Aetna Student Health

THE GEORGE WASHINGTON UNIVERSITY
WASHINGTON, DC

Plan Design and Benefits Summary
George Washington University

Policy Year: 2016 - 2017
Policy Number: 474952

aetna®

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 governing this insurance, including definitions, are contained in the Master Policy issued to the George Washington University and may be viewed online at **www.aetnastudenthealth.com.** If any discrepancy exists between this Benefit Summary and the Policy, the Master Policy will govern and control the payment of benefits.

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 Saturdays 9:00am-12:00pm, Fall & Spring Semesters. A healthcare professional is on call for medical consultations at all times.

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

GW Colonial Health Center- Mental Health Services

Annual Deductible waived for services rendered at GW Mental Health Services

Office Visits covered at **100%**.

Group Counseling covered at **100%.** Referrals 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) 994-6110**.

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 **August 12, 2016**, and will terminate at 11:59 p.m. on **August 11, 2017**.

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 **January 1, 2017**, and will terminate at 11:59 p.m. on **August 11, 2017**.

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.

Voluntarily Enrolled Students and Dependents

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Rates

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

Mandatory and Subsidized Graduate Assistants and Dependents

Annual Waiver Deadline for Students: September 30, 2016

	Annual** 08/12/16 - 08/11/17	Fall Semester 08/12/16 - 12/31/16	Spring/Summer Semester 01/01/17 - 08/11/17	Summer Only 05/01/17 - 8/11/17
Dependent Enrollment	09/30/2016	09/30/2016	01/31/2017	05/31/2017
Student	$2,651	$1,055	$1,596	$748
Spouse	$2,420	$939.50	$1,480.50	$676
One Child	$2,420	$939.50	$1,480.50	$676
Children	$4,840	$1,879	$2,961	$1,352

Voluntarily Enrolled Students and Dependents

	Annual** 08/12/16 - 08/11/17	Fall** 08/11/16 - 12/31/16	Spring Only 01/01/17 - 05/31/17	Summer 06/01/17 - 08/11/17
Enrollment Deadline	09/30/2016	09/30/2016	01/31/2017	06/30/2017
Student	$4,103	$1,626	$1,698	$821
Spouse	$3,806	$1,477.50	$1,576	$752.50
One Child	$3,806	$1,477.50	$1,576	$752.50
Children	$7,612	$2,955	$3,152	$1,505

Annual Monthly Option:

(See Below for enrollment details)

Voluntarily Enrolled Students and Dependents

Annual Monthly Option: *	**Annual Coverage Automatic Credit Card Charge Option * 8/12/16-8/11/2017** **Deadline Date: September 30, 2016**
1.Student	☐ **$ 342**
2. Spouse/Domestic Partner	☐ **$ 317.17**
3. Child Only	☐ **$ 317.17**
4. 2 or more Children	☐ **$ 634.34**

***Please Note:**

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

I understand this option is only available when paying by credit card. I authorize the monthly payment of 12 equal installments by auto-debiting my credit card. My signature provides authorization to charge my 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 my 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)**

Student Coverage

Eligibility

All full-time and part-time undergraduate and graduate students matriculated in a degree program at The George Washington University, and who actively attend classes for at least the first 31 days, after the date when coverage becomes effective are eligible to enroll. The plan is also available for all non-degree seeking undergraduate students with at least 12 credit hours, and non-degree seeking graduate students with at least 9 credit hours. Post-Doctoral trainees are also eligible.

Home study, correspondence, Internet classes, and television (TV) courses, do not fulfill the eligibility requirement that the student actively attend classes. If it is discovered that this eligibility requirement has not been met, our only obligation is to refund premium, less any claims paid.

Medicare Eligibility Notice:

As to medical expense coverage and prescribed medicines expense coverage only, a person eligible for **Medicare** at the time of enrollment under the Policyholder's plan is not eligible for medical expense coverage and prescribed medicines expense coverage. If a **covered person** becomes eligible for **Medicare** after he or she is enrolled in the Policyholder's plan, such Medicare eligibility will not result in the termination of medical expense coverage and prescribed medicines expense coverage under the plan. As used within this provision, persons are "eligible for **Medicare"** if they are entitled to benefits under Part A (receiving free Part A) or enrolled in Part B or Premium Part A.

Enrollment/Waiver Process

All Medical, on-campus Nursing, on-campus Health and International Students holding an F1 or J1 visa are required to have Health Insurance and are automatically enrolled into the George Washington Student Health Insurance Plan 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**.

GWU Waiver Requirements: Students whose insurance policy does not meet with the University minimum requirements will remain on the GWU Student Health Insurance Plan

Minimum Requirement to Waive the GWU Student Health Insurance Policy

- Policy must be with an American Insurance Carrier.
- Policy must provide:
  - International Students **$100,000** in coverage
  - Domestic Students Unlimited in coverage
- No exclusion for self-inflicted injuries
- Policy must provide medical & mental health coverage in the DC area
- Deductible:
  - International Students **$500** Maximum
  - Domestic Students **$1,500** Maximum
- All International Students must have a minimum of $50,000 in Emergency Medical Evacuation
- International Student must have a policy that provides Medical Evacuation and a minimum of $25,000 in benefits for return of deceased remains

To enroll online or obtain an enrollment form for voluntary coverage, log on to **www.aetnastudenthealth.com** and search for your school, then click on Enroll to download the appropriate form. Aetna Student Health reserves the right to review, at any time, your eligibility to enroll in this plan. If it is determined that you did not meet the school's eligibility requirements for enrollment, your participation in the plan may be rescinded in accordance with its terms.

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Hard Waiver Students & GA Assistants	Waiver Deadline Date
Annual Plan	**09/30/2016**
Fall Semester	**09/30/2016**
Spring Semester	**01/31/2017**
Summer Semester	**05/31/2017**

Waiver submissions may be audited by George Washington University, Aetna Student Health, and/or their contractors or representatives. You may be required to provide, upon request, any coverage documents and/or other records demonstrating that you meet the school's requirements for waiving the student health insurance plan. By submitting the waiver request, you agree that your current insurance plan may be contacted for confirmation that your coverage is in force for the applicable policy year and that it meets the school's waiver requirements.

Dependent Coverage

Eligibility

Covered students may also enroll their lawful spouse (including legally recognized same-sex marriages), same-sex domestic partners, and dependent children under age 26.

Enrollment

To enroll the dependent(s) of a covered student, please complete the Online Enrollment process 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** to obtain an Enrollment Form. The Fall enrollment deadline is **September 30, 2016**.

Enrollment applications will not be accepted after **September 30, 2016** 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 Spring enrollment deadline is **January 31, 2017**.

The completed Enrollment Application, and premium, must be sent to Aetna Student Health.

