the school's eligibility requirements for enrollment, your participation in the plan may be terminated or rescinded in accordance with its terms and applicable law.

Enrollment

Domestic Students

All eligible undergraduate and graduate students may enroll in the Plan through the ASU student registration system at **www.asu.edu/**. On your MyASU page select: Campus Services, Health & Wellness Resources, Health Insurance. The ASU Student Insurance Office can provide you with detailed enrollment instructions. Students may contact the Insurance Office by calling **(480) 965-2411**, or via e-mail at insurance@asu.edu. Once enrolled, coverage is automatically continued each semester and premiums are charged to your ASU student account.

International Students

Participation in the Plan is required for all non-sponsored International students, regardless of the number of units being taken. All International students with an F-1 or J-1 visa are automatically enrolled in the Plan.

The premium for the Plan will be added to your tuition bill.

If withdrawal from classes is before the end of the open enrollment or is for entering the armed forces a full refund will be made. If withdrawal is after the last day of the open enrollment no premium refund will be made and students will be covered for the Policy term for which they are enrolled.

However, if **covered student** withdraws from classes for a second consecutive semester, coverage will terminate on the date of the second withdrawal and a pro-rated premium refund will be made.

Premiums will be refunded on a pro-rata basis if withdrawal from the school is due to entering the armed forces of any country.

Medicare Notice

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

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

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

Preferred Provider Network

Aetna Student Health offers Aetna's broad network of Preferred Providers. You can save money by seeing Preferred 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 a Preferred 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 a Non- Preferred Provider. When a pre-approval is issued by Aetna, the benefit level is the same as for Preferred Providers.

Pre-certification Program

Some services have to be pre-certified by Aetna beforehand if you want the Plan to cover them. Preferred Providers are responsible for requesting pre-certification for their services. You are responsible for requesting pre-certification if you seek care from a Non- Preferred Provider for any of the services listed in the Schedule of Benefits section of the Certificate.

If you want the Plan to cover a service from a Non- Preferred Provider that requires pre-certification, you must call Aetna at the number on your ID card. After Aetna receives a request for pre-certification, we will review the reasons for your planned treatment and determine if benefits are available.

If you do not get pre-certification for non-emergency inpatient admissions, or give notification for emergency admissions, your covered medical expenses will be subject to a **$500** per admission Deductible.

If you do not get pre-certification for partial hospitalizations, your covered medical expenses will be subject to a **$500** per admission Deductible.

You'll need pre-certification for the following inpatient services:

- All inpatient admissions, including length of stay, to a hospital, skilled nursing facility, a facility established primarily for the treatment of substance abuse, or a residential treatment facility;
- All inpatient maternity care, after the initial 48 hours for a vaginal delivery or 96 hours for a cesarean section;
- All partial hospitalization in a hospital, residential treatment facility, or facility established primarily for the treatment of substance abuse

Pre-certification does not guarantee the payment of benefits for your inpatient admission.

Each claim is subject to medical policy review, in accordance with the exclusions and limitations contained in the Policy, as well as a review of eligibility, adherence to notification guidelines, and benefit coverage under the student Accident and Sickness Plan.

Pre-certification of non-emergency inpatient admissions and partial hospitalization

Non-emergency admissions must be requested at least **three (3) business days** prior to the planned admission or prior to the date the services are scheduled to begin.

Pre-certification of emergency inpatient admissions

Emergency admissions must be requested within **one (1) business day** after the admission.

Please see the “Pre-certification” provision in the [Master Policy][Certificate of Coverage] for a list of services that require pre-certification. Please see the Schedule of Benefits for any penalty or benefit reduction that may apply to your coverage when pre-certification is not obtained for the services or supplies listed above when received from an out-of-network provider.

Description of Benefits

The Plan excludes coverage for certain services and contains limitations on the amounts it will pay. While this Plan Design and Benefits Summary document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. The full Plan description, which is contained in the Master Policy issued to Arizona State University, may be accessed online at **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Policy, the Master Policy will govern and control the payment of benefits. All coverage is based on Recognized Charges unless otherwise specified.

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

Metallic Level: Platinum/Tested at: 89.28%

<table>
<tr><th>DEDUCTIBLE</th><th>Preferred Care</th><th>Non-Preferred Care</th></tr>
<tr><td rowspan="2">The policy year deductible is waived for Preferred Care covered medical expenses that apply to:
• Preventive Care Expense benefits
• Outpatient Labs, Outpatient X-rays and Outpatient High Cost Procedures

In addition to state and federal requirements for waiver of the policy year deductible, the plan will waive the policy year deductible for:
• Ambulance Expenses
• Emergency Room Expenses
• Services illustrated with a Copay (Additional services provided during the course of these services, will be subject to the annual deductible, i.e. surgical procedures etc.)

Per visit or admission Copays/Deductibles do not apply towards satisfying the Policy Year Deductible. This Policy Year Deductible and the Prescribed Medicine Expense Deductible do not apply towards satisfying each other.

*Annual Deductible does not apply to these services.</td><td>Individual:
$250 per Policy Year</td><td>Individual:
$1,000 per Policy Year</td></tr>
<tr><td colspan="2">Pharmacy Deductible: $125 per Policy Year</td></tr>
<tr><td>COINSURANCE
Coinsurance is both the percentage of covered medical expenses that the plan pays, and the percentage of covered medical expenses that you pay. The percentage that the plan pays is referred to as “plan coinsurance” or the “payment percentage,” and varies by the type of expense. Please refer to the Schedule of Benefits for specific information on coinsurance amounts.</td><td colspan="2">Covered Medical Expenses are payable at the plan coinsurance percentage specified below, after any applicable Deductible.</td></tr>
</table>

OUT-OF-POCKET MAXIMUMS		
Once the Individual Out-of-Pocket Limit has been satisfied, Covered Medical Expenses will be payable at 100% for the remainder of the Policy Year. The following expenses do not apply toward meeting the plan's preferred care and non-preferred care out-of-pocket limits: • Non-covered medical expenses; • Referral penalties because a required referral for the service(s) or supply was not obtained; and • Expenses that are not paid or pre-certification benefit reductions or penalties because a required pre-certification for the service(s) or supply was not obtained from Aetna.	Individual Out-of-Pocket: $1,500 per Policy Year	Individual Out-of-Pocket: $3,000 per Policy Year

REFERRAL REQUIREMENTS

Except for the services noted below that do not require a referral, if you do not obtain a referral from ASU Health Services, your benefits will be payable at the Non-Preferred Care Benefit level.

