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Aetna Student Health Plan Design and Benefits Summary George Washington University

Policy Year: 2019 - 2020

Policy Number: 474952

www.aetnastudenthealth.com

(800)213-0579



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

GW Colonial Health Center-Medical Services

The Colonial Health Center is the University's on-campus health facility. It is located at 800 21st St. NW, Ground Floor, Washington D.C, 20052. Staffed by Physicians, Nurse Practitioners, Physician Assistants, Mental Health Providers and Registered Nurses, the Facility is open weekdays from 8:30 a.m. to 5:00 p.m., during the Fall and Spring semesters. Emergency care is available Saturdays from 9:00am-12:00pm for the Fall & Spring Semesters. Healthcare professionals are available (on call) for medical consultations at all times at (202) 994-5300.

When the following services are provided at the GW Colonial Health Center (CHC) they are covered at **100%** with no Copay or Deductible.

- Medical office visits,
- Prescription medications routinely dispensed at Health Service,
- Routine STD screenings, (Once Annually)
- Physical Examinations
- Immunizations
- A yearly influenza vaccination when provided at the CHC only

Annual Deductible waived for services rendered at GW Mental Health Services

Office Visits are covered at **100%**.

Group Counseling is covered at **100%**. Referrals are available to providers in the community.

For more information, call the CHC Mental Health Services at **(202) 994-5300**. In the event of an emergency, call **911** or the Campus Police at **(202) 994-6111**.

Policy Period

Mandatory and Subsidized Graduate Assistants and Dependents

1. ****Students:** Coverage for all insured students enrolled for the Fall Semester that enroll in the annual plan, will become effective at 12:01 a.m. on **8/12/2019**, and will terminate at 11:59 p.m. on **08/11/2020**.
2. **New Spring Semester students:** Coverage for all insured students enrolled for the Spring/Summer Semester, will become effective at 12:01 a.m. on **01/01/2020**, and will terminate at 11:59 p.m. on **08/11/2020**.
3. **Insured dependents:** Coverage will become effective on the same date the insured student's coverage becomes effective, or the day after the postmarked date when the completed application and premium are sent, if later. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy. Examples include but are not limited to: the date the student's coverage terminates, the date the dependent no longer meets the definition of a dependent.

Mandatory Student Health Insurance Coverage

Eligibility

The following groups of students are automatically enrolled in the Plan unless proof of comparable coverage is furnished:

- All Undergraduate students matriculated in a degree granting program
- All international students on a J1 or F1 Visa;
- All Medical, On Campus Nursing, On-Campus Health Science students.

The plan is also available on a voluntary basis for:

- All Graduate students not listed above matriculated in a degree granting program (Note that some GW graduate assistants or graduate research assistants receive subsidized funding to cover the costs of the GW SHIP. Contact your department or research advisor for more information.);
- All non-degree seeking undergraduate students with at least 12 credit hours;
- Non-degree seeking graduate students with at least 9 credit hours;

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.

Rates

The rates below include both premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna), as well as George Washington University administrative fee.

Annual Waiver Deadline for Students: 9/30/2019

WAIVE/ENROLLMENT INFORMATION:

HOW TO WAIVE:

Students the premium for the Plan will be added to your tuition bill. If you have comparable coverage and wish to waive coverage under the Plan, you must submit an Online Waiver Form. To complete the Online Waiver Form, visit www.aetnastudenthealth.com.

Rates				
All Undergraduate, International and other Mandatory Students				
	Annual**	Fall Semester	Spring/Summer Semester	Summer Only
	08/12/19-08/11/20	08/12/19-12/31/19	01/01/20-08/11/20	06/01/20-08/11/20
Dependent Enrollment	09/30/19	09/30/19	01/31/20	06/30/20
Student	\$2,690	\$1,075	\$1,615	\$753
Spouse	\$2,440	\$950	\$1,490	\$682
One Child	\$2,440	\$950	\$1,490	\$682
Children	\$4,880	\$1,900	\$2,980	\$1,364

- **Please Note:** GW graduate assistants or graduate research assistants receive subsidized funding to cover the costs of the GW SHIP. Those students and their dependents are eligible for the above hard waiver rates. Contact your department or research advisor for more information.”