Preferred Provider Network

Aetna Student Health has arranged for you to access a Preferred Provider Network in your local community. To maximize your savings and reduce your out-of-pocket expenses, select a Preferred Provider. It is to your advantage to use a Preferred Provider because savings may be achieved from the Negotiated Charges these providers have agreed to accept as payment for their services.

If a service or supply that a covered person needs is covered under the Plan but not available from a Preferred Care Provider, covered persons should contact Member Services for assistance at the toll-free number on the back of the ID card. In this situation, Aetna may issue a pre-approval for a covered person to obtain the service or supply from a Non-Preferred Care Provider. When a pre-approval is issued by Aetna, covered medical expenses are reimbursed at the Preferred Care network level of benefits.

Pre-certification Program

Your Plan requires pre-certification for certain services, such as inpatient stays, certain tests, procedures, outpatient surgery, therapies and equipment, and prescribed medications. Pre-certification simply means calling Aetna Student Health prior to treatment to get approval for coverage under your Plan for a medical procedure, service or supply. For preferred care, the preferred care provider is responsible for obtaining pre-certification. Since pre-certification is the preferred care provider's responsibility, there is no additional out-of-pocket cost to you as a result of a designated care provider's or a preferred care provider's failure to precertify services. For non-preferred care, you are responsible for obtaining pre-certification which can be initiated by you, a member of your family, a hospital staff member or the attending physician. The pre-certification process can be initiated by calling Aetna at the telephone number listed on your ID card.

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

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

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

- All inpatient maternity and newborn care, after the initial 48 hours for a vaginal delivery or 96 hours for a cesarean section;
- Ambulance (non-emergency transportation);
- Autologous chondrocyte implantation, Carticel®;
- Bariatric surgery (bariatric surgery is not covered under the Policy unless specifically described in the Policy);
- BRCA genetic testing;
- Cardiac rhythm implantable devices;
- Cochlear device and/or implantation;
- Dental implants and oral appliances;
- Dorsal column (lumbar) neurostimulators: trial or implantation;
- Drugs and Medical Injectables;
- Electric or motorized wheelchairs and scooters;
- Gender Reassignment (Sex Change) Surgery;
- Home health care related services (i.e. private duty nursing);
- Hyperbaric oxygen therapy;
- Infertility treatment (Comprehensive and ART infertility treatment is not covered under the plan unless specifically described in the Policy);
- Inpatient Confinements (surgical and non-surgical); hospital, skilled nursing facility, rehabilitation facility, residential treatment facility for mental disorders and substance abuse, hospice care;
- Inpatient mental disorders treatment;
- Inpatient substance abuse treatment;
- Kidney dialysis;
- Knee surgery;
- Limb Prosthetics;
- Out-of-network freestanding ambulatory surgical facility services when referred by a network provider;
- Oncotype DX;

- Orthognatic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint;
- Osseointegrated implant;
- Osteochondral allograft/knee;
- Outpatient back surgery not performed in a physician's office;
- Pediatric Congenital Heart Surgery;
- Pre-implantation genetic testing;
- Procedures that may be considered cosmetic. Cosmetic services and supplies are not covered under the plan unless specifically described in the Policy;
- Proton beam radiotherapy;
- Referral or use of out-of-network providers for non-emergency services, unless the covered person understands and consents to the use of an out-of-network provider under their out-of-network benefits when available in their plan;
- Spinal Procedures;
- Transplant Services;
- Uvulopalatopharyngoplasty, including laser-assisted procedures; and
- Ventricular assist devices.

*Your Plan may not include coverage for all of the services and supplies listed above. Please check your Master Policy for confirmation of which services and supplies are covered and which services and supplies are excluded under your Plan. If you cannot locate the benefit you are looking for in your Master Policy, contact Customer Service at the number listed on your ID card for further assistance.

Pre-certification DOES NOT guarantee the payment of benefits for your inpatient stays, certain tests, procedures, outpatient surgeries, therapies and equipment, and prescribed medications

Each claim is subject to medical policy review, in accordance with the exclusions and limitations contained in the Master Policy. The Master Policy also includes information regarding your eligibility criteria, notification guidelines, and benefit coverage.

Pre-certification of non-emergency admissions

Non-emergency admissions must be requested at least **fifteen (15) days** prior to the date they are scheduled to be admitted.

Pre-certification of emergency admissions

Emergency admissions must be requested within **twenty-four (24) hours** or as soon as reasonably possible after the admission.

Pre-certification of urgent admissions

Urgent admissions must be requested before you are scheduled to be admitted.

Pre-certification of outpatient non-emergency medical services

Outpatient non-emergency medical services must be requested within **fifteen (15) days** before the outpatient services, treatments, procedures, visits or supplies are provided or scheduled.

Pre-certification of prenatal care and delivery

Pre-natal care medical services must be requested as soon as possible after the attending physician confirms pregnancy. Delivery medical services, which exceed the first 48 hours after delivery for a routine delivery and 96 hours for a cesarean delivery, must be requested within twenty-four (24) hours of the birth or as soon thereafter as possible.

Description of Benefits

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

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

Metallic Level: Gold, Tested at 81.16%

<table>
<tr><th>DEDUCTIBLE</th><th>Preferred Care</th><th>Non-Preferred Care</th></tr>
<tr><td rowspan="4">The policy year deductible is waived for preferred care covered medical expenses that apply to Preventive Care Expense benefits.

In compliance with DC State Mandate(s), the Policy Year Deductible is waived for Pap Smear Screening Expense and Mammogram Expense.

In addition to state and federal requirements for waiver of the Policy Year Deductible, this Plan will waive the 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, and 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.</td><td>Students:
$300 per Policy Year

Spouse:
$300 per Policy Year

Child:
$300 per Policy Year</td><td>Students:
$3,000 per Policy Year

Spouse:
$3,000 per Policy Year

Child:
$3,000 per Policy Year</td></tr>
<tr><td colspan="2">PRESCRIBED MEDICINES EXPENSE</td></tr>
<tr><td colspan="2">Students:
$100 per Policy Year