- Care received beyond 50 miles from the Tempe Campus (Upon return to the campus area, the student must return to Health Services for necessary follow-up care)
- Treatment is for an Emergency Medical Condition (all follow-up treatment must be obtained through Health Services)
- Urgent Care Expenses
- Maternity Care
- Obstetric and Gynecological Treatment
- Annual Eye Exam
- Injury to Sound Natural teeth
- Preventive/Routine Services (services considered preventive according to United States Preventive Services Task Force, American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents, Health Resources and Services Administration and/or services rendered not to diagnosis or treat an Accident or Sickness)
- Pediatric Care
- Vasectomies

INPATIENT HOSPITALIZATION BENEFITS	Preferred Care	Non-Preferred Care
Room and Board Expense The covered room and board expense does not include any charge in excess of the daily room and board maximum.	80% of the Negotiated Charge	50% of the Recognized Charge for a semi-private room
Intensive Care The covered room and board expense does not include any charge in excess of the daily room and board maximum.	80% of the Negotiated Charge	50% of the Recognized Charge
Miscellaneous Hospital Expense Includes but not limited to: operating room, laboratory tests/X rays, oxygen tent, drugs, medicines and dressings.	80% of the Negotiated Charge	50% of the Recognized Charge
Licensed Nurse Expense Includes charges incurred by a covered person who is confined in a hospital as a resident bed patient and requires the services of a registered nurse or licensed practical nurse.	80% of the Negotiated Charge	50% of the Recognized Charge
Well Newborn Nursery Care	80% of the Negotiated Charge*	50% of the Recognized Charge

INPATIENT HOSPITALIZATION BENEFITS (continued)	Preferred Care	Non-Preferred Care
Non-Surgical Physicians Expense Includes hospital charges incurred by a covered person who is confined as an inpatient in a hospital for a surgical procedure for the services of a physician who is not the physician who may have performed surgery on the covered person.	80% of the Negotiated Charge	50% of the Recognized Charge
SURGICAL EXPENSES	**Preferred Care**	**Non-Preferred Care**
Surgical Expense (Inpatient and Outpatient) When injury or sickness requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, covered medical expenses only include expenses incurred for the most expensive procedure.	80% of the Negotiated Charge	50% of the Recognized Charge
Anesthesia Expense (Inpatient and Outpatient) If, in connection with such operation, the covered person requires the services of an anesthetist who is not employed or retained by the hospital in which the operation is performed, the expenses incurred will be Covered Medical Expenses.	80% of the Negotiated Charge	50% of the Recognized Charge
Assistant Surgeon Expense (Inpatient and Outpatient)	80% of the Negotiated Charge	50% of the Recognized Charge
OUTPATIENT EXPENSE	**Preferred Care**	**Non-Preferred Care**
Physician or Specialist Office Visit Expense Includes the charges made by the physician or specialist if a covered person requires the services of a physician or specialist in the physician's or specialist's office while not confined as an inpatient in a hospital.	After a $25 Copay per visit, 100% of the Negotiated Charge*	50% of the Recognized Charge
Laboratory and X-ray Expense	100% of the Negotiated Charge*	50% of the Recognized Charge
Hospital Outpatient Department Expense	100% of the Negotiated Charge*	50% of the Recognized Charge
Therapy Expense Covered medical expenses include charges incurred by a covered person for the following types of therapy provided on an outpatient basis: • Radiation therapy; • Inhalation therapy; • Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy; • Kidney dialysis; and • Respiratory therapy.	80% of the Negotiated Charge	50% of the Recognized Charge
Pre-Admission Testing Expense Includes charges incurred by a covered person for pre-admission testing charges made by a hospital, surgery center, licensed diagnostic lab facility, or physician, in its own behalf, to test a person while an outpatient before scheduled surgery.	Payable in accordance with the type of expense incurred and the place where service is provided.	50% of the Recognized Charge
Ambulatory Surgical Expense Covered medical expenses include expenses incurred by a covered person for outpatient surgery performed in an ambulatory surgical center. Covered medical expenses must be incurred on the day of the surgery or within 24 hours after the surgery.	80% of the Negotiated Charge	50% of the Recognized Charge
Walk-in Clinic Visit Expense	100% of the Negotiated Charge*	50% of the Recognized Charge

OUTPATIENT EXPENSE (continued)	Preferred Care	Non-Preferred Care
Emergency Room Expense Covered medical expenses incurred by a covered person for services received in the emergency room of a hospital while the covered person is not a full-time inpatient of the hospital. The treatment received must be emergency care for an emergency medical condition. There is no coverage for elective treatment, routine care or care for a non-emergency sickness. As to emergency care incurred for the treatment of an emergency medical condition or psychiatric condition, any referral requirement will not apply & any expenses incurred for non-preferred care will be paid at the same cost-sharing level as if they had been incurred for preferred care. Prior Authorization is not required for an initial medical screening exam and any immediately necessary stabilizing treatment, but may be required for services arising after the initial screening and/or necessary stabilizing treatment. **Important Notice:** A separate hospital emergency room visit benefit deductible or copay applies for each visit to an emergency room for emergency care. If a covered person is admitted to a hospital as an inpatient immediately following a visit to an emergency room, the emergency room visit benefit deductible or copay is waived. Covered medical expenses that are applied to the emergency room visit benefit deductible or copay cannot be applied to any other benefit deductible or copay under the plan. Likewise, covered medical expenses that are applied to any of the plan's other benefit deductibles or copays cannot be applied to the emergency room visit benefit deductible or copay. Separate benefit deductibles or copays may apply for certain services rendered in the emergency room that are not included in the hospital emergency room visit benefit. These benefit deductibles or copays may be different from the hospital emergency room visit benefit deductible or copay, and will be based on the specific service rendered. Similarly, services rendered in the emergency room that are not included in the hospital emergency room visit benefit may be subject to coinsurance. **Important Note**: Please note that Non-Preferred Care Providers do not have a contract with Aetna; the provider may not accept payment of your cost share (your deductible 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. Please send Aetna the bill at the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.	After a $200 Copay per visit (waived if admitted), 100% of the Negotiated Charge*	After a $200 Deductible per visit (waived if admitted), 100% of the Actual Charge*

OUTPATIENT EXPENSE (continued)	Preferred Care	Non-Preferred Care
Durable Medical and Surgical Equipment Expense Durable medical and surgical equipment would include: • Artificial arms and legs; including accessories; • Arm, back, neck braces, leg braces; including attached shoes (but not corrective shoes); • Surgical supports; • Scalp hair prostheses required as the result of hair loss due to injury; sickness; or treatment of sickness; and • Head halters.	80% of the Negotiated Charge	50% of the Recognized Charge

PREVENTIVE CARE EXPENSES

Preventive Care is services provided for a reason other than to diagnose or treat a suspected or identified sickness or injury and rendered in accordance with the guidelines provided by the following agencies:

- 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 uspreventiveservicestaskforce.org.
- Services as recommended in the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents http://brightfutures.aap.org/.
- For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration http://www.hrsa.gov/index.html.