Voluntarily Enrolled Students and Dependents

1. ****Students:** Coverage for all insured students enrolled for the Fall Semester that enroll in the annual plan will become effective at 12:01 a.m. on **8/12/2019** and will terminate at 11:59 p.m. on **8/11/2020**.
2. **New Spring Semester students:** Coverage for all insured students enrolled for the Spring/Summer Semester, will become effective at 12:01 a.m. on **01/01/2020**, and will terminate at 11:59 p.m. on **8/11/2020**.
3. **Insured dependents:** Coverage will become effective on the same date the insured student's coverage becomes effective, or the day after the postmarked date when the completed application and premium are sent, if later. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy. Examples include but are not limited to: the date the student’s coverage terminates, the date the dependent no longer meets the definition of a dependent.

Rates

The rates below include both premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna), as well as George Washington University administrative fee.

	Rates				
	Voluntary Graduate Students				
	Annual**	Fall**	Spring/Summer		Summer
	08/12/19-08/11/20	08/12/19-12/31/19	01/01/20-08/11/20	Spring Only 01/01/20-05/31/20	06/01/20-08/11/20
Enrollment Deadline	09/30/19	09/30/19	01/31/20	01/31/20	06/30/20
Student	\$4,103	\$1,626	\$2,477	\$1,698.50	\$821
Spouse	\$3,826	\$1,487.50	\$2,238.50	\$1,583.50	\$755
One Child	\$3,826	\$1,487.50	\$2,238.50	\$1,583.50	\$755
Children	\$7,652	\$2,975	\$4,677	\$3,167	\$1,510

Annual Monthly Option:

Voluntarily Enrolled Students and Dependents

Annual Monthly Option: *	Annual Coverage Automatic Credit Card Charge Option * 08/12/19-08/11/20 Deadline Date: 09/30/20
1. Student	<input type="checkbox"/> \$342
2. Spouse/Domestic Partner	<input type="checkbox"/> \$203
3. Child Only	<input type="checkbox"/> \$203
4. 2 or more Children	<input type="checkbox"/> \$406

*Please Note:

Monthly payment 12 equal installments by auto-debit to credit card for coverage

This option is only available when paying by credit card. You may authorize the monthly payment of 12 equal installments by auto-debiting via credit card. Your signature provides authorization to charge your credit card for the 1st payment at the time of enrollment and continued monthly debits for the remainder of the policy year. If for any reason your credit card does not accept the monthly debit, an alternate credit card payment must be provided within 20 days of the end of the month for which premium has been previously received.

We will attempt to charge your credit card/bank account 3 times.

For any reason, if the charge is unable to be processed, a warning letter will be sent to your address on file.

If the charge fails on the 3rd attempt, a termination letter will be sent notifying you that payment has failed, and coverage will be terminated.

Termination of Coverage & Re-Enrollment Options:

- Electing the monthly payment option requires you to pay each month.
- If you fail to make a payment, a termination letter will be sent describing the re-enrollment guidelines.

If you terminate for lack of payment and wish to re-enroll, you must re-send the application information, a letter explaining the reason for the request for an exception request and premium payment for the remainder of the plan year. **(A petition to be reinstated is not a guarantee of reinstatement of the policy)**

Enrollment

To enroll online or obtain an enrollment application for voluntary coverage, log on to www.aetnastudenthealth.com and search for your school, then click on Enroll to download the appropriate form.

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

Dependent Coverage

Eligibility

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

Enrollment

To enroll the dependent(s) of a covered student, please complete the Enrollment Form by visiting www.aetnastudenthealth.com, selecting the school name, and clicking on the “Plans & Products Offered to You” link on the left hand side of the screen, or by calling customer service at (800)213-0579 and requesting that an Enrollment Form be sent in the mail. Please refer to the Coverage Periods section of this document for coverage dates and deadline dates. Dependent enrollment applications will not be accepted after the enrollment deadline, unless there is a significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage under another health plan.) The completed Enrollment Form and premium must be sent to Aetna Student Health.

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

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

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

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

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

If you need information or have general questions on dependent enrollment, call Member Services at (800)213-0579.