Spouse:
$100 per Policy Year

Child:
$100 per Policy Year</td></tr>
</table>

COINSURANCE		
Coinsurance is both the percentage of covered medical expenses that the plan pays, and the percentage of covered medical expenses that you pay. The percentage that the plan pays is referred to as "plan coinsurance" or the "payment percentage," and varies by the type of expense. Please refer to the Schedule of Benefits for specific information on coinsurance amounts.	Covered Medical Expenses are payable at the plan coinsurance percentage specified below, after any applicable Deductible.	
OUT-OF-POCKET MAXIMUMS	**Preferred Care**	**Non-Preferred Care**
Once the Individual or Family Out-of-Pocket Limit has been satisfied, Covered Medical Expenses will be payable at **100%** for the remainder of the Policy Year. The following expenses do not apply toward meeting the plan's out-of-pocket limits: • Non-covered medical expenses; • Expenses that are not paid or pre-certification benefit reductions or penalties because a required pre-certification for the service(s) or supply was not obtained from Aetna.	Individual Out-of-Pocket: **$6,350** Family Out-of-Pocket: **$12,700**	Individual Out-of-Pocket: **$15,000** Family Out-of-Pocket: **$30,000**
INPATIENT HOSPITALIZATION BENEFITS	**Preferred Care**	**Non-Preferred Care**
Room and Board Expense The covered room and board expense does not include any charge in excess of the daily room and board maximum.	**80%** of the Negotiated Charge for a semi-private room	**60%** of the Recognized Charge for a semi-private room
Intensive Care The covered room and board expense does not include any charge in excess of the daily room and board maximum.	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Miscellaneous Hospital Expense Includes but not limited to: operating room, laboratory tests/X rays, oxygen tent, drugs, medicines and dressings.	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Licensed Nurse Expense Includes charges incurred by a covered person who is confined in a hospital as a resident bed patient and requires the services of a registered nurse or licensed practical nurse.	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Well Newborn Nursery Care	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Non-Surgical Physicians Expense Includes hospital charges incurred by a covered person who is confined as an inpatient in a hospital for a surgical procedure for the services of a physician who is not the physician who may have performed surgery on the covered person.	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
SURGICAL EXPENSES	**Preferred Care**	**Non-Preferred Care**
Surgical Expense (Inpatient and Outpatient) When injury or sickness requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, covered medical expenses only include expenses incurred for the most expensive procedure.	**80%** of the Negotiated Charge	**60%** of the Recognized Charge

SURGICAL EXPENSES (continued)	Preferred Care	Non-Preferred Care
Anesthesia Expense (Inpatient and Outpatient) If, in connection with such operation, the covered person requires the services of an anesthetist who is not employed or retained by the hospital in which the operation is performed, the expenses incurred will be Covered Medical Expenses.	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Assistant Surgeon Expense (Inpatient and Outpatient)	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
OUTPATIENT EXPENSES	**Preferred Care**	**Non-Preferred Care**
Physician or Specialist Office Visit Expense Includes the charges made by the physician or specialist if a covered person requires the services of a physician or specialist in the physician's or specialist's office while not confined as an inpatient in a hospital. Includes second surgical opinion visits. Includes coverage for Telehealth Services. "Telehealth" means the delivery of healthcare services through the use of interactive audio, video, or other electronic media used for the purpose of diagnosis, consultation, or treatment. Services delivered through audio-only telephones, e-mail or fax transmissions are not included in this definition.	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Laboratory and X-ray Expense	**80%** of the Negotiated Charge*	**60%** of the Recognized Charge
Hospital Outpatient Department Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Therapy Expense Covered medical expenses include charges incurred by a covered person for the following types of therapy provided on an outpatient basis: • Radiation therapy; • Inhalation therapy; • Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy; • Kidney dialysis; and • Respiratory therapy. Orally administered anticancer drugs prescribed to kill or slow the growth of cancerous cells will be payable on the same basis as chemotherapy that is administered intravenously or by injection.	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Pre-Admission Testing Expense Includes charges incurred by a covered person for pre-admission testing charges made by a hospital, surgery center, licensed diagnostic lab facility, or physician, in its own behalf, to test a person while an outpatient before scheduled surgery.	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Ambulatory Surgical Expense Covered medical expenses include expenses incurred by a covered person for outpatient surgery performed in an ambulatory surgical center. Covered medical expenses must be incurred on the day of the surgery or within **24** hours after the surgery.	**80%** of the Negotiated Charge	**60%** of the Recognized Charge

OUTPATIENT EXPENSES (continued)	Preferred Care	Non-Preferred Care
Walk-in Clinic Visit Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Emergency Room Expense Covered medical expenses incurred by a covered person for services received in the emergency room of a hospital while the covered person is not a full-time inpatient of the hospital. The treatment received must be emergency care for an emergency medical condition. There is no coverage for elective treatment, routine care or care for a non-emergency sickness. As to emergency care incurred for the treatment of an emergency medical condition or psychiatric condition, any referral requirement will not apply & any expenses incurred for non-preferred care will be paid at the same cost-sharing level as if they had been incurred for preferred care. **Important Notice:** A separate hospital emergency room visit benefit deductible or copay applies for each visit to an emergency room for emergency care. If a covered person is admitted to a hospital as an inpatient immediately following a visit to an emergency room, the emergency room visit benefit deductible or copay is waived. Covered medical expenses that are applied to the emergency room visit benefit deductible or copay cannot be applied to any other benefit deductible or copay under the plan. Likewise, covered medical expenses that are applied to any of the plan's other benefit deductibles or copays cannot be applied to the emergency room visit benefit deductible or copay. Separate benefit deductibles or copays may apply for certain services rendered in the emergency room that are not included in the hospital emergency room visit benefit. These benefit deductibles or copays may be different from the hospital emergency room visit benefit deductible or copay, and will be based on the specific service rendered. Similarly, services rendered in the emergency room that are not included in the hospital emergency room visit benefit may be subject to coinsurance rates that are different from the coinsurance rate applicable to the hospital emergency room visit benefit. Important Note: Please note that Non-Preferred Care Providers do not have a contract with Aetna. The provider may not accept payment of your cost share (your deductible and coinsurance) as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. Please send Aetna the bill at the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.	After a **$100** Copay per visit (waived if admitted), **80%** of the Negotiated Charge	After a **$100** per visit Deductible (waived if admitted), **80%** of the Recognized Charge

OUTPATIENT EXPENSES (continued)	Preferred Care	Non-Preferred Care
Durable Medical and Surgical Equipment Expense Durable medical and surgical equipment would include: • Artificial arms and legs; including accessories; • Arm, back, neck braces, leg braces; including attached shoes (but not corrective shoes); • Surgical supports; • Scalp hair prostheses required as the result of hair loss due to injury; sickness; or treatment of sickness; and • Head halters.	**80%** of the Negotiated Charge	**80%** of the Recognized Charge
PREVENTIVE CARE EXPENSES Preventive Care is services provided for a reason other than to diagnose or treat a suspected or identified sickness or injury and rendered in accordance with the guidelines provided by the following agencies: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force uspreventiveservicestaskforce.org. • Services as recommended in the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents http://brightfutures.aap.org/. • For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration http://www.hrsa.gov/index.html.		
Routine Physical Exam Includes routine vision & hearing screenings given as part of the routine physical exam.	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Preventive Care Immunizations	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Preventive Health Care Services Expense Even though the charges are not incurred in connection with treatment of a sickness or injury, the plan will pay for the preventive health care services listed below for physicians and laboratory services. Children who are residents of the District of Columbia, wards of the District and have special needs shall be covered for benefits until age **21**. All other dependent children are covered from birth through age **21**. Covered medical expenses will only include charges incurred for: • An exam performed at birth; • All exams performed during the first **12** years of the child's life; • **3** exams performed during each year of life thereafter up to age **21.**	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Well Woman Preventive Visits Routine well woman preventive exam office visit, including Pap smears.	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Sexually Transmitted Infections Includes the counseling services to help a covered person prevent or reduce sexually transmitted infections.	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge

PREVENTIVE CARE EXPENSES (continued)	Preferred Care	Non-Preferred Care
Preventive Care Screening and Counseling Services for Obesity and/or Healthy Diet Screening and counseling services to aid in weight reduction due to obesity. Coverage includes: • Preventive counseling visits and/or risk factor reduction intervention; • Nutritional counseling; and • Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Misuse of Alcohol and/or Drugs Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Use of Tobacco Products Screening and counseling services to aid a covered person to stop the use of tobacco products. Coverage includes: • Preventive counseling visits; • Treatment visits; and • Class visits; to aid a covered person to stop the use of tobacco products.	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Use of Tobacco Products (continued) Tobacco product means a substance containing tobacco or nicotine including: • Cigarettes; • Cigars; • Smoking tobacco; • Snuff; • Smokeless tobacco; and • Candy-like products that contain tobacco.	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Depression Screening Screening or test to determine if depression is present.	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Preventive Care Routine Cancer Screenings Covered expenses include but are not limited to: Pap smears; Mammograms	**100%** of the Negotiated Charge*	**100%** of the Recognized Charge*
Preventive Care Routine Cancer Screenings Covered expenses include but are not limited to: Fecal occult blood tests; Digital rectal exams; Prostate specific antigen (PSA) tests; Sigmoidoscopies; Double contrast barium enemas (DCBE); Colonoscopies (anesthesia and the removal of polyps performed during a screening procedure are **covered medical expenses**); and Lung cancer screenings.	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge

PREVENTIVE CARE EXPENSES (continued)	Preferred Care	Non-Preferred Care
Preventive Care Screening and Counseling Services for Genetic Risk for Breast and Ovarian Cancer Covered medical expenses include the counseling and evaluation services to help assess a covered person's risk of breast and ovarian cancer susceptibility.	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Preventive Care Prenatal Care Coverage for prenatal care under this Preventive Care Expense benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check, and fundal height). Refer to the Maternity Expense benefit for more information on coverage for maternity expenses under the Policy, including other prenatal care, delivery and postnatal care office visits.	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Preventive Care Lactation Counseling Services Lactation support and lactation counseling services are covered medical expenses when provided in either a group or individual setting.	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Preventive Care Breast Pumps and Supplies	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge
Preventive Care Female Contraceptive Counseling Services, Preventive Care Female Contraceptive Generic, Brand Name, Biosimilar Prescription Drugs and Devices provided, administered, or removed, by a Physician during an Office Visit, Preventive Care Female Voluntary Sterilization (Inpatient), Preventive Care Female Voluntary Sterilization (Outpatient) Includes counseling services on contraceptive methods provided by a physician, obstetrician or gynecologist. Such counseling services are covered medical expenses when provided in either a group or individual setting. **Voluntary Sterilization** Includes charges billed separately by the provider for female voluntary sterilization procedures & related services & supplies including, but not limited to, tubal ligation and sterilization implants. Covered medical expenses under this benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement. **Contraceptives** can be paid either under this benefit or the prescribed medicines expense depending on the type of expense and how and where the expense is incurred. Benefits are paid under this benefit for female contraceptive prescription drugs and devices (including any related services and supplies) when they are provided, administered, or removed, by a physician during an office visit.	**100%** of the Negotiated Charge*	**60%** of the Recognized Charge