PREVENTIVE CARE EXPENSES	Preferred Care	Non-Preferred Care
Routine Physical Exam Includes routine vision & hearing screenings given as part of the routine physical exam.	100% of the Negotiated Charge*	50% of the Recognized Charge
Preventive Care Immunizations	100% of the Negotiated Charge*	50% of the Recognized Charge
Well Woman Preventive Visits Routine well woman preventive exam office visit, including Pap smears.	100% of the Negotiated Charge*	50% of the Recognized Charge
Preventive Care Screening and Counseling Services for Sexually Transmitted Infections Includes the counseling services to help a covered person prevent or reduce sexually transmitted infections.	100% of the Negotiated Charge*	50% of the Recognized Charge
Preventive Care Screening and Counseling Services for Obesity and/or Healthy Diet Screening and counseling services to aid in weight reduction due to obesity. Coverage includes: • Preventive counseling visits and/or risk factor reduction intervention; • Nutritional counseling; and • Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.	100% of the Negotiated Charge*	50% of the Recognized Charge
Preventive Care Screening and Counseling Services for Misuse of Alcohol and/or Drugs Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.	100% of the Negotiated Charge*	50% of the Recognized Charge

PREVENTIVE CARE EXPENSES (continued)	Preferred Care	Non-Preferred Care
Preventive Care Screening and Counseling Services for Use of Tobacco Products Screening and counseling services to aid a covered person to stop the use of tobacco products. Coverage includes: • Preventive counseling visits; • Treatment visits; and • Class visits; to aid a covered person to stop the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: • Cigarettes; • Cigars • Smoking tobacco; • Snuff; • Smokeless tobacco; and Candy-like products that contain tobacco.	100% of the Negotiated Charge*	50% of the Recognized Charge
Preventive Care Screening and Counseling Services for Depression Screening Screening or test to determine if depression is present.	100% of the Negotiated Charge*	50% of the Recognized Charge
Preventive Care Routine Cancer Screenings Covered expenses include but are not limited to: Pap smears; Mammograms; Fecal occult blood tests; Digital rectal exams; Prostate specific antigen (PSA) tests; Sigmoidoscopies; Double contrast barium enemas (DCBE); Colonoscopies. Includes: • Bowel preparation medications • Anesthesia • Removal of polyps performed during a screening procedure • Pathology exam on any removed polyps); and Lung cancer screenings.	100% of the Negotiated Charge*	50% of the Recognized Charge
Preventive Care Screening and Counseling Services for Genetic Risk for Breast and Ovarian Cancer Covered medical expenses include the counseling and evaluation services to help assess a covered person's risk of breast and ovarian cancer susceptibility.	100% of the Negotiated Charge*	50% of the Recognized Charge

PREVENTIVE CARE EXPENSES (continued)	Preferred Care	Non-Preferred Care
Preventive Care Prenatal Care Coverage for prenatal care under this Preventive Care Expense benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check, and fundal height). Refer to the Maternity Expense benefit for more information on coverage for maternity expenses under the Policy, including other prenatal care, delivery and postnatal care office visits.	100% of the Negotiated Charge*	50% of the Recognized Charge
Preventive Care Lactation Counseling Services Lactation support and lactation counseling services are covered medical expenses when provided in either a group or individual setting.	100% of the Negotiated Charge*	50% of the Recognized Charge
Preventive Care Breast Pumps and Supplies	100% of the Negotiated Charge*	50% of the Recognized Charge
Preventive Care Female Contraceptive Counseling Services, Preventive Care Female Contraceptive Generic, Brand Name, Biosimilar Prescription Drugs and Devices provided, administered, or removed, by a Physician during an Office Visit, Preventive Care Female Voluntary Sterilization (Inpatient), Preventive Care Female Voluntary Sterilization (Outpatient) Includes counseling services on contraceptive methods provided by a physician, obstetrician or gynecologist. Such counseling services are covered medical expenses when provided in either a group or individual setting. **Voluntary Sterilization** Includes charges billed separately by the provider for female voluntary sterilization procedures & related services & supplies including, but not limited to, tubal ligation and sterilization implants. Covered medical expenses under this benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.	100% of the Negotiated Charge*	50% of the Recognized Charge
Preventive Care Female Contraceptive Counseling Services, Preventive Care Female Contraceptive Generic, Brand Name, Biosimilar Prescription Drugs and Devices provided, administered, or removed, by a Physician during an Office Visit, Preventive Care Female Voluntary Sterilization (Inpatient), Preventive Care Female Voluntary Sterilization (Outpatient) (continued) **Contraceptives** can be paid either under this benefit or the prescribed medicines expense depending on the type of expense and how and where the expense is incurred. Benefits are paid under this benefit for female contraceptive prescription drugs and devices (including any related services and supplies) when they are provided, administered, or removed, by a physician during an office visit.	100% of the Negotiated Charge*	50% of the Recognized Charge

OTHER FAMILY PLANNING SERVICES EXPENSE	Preferred Care	Non-Preferred Care
Voluntary Sterilization for Males (Outpatient) Covered medical expenses include charges for certain family planning services, even though not provided to treat a sickness or injury as follows. -Voluntary sterilization for males.	Payable in accordance with the type of expense incurred and the place where service is provided.	Payable in accordance with the type of expense incurred and the place where service is provided.
AMBULANCE EXPENSE	**Preferred Care**	**Non-Preferred Care**
Ground, Air, Water and Non-Emergency Ambulance Includes charges incurred by a covered person for the use of a professional ambulance in an emergency. Covered medical expenses for the service are limited to charges for ground transportation to the nearest hospital equipped to render treatment for the condition. Air transportation is covered only when medically necessary.	100% of the Negotiated Charge*	100% of the Actual Charge*
ADDITIONAL BENEFITS	**Preferred Care**	**Non-Preferred Care**
Allergy Testing and Treatment Expense Includes charges incurred by a covered person for diagnostic testing and treatment of allergies and immunology services.	Payable in accordance with the type of expense incurred and the place where service is provided.	50% of the Recognized Charge
Diagnostic Testing For Learning Disabilities Expense Covered medical expenses include charges incurred by a covered person for diagnostic testing for: • Attention deficit disorder; or • Attention deficit hyperactive disorder.	Payable in accordance with the type of expense incurred and the place where service is provided.	50% of the Recognized Charge
High Cost Procedures Expense Includes charges incurred by a covered person as a result of certain high cost procedures provided on an outpatient basis. Covered medical expenses for high cost procedures include; but are not limited to; charges for the following procedures and services: • Computerized Axial Tomography (C.A.T.) scans; • Magnetic Resonance Imaging (MRI); and • Positron Emission Tomography (PET) Scans.	100% of the Negotiated Charge*	50% of the Recognized Charge
Urgent Care Expense	After a $25 Copay per visit, 100% of the Negotiated Charge*	50% of the Recognized Charge
Dental Expense for Impacted Wisdom Teeth Includes charges incurred by a covered person for services of a dentist or dental surgeon for medically necessary removal of one or more impacted wisdom teeth. Includes expenses for the treatment of: the mouth; teeth; and jaws; but only those for services rendered and supplies needed for the following treatment of; or related to conditions; of the: • mouth; jaws; jaw joints; or • supporting tissues; (this includes: bones; muscles; and nerves).	80% of the Negotiated Charge*	80% of the Actual Charge

