Aetna Student Health

Plan Design and Benefits Summary
Texas Christian University

Policy Year: 2015 - 2016
Policy Number: 711142

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(877) 480-4161

This is a brief description of the Student Health Plan. The Plan is available for Texas Christian University students. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions governing this insurance are contained in the Master Policy issued to the Texas Christian University and may be viewed online at **www.aetnastudenthealth.com.**

Brown-Lupton Health Center

The Brown-Lupton Health Center, (a.k.a. The TCU Health Center), is an outpatient facility providing services similar to those found in a private practitioner's office. It is staffed by M.D.'s, a Nurse Practitioner who specializes in Women's Health Care, a Physician Assistant, and nurses – both R.N.'s and L.V.N's. During the academic year hours are 8:00 a.m. to 5:00 p.m. Summer hours are 9:00a.m. to 4:30 p.m.

Aetna Student Health Insurance Coverage at Brown-Lupton Health Center

The Brown-Lupton Health Center is an on-campus facility designed to meet the various health needs of TCU students exclusively. Students will receive a greater cost-savings by utilizing the Health Center as their primary source of care. A portion of the student health insurance premium will provide the following benefits at the Health Center:

- The Plan will pay **100%** of eligible, non-prescription expenses incurred at the Health Center for the treatment of an Injury or illness.
- The deductible and Coinsurance do not apply to eligible, non-prescription expenses incurred at the Health Center.
- Non-prescription, eligible expenses are billed to Aetna Student Health by the Health Center.
- Deductibles and Coinsurance will apply on Covered Prescription Drug charges written by a Health Center Doctor and obtained from the Health Center Pharmacy.
- For more information, call the Health Services at **(817) 257-7940**. In the event of an emergency, call **911.**
- TCU Pharmacy Benefits at the Brown Lupton Health Center. Prescriptions purchased at the TCU Pharmacy may be reimbursed at 80% if the student submits a claim form and receipt to Aetna Student Health and has met the in-network deductible of $350

Contact Information
Brown-Lupton Health Center
TCU BOX 297400
Fort Worth, TX 76129
(817) 257-7940

Your Web ID Card 2015-2016

New for the 2015-2016 academic year. All ID Cards will be available on line the first week in September. Go to the TCU Health Center's website.

Coverage Periods

Students: Coverage for all insured students enrolled for coverage in the Plan for the following Coverage Periods. Coverage Periods will become effective at 12:01 AM on the Coverage Period Start Date indicated below, and will terminate at 11:59 PM on the Coverage Period End Date indicated.

Coverage Period	Coverage Start Date	Coverage End Date	Waiver Deadline
Fall	8/15/2015	1/10/2016	8/28/2015
Spring	1/11/2016	8/14/2016	1/22/2016
Summer Session I	5/09/2016	8/14/2016	5/11/2016
Summer Session II	5/31/2016	8/14/2016	6/03/2016
Summer Session III	7/05/2016	8/14/2016	7/08/2016

Rates

The rates below include both premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna), as well as Texas Christian University administrative fee. (**PLEASE NOTE:** A continuation option is not available under this plan.)

Rates
Undergraduates and Graduate Students

Coverage Period	Coverage Start Date	Coverage End Date	Rate
Fall Semester	8/15/2015	1/10/2016	**$979**
Spring Semester	1/11/2016	8/14/2016	**$979**
Summer Session I	5/09/2016	8/14/2016	**$646**
Summer Session II	5/31/2016	8/14/2016	**$646**
Summer Session III	7/05/2016	8/14/2016	**$646**

Student Coverage

Eligibility

All undergraduate students carrying nine or more semester hours are required to have health insurance either through the Texas Christian University Student Health Insurance Plan or through another individual or family Plan. Although not required for graduate students or undergraduates carrying less than nine semester hours, the Texas Christian University Student Health Insurance Plan is available for students attending credit courses by specifically enrolling in the Plan during the elect/waive period at the beginning of each semester. Students must actively attend classes for at least the **first 31 days** after the date for which coverage is purchased.