OTHER FAMILY PLANNING SERVICES EXPENSE	Preferred Care	Non-Preferred Care
Voluntary Termination of Pregnancy (Outpatient) Covered medical expenses include charges for certain family planning services, even though not provided to treat a sickness or injury as follows. • Voluntary termination of pregnancy	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
AMBULANCE EXPENSE	**Preferred Care**	**Non-Preferred Care**
Ground, Air, Water and Non-Emergency Ambulance Includes charges incurred by a covered person for the use of a professional ambulance in an emergency. Covered medical expenses for the service are limited to charges for ground transportation to the nearest hospital equipped to render treatment for the condition. Air transportation is covered only when medically necessary.	**100%** of the Negotiated Charge	**100%** of the Recognized Charge
ADDITIONAL BENEFITS	**Preferred Care**	**Non-Preferred Care**
Allergy Testing and Treatment Expense Includes charges incurred by a covered person for diagnostic testing and treatment of allergies and immunology services.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Diagnostic Testing For Learning Disabilities Expense Covered medical expenses include charges incurred by a covered person for diagnostic testing for: • Attention deficit disorder; or • Attention deficit hyperactive disorder.	Payable in accordance with the type of expense incurred and the place where service is provided.	
High Cost Procedures Expense Includes charges incurred by a covered person as a result of certain high cost procedures provided on an outpatient basis. Covered medical expenses for high cost procedures include; but are not limited to; charges for the following procedures and services: • Computerized Axial Tomography (C.A.T.) scans; • Magnetic Resonance Imaging (MRI); and • Positron Emission Tomography (PET) Scans.	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Urgent Care Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Dental Expense for Impacted Wisdom Teeth Includes charges incurred by a covered person for services of a dentist or dental surgeon for medically necessary removal of one or more impacted wisdom teeth. Includes expenses for the treatment of: the mouth; teeth; and jaws; but only those for services rendered and supplies needed for the following treatment of; or related to conditions; of the: • mouth; jaws; jaw joints; or • supporting tissues; (this includes: bones; muscles; and nerves).	**100%** of the Negotiated Charge	**100%** of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Accidental Injury to Sound Natural Teeth Expense Covered medical expenses include charges incurred by a covered person for services of a dentist or dental surgeon as a result of an injury to sound natural teeth.	**100%** of the Negotiated Charge	**100%** of the Recognized Charge
Non-Elective Second Surgical Opinion Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Consultant Expense Includes the charges incurred by covered person in connection with the services of a consultant. The services must be requested by the attending physician to confirm or determine a diagnosis. Coverage may be extended to include treatment by the consultant.	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Skilled Nursing Facility Expense	**80%** of the Negotiated Charge for a semi-private room	**60%** of the Recognized Charge for a semi-private room
Rehabilitation Facility Expense Includes charges incurred by a covered person for confinement as a full time inpatient in a rehabilitation facility.	**80%** of the Negotiated Charge for a semi-private room	**60%** of the Recognized Charge for a semi-private room
Home Health Care Expense Covered medical expenses **will not** include: • Services by a person who resides in the covered person's home, or is a member of the covered person's immediate family • Homemaker or housekeeper services; • Maintenance therapy; • Dialysis treatment; • Purchase or rental of dialysis equipment; • Food or home delivered services; or • Custodial care.	**80%** of the Negotiated Charge	**80%** of the Recognized Charge
Temporomandibular Joint Dysfunction Expense Covered medical expenses include physician's charges incurred by a covered person for treatment of Temporomandibular Joint (TMJ) Dysfunction.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Dermatological Expense Includes physician's charges incurred by a covered person for the diagnosis and treatment of skin disorders. Related laboratory expenses are covered under the Lab and X-ray Expense benefit. Unless specified above, not covered under this benefit are charges incurred for: • Treatment for acne; • Cosmetic treatment and procedures; and Laboratory fees.	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Prosthetic Devices Expense Includes charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by sickness, injury or congenital defect. Covered medical expenses also include instruction and incidental supplies needed to use a covered prosthetic device. The plan covers the first prosthesis a covered person need that temporarily or permanently replaces all or part of an body part lost or impaired as a result of sickness or injury or congenital defects as described in the list of covered devices below for an: • Internal body part or organ; or • External body part. **Limitations** Unless specified above, not covered under this benefit are charges for: • Eye exams; • Eyeglasses; • Vision aids; • Hearing aids; • Communication aids.	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Podiatric Expense Includes charges incurred by a covered person for podiatric services; provided on an outpatient basis following an injury. Unless specified above, not covered under this benefit are charges incurred for routine foot care, such as trimming of corns, calluses, and nails.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Hypodermic Needles Expense Includes expenses incurred by a covered person for hypodermic needles and syringes.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Maternity Expense Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other Sickness. In the event of an inpatient confinement, such benefits would be payable for inpatient care of the Covered Person, and any newborn child, for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother and done in accordance with the rules and regulations promulgated by State Mandate. Covered medical expenses may include home visits, parent education, and assistance and training in breast or bottle-feeding.	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Non-Prescription Enteral Formula Expense Includes charges incurred by a covered person, for non-prescription enteral formulas for which a physician has issued a written order, and are for the treatment of malabsorption caused by: • Crohn's Disease; • Ulcerative colitis; • Gastroesophageal reflux; • Gastrointestinal motility; • Chronic intestinal pseudo obstruction; and • Inherited diseases of amino acids and organic acids. Covered medical expenses for inherited diseases of amino acids; and organic acids; will also include food products modified to be low protein.	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Acupuncture in Lieu of Anesthesia Expense Includes charges incurred by a covered person for acupuncture therapy when acupuncture is used in lieu of other anesthesia for a surgical or dental procedure covered under this Plan. The acupuncture must be administered by a health care provider who is a legally qualified physician; practicing within the scope of their license.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Transfusion or Kidney Dialysis of Blood Expense Includes charges incurred by a covered person for the transfusion or kidney dialysis of blood, including the cost of: Whole blood; blood components; and the administration of whole blood and blood components.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Hospice Expense	**80%** of the Negotiated Charge for a semi-private room	**60%** of the Recognized Charge for a semi-private room
Habilitative Services for the Treatment of Congenital or Genetic Birth Defects Congenital or genetic birth defects are defects existing at or from birth, including a hereditary defect. The term "congenital or genetic birth defect" includes: • Autism or an Autism Spectrum Disorder; and • Cerebral palsy.	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Habilitative Services for the Treatment of Congenital or Genetic Birth Defects (continued) Except for habilitative services provided in early intervention or school programs, covered medical expenses include: • The treatment of congenital or genetic birth defects to enhance a child's ability to function; • Occupational therapy, physical therapy and speech therapy; and • Health care services that help a covered person keep, learn or improve skills and functioning for or daily living, including, but not limited, to applied behavioral analysis (ABA) for the treatment of Autism Spectrum Disorder. Applied behavioral analysis is an educational service that is the process of applying interventions: • That systematically change behavior; and • That are responsible for the observable improvement in behavior.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Blood and Blood Products Covered expenses include charges made for blood, blood products and the administration of blood and blood products.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Emergency Department HIV Screening and Testing Covered medical expenses include the cost of voluntary HIV screening tests performed while receiving emergency medical services, other than HIV screening, in a hospital emergency room, including: • one annual HIV screening performed in a hospital emergency room. • reimbursement of the costs of administering such a test, all laboratory expenses to analyze the test, and the costs of communicating to the patient the results of the test and any applicable follow-up instructions for obtaining health care and • supportive services; and • This coverage shall not be subject to any annual or coinsurance deductible or any co-payment other than the co-payment that the insured would have to pay for the applicable hospital emergency department visit.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Blood and Body Fluid Exposure/Needle Stick Coverage Expense Limited to those charges related to a clinical related injury. Any expense related to the treatment of any sickness resulting from a clinical related injury is not covered under this benefit. Incidents include, but are not limited to needle sticks, unprotected exposure to blood and body fluid, and unprotected exposure to highly contagious pathogens.	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Diabetes Benefit Expense Includes charges for services, supplies, equipment, & training for the treatment of insulin and non-insulin dependent diabetes &elevated blood glucose levels during pregnancy. Self-management training provided by a licensed health care provider certified in diabetes self-management training.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Reconstructive Breast Surgery Expense Covered medical expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Autism Spectrum Disorder Expense Includes charges incurred for services and supplies required for the diagnosis & treatment of autism spectrum disorder when ordered by a physician or behavioral health provider as part of a treatment plan.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Basic Infertility Expense Covered medical expenses include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Clinical Trials Expense (Experimental or Investigational Treatment) Includes charges made by a provider for experimental or investigational drugs, devices, treatments or procedures “under an approved clinical trial” only when a covered person has cancer or a terminal illness.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Clinical Trials Expense Routine Patient Costs Covered Percentage Includes charges made by a provider for "routine patient costs" furnished in connection with a covered person’s participation in an "approved clinical trial” for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Gender Dysphoria Including Gender Treatment (Sex Change) Treatment Expense Covered medical expenses include charges made in connection with a medically necessary gender reassignment surgery (sometimes called sex change surgery) as long the covered student or their covered dependent has obtained pre-certification from Aetna. Covered medical expenses include: • Charges made by a physician for: o Performing the surgical procedure; and o Pre-operative and post-operative hospital and office visits.	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Gender Dysphoria Including Gender Treatment (Sex Change) Treatment Expense (continued) • Charges made by a hospital for inpatient and outpatient services (including outpatient surgery). Room and board charges in excess of the hospital's semi-private rate will not be covered unless a private room is ordered by the covered student's or covered dependent's physician and pre-certification has been obtained. • Charges made by a Skilled Nursing Facility for inpatient services and supplies. Daily room and board charges over the semi-private rate will not be covered. • Charges made for the administration of anesthetics. • Charges for outpatient diagnostic laboratory and x-rays. • Charges for blood transfusion and the cost of unreplaced blood and blood products. Also included are the charges for the administration of blood and blood products, collecting, processing and storage of self-donated blood after the surgery has been scheduled. • Charges made by a behavioral health provider for gender reassignment counseling. • Charges incurred for injectable and non-injectable hormone replacement therapy.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Chiropractic Treatment Expense Includes charges made by a physician on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
SHORT-TERM CARDIAC AND PULMONARY REHABILITATION THERAPY SERVICES EXPENSE Inpatient rehabilitation benefits for the services listed will be paid as part of the Hospital Expense and Skilled Nursing Facility Expense benefits. Cardiac Rehabilitation Benefits • Cardiac rehabilitation benefits received at a hospital, skilled nursing facility, or physician's office. This Plan will cover charges in accordance with a treatment plan as determined by a covered person's risk level when recommended by a physician. Pulmonary Rehabilitation Benefits • Pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states.		
Cardiac Rehabilitation	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Pulmonary Rehabilitation	**80%** of the Negotiated Charge	**60%** of the Recognized Charge