Medicare Eligibility Notice

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

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

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

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.

Precertification for medical services and supplies

In-network care

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

Out-of-network care

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

Precertification call

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

Non-emergency admissions:	You, your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.
An emergency admission:	You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
An urgent admission:	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.
Outpatient non-emergency services requiring precertification:	You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

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

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

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

What if you don't obtain the required precertification?

If you don't obtain the required precertification:

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

What types of services and supplies require precertification?

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

Inpatient services and supplies	Outpatient services and supplies
ART services	Applied behavior analysis
Obesity (bariatric) surgery	Certain prescription drugs and devices*
Stays in a hospice facility	Complex imaging
Stays in a hospital	Comprehensive infertility services
Stays in a rehabilitation facility	Cosmetic and reconstructive surgery
Stays in a residential treatment facility for treatment of mental disorders and substance abuse	Emergency transportation by airplane
Stays in a skilled nursing facility	Home health care
	Hospice services
	Intensive outpatient program (IOP) – mental disorder and substance abuse diagnoses
	Kidney dialysis
	Knee surgery
	Medical injectable drugs, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, botox, hepatitis C medications)*
	Outpatient back surgery not performed in a physician's office
	Partial hospitalization treatment – mental disorder and substance abuse diagnoses
	Private duty nursing services
	Psychological testing/neuropsychological testing
	Sleep studies
	Transcranial magnetic stimulation (TMS)
	Wrist surgery

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

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).

Here's how COB works

- When this is the primary plan, we will pay your medical claims first as if the other plan does not exist
- When this is the secondary plan, we will pay benefits after the primary plan and will reduce the payment based on any amount the primary plan paid
- We will never pay an amount that, together with payments from your other coverage, add up to more than 100% of the allowable submitted expenses

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

Description of Benefits

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

How your plan works while you are covered for in-network coverage

Your in-network coverage helps you:

- Get and pay for a lot of – but not all – health care services
- Pay less cost share when you use an in-network provider

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

Metallic Level: Gold Tested at 82.79%

Policy year deductible	In-network coverage	Out-of-network coverage
You have to meet your policy year deductible before this plan pays for benefits. The policy year deductible will not be applied until this plan has paid \$10,000 in covered benefits. After that, you have to meet your policy year deductible before this plan pays for additional benefits.		
Student	\$300 per policy year	\$3,000 per policy year
Spouse	\$300 per policy year	\$3,000 per policy year
Each child	\$300 per policy year	\$3,000 per policy year
Family	None	None
PRESCRIBED MEDICINES EXPENSE		
Student	\$100 per policy year	
Spouse	\$100 per policy year	
Each child	\$100 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 *Preventive care and wellness*
- Pap Smear Screening Expense; and
- Mammogram Expense.

In addition to state and federal requirements for waiver of the policy year deductible, the plan will waive the policy year deductible for:

- Preferred Care Laboratory and X-Ray Expense;
- Preferred Care Allergy Testing Expense;
- Preferred Care Diagnostic Testing For Learning Disabilities Expense; Preferred Care Maternity Expense;
- Preferred Care Gynecology;
- Preferred Care Outpatient Treatment of Mental Health;
- Preferred Care Pediatric Preventive Dental; and
- Preferred and Non-Preferred Care Pediatric Vision Services.

Per visit or admission 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.

Maximum out-of-pocket limits

Maximum out-of-pocket limit per policy year

Student	\$6,350 per policy year	\$15,000 per policy year
Spouse	\$6,350 per policy year	\$15,000 per policy year
Each child	\$6,350 per policy year	\$15,000 per policy year
Family	\$12,700 per policy year	\$30,000 per policy year

Precertification covered benefit penalty

This only applies to out-of-network coverage: The certificate of coverage contains a complete description of the precertification program. You will find details on precertification requirements in the *Medical necessity and precertification requirements* section.

Failure to precertify your eligible health services when required will result in the following benefit penalties:

- A \$500 benefit penalty will be applied separately to each type of eligible health services.