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.

Waiver Process/Procedure

Undergraduate students registered for nine or more semester hours who have adequate (coverage comparable to the Student Health Insurance Plan offered through TCU) health insurance coverage which will remain in effect throughout the 2015/2016 academic year and who do not choose to participate in the University's Student Health Insurance Plan MUST file a Waiver with the University. Participation in the University-sponsored Student Health Insurance Plan can be waived online at **http://healthcenter.tcu.edu** once the student has registered for classes. The deadline for waiving participation in the Student Health Insurance Plan for the Fall Semester is **August 28, 2015**. If the waiver information has not been entered online by the deadline, the student will be automatically enrolled in the University's Student Health Insurance Plan and the charge of **$979** for health insurance will be posted to the student's account.

Semester	Waiver Deadline Date
Fall 2015	August 28, 2015
Spring 2016	January 22, 2016

Waiver submissions may be audited by Texas Christian 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.

Voluntary Enrollment Option: Graduate Students and Part-Time Undergraduate Students

All Graduate and Undergraduate Students with less than 9 hours may elect to self-enroll into the Plan by the dates below.

Semester	Voluntary Enrollment Deadline
Fall 2015	August 28, 2015
Spring 2016	January 22, 2016

Exception: A Covered Person entering the armed forces of any country will not be covered under the Policy as of the date of such entry. A pro rata refund of premium will be made for such person upon written request received by Aetna within 90 days of withdrawal from school.

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.

Texas Department of Insurance Notice

You have the right to an adequate network of preferred providers. If you believe that the network is inadequate, you may file a complaint with the Texas Department of Insurance.

If you obtain out-of-network services because no preferred provider was reasonably available, you may be entitled to have the claim paid at the in- network coinsurance rate and your out-of-pocket expenses counted toward your in-network, out-of-network, or general out-of-pocket maximum, as appropriate.

You have the right to obtain advance estimates: of the amounts that the providers may bill for projected services, from your out-of-network provider, and of the amounts that the insurer may pay for the projected services, from your insurer.

You may obtain a current directory of preferred providers at the following website: **www.aetnastudenthealth.com** or by calling **1-877-480-4161** for assistance in finding available preferred providers. If the directory is materially inaccurate, you may be entitled to have an out-of-network claim paid at the in-network level of benefits.

If you are treated by a provider or hospital that is not contracted with your insurer, you may be billed for anything not paid by the insurer.

If the amount you owe to an out-of-network hospital-based radiologist, anesthesiologist, pathologist, emergency department physician, or neonatologist is greater than **$1,000** (not including your copayment, coinsurance, and deductible responsibilities) for services received in a network hospital, you may be entitled to have the parties participate in a teleconference, and, if the result is not to your satisfaction, in a mandatory mediation at no cost to you. You can learn more about mediation at the Texas Department of Insurance website: **www.tdi.state.tx.us/consumer/cpmmediation.html**.

Preauthorization Program

Your Plan requires preauthorization for certain services, such as inpatient stays, certain tests, procedures, outpatient surgery, therapies and equipment, and prescribed medications. Preauthorization simply means calling Aetna Student Health prior to treatment to get approval for coverage under your Plan for a medical procedure or service. For preferred care and designated care, the preferred care or designated care provider is responsible for obtaining preauthorization Since preauthorization is the preferred care or designated 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 preauthorize services. For non-preferred care, you are responsible for obtaining preauthorization which can be initiated by you, a member of your family, a hospital staff member or the attending physician. The preauthorization process can be initiated by calling Aetna at the telephone number listed on your ID card.