SHORT-TERM REHABILITATION SERVICES EXPENSE

Includes charges for short-term rehabilitation services, as described below, when prescribed by a physician. Short-term rehabilitation services must follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration;
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate; and
- Allows therapy services, provided in a covered person's home, if the covered person is homebound.

Inpatient rehabilitation benefits for the services listed will be paid as part of the inpatient hospital and skilled nursing facility benefits.

	Preferred Care	Non-Preferred Care
Short-Term Rehabilitation Services Expense Outpatient Cognitive, Physical, Occupational and Speech Rehabilitation and Habilitation Therapy Services (combined)	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
HEARING AIDS	**Preferred Care**	**Non-Preferred Care**
Cochlear Implants	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
TREATMENT OF MENTAL DISORDER EXPENSE	**Preferred Care**	**Non-Preferred Care**
Inpatient Mental Health Expense & Residential Mental Health Treatment Facility Expense Covered medical expenses include charges made by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider for the treatment of mental disorders for Inpatient room and board at the semi-private room rate, and other services and supplies related to a covered person's condition that are provided during a covered person's stay in a hospital, psychiatric hospital, or residential treatment facility.	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Inpatient Mental Health Physician Services per Admission Expense & Residential Mental Health Treatment Physician Services Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Outpatient Mental Health Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Outpatient Mental Health Partial Hospitalization Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
ALCOHOLISM AND DRUG ADDICTION TREATMENT	**Preferred Care**	**Non-Preferred Care**
Inpatient Substance Abuse Treatment Residential Treatment Facility Expense Covered medical expenses include charges made by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider for the treatment of mental disorders for Inpatient room and board at the semi-private room rate, and other services and supplies related to a covered person's condition that are provided during a covered person's stay in a hospital, psychiatric hospital, or residential treatment facility.	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Inpatient Substance Abuse Physician Services per Admission Expense & Residential Mental Health Treatment Physician Services Expense	**80%** of the Negotiated Charge	**60%** of the Recognized Charge
Outpatient Substance Abuse Treatment	**80%** of the Negotiated Charge	**60%** of the Recognized Charge

TRANSPLANT SERVICE EXPENSE	Preferred Care	Non-Preferred Care
Transplant Services Expense Benefits may vary if an Institute of Excellence™ (IOE) facility or non-IOE or non-preferred care provider is used. Through the IOE network, the covered person will have access to a provider network that specializes in transplants. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure the covered person requires. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Transplant Travel and Lodging Expense The plan will reimburse a covered person for some of the cost of their travel and lodging expenses. Benefit maximum of **$10,000** per transplant.	**$50** per night Maximum Benefit for Lodging Expenses per IOE patient & **$50** per night Maximum Benefit for Lodging Expenses per companion up to **$10,000** per transplant.	
PEDIATRIC DENTAL SERVICES EXPENSE **(Coverage is limited to covered persons until the end of the month in which the covered person turns 19.)**	**Preferred Care**	**Non-Preferred Care**
Type A Expense (Pediatric Routine Dental Exam Expense)	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Type B Expense (Pediatric Basic Dental Care Expense)	**70%** of the Negotiated Charge*	**50%** of the Recognized Charge
Type C Expense (Pediatric Major Dental Care Expense)	**50%** of the Negotiated Charge*	**50%** of the Recognized Charge
Pediatric Orthodontia Expense Orthodontics Medically necessary comprehensive treatment • Replacement of retainer (limit one per lifetime).	**50%** of the Negotiated Charge*	**50%** of the Recognized Charge
PEDIATRIC ROUTINE VISION **(Coverage is limited to covered persons until the end of the month in which the covered person turns 19.)**	**Preferred Care**	**Non-Preferred Care**
Pediatric Routine Vision Exams (including refractions) Includes charges made by a legally qualified ophthalmologist or optometrist for a routine vision exam. The exam will include refraction & glaucoma testing. Benefits limited to **1** exam per policy year.	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge*

PEDIATRIC ROUTINE VISION (Coverage is limited to covered persons until the end of the month in which the covered person turns 19.) (continued)	Preferred Care	Non-Preferred Care
Pediatric Visit for the fitting of prescription contact lenses, Pediatric Eyeglass Frames, Prescription Lenses or Prescription Contact Lenses Includes charges for the following vision care services and supplies: • Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses. • Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a preferred care provider. Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a non-preferred care provider. Coverage includes charges incurred for: • Non-conventional prescription contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses. Aphakic prescription lenses prescribed after cataract surgery has been performed. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge*