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Accidental Injury to Sound Natural Teeth Expense Covered medical expenses include charges incurred by a covered person for services of a dentist or dental surgeon as a result of an injury to sound natural teeth.	80% of the Negotiated*	80% of the Actual Charge
Non-Elective Second Surgical Opinion Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	50% of the Recognized Charge
Consultant Expense Includes the charges incurred by covered person in connection with the services of a consultant. The services must be requested by the attending physician to confirm or determine a diagnosis. Coverage may be extended to include treatment by the consultant.	After a $25 Copay per visit, 100% of the Negotiated Charge *	50% of the Recognized Charge
Skilled Nursing Facility Expense Benefits limited to 90 days per Policy Year.	80% of the Negotiated Charge	50% of the Recognized Charge
Rehabilitation Facility Expense Includes charges incurred by a covered person for confinement as a full time inpatient in a rehabilitation facility.	80% of the Negotiated Charge	50% of the Recognized Charge
Home Health Care Expense Covered medical expenses **will not** include: • Services by a person who resides in the covered person's home, or is a member of the covered person's immediate family; • Homemaker or housekeeper services; • Maintenance therapy; • Dialysis treatment; • Purchase or rental of dialysis equipment; • Food or home delivered services; or • Custodial care.	80% of the Negotiated Charge	50% of the Recognized Charge
Temporomandibular Joint Dysfunction Expense Covered medical expenses include physician's charges incurred by a covered person for non-surgical treatment of Temporomandibular Joint (TMJ) Dysfunction. Covered medical expenses also include orthognathic surgery to correct deformities of the jaw and the associated malocclusion	Payable in accordance with the type of expense incurred and the place where service is provided.	50% of the Recognized Charge
Dermatological Expense Includes physician's charges incurred by a covered person for the diagnosis and treatment of skin disorders. Related laboratory expenses are covered under the Lab and X-ray Expense benefit. Unless specified above, not covered under this benefit are charges incurred for: • Cosmetic treatment and procedures; and Laboratory fees.	Payable in accordance with the type of expense incurred and the place where service is provided.	50% of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Prosthetic Devices Expense Includes charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by sickness, injury or congenital defect. Covered medical expenses also include instruction and incidental supplies needed to use a covered prosthetic device. The plan covers the first prosthesis a covered person need that temporarily or permanently replaces all or part of an body part lost or impaired as a result of sickness or injury or congenital defects as described in the list of covered devices below for an: • Internal body part or organ; or • External body part. The list of covered devices includes, but is not limited to: • An artificial arm, leg, hip, knee or eye; • Eye lens; • An external breast prosthesis and the first bra made solely for use with it after a mastectomy; • A breast implant after a mastectomy; • Ostomy supplies, urinary catheters and external urinary collection devices; • Speech generating device; • Orthopedic shoes; foot orthotics; or other devices to support the feet but only when required for the treatment of, or to prevent complications of, diabetes; • A cardiac pacemaker and pacemaker defibrillators; and • A durable brace that is custom made for and fitted for the covered person. **Limitations** Unless specified above, not covered under this benefit are charges for: • Eye exams; • Eyeglasses; • Vision aids; • Hearing aids; • Communication aids.	80% of the Negotiated Charge	50% of the Recognized Charge
Podiatric Expense Includes charges incurred by a covered person for podiatric services; provided on an outpatient basis following an injury. Unless specified above, not covered under this benefit are charges incurred for routine foot care, such as trimming of corns, calluses, and nails.	Payable in accordance with the type of expense incurred and the place where service is provided.	50% of the Recognized Charge
Hypodermic Needles Expense Includes expenses incurred by a covered person for hypodermic needles and syringes.	Payable in accordance with the type of expense incurred and the place where service is provided.	50% of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Maternity Expense Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other Sickness. In the event of an inpatient confinement, such benefits would be payable for inpatient care of the Covered Person, and any newborn child, for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother and done in accordance with the rules and regulations promulgated by State Mandate. Covered medical expenses may include home visits, parent education, and assistance and training in breast or bottle-feeding.	Payable in accordance with the type of expense incurred and the place where service is provided.	50% of the Recognized Charge
Non-Prescription Enteral Formula Expense Includes charges incurred by a covered person, for non-prescription enteral formulas for which a physician has issued a written order, and are for the treatment of malabsorption caused by: • Crohn's Disease; • Ulcerative colitis; • Gastroesophageal reflux; • Gastrointestinal motility; • Chronic intestinal pseudo obstruction; and • Inherited diseases of amino acids and organic acids. Covered medical expenses for inherited diseases of amino acids; and organic acids; will also include food products modified to be low protein.	80% of the Negotiated Charge	50% of the Recognized Charge
Vision Care Exam Expense Routine Eye Exam Expenses: Charges for a complete eye exam that includes refraction. Contact Lens Exam Expenses: Charges for an eye exam performed for the sole purpose of the fitting of contact lenses.	After a $25 Copay per visit, 100% of the Negotiated Charge*	50% of the Recognized Charge
Acupuncture in Lieu of Anesthesia Expense Includes charges incurred by a covered person for acupuncture therapy when acupuncture is used in lieu of other anesthesia for a surgical or dental procedure covered under this Plan. The acupuncture must be administered by a health care provider who is a legally qualified physician; practicing within the scope of their license.	Payable in accordance with the type of expense incurred and the place where service is provided.	50% of the Recognized Charge
Transfusion or Kidney Dialysis of Blood Expense Includes charges incurred by a covered person for the transfusion or kidney dialysis of blood, including the cost of: Whole blood; blood components; and the administration of whole blood and blood components.	Payable in accordance with the type of expense incurred and the place where service is provided.	50% of the Recognized Charge
Hospice Expense	100% of the Negotiated Charge*	50% of the Recognized Charge
Private Duty Nursing Includes private duty nursing services provided by an R.N. or L.P.N. if the covered person's condition requires skilled nursing care and visiting nursing care is not adequate.	80% of the Negotiated Charge	50% of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Diabetes Benefit Expense Includes charges for services, supplies, equipment, & training for the treatment of insulin and non-insulin dependent diabetes &elevated blood glucose levels during pregnancy. Self-management training provided by a licensed health care provider certified in diabetes self-management training.	80% of the Negotiated Charge	50% of the Recognized Charge
Eosinophilic Gastrointestinal Disorder Expense	75% of the Actual Charge	75% of the Actual Charge
Inherited Metabolic Disorder Covered medical expenses include charges made for modified low protein foods and metabolic formulas necessary for the therapeutic treatment of inherited metabolic disorders, and for amino acid-based formulas necessary for the treatment of eosinophilic gastrointestinal disorder, when prescribed or ordered by a physician.	50% of the Actual Charge	50% of the Actual Charge
Reconstructive Breast Surgery Expense Covered medical expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.	Payable in accordance with the type of expense incurred and the place where service is provided.	50% of the Recognized Charge
Autism Spectrum Disorder Expense - Physician Office Visits (non-surgical) Includes charges incurred for services and supplies required for the diagnosis & treatment of autism spectrum disorder when ordered by a physician or behavioral health provider as part of a treatment plan.	Payable in accordance with the type of expense incurred and the place where service is provided.	50% of the Recognized Charge
Autism Spectrum Disorder Expense - Specialist and Behavioral Provider Office Visits (non-surgical) Coverage includes early intensive behavioral interventions such as Applied Behavioral Analysis (ABA). Applied Behavioral Analysis is an educational service that is the process of applying interventions that: • Systematically change behavior; and • Are responsible for the observable improvement in behavior	100% of the Negotiated Charge	50% of the Recognized Charge
Telemedicine Services Expense Covered medical expenses include charges for the provision of health care services that are covered under this policy and are appropriately provided through telemedicine services.	Payable in accordance with the type of expense incurred and the place where service is provided	50% of the Recognized Charge
Basic Infertility Expense Covered medical expenses include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility.	Payable in accordance with the type of expense incurred and the place where service is provided	50% of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Bariatric Surgery Expense Covered medical expenses for the treatment of morbid obesity include one bariatric surgical procedure including related outpatient services, within a two-year period, beginning with the date of the first bariatric surgical procedure, unless a multi-stage procedure is planned. **Limitations:** Unless specified above, not covered under this benefit are charges incurred for: Weight control services including open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, laparoscopic sleeve gastrectomy, open adjustable gastric banding, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions; except as provided in the Policy.	Payable in accordance with the type of expense incurred and the place where service is provided.	50% of the Recognized Charge
Clinical Trials Expense (Experimental or Investigational Treatment) Includes charges made by a provider for experimental or investigational drugs, devices, treatments or procedures "under an approved clinical trial" only when a covered person has cancer or a terminal illness.	Payable in accordance with the type of expense incurred and the place where service is provided.	50% of the Recognized Charge
Clinical Trials Expense Routine Patient Costs Covered Percentage Includes charges made by a provider for "routine patient costs" furnished in connection with a covered person's participation in an "approved clinical trial" for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.	Payable in accordance with the type of expense incurred and the place where service is provided.	50% of the Recognized Charge
Gender Reassignment (Sex Change) Treatment Expense Includes charges made in connection with a medically necessary gender reassignment surgery (sometimes called sex change surgery) as long the covered student has obtained pre-certification from Aetna. Covered medical expenses include: • Charges made by a physician for: • Performing the surgical procedure; and • Pre-operative and post-operative hospital and office visits. • Charges made by a hospital for inpatient and outpatient services (including outpatient surgery). • Charges made by a Skilled Nursing Facility for inpatient services and supplies. • Charges made for the administration of anesthetics.		