- **If you do not secure preauthorization** for the below listed inpatient and outpatient covered medical services and supplies obtained from a non-preferred provider your covered medical expenses will be subject to a **$500 per service, treatment, procedure, visit, or supply benefit reduction.**

Preauthorization for the following inpatient and outpatient services or supplies is needed:

- All inpatient maternity and newborn care, after the initial 48 hours for a vaginal delivery or 96 hours for a cesarean section;
- All inpatient maternity and newborn care, after the initial 48 hours for a vaginal delivery or 96 hours for a cesarean section;
- Ambulance (emergency transportation by airplane);
- 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;
- Home health care related services (ie. 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;
- Non-Preferred Care freestanding ambulatory surgical facility services when referred by a Preferred Care 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 Non-Preferred Care Providers for non-emergency services, unless the covered person understands and consents to the use of a Non-Preferred Care Provider under their under Non-Preferred Care benefits when available in their plan;
- Spinal Procedures;
- Transplant Services;
- Uvulopalatopharyngoplasty, including laser-assisted procedures; and
- Ventricular assist devices.

Preauthorization 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.

Preauthorization 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.

Preauthorization of emergency admissions

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

Preauthorization of urgent admissions

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

Preauthorization 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.

Preauthorization of prenatal care and delivery

Prenatal 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.

Please see the "Precertification" provision in the Master Policy for a list of services under the Plan that require precertification. Please see the Schedule of Benefits for any penalty or benefit reduction that may apply to your coverage when precertification is not obtained for the listed services or supplies when received from a non-preferred care provider.

Description of Benefits

The Plan excludes coverage for certain services and contains limitations on the amounts it will pay. While this Plan Design and Benefits Summary document will tell you about some of the important features of the Plan, other features may be important to you and some may further limit what the Plan will pay. To look at the full Plan description, which is contained in the Master Policy issued to Texas Christian 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 Texas Insurance Law(s).

	Preferred Care	Non- Preferred Care
DEDUCTIBLE* The policy year deductible is waived for Preferred Care covered medical expenses that apply to Preventive Care Expense benefits. In addition to state and federal requirements for waiver of the policy year deductible, the plan will waive the policy year deductible for: Pre-admission testing if done within 10 days prior to an admission. Per visit or admission Deductibles do not apply towards satisfying the Policy Year Deductible.	Individual: $350 per Policy Year	Individual: $600 per Policy Year
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 Out-of-Pocket Limit has been satisfied, Covered Medical Expenses will be payable at 100% for the remainder of the Policy Year. The following expenses do not apply toward meeting the plan's preferred care and non-preferred care out-of-pocket limits: • Non-covered medical expenses; and • Expenses that are not paid or precertification benefit penalties because a required precertification for the service(s) or supply was not obtained from Aetna	Individual Out-of-Pocket: $4,100 per Policy Year	Individual Out-of-Pocket: $8,000 per Policy Year
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	70% 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	70% 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	70% 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. Not more than the Daily Maximum Benefit per shift will be paid. For purposes of determining this maximum, a shift means 8 consecutive hours.	80% of the Negotiated Charge	70% 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	70% of the Recognized Charge
Well Newborn Nursery Care	80% of the Negotiated Charge	70% 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	70% of the Recognized Charge
Anesthesia Expense (Inpatient and Outpatient) If, in connection with such operation, the covered person requires the services of an anesthetist who is not employed or retained by the hospital in which the operation is performed, the expenses incurred will be Covered Medical Expenses.	80% of the Negotiated Charge	70% of the Recognized Charge