***Annual Deductible does not apply to these services**

PRESCRIBED MEDICINES EXPENSE

COVERED PERCENTAGE*	Preferred Care	Non-Preferred Care
Preventive Care Drugs and Supplements **Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.**		
Risk Reducing Breast Cancer Prescription Drugs For each **30**-day supply filled at a retail pharmacy.	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits	**60%** of the Recognized Charge
Other preventive care drugs and supplements For each **30**-day supply filled at a retail pharmacy.	**100%** per supply	**60%** of the Recognized Charge
Tobacco Cessation Prescription Drugs and Over-the-Counter Drugs. (for two **90**-day treatment regimens only)	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits	**60%** of the Recognized Charge
CONTRACEPTIVES	**Preferred Care**	**Non-Preferred Care**
For each **30**-day supply filled at a retail pharmacy.	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits	**60%** of the Recognized Charge
FDA-Approved Female Generic Over-the-Counter Contraceptives (Non-Emergency) For each **30**-day Supply	**100%** per supply No copay or deductible applies.	**60%** of the recognized charge after policy year deductible
FDA-Approved Female Generic Emergency Contraceptives	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits
ALL OTHER PRESCRIPTION DRUGS	**Preferred Care**	**Non-Preferred Care**
For each **30**-day supply filled at a retail pharmacy.	**100%** of the Negotiated Charge	**60%** of the Recognized Charge

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

PER PRESCRIPTION COPAY/DEDUCTIBLE

GENERIC PRESCRIPTION DRUGS	Preferred Care	Non-Preferred Care
For each **30**-day supply filled at a retail pharmacy.	**$25** Copay per supply after the policy year deductible	**40%** Deductible per supply after the policy year deductible
For all fills of at least a **30**-day supply and up to a **90**-day supply filled at a mail order pharmacy.	Copay per supply of 2 times the initial **30**-day copay per supply after the policy year deductible	Copay per supply of 2 times the initial **30**-day copay per supply after the policy year deductible

PREFERRED BRAND-NAME PRESCRIPTION DRUGS	Preferred Care	Non-Preferred Care
For each **30**-day supply filled at a retail pharmacy.	**$35** Copay per supply after the policy year deductible	**40%** Deductible per supply after the policy year deductible
For all fills of at least a **30**-day supply and up to a **90**-day supply filled at a mail order pharmacy.	Copay per supply of 2 times the initial **30**-day copay per supply after the policy year deductible	Copay per supply of 2 times the initial **30**-day copay per supply after the policy year deductible
NON-PREFERRED BRAND-NAME PRESCRIPTION DRUGS	**Preferred Care**	**Non-Preferred Care**
For each **30**-day supply filled at a retail pharmacy.	**$50** Copay per supply after the policy year deductible	**40%** Deductible per supply after the policy year deductible
For all fills of at least a **30**-day supply and up to a **90**-day supply filled at a mail order pharmacy.	Copay per supply of 2 times the initial **30**-day copay per supply after the policy year deductible	Copay per supply of 2 times the initial **30**-day copay per supply after the policy year deductible
Orally Administered Anti-Cancer Prescription Drugs (including Chemotherapy Drugs)	Payable on the same basis as covered cancer chemotherapy medications that are administered intravenously or by injection.	

Copay and Deductible Waiver

Waiver for Risk-Reducing Breast Cancer Prescription Drugs

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

Waiver for Prescription Drug Contraceptives

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

- Female contraceptives that are:
  - Oral prescription drugs that are generic prescription drugs.
  - Injectable prescription drugs that are generic prescription drugs.
  - Vaginal ring prescription drugs that are generic prescription drugs, brand-name prescription drugs and biosimilar prescription drugs.
  - Transdermal contraceptive patch prescription drugs that are generic prescription drugs, brand-name prescription drugs, and biosimilar prescription drugs.
- Female contraceptive devices.

- FDA-approved female:
    - generic emergency contraceptives; and
    - generic over-the-counter (OTC) emergency contraceptives.

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

- When the contraceptive methods listed above are obtained at a non-preferred pharmacy.
- To female contraceptives that are:
    - Oral prescription drugs that are brand-name prescription drugs and biosimilar prescription drugs.
    - Injectable prescription drugs that are brand-name prescription drugs and biosimilar prescription drugs.

To female contraceptive devices that are brand-name devices.

- To FDA-approved female:
    - brand-name and biosimilar emergency contraceptives; and
    - brand-name over-the-counter (OTC) emergency contraceptives.
- To FDA-approved female brand-name over-the-counter (OTC) contraceptives
- To FDA-approved male brand-name over-the-counter (OTC) contraceptives.

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

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

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

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

Aetna will make a coverage determination within 24 hours after receipt of the request and will notify the covered person, the covered person’s designee or the covered person’s prescriber of Aetna’s decision.”

Exclusions

This Plan does not cover nor provide benefits for:

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

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

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

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

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

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

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

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

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

10. For reconstructive breast surgery following a mastectomy, including (1) all stages of reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas, in a manner determined by the attending physician and patient to be appropriate.

11. Expense covered by any other valid and collectible medical; health or accident insurance to the extent that benefits are payable under other valid and collectible insurance whether or not a claim is made for such benefits.

12. Expense incurred as a result of commission of a felony.

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

14. Expense incurred for services normally provided without charge by the school and covered by the school fee for services.

15. Expense incurred for any services rendered by a member of the covered person's immediate family or a person who lives in the covered person's home.

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

17. Expense incurred for the male or female reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.

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

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

20. Expense incurred for custodial care.

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

22. Expenses incurred for blood or blood plasma; except charges made by a hospital for the processing or administration of blood.

23. Expense incurred for, or in connection with, drugs, devices, procedures, or treatments that are, as determined by Aetna to be, experimental or investigational except as specifically covered under the Policy or as mandated by the laws of the District of Columbia.

24. Expenses incurred for gastric bypass; and any restrictive procedures; for weight loss except screening and counseling services specifically covered under the Policy.

25. Expenses incurred for breast reduction/mammoplasty except as mandated by the laws of the District of Columbia.

26. Expenses incurred for gynecomastia (male breasts).

27. Expenses incurred for any sinus surgery; except for acute purulent sinusitis.

28. Expense incurred by a covered person; not a United States citizen; for services performed within the covered person’s home country; if the covered person’s home country has a socialized medicine program.

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

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

31. Expense for: (a) care of flat feet; (b) supportive devices for the foot; (c) care of corns; bunions; or calluses; (d) care of toenails; and (e) care of fallen arches; weak feet; or chronic foot strain; except that (c) and (d) are not excluded when medically necessary; because the covered person is diabetic; or suffers from circulatory problems.

32. Expense for injuries sustained as the result of a motor vehicle accident; to the extent that benefits are payable under other valid and collectible insurance; whether or not claim is made for such benefits. The Policy will only pay for those losses; which are not payable under the automobile medical payment insurance Policy.

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

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

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

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

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

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

39. Expense for services or supplies provided for the treatment of obesity and/or weight control except screening and counseling services as specifically covered under the Policy. Not covered is any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions, including but not limited to:
    - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery;
    - surgical procedures, medical treatments, weight control/loss programs and other services and supplies that are 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 or food supplements, appetite suppressants and other medications;
    - Counseling, coaching, training, hypnosis, or other forms of therapy; and
    - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy, or other forms of activity or activity enhancement.