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

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

Eligible health services	In-network coverage	Out-of-network coverage
Preventive care and wellness		
Routine physical exams		
Performed at a physician's office	100% (of the negotiated charge) per visit Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Covered persons through age 21: Maximum age and visit limits per policy year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Aetna secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Covered persons age 22 and over: Maximum visits per policy year	1 visit	
Preventive care immunizations		
Performed in a facility or at a physician's office	100% (of the negotiated charge) per visit. Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician or Member Services by logging onto your Aetna secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Well woman preventive visits		
Routine gynecological exams (including Pap smears and cytology tests)		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	
Maximum visits per policy year	1 visit	

Eligible health services	In-network coverage	Out-of-network coverage
Preventive screening and counseling services		
Obesity and/or healthy diet counseling office visits	100% (of the negotiated charge) per visit Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Maximum visits per policy year (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)	
Misuse of alcohol and/or drugs counseling office visits	100% (of the negotiated charge) per visit Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Maximum visits per policy year	5 visits	
Use of tobacco products counseling office visits	100% (of the negotiated charge) per visit Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Maximum visits per policy year	8 visits	
Depression screening counseling office visits	100% (of the negotiated charge) per visit Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Maximum visits per policy year	1 visit	
Sexually transmitted infection counseling office visits	100% (of the negotiated charge) per visit Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Maximum visits per policy year	2 visits	
Genetic risk counseling for breast and ovarian cancer counseling office visits	100% (of the negotiated charge) per visit Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Age limitations	Not subject to any age limitations	

Eligible health services	In-network coverage	Out-of-network coverage
Routine cancer screenings performed at a physician's office, specialist's office or facility.		
Routine cancer screenings Deductible does not apply to routine mammography	100% (of the negotiated charge) per visit Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Maximums	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. For details, contact your physician or Member Services by logging onto your Aetna secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Lung cancer screening maximums	1 screening every 12 months*	
*Important note: Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the <i>Outpatient diagnostic testing</i> section.		
Prenatal care services (provided by a physician, an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)		
Preventive care services only	100% (of the negotiated charge) per visit Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Important note: You should review the <i>Maternity care and Well newborn nursery care</i> sections. They will give you more information on coverage levels for maternity care under this plan.		
Comprehensive lactation support and counseling services		
Lactation counseling services - facility or office visits	100% (of the negotiated charge) per visit Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits	
Important note: Any visits that exceed the lactation counseling services maximum are covered under the <i>Physicians and other health professionals'</i> section.		
Breast feeding durable medical equipment: Breast pump supplies and accessories	100% (of the negotiated charge) per item Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Important note: See the Breast feeding durable medical equipment section of the certificate of coverage for limitations on breast pump and supplies.		

Eligible health services	In-network coverage	Out-of-network coverage
Family planning services – female contraceptives		
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Contraceptive counseling services maximum visits per policy year either in a group or individual setting	2 visits	
Important note: Any visits that exceed the contraceptive counseling services maximum are covered under <i>Physician services</i> office visits.		
Contraceptives (prescription drugs and devices)		
Female contraceptive prescription drugs and devices provided, administered, or removed, by a physician during an office visit	100% (of the negotiated charge) per item Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Female voluntary sterilization		
Inpatient provider services	100% (of the negotiated charge) Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Outpatient provider services	100% (of the negotiated charge) per visit Deductible does not apply	60% (of the recognized charge) per visit Policy year deductible applies
Physicians and other health professionals		
Physician and specialist services		
Office hours visits (non-surgical and non-preventive care by a physician and specialist)	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Telemedicine consultation By a physician or specialist	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Allergy testing and treatment		
Allergy testing performed at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Allergy injections treatment performed at a physician's, or specialist office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
Allergy sera and extracts administered via injection at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Physician and specialist - inpatient surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Anesthetist	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Surgical assistant	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Physician and specialist - outpatient surgical services		
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Anesthetist	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Surgical assistant	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
In-hospital non-surgical physician services		
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Consultant services (non-surgical and non-preventive)		
Office hours visits (non-surgical and non-preventive care) includes telemedicine consultations)	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Telemedicine consultation by a consultant	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.
Second surgical opinion	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Hospital and other facility care		
Hospital care (facility charges) Inpatient hospital (room and board) and other miscellaneous services and supplies) Subject to semi-private room rate unless intensive care unit required Room and board includes intensive care For physician charges, refer to the <i>Physician and specialist – inpatient surgical services</i> benefit	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
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.