Surgical Expenses (continued)	Preferred Care	Non-Preferred Care
Assistant Surgeon Expense (Inpatient and Outpatient)	80% of the Negotiated Charge	70% of the Recognized Charge
Telemedicine Services and 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.	80% of the Negotiated Charge	70% of the Recognized Charge
Laboratory and X-ray Expense	80% of the Negotiated Charge	70% of the Recognized Charge
Hospital Outpatient Department Expense	80% of the Negotiated Charge	70% of the Recognized Charge
Outpatient Expense	**Preferred Care**	**Non-Preferred Care**
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; Oral anticancer medications, • Kidney dialysis; and • Respiratory therapy.	80% of the Negotiated Charge	70% of the Recognized Charge
Pre-Admission Testing Expense Includes charges incurred by a covered person for pre-admission testing charges made by a hospital, surgery center, licensed diagnostic lab facility, or physician, in its own behalf, to test a person while an outpatient before scheduled surgery.	Payable in accordance with the type of expense incurred and the place where service is provided.	
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	70% of the Recognized Charge
Walk-in Clinic Visit Expense	80% of the Negotiated Charge	70% of the Recognized Charge
Emergency Room and Freestanding Emergency Medical Facility Expense Covered medical expenses incurred by a covered person for services received a Freestanding Emergency Medical Facility and 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.	After $100 Copay per visit (waived if admitted), 80% of the Negotiated Charge	After $100 Deductible per visit (waived if admitted), 80% of the Recognized Charge

Outpatient Expense (continued)	Preferred Care	Non-Preferred Care
Emergency Room and Freestanding Emergency Medical Facility Expense (continued) 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 $100 Copay per visit (waived if admitted), 80% of the Negotiated Charge	After $100 Deductible per visit (waived if admitted), 80% of the Recognized Charge
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.	75% of the Negotiated Charge	75% of the Recognized Charge

Preventive Care Expenses

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

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force uspreventiveservicestaskforce.org**.**
- Services as recommended in the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents http://brightfutures.aap.org/.
- For females, screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration
- http://www.hrsa.gov/index.html.

Preventive Care Expenses	Preferred Care	Non-Preferred Care
Routine Physical Exam Includes routine vision & hearing screenings given as part of the routine physical exam.	100% of the Negotiated Charge*	70% of the Recognized Charge
Preventive Care Immunizations Includes charges made by a physician or a facility for: • Immunizations for infectious diseases; and • The materials for administration of immunizations; that have been recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	100% of the Negotiated Charge*	70% of the Recognized Charge

Preventive Care Expenses (continued)	Preferred Care	Non-Preferred Care
Preventive Care Immunizations (continued) Not covered under this Preventive Care Expense benefit are charges incurred for: • Immunizations that are not considered Preventive Care such as those required due to employment or travel; and • If applicable and currently excluded by the Policy, services and supplies furnished by a non-preferred care provider.	100% of the Negotiated Charge*	70% of the Recognized Charge
Well Woman Preventive Visits Routine well woman preventive exam office visit, including Pap smears. Coverage includes at a minimum, a conventional pap smear screening or a screening using liquid based cytology methods, alone or in combination with another test approved by US FDA for detection of HPV.	100% of the Negotiated Charge*	70% 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*	70% of the Recognized Charge
Preventive Care Screening and Counseling Services for Obesity and/or Healthy Diet Screening and counseling services to aid in weight reduction due to obesity. Coverage includes: • Preventive counseling visits and/or risk factor reduction intervention; • Nutritional counseling; and • Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.	100% of the Negotiated Charge*	70% 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*	70% 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. 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*	70% of the Recognized Charge

Preventive Care Expenses (continued)	Preferred Care	Non-Preferred Care
Preventive Care Screening and Counseling Services for Use of Tobacco Products (continued) Preventive Care Screening and Counseling Services for Depression Screening. Screening or test to determine if depression is present.	100% of the Negotiated Charge*	70% of the Recognized Charge
Preventive Care Screening and Counseling Services for Genetic Risk for Breast and Ovarian Cancer Covered medical expenses include the counseling and evaluation services to help assess a covered person's risk of breast and ovarian cancer susceptibility.	100% of the Negotiated Charge*	70% of the Recognized Charge
Preventive Care Routine Cancer Screenings Covered expenses include but are not limited to: Pap smears; Mammograms; Fecal occult blood tests; Digital rectal exams; Prostate specific antigen (PSA) tests; Sigmoidoscopies; Double contrast barium enemas (DCBE); Colonoscopies (removal of polyps performed during a screening procedure is a covered medical expense); and Lung cancer screenings.	100% of the Negotiated Charge*	70% 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*	70% 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*	70% of the Recognized Charge
Preventive Care Breast Pumps and Supplies	100% of the Negotiated Charge*	75% 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.	100% of the Negotiated Charge*	70% of the Recognized Charge