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Gender Reassignment (Sex Change) Treatment Expense (continued) • Charges for outpatient diagnostic laboratory and x-rays. • Charges for blood transfusion and the cost of unreplaced blood and blood products. • Charges made by a behavioral health provider for gender reassignment counseling. • Charges incurred for injectable and non-injectable hormone replacement therapy. No benefits will be paid for covered medical expenses under this benefit unless they have been precertified by Aetna. Refer to the Pre-certification section for more information.	Payable in accordance with the type of expense incurred and the place where service is provided.	50% of the Recognized Charge
Tracheal Shave Expense Covered medical expenses include charges made for tracheal shave, subsequent to a medically necessary, male to female, gender reassignment surgery (sometimes called sex change surgery) as long as the student has an approved pre-certification from Aetna for gender reassignment surgery based on a documented diagnosis of gender dysphoria. The member out of pocket maximum does not apply to this benefit.	Payable in accordance with the type of expense incurred and the place where service is provided.	50% of the Recognized Charge
Electrolysis Expense Covered medical expenses include charges for electrolysis of the face or neck made subsequent to a medically necessary, male to female, gender reassignment surgery (sometimes called sex change surgery) as long as the student has an approved pre-certification from Aetna for gender reassignment surgery based on a documented diagnosis of gender dysphoria. The member out of pocket maximum does not apply to this benefit. There is a 6 visit maximum per policy year combined in and out of network visits.	Payable in accordance with the type of expense incurred and the place where service is provided.	50% of the Recognized Charge
Spinal Manipulation Treatment Expense Includes charges made by a physician on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.	After a $25 Copay per visit, 100% of the Negotiated Charge*	50% of the Recognized Charge

SHORT-TERM CARDIAC AND PULMONARY REHABILITATION THERAPY SERVICES EXPENSE Inpatient rehabilitation benefits for the services listed will be paid as part of the Hospital Expense and Skilled Nursing Facility Expense benefits. **Cardiac Rehabilitation Benefits** Cardiac rehabilitation benefits received at a hospital, skilled nursing facility, or physician's office. This Plan will cover charges in accordance with a treatment plan as determined by a covered person's risk level when recommended by a physician. **Pulmonary Rehabilitation Benefits** Pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. **Limitations** Unless specifically covered above, not covered under this benefit are charges for: • Any services which are covered medical expenses in whole or in part under any other student plan sponsored by the Policyholder. • Any services unless provided in accordance with a specific treatment plan. • Services not performed by a physician or under the direct supervision of a physician.		
Cardiac Rehabilitation	80% of the Negotiated Charge	50% of the Recognized Charge
Pulmonary Rehabilitation	80% of the Negotiated Charge	50% of the Recognized Charge
SHORT-TERM REHABILITATION SERVICES EXPENSE Includes charges for short-term rehabilitation services, as described below, when prescribed by a physician. Short-term rehabilitation services must follow a specific treatment plan that: • Details the treatment, and specifies frequency and duration; • Provides for ongoing reviews and is renewed only if continued therapy is appropriate; and • Allows therapy services, provided in a covered person's home, if the covered person is homebound. Inpatient rehabilitation benefits for the services listed will be paid as part of the inpatient hospital and skilled nursing facility benefits.		
Short-Term Rehabilitation and Habilitation Therapies Expense Outpatient Cognitive, Physical, Occupational and Speech Rehabilitation and Habilitation Therapy Services (combined)	After a $25 Copay per visit, 100% of the Negotiated Charge*	50% of the Recognized Charge
Habilitation Therapy Services-Applied Behavioral Analysis	After a $25 Copay per visit, 100% of the Negotiated Charge*	50% of the Recognized Charge
HEARING AIDS	**Preferred Care**	**Non-Preferred Care**
Hearing Aid Expenses One hearing aid per ear per policy year.	80% of the Negotiated Charge	50% of the Recognized Charge
Cochlear Implants	80% of the Negotiated Charge	50% of the Recognized Charge