Eligible health services	In-network coverage	Out-of-network coverage
Alternatives to hospital stays		
Outpatient surgery (facility charges)		
Facility charges for surgery performed in the outpatient department of a hospital or surgery center For physician charges, refer to the <i>Physician and specialist - outpatient surgical services</i> benefit	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Home health care		
Outpatient	80% (of the negotiated charge) per visit Policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies
Maximum visits per episode per policy year	unlimited	
Outpatient private duty nursing	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Hospice care		
Inpatient facility (room and board and other miscellaneous services and supplies)	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Maximum days per confinement per policy year	unlimited	
Outpatient	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Maximum visits per policy year	unlimited	
Skilled nursing facility		
Inpatient facility (room and board and miscellaneous inpatient care services and supplies) Subject to semi-private room rate unless intensive care required Room and board include intensive care	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Emergency services and urgent care		
Emergency services		
Hospital emergency room	\$100 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit Policy year deductible applies	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered
<p>Important note:</p> <ul style="list-style-type: none"> As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment/coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill. A separate hospital emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived, and your inpatient copayment/coinsurance will apply. Covered benefits that are applied to the hospital emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment/coinsurance. Separate copayment/coinsurance amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment/coinsurance amounts may be different from the hospital emergency room copayment/coinsurance. They are based on the specific service given to you. Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment/coinsurance amounts that are different from the hospital emergency room copayment/coinsurance amounts. 		
Urgent care		
Urgent medical care provided by an urgent care provider	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Non-urgent use of urgent care provider	Not covered	Not covered

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	70% (of the recognized charge) per visit Policy year deductible applies
Type B services	70% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Type C services	50% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Orthodontic services	50% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Dental emergency treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received.
Specific conditions		
Birthing center (facility charges)		
Inpatient (room and board and other miscellaneous services and supplies)	Paid at the same cost-sharing as hospital care.	Paid at the same cost-sharing as hospital care.
Diabetic services and supplies (including equipment and training)		
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Impacted wisdom teeth		
Impacted wisdom teeth	100% (of the negotiated charge) per visit Policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Accidental injury to sound natural teeth		
Accidental injury to sound natural teeth	100% (of the negotiated charge) per visit Policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies
Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment		
TMJ and CMJ treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Dermatological treatment		
Dermatological treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maternity care		
Maternity care (includes delivery and postpartum care services in a hospital or birthing center)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Note: The per admission copayment amount and/or policy year deductible for newborns will be waived for nursery charges for the duration of the newborn's initial routine facility stay. The nursery charges waiver will not apply for non-routine facility stays.		
Pregnancy complications		
Inpatient (room and board and other miscellaneous services and supplies) Subject to semi-private room rate unless intensive care unit required Room and board includes intensive care	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
Family planning services – other		
Voluntary sterilization for Males- Inpatient physician or specialist surgical services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Voluntary sterilization for males- Outpatient physician or specialist surgical services	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Gender reassignment (sex change) treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Tracheal shave	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.
Tracheal shave maximum per policy year	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.
Electrolysis of face and neck Maximum Benefit: \$1,200 per policy year	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 diagnosis and testing	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Autism spectrum disorder treatment (includes physician and specialist office visits, diagnosis and testing)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Eligible health services	In-network coverage	Out-of-network coverage
Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Applied behavior analysis	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Mental health treatment		
Mental health treatment – inpatient		
<p>Inpatient hospital mental disorders treatment (room and board and other miscellaneous hospital services and supplies)</p> <p>Inpatient residential treatment facility mental disorders treatment (room and board and other miscellaneous residential treatment facility services and supplies)</p> <p>Subject to semi-private room rate unless intensive care unit is required</p> <p>Mental disorder room and board intensive care</p>	<p>80% (of the negotiated charge) per visit</p> <p>Policy year deductible applies</p>	<p>60% (of the recognized charge) per visit</p> <p>Policy year deductible applies</p>
Mental health treatment - outpatient		
<p>Outpatient mental disorders treatment office visits to a physician or behavioral health provider</p> <p>(includes telemedicine consultations)</p>	<p>80% (of the negotiated charge) per visit</p> <p>Policy year deductible applies</p>	<p>60% (of the recognized charge) per visit</p> <p>Policy year deductible applies</p>
<p>Other outpatient mental disorders treatment (includes skilled behavioral health services in the home)</p> <p>Partial hospitalization treatment</p> <p>Intensive Outpatient Program</p>	<p>80% (of the negotiated charge) per visit</p> <p>Policy year deductible applies</p>	<p>60% (of the recognized charge) per visit</p> <p>Policy year deductible applies</p>