Preventive Care Expenses (continued)	Preferred Care	Non-Preferred Care
Voluntary Sterilization (continued) 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*	70% of the Recognized Charge
Other Family Planning Services Expense	**Preferred Care**	**Non-Preferred Care**
Voluntary Sterilization for Males (Outpatient Covered medical expenses include charges for certain family planning services, even though not provided to treat a sickness or injury as follows. • Voluntary sterilization for males	Payable in accordance with the type of expense incurred and the place where service is provided.	
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.	75% of the Negotiated Charge	75% of the Recognized Charge
Non-Emergency Ambulance Covered medical expenses include charges for transportation: • From hospital to home or to another facility when other means of transportation would be considered unsafe due to the covered person's medical condition; • From home to hospital for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to the covered person's medical condition. Transport is limited to 200 miles; and • During a covered inpatient stay at a hospital, skilled nursing facility or acute rehabilitation hospital, to transport a covered person for inpatient or outpatient medically necessary treatment when an ambulance is required to safely and adequately transport the covered person.	75% of the Negotiated Charge	75% 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.	80% of the Negotiated Charge	70% of the Recognized Charge
High Cost Procedures Expense Includes charges incurred by a covered person as a result of certain high cost procedures provided on an outpatient basis. Covered medical expenses for high cost procedures include; but are not limited to; charges for the following procedures and services: • Computerized Axial Tomography (C.A.T.) scans; • Magnetic Resonance Imaging (MRI); and • Positron Emission Tomography (PET) Scans.	80% of the Negotiated Charge	70% of the Recognized Charge
Urgent Care Expense	80% of the Negotiated Charge	70% 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 removal of one or more impacted wisdom teeth. Not more than the Maximum Benefit will be paid. 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:	80% of the Actual Charge	80% of the Actual Charge
Dental Expense for Impacted Wisdom Teeth (continued) • mouth; jaws; jaw joints; or • supporting tissues; (this includes: bones; muscles; and nerves).	80% of the Actual Charge	80% of the Actual Charge
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.	75% of the Actual Charge	75% of the Actual Charge
Second Surgical Opinion Expense	80% of the Negotiated Charge	70% of the Recognized Charge
Consultant Expense Includes the charges incurred by covered person in connection with the services of a consultant. The services must be requested by the attending physician to confirm or determine a diagnosis. Coverage may be extended to include treatment by the consultant.	80% of the Negotiated Charge	70% of the Recognized Charge
Skilled Nursing Facility Expense	75% of the Negotiated Charge	75% of the Recognized Charge
Rehabilitation Facility Expense Includes charges incurred by a covered person for confinement as a full time inpatient in a rehabilitation facility.	80% of the Negotiated Charge	70% of the Recognized Charge

Additional Benefits (continued)	Preferred Care	Non-Preferred Care
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.	100% of the Negotiated Charge	100% of the Recognized Charge
Temporomandibular Joint Dysfunction Expense Covered medical expenses include physician's charges incurred by a covered person for diagnostic, surgical, and non-surgical treatment of Temporomandibular Joint (TMJ) Dysfunction resulting from: • An accident or trauma • Congenital defect • Developmental defect • A pathology.	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:	Payable in accordance with the type of expense incurred and the place where service is provided.	
Dermatological Expense (continued) • 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.	
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.	75% of the Negotiated Charge	75% 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.	