TREATMENT OF MENTAL DISORDERS EXPENSE	Preferred Care	Non-Preferred Care
Inpatient Mental Health Expense Covered medical expenses include charges made by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider for the treatment of mental disorders for Inpatient room and board at the semi-private room rate, and other services and supplies related to a covered person's condition that are provided during a covered person's stay in a hospital, psychiatric hospital, or residential treatment facility.	80% of the Negotiated Charge	50% of the Recognized Charge
Inpatient Mental Health Physician Services per Admission Expense	80% of the Negotiated Charge	50% of the Recognized Charge
Residential Mental Health Treatment Facility Expense	80% of the Negotiated Charge	50% of the Recognized Charge
Residential Mental Health Treatment Physician Services Expense	80% of the Negotiated Charge	50% of the Recognized Charge
Outpatient Mental Health Expense	After a $25 Copay per visit, 100% of the Negotiated Charge*	50% of the Recognized Charge
Outpatient Mental Health Partial Hospitalization Expense	80% of the Negotiated Charge	50% of the Recognized Charge
ALCOHOLISM AND DRUG ADDICTION TREATMENT	Preferred Care	Non-Preferred Care
Inpatient Substance Abuse Treatment Covered medical expenses include charges made by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider for the treatment of mental disorders for Inpatient room and board at the semi-private room rate, and other services and supplies related to a covered person's condition that are provided during a covered person's stay in a hospital, psychiatric hospital, or residential treatment facility.	80% of the Negotiated Charge	50% of the Recognized Charge
Inpatient Substance Abuse Physician Services per Admission Expense	80% of the Negotiated Charge	50% of the Recognized Charge
Residential Substance Abuse Treatment Facility Expense	80% of the Negotiated Charge	50% of the Recognized Charge
Residential Substance Abuse Treatment Physician Services Expense	80% of the Negotiated Charge	50% of the Recognized Charge
Outpatient Substance Abuse Treatment	After a $25 Copay per visit, 100% of the Negotiated Charge*	50% of the Recognized Charge
TRANSPLANT SERVICES EXPENSE	Preferred Care	Non-Preferred Care
Transplant Services Expense Benefits may vary if an Institute of Excellence™ (IOE) facility or non-IOE or non-preferred care provider is used. Through the IOE network, the covered person will have access to a provider network that specializes in transplants. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure the covered person requires. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.	Payable in accordance with the type of expense incurred and the place where service is provided.	50% of the Recognized Charge

TRANSPLANT SERVICES EXPENSE (continued)	Preferred Care	Non-Preferred Care
Transplant Travel and Lodging Expense The plan will reimburse a covered person for some of the cost of their travel and lodging expenses. Benefit limited to $10,000 per transplant.	100% of the Actual Charge	
PEDIATRIC DENTAL SERVICES EXPENSE (Coverage is limited to covered persons until the end of the month in which the covered person turns 19)	**Preferred Care**	**Non-Preferred Care**
Type A Expense (Pediatric Routine Dental Exam Expense) Benefits are limited to 1 exam every 6 months.	100% of the Negotiated Charge*	70% of the Recognized Charge
Type B Expense (Pediatric Basic Dental Care Expense)	70% of the Negotiated Charge*	50% of the Recognized Charge
Type C Expense (Pediatric Major Dental Care Expense)	50% of the Negotiated Charge*	50% of the Recognized Charge
Pediatric Orthodontia Expense • Orthodontics • Medically necessary comprehensive treatment • Replacement of retainer (limit one per lifetime).	50% of the Negotiated Charge*	50% of the Recognized Charge
PEDIATRIC ROUTINE VISION (Coverage is limited to covered persons until the end of the month in which the covered person turns 19)	**Preferred Care**	**Non-Preferred Care**
Pediatric Routine Vision Exams (including refractions) Includes charges made by a legally qualified ophthalmologist or optometrist for a routine vision exam. The exam will include refraction & glaucoma testing. Limited to 1 visit every 6 months.	100% of the Negotiated Charge*	50% of the Recognized Charge
Pediatric Visit for the fitting of prescription contact lenses, Pediatric Eyeglass Frames, Prescription Lenses or Prescription Contact Lenses Includes charges for the following vision care services and supplies: • Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses. • Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a preferred care provider. • Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a non-preferred care provider. Coverage includes charges incurred for: • Non-conventional prescription contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses. Aphakic prescription lenses prescribed after cataract surgery has been performed. 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.	100% of the Negotiated Charge *	50% of the Recognized Charge

PRESCRIBED MEDICINES EXPENSE

COVERED PERCENTAGE*	Preferred Care	Non-Preferred Care
Preventive Care Drugs and Supplements 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.		
Risk Reducing Breast Cancer Prescription Drugs For each 30 day supply filled at a retail pharmacy.	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits.	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits.
Other preventive care drugs and supplements For each 30 day supply filled at a retail pharmacy.	100% per supply	100% of the Recognized Charge
Tobacco Cessation Prescription Drugs and Over-the-Counter Drugs (for two 90-day treatment regimens only)	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits.	100% of the Recognized Charge
CONTRACEPTIVES		
FDA-Approved Female Generic Over-the-Counter Contraceptives (Non-Emergency) **For each 30 day Supply**	100% per supply	100% of the Recognized Charge
FDA-Approved Female Generic Emergency Contraceptives	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits.	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits.
ALL OTHER PRESCRIPTION DRUGS		
For each 30 day supply filled at a retail pharmacy.	100% of the Negotiated Charge	100% of the Recognized Charge

*The prescription drug plan covered percentage is the percentage of prescription drug covered medical expenses that the plan pays after any applicable deductibles and copays have been met.

PER PRESCRIPTION COPAY/DEDUCTIBLE		
Generic Prescription Drugs	**Preferred Care**	**Non-Preferred Care**
For each 30 day supply filled at a retail pharmacy.	$15 Copay per supply after the Policy Year Deductible	$15 Deductible per supply after the Policy Year Deductible
Preferred Brand-Name Prescription Drug	**Preferred Care**	**Non-Preferred Care**
For each 30 day supply filled at a retail pharmacy.	$40 Copay per supply after the Policy Year Deductible	$40 Deductible per supply after the Policy Year Deductible
Non-Preferred Brand-Name Prescription Drugs	**Preferred Care**	**Non-Preferred Care**
For each 30 day supply filled at a retail pharmacy.	$80 Copay per supply after the Policy Year Deductible	$80 Deductible per supply after the Policy Year Deductible
Specialty Care Prescription Drugs	**Preferred Care**	**Non-Preferred Care**
For each 30 day supply filled at a retail pharmacy.	$80 Copay per supply after the Policy Year Deductible	$80 Deductible per supply after the Policy Year Deductible
Orally Administered Anti-Cancer Prescription Drugs (including Chemotherapy Drugs)	Payable on the same basis as covered cancer chemotherapy medications that are administered intravenously or by injection.	