Eligible health services	In-network coverage	Out-of-network coverage
Substance abuse related disorders treatment-inpatient		
<p>Inpatient hospital substance abuse detoxification (room and board and other miscellaneous hospital services and supplies)</p> <p>Inpatient hospital substance abuse rehabilitation (room and board and other miscellaneous hospital services and supplies)</p> <p>Inpatient residential treatment facility substance abuse (room and board and miscellaneous residential treatment facility services and supplies)</p> <p>Subject to semi-private room rate unless intensive care unit is required</p> <p>Substance abuse room and board intensive care</p>	<p>80% (of the negotiated charge) per visit</p> <p>Policy year deductible applies</p>	<p>60% (of the recognized charge) per visit</p> <p>Policy year deductible applies</p>
Substance abuse related disorders treatment-outpatient: detoxification and rehabilitation		
<p>Outpatient substance abuse office visits to a physician or behavioral health provider</p> <p>(includes telemedicine consultations)</p>	<p>80% (of the negotiated charge) per visit</p> <p>Policy year deductible applies</p>	<p>60% (of the recognized charge) per visit</p> <p>Policy year deductible applies</p>
<p>Other outpatient substance abuse services</p> <p>Partial hospitalization treatment</p> <p>Intensive Outpatient Program</p>	<p>80% (of the negotiated charge) per visit</p> <p>Policy year deductible applies</p>	<p>60% (of the recognized charge) per visit</p> <p>Policy year deductible applies</p>
Reconstructive surgery and supplies		
<p>Reconstructive surgery and supplies (includes reconstructive breast surgery)</p>	<p>Covered according to the type of benefit and the place where the service is received.</p>	<p>Covered according to the type of benefit and the place where the service is received.</p>

Eligible health services	In-network coverage Network (IOE facility)	In-network coverage Network (Non-IOE facility)	Out-of-network coverage Network Non-IOE facility and out-of-network facility
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.	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.	Covered according to the type of benefit and the place where the service is received.
Transplant services-travel and lodging	Covered	Covered	Covered
Lifetime Maximum payable for Travel and Lodging Expenses for any one transplant, including tandem transplants	\$10,000	\$10,000	\$10,000
Maximum payable for Lodging Expenses per IOE patient	\$50 per night	\$50 per night	\$50 per night
Maximum payable for Lodging Expenses per companion	\$50 per night	\$50 per night	\$50 per night
Eligible health services	In-network coverage	Out-of-network coverage	
Treatment of infertility			
Basic infertility services Inpatient and outpatient care - basic infertility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	
Specific therapies and tests			
Outpatient diagnostic testing			
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies	
Diagnostic lab work and radiological services performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies	