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

41. Expense incurred for foot orthotics; orthopedic shoes; or supportive devices of the feet, unless when medically necessary; because the covered person is diabetic; or suffers from circulatory problems.

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

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

44. Expenses incurred for massage therapy.

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

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

47. Expense incurred for routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically covered in the Policy.

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

49. Expenses incurred for vision-related services and supplies, except as specifically covered in the Policy. In addition, the plan does not cover:
    - Special supplies such as non-prescription sunglasses;
    - Vision service or supply which does not meet professionally accepted standards;
    - Special vision procedures, such as orthoptics or vision training;
    - Eye exams during a stay in a hospital or other facility for health care;
    - 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; and
    - Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
    - Services to treat errors of refraction.

50. Expense incurred for private duty nursing services during a stay in a hospital, and outpatient private duty nursing services. Skilled nursing services are covered as specifically described in the Policy in accordance with a home health care plan approved by Aetna.

51. Expense incurred for preferred care charges in excess of the negotiated charge.

52. Expense incurred for behavioral health services for the following categories (or equivalent terms as listed in the most recent version of the International Classification of Diseases (ICD)) except as specifically covered in the Policy or as mandated by the laws of the District of Columbia:
    - Dementias and amnesias without behavioral disturbances;
    - Tobacco use disorders;
    - Specific disorders of sleep;
    - Antisocial or dissocial personality disorder;
    - Pathological gambling, kleptomania, pyromania;
    - Specific delays in development (learning disorders, academic underachievement); and
    - Mental retardation.

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

54. Expense incurred for early intensive behavioral interventions (including Applied Behavior Analysis, Denver, LEAP, TEACHH, Rutgers, floor time, Lovaas and similar programs) except as specifically covered in the Policy or as mandated by the laws of the District of Columbia.

55. 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).

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

57. Expense incurred for educational services:
    - Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
    - Evaluation or treatment of learning disabilities, attention deficit disorder, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and
    - Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills
    - Services eligible under the Individuals with Disabilities in Education Act (IDEA).

58. Expenses incurred for food items except as specifically covered under the Policy: Any food item, including infant formulas, nutritional supplements, vitamins, including prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.

59. Expense incurred in relation to genetics: Except as specifically covered in the Policy, the plan does not cover 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.

60. Expense incurred for any treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth, including surgical procedures, devices to stimulate growth, and growth hormones except as specifically covered in the Policy.

61. Expense incurred for outpatient cognitive therapy, physical therapy, and occupational therapy, except as specifically covered in the Policy. Not covered under the Policy are charges for:
    - Educational services;
    - Any services unless provided in accordance with a specific treatment plan;
    - Any services which are covered medical expenses in whole or in part under any other group plan sponsored by an employer;
    - Services provided during a stay in a hospital, skilled nursing facility or hospice facility except as specifically covered in Policy section;
    - Services provided by a home health care agency;
    - Services provided by a physician or treatment covered as part of Chiropractic Treatment. This applies whether or not benefits have been paid under the Chiropractic Treatment benefit;
    - Services not performed by a physician, occupational or physical therapist or under the direct supervision of a physician;
    - Services provided by a physician or physical or occupational therapist who resides in your home; or who is a member of your family, or a member of your spouse's, domestic partner's, legal partner's or civil union partner's family; and
    - Special education to instruct a person to function. This includes lessons in sign language.

62. Expense incurred for outpatient speech therapy. Except as specifically covered in the Policy, not covered are charges for:
    - Any services unless provided in accordance with a specific treatment plan;
    - Services provided during a stay in a hospital, skilled nursing facility or hospice facility except as specifically covered in the Policy;
    - Services provided by a home health care agency;
    - Services not performed by a physician, or speech therapist or under the direct supervision of a physician;
    - Services provided by a physician or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's or your domestic partner's family; and

- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

63. Expense incurred for therapies and tests: Any of the following treatments or procedures including but not limited to:
    - Aromatherapy;
    - Bio-feedback and bioenergetic therapy;
    - Carbon dioxide therapy;
    - Chelation therapy (except for heavy metal poisoning);
    - Computer-aided tomography (CAT) scanning of the entire body;
    - Early intensive behavioral interventions (including Applied Behavior Analysis, Denver, LEAP, TEACHH, Rutgers programs) except as specifically covered in the What the Medical Plan Covers Section;
    - Educational therapy;
    - Gastric irrigation;
    - Hair analysis;
    - Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
    - Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery;
    - Lovaas therapy;
    - Massage therapy;
    - Megavitamin therapy;
    - Primal therapy;
    - Psychodrama;
    - Purging;
    - Recreational therapy;
    - Rolfing;
    - Sensory or auditory integration therapy;
    - Sleep therapy;
    - Thermograms and thermography.

Additional Pediatric Dental Services Exclusions and Limitations

The Pediatric Dental Services benefit is subject to the following additional exclusions and limitations:

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

65. Expenses incurred for cosmetic services and supplies including plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve alter or enhance appearance, augmentation and vestibuloplasty, and other substances to protect, clean, whiten bleach or alter the appearance of teeth; whether or not for psychological or emotional reasons; except to the extent coverage is specifically covered in the Policy. Facings on molar crowns and pontics will always be considered cosmetic.

66. Expenses incurred for crown, inlays and onlays, and veneers unless:
    - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
    - The tooth is an abutment to a covered partial denture or fixed bridge.

67. Expenses incurred for dental examinations that are:
    - Required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;

- Required by any law of a government, securing insurance or school admissions, or professional or other licenses;
- Required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
- Any special medical reports not directly related to treatment except when provided as part of a covered service.

68. Expenses incurred for dental implants, braces (that are not determined to be medically necessary), mouth guards, and other devices to protect, replace or reposition teeth and removal of implants.

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

70. Expenses incurred for dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, abfraction or erosion.

71. Expenses incurred for general anesthesia and intravenous sedation, except as specifically covered in the Policy and only when done in connection with another medically necessary covered service or supply.

72. Expenses incurred for orthodontic treatment except as specifically covered in the Policy.

73. Expenses incurred for pontics, crowns, cast or processed restorations made with high noble metals (gold or titanium).

74. Expenses incurred for replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures.

75. Expenses incurred for replacement of teeth beyond the normal complement of 32.

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

77. Expenses incurred for space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.

78. Expenses incurred for the surgical removal of impacted wisdom teeth only for orthodontic reasons.

79. Expenses incurred for treatment by other than a dentist or dental provider that is legally qualified to furnish dental services or supplies.

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

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

Notice of Non-Discrimination:

Aetna Life Insurance Company does not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation, or health status in the administration of the plan including enrollment and benefit determinations.

Sanctioned Countries:

If coverage provided by this plan 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**.