Includes any and all drugs and pharmaceutical forms of treatment for HIV and/or AIDS approved by the Food and Drug Administration, including but not limited to Zidovudine, formerly Azidothymidine ("AZT"), Didanosine (ddI) and Zalcitabine (ddC), to the same extent as other prescription drugs and treatments.

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

Copay and Deductible Waiver

Waiver for Risk-Reducing Breast Cancer Prescription Drugs

The per prescription copay/deductible and policy year deductible will not apply to risk-reducing breast cancer generic, prescription drugs when obtained at a preferred care pharmacy. This means that such risk-reducing breast cancer generic prescription drugs will be paid at 100%.

Waiver for Prescription Drug Contraceptives

The per prescription copay/deductible and policy year deductible will not apply to:

- Female contraceptives that are:
  - Oral prescription drugs that are generic prescription drugs.
  - Injectable prescription drugs that are generic prescription drugs.
  - Vaginal ring prescription drugs that are generic prescription drugs, brand-name prescription drugs and biosimilar prescription drugs.
  - Transdermal contraceptive patch prescription drugs that are generic prescription drugs, brand-name prescription drugs, and biosimilar prescription drugs.
- Female contraceptive devices.
- FDA-approved female:
  - generic emergency contraceptives; and
  - generic over-the-counter (OTC) emergency contraceptives

when obtained at a preferred care pharmacy. This means that such contraceptive methods will be paid at 100%.
The per prescription copay/deductible and policy year deductible continue to apply:

- When the contraceptive methods listed above are obtained at a non-preferred pharmacy.
- To female contraceptives that are:
  - Oral prescription drugs that are brand-name prescription drugs and biosimilar prescription drugs.
  - Injectable prescription drugs that are brand-name prescription drugs and biosimilar prescription drugs.
  - Vaginal ring prescription drugs that are brand-name prescription drugs and biosimilar prescription drugs.
  - Transdermal contraceptive patch prescription drugs that are brand-name prescription drugs and biosimilar prescription drugs.
- To female contraceptive devices that are brand-name devices.
- To FDA-approved female:
  - brand-name and biosimilar emergency contraceptives; and
  - brand-name over-the-counter (OTC) emergency contraceptives.
- To FDA-approved female brand-name over-the-counter (OTC) contraceptives
- To FDA-approved male brand-name over-the-counter (OTC) contraceptives.

However, the per prescription copay/deductible and policy year deductible will not apply to such contraceptive methods if:

- A generic equivalent, biosimilar or generic alternative, within the same therapeutic drug class is not available; or
- A covered person is granted a medical exception; or
- A physician specifies "Dispense as Written" (DAW).

To the extent:

- FDA-approved female generic prescription drugs are not available, brand name prescription drugs will be covered;
- FDA-approved female generic vaginal rings are not available, brand name vaginal rings will be covered.
- FDA-approved female generic devices are not available, brand name devices will be covered.
- One of the FDA-approved female emergency contraceptive methods are not available as generic, a brand name emergency contraceptive will be covered.

A covered person's prescriber may seek a medical exception by submitting a request to Aetna's Pre-certification Department. Any waiver granted as a result of a medical exception shall be based upon an individual, case by case medically necessary determination and coverage will not apply or extend to other covered persons.

Exclusions

This Plan does not cover nor provide benefits for:

1. Expense incurred for dental treatment, services and supplies except for those resulting from injury to sound natural teeth or for extraction of impacted wisdom teeth and those **as specifically covered under the Policy.**

2. Expense incurred for services normally provided without charge by the Policyholder's school health services; infirmary or hospital; or by health care providers employed by the Policyholder.

3. Expense incurred as a result of injury due to participation in a riot. "Participation in a riot" means taking part in a riot in any way; including inciting the riot or conspiring to incite it. It does not include actions taken in self - defense; so long as they are not taken against persons who are trying to restore law and order.

4. Expense incurred as a result of an accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation; except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.

5. Expense incurred as a result of an injury or sickness due to working for wage or profit or for which benefits are payable under any Workers' Compensation or Occupational Disease Law.

6. Expense incurred as a result of an injury sustained or sickness contracted while in the service of the Armed Forces of any country. Upon the covered person entering the Armed Forces of any country; the unearned pro rata premium will be refunded to the Policyholder.

7. Expense incurred for treatment provided in a governmental hospital unless there is a legal or regulatory obligation to pay such charges in the absence of insurance.

8. Expense incurred for elective treatment or elective surgery **except as specifically covered under the Policy and provided while the Policy is in effect.**

9. Expense incurred for cosmetic surgery; reconstructive surgery; or other services and supplies which improve; alter; or enhance appearance; whether or not for psychological or emotional reasons; except to the extent needed to: Improve the function of a part of the body that: is not a tooth or structure that supports the teeth; and is malformed: as a result of a severe birth defect; including harelip; webbed fingers; or toes; or as direct result of: disease; or surgery performed to treat a disease or injury. Repair an injury (including reconstructive surgery for prosthetic device for a covered person who has undergone a mastectomy;) which occurs while the covered person is covered under the Policy. Surgery must be performed:
   - in the policy year of the accident which causes the injury; or
   - in the next policy year.

10. Expense incurred for voluntary or elective abortions **unless specifically covered under the Policy**.

11. Expense incurred after the date insurance terminates for a covered person **except as may be specifically provided in the Extension of Benefits provision.**

12. Treatment for injury to the extent benefits are payable under any state no-fault automobile coverage; first party medical benefits payable under any other mandatory No-fault law.

13. Expenses for treatment of injury or sickness to the extent that payment is made; as a judgment or settlement; by any person deemed responsible for the injury or sickness (or their insurers).

14. Expense incurred for which no member of the covered person's immediate family has any legal obligation for payment.

15. Expense incurred for custodial care.

16. Expense incurred for the removal of an organ from a covered person for the purpose of donating or selling the organ to any person or organization **except as specifically covered in the Policy.** This limitation does not apply to a donation by a covered person to a spouse; child; brother; sister; or parent.

17. Expense incurred for, or in connection with, drugs, devices, procedures, or treatments that are, as determined by Aetna to be, experimental or investigational **except as specifically covered under the Policy.**

18. Expenses incurred for breast reduction/mammoplasty.

19. Expenses incurred for gynecomastia (male breasts).

20. Expense incurred for acupuncture **except as specifically covered under the Policy.**

21. Expense for care or services to the extent the charge would have been covered under Medicare Part A or Part B; even though the covered person is eligible; but did not enroll in Part B.