Eligible health services	In-network coverage	Out-of-network coverage
Chemotherapy		
Chemotherapy	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Hormone replacement therapy		
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		
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient radiation therapy		
Outpatient radiation therapy	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Outpatient respiratory therapy		
Respiratory therapy	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Transfusion or kidney dialysis of blood		
Transfusion or kidney dialysis of blood	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Short-term cardiac and pulmonary rehabilitation services		
Cardiac rehabilitation	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Pulmonary rehabilitation	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Short-term rehabilitation and habilitation therapy services		
Outpatient physical, occupational, speech, and cognitive therapies Combined for short-term rehabilitation services and habilitation therapy services	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Chiropractic services		
Chiropractic services	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Diagnostic testing for learning disabilities		
Diagnostic testing for learning disabilities	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Specialty prescription drugs (Purchased and injected or infused by your provider in an outpatient setting)		
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
Other services and supplies		
Acupuncture in lieu of anesthesia	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Emergency ground, air, and water ambulance	100% (of the negotiated charge) per visit Policy year deductible applies	100% (of the recognized charge) per visit Policy year deductible applies
Clinical trial therapies (experimental or investigational)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Durable medical and surgical equipment	80% (of the negotiated charge) per visit Policy year deductible applies	80% (of the recognized charge) per visit Policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Enteral formulas and nutritional supplements	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
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		
Prosthetic devices	80% (of the negotiated charge) per item Policy year deductible applies	60% (of the recognized charge) per item Policy year deductible applies
Hearing aids and exams		
Hearing aid exams	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Hearing aid exam maximum	One hearing exam every policy year	
Hearing aids	80% (of the negotiated charge) per visit Policy year deductible applies	60% (of the recognized charge) per visit Policy year deductible applies
Hearing aids maximum per ear	One hearing aid per ear every policy year	
Podiatric (foot care) treatment		
Physician and Specialist non-routine foot care treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Vision care		
Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)		
Pediatric routine vision exams (including refraction)		
Performed by a legally qualified ophthalmologist or optometrist	100% (of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit No policy year deductible applies
Maximum visits per policy year	1 visit	
Pediatric comprehensive low vision evaluations		
Performed by a legally qualified ophthalmologist or optometrist	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum	One comprehensive low vision evaluation every policy year	

Eligible health services	In-network coverage	Out-of-network coverage
Pediatric vision care services and supplies		
Eye-glass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit No policy year deductible applies
Maximum number of eye-glass frames per policy year	One set of eye-glass frames	
Maximum number of prescription lenses per policy year	One pair of prescription lenses	
Maximum number of prescription contact lenses per policy year (includes non-conventional prescription contact lenses and aphakic lenses prescribed after cataract surgery)	Daily disposables: up to 3-month supply Extended wear disposable: up to 6-month supply Non-disposable lenses: one set	
Office visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit No policy year deductible applies
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	
<p>*Important note: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies.</p> <p>As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eye-glass frames or prescription contact lenses, but not both.</p> <p>Coverage does not include the office visit for the fitting of prescription contact lenses.</p>		
Outpatient prescription drugs		
Policy year deductible and copayment waiver for risk reducing breast cancer		
<p>The policy year deductible and the 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%.</p>		
Policy year deductible and copayment waiver for tobacco cessation prescription and over-the-counter drugs		
<p>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%.</p> <p>Your policy year deductible and any prescription drug copayment will apply after those two regimens per policy year have been exhausted.</p>		

Policy year deductible and copayment waiver for contraceptives

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

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

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

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

Eligible health services	In-network coverage	Out-of-network coverage
Preferred generic prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	\$15 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	40% (of the recognized charge) Policy year deductible applies
More than a 30 day supply but less than a 101 day supply filled at a mail order pharmacy	\$30 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) Policy year deductible applies	Not covered
Preferred brand-name prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	\$45 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	40% (of the recognized charge) Policy year deductible applies
More than a 30 day supply but less than a 101 day supply filled at a mail order pharmacy	\$90 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) Policy year deductible applies	Not covered

Eligible health services	In-network coverage	Out-of-network coverage
Non-preferred brand-name prescription drugs		
Per prescription copayment/coinsurance		
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 negotiated charge) No policy year deductible applies	40% (of the recognized charge) Policy year deductible applies
More than a 30 day supply but less than a 101 day supply filled at a mail order pharmacy	\$140 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) Policy year deductible applies	Not covered
Specialty drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	\$120 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) Policy year deductible applies	Not covered
Tobacco cessation prescription drugs and over-the-counter drugs		
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each 30 day supply	100% (of the negotiated charge per prescription or refill) No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Orally administered anti-cancer prescription drugs		
Per prescription copayment/coinsurance		
For each fill up to a 30 day supply filled at a retail pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
Preventive care drugs and supplements		
Preventive care drugs and supplements filled at a retail pharmacy For each 30 day supply	100% (of the negotiated charge per prescription or refill) No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna secure website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card.	