22. Expense incurred for alternative; holistic medicine; and/or therapy; including but not limited to; yoga and hypnotherapy **unless specifically covered under the Policy.**

23. Expense incurred when the person or individual is acting beyond the scope of his/her/its legal authority.

24. Expense incurred for hearing exams, hearing aids; the fitting; or prescription of hearing aids **except as specifically covered under the Policy.** Not covered are: Any hearing service or supply that does not meet professionally accepted standards;
    - Hearing exams given during a stay in a hospital or other facility;
    - Any tests, appliances, and devices for the improvement of hearing, including aids, hearing aids and amplifiers, or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech; and
    - Routine hearing exams, except for routine hearing screenings as specifically described under Preventive Care Benefits.

25. Expense for charges for failure to keep a scheduled visit; or charges for completion of a claim form.

26. Expense for personal hygiene and convenience items; such as air conditioners; humidifiers; hot tubs; whirlpools; or physical exercise equipment; even if such items are prescribed by a physician.

27. Expense incurred for any non-emergency charges incurred outside of the United States 1) if you traveled to such location to obtain prescription drugs, or supplies, even if otherwise covered under this Policy, or 2) such drugs or supplies are unavailable or illegal in the United States, or 3) the purchase of such prescription drugs or supplies outside the United States is considered illegal.

28. Expense for incidental surgeries; and standby charges of a physician.

29. Expense incurred for 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 counseling, hypnosis and other therapies, medications, nicotine patches and gum **except as specifically covered under the Policy.**

30. Expense incurred for injury resulting from the play or practice of intercollegiate sports (participating in sports clubs; or intramural athletic activities; is not excluded).

31. Expense for services and supplies for or related to gamete intrafallopian transfer; artificial insemination; in-vitro fertilization (except as required by the state law); or embryo transfer procedures; male or female elective sterilization reversal; or elective abortion; **unless specifically covered in the Policy.**

32. Expenses incurred for massage therapy.

33. Expense incurred for non-preferred care charges that are not recognized charges.

34. Expense for treatment of covered students who specialize in the mental health care field; and who receive treatment as a part of their training in that field.

35. Expense incurred for a treatment; service; prescription drug, or supply; which is not medically necessary; as determined by Aetna; for the diagnosis, care, or treatment of the sickness or injury involved, the restoration of physiological functions, or covered preventive services. This includes behavioral health services that are not primarily aimed at treatment of sickness, 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 the person's attending physician, dentist, or vision provider.

36. Expenses incurred for vision-related services and supplies, **except as specifically covered in the Policy.** In addition, the plan does not cover:
    - Special supplies such as non-prescription sunglasses;
    - Vision service or supply which does not meet professionally accepted standards;
    - Special vision procedures, such as orthoptics or vision training;
    - Eye exams during a stay in a hospital or other facility for health care;
    - Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
    - Replacement of lenses or frames that are lost or stolen or broken;
    - Acuity tests; and
    - Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
    - Services to treat errors of refraction.

37. Expense incurred in a facility for care, services or supplies provided in:
    - Rest homes;
    - Assisted living facilities;
    - Similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
    - Health resorts;
    - Spas, sanitariums;
    - Infirmaries at schools, colleges or camps; and
    - Wilderness Treatment Programs or any such related or similar program, school and/or education service.

38. 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).

39. Expense incurred for contraception **except as specifically covered in the Policy.**

40. Expense incurred for disposable outpatient supplies **except as specifically covered in the Policy.** Any outpatient disposable supply or device, including but not limited to sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.

41. Expense incurred for drugs, medications and supplies, **except as specifically covered in the Policy.**
Not covered are:
    - Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a prescription including vitamins;
    - Services related to the dispensing, injection or application of a drug;
    - A prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
    - Immunizations related to work;
    - Needles, syringes and other injectable aids, except as covered for diabetic supplies, and for a covered drug;
    - Drugs related to the treatment of non-covered medical expenses;
    - Performance enhancing steroids;
    - Implantable drugs and associated devices;
    - Injectable drugs if an alternative oral drug is available, unless medically necessary;
    - Any expenses for prescription drugs, and supplies covered under the Pharmacy Plan will not be covered under this medical expense plan. Prescription drug exclusions that apply to the Aetna Pharmacy plan will apply to the medical expense coverage; and
    - Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy whether functional or organic.

42. Expense incurred for educational services:
    - Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
    - Evaluation or treatment of developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause;" (this exclusion does not apply to autism spectrum disorders) and
    - Services, treatment, and educational testing and training related to behavioral (conduct) problems, and delays in developing skills;
    - Services eligible under the Individuals with Disabilities in Education Act (IDEA).

43. Expenses incurred for food items **except as specifically covered under the Policy:** Any food item, including infant formulas, nutritional supplements, and vitamins, including prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition. This limitation will not apply to formulas and special modified food products to treat inherited metabolic disorders and amino acid-based formulas to treat eosinophilic gastrointestinal disorders.

44. Expense incurred for therapies and tests: Any of the following treatments or procedures including but not limited to:
    - Aromatherapy;
    - Bio-feedback and bio-energetic therapy;
    - Carbon dioxide therapy;
    - Chelation therapy (except for heavy metal poisoning);
    - Computer-aided tomography (CAT) scanning of the entire body;
    - Early intensive behavioral interventions (including [Applied Behavior Analysis], Denver, LEAP, TEACHH, Rutgers programs) **except as specifically covered in the What the Medical Plan Covers Section;**
    - Educational therapy, **except as specifically covered in the Policy;**

- Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

45. Expenses incurred for any instruction for diet, plaque control and oral hygiene.

46. Expenses incurred for dental services and supplies that are covered in whole or in part under any other part of this plan.

47. Expenses incurred for jaw joint disorder treatment, services and supplies, **except as specifically covered in the Policy,** to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

48. Expenses incurred for orthodontic treatment **except as specifically covered in the Orthodontic Treatment Rule section of the Policy.**

49. Expenses incurred for routine dental exams and other preventive services and supplies, **except as specifically covered in the Policy.**

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

Sanctioned Countries:

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

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

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

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-866-378-0178.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

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

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TTY: 711

To access language services at no cost to you, call 1-866-378-0178.

Para acceder a los servicios de idiomas sin costo, llame al 1-866-378-0178. (Spanish)

如欲使用免費語言服務，請致電 1-866-378-0178。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-866-378-0178. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-866-378-0178. (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-866-378-0178 an. (German)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-866-378-0178. (Arabic)

Pou jwenn sèvis lang gratis, rele 1-866-378-0178. (French Creole-Haitian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-866-378-0178. (Italian)

言語サービスを無料でご利用いただくには、1-866-378-0178までお電話ください。(Japanese)

무료 언어 서비스를 이용하려면 1-866-378-0178 번으로 전화해 주십시오. (Korean)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-866-378-0178 تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-866-378-0178. (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-866-378-0178. (Portuguese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-866-378-0178. (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-866-378-0178. (Vietnamese)