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

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

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

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

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

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

General exceptions and exclusions

Acupuncture therapy

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

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

Air or space travel

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

This exclusion does not apply if:

- You are traveling solely as a fare-paying passenger
- You are traveling on a licensed, commercial, regularly scheduled non-military aircraft
- You are traveling solely in a civil aircraft with a current valid "Standard Federal Aviation Agency Airworthiness Certificate" and:
 - The civil aircraft is piloted by a person with a current valid pilot's certificate with proper ratings for the type of flight and aircraft involved
 - You are as a passenger with no duties at all on an aircraft used only to carry passengers or you are a pilot or a part of the flight crew on an aircraft owned or leased by the policyholder performing duties for the policyholder

Alternative health care

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

Armed forces

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

Beyond legal authority

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

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

Examples of these are:

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

Breasts

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

Cosmetic services and plastic surgery

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

This exclusion does not apply to:

- Surgery after an accidental injury when performed as soon as medically feasible
- Coverage that may be provided under the *Eligible health services under your plan - Gender reassignment (sex change) treatment* section.

Dental care for adults

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

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

Durable medical equipment (DME)

Examples of these items are:

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

Early intensive behavioral interventions

Examples of these services are:

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

Educational services

Examples of these services are:

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

Elective treatment or elective surgery

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

Enteral formulas and nutritional supplements

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

Experimental or investigational

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

Facility charges

For care, services or supplies provided in:

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

Family planning services - other

- Abortion except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger
- Reversal of voluntary sterilization procedures, including related follow-up care
- Family planning services received while confined as an inpatient in a hospital or other facility
- Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care

Felony

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

Foot care

- 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

Gender reassignment (sex change) treatment

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

Genetic care

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

Growth/Height care

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

Hearing aids and exams

The following services or supplies:

- A replacement of:
 - A hearing aid that is lost, stolen or broken
 - A hearing aid installed within the prior 12 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- Cochlear implants
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist
- Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay
- Any tests, appliances and devices to:
 - Improve your hearing. This includes hearing aid batteries, amplifiers, and auxiliary equipment
 - Enhance other forms of communication to make up for hearing loss or devices that simulate speech

Home health care

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

Hospice care

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

Incidental surgeries

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

Jaw joint disorder

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

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

Judgment or settlement

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

Mandatory no-fault laws

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

Medical supplies – outpatient disposable

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

Medicare

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

Mental health treatment

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

Motor vehicle accidents

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

Non-medically necessary services and supplies

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

Non-U.S. citizen

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

Obesity (bariatric) surgery

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

Organ removal

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

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 (outpatient only)

Prosthetic devices

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

Riot

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

Routine exams

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

School health services

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

by health professionals who

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

Services provided by a family member

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

Sinus surgery

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

Sleep apnea

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

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

Students in mental health field

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

Therapies and tests

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

Tobacco cessation

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

Treatment in a federal, state, or governmental entity

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

Treatment of infertility

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

Vision Care

Pediatric vision care services and supplies

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

Adult vision care

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

Adult vision care services and supplies

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

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

Work related illness or injuries

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

Exceptions and exclusions that apply to outpatient prescription drugs

Drugs or medications

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

Genetic care

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

We reserve the right to exclude:

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

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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>.

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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 1-877-480-4161.

Para acceder a los servicios de idiomas sin costo, llame al 1-877-480-4161. (Spanish)

如欲使用免費語言服務，請致電 1-877-480-4161。 (Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-877-480-4161. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-877-480-4161. (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-877-480-4161 an. (German)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-877-480-4161. (Arabic)

Pou jwenn sèvis lang gratis, rele 1-877-480-4161. (French Creole-Haitian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-877-480-4161. (Italian)

言語サービスを無料でご利用いただくには、1-877-480-4161 までお電話ください。 (Japanese)

무료 언어 서비스를 이용하려면 1-877-480-4161 번으로 전화해 주십시오. (Korean)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-877-480-4161 تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-877-480-4161. (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-877-480-4161. (Portuguese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-877-480-4161. (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-877-480-4161. (Vietnamese)