Additional Benefits (continued)	Preferred Care	Non-Preferred Care
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 include charges made by a physician for pregnancy and childbirth services and supplies. This includes prenatal visits (non-preventive care), delivery, and postnatal visits. For inpatient care of the mother and newborn child, covered medical expenses include charges made by a hospital for a minimum of: a) 48 hours following an uncomplicated vaginal delivery; b) 96 hours following an uncomplicated cesarean section; and c) a shorter stay, if the attending physician, with the consent of the mother, discharges the mother or newborn earlier. If the mother is discharged earlier, the plan will pay for 2 post-delivery home visits by a health care provider. During the initial 48 or 96 hours; no precertification is required for the mother or her newly born child. Precertification is required after the 48 or 96 hours. Any decision to shorten such minimum coverage shall be made by the attending physician and in consultation with the mother. In such cases; covered services may include parent education. Pregnancy Complications shall be treated as any other covered medical expenses.	Payable in accordance with the type of expense incurred and the place where service is provided.	
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	70% 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.	

Additional Benefits (continued)	Preferred Care	Non-Preferred Care
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	70% of the Recognized Charge
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.	
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.	
Autism Spectrum Disorder Expense Includes charges incurred for services and supplies required for the diagnosis and treatment of autism spectrum disorder when ordered by a physician or behavioral health provider as part of a treatment plan. This benefit is subject to an age limit as shown on the Schedule of Benefits. Includes early intensive behavioral interventions such as Applied Behavior Analysis (ABA). Applied Behavior Analysis is an educational service that is the process of applying interventions that: Systematically change behavior; and • Are responsible for the observable improvement in behavior. Coverage does not include early intensive behavioral interventions such as Applied Behavior Analysis (ABA).	Payable in accordance with the type of expense incurred and the place where service is provided.	
Anesthesia and Hospital Charges for Dental Care Includes anesthesia for dental care only if the covered person: • Has a disability or a physical, mental, or medical condition that requires that a dental procedure be done in a hospital or outpatient surgery center; • Is developmentally disabled ; and • Is in poor health and have a medical need for general anesthesia.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Reconstructive Surgery for Craniofacial Abnormalities Expense Includes coverage for reconstructive surgery for craniofacial abnormalities for a child who is less than age 18. Reconstructive surgery for craniofacial abnormalities means surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.	Payable in accordance with the type of expense incurred and the place where service is provided.	

Additional Benefits (continued)	Preferred Care	Non-Preferred Care
Orthotic Devices Expense Includes coverage for orthotic devices, including custom-fitted or custom-fabricated medical devices that are applied to a part of the human body to correct a deformity, improve function, or relieve symptoms of a disease. The coverage includes the professional services related to the fitting and use of the devices, as well as repair and replacement unless due to misuse by the covered person. Coverage is limited to the most appropriate model orthotic device that adequately meets the medical needs of the covered person as determined by the covered person's treating physician, podiatrist or orthotist, and the covered person as applicable.	75% of the Negotiated Charge	75% of the Recognized Charge
Habilitation Therapy Includes charges for habilitation therapy services, as described below, when prescribed by a physician. Habilitation 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 a covered person is homebound. • Inpatient habilitation benefits for the services listed will be paid as part of the inpatient hospital and skilled nursing facility benefits. • Physical therapy (except for services provided in an educational or training setting) is covered provided that the therapy is expected to develop any impaired function. • Occupational therapy, (except for vocational rehabilitation, employment counseling, and services provided in an educational or training setting), is covered provided that the therapy is expected to develop any impaired function; • Speech therapy is covered provided that the therapy is expected to develop speech function as a result of delayed development. Speech function is the ability to express thoughts, speak words, and form sentences.	80% of the Negotiated Charge	70% of the Recognized Charge
Acquired Brain Injury Coverage An "acquired brain injury" is a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Amino Acid-Based Elemental Formulas Coverage will be provided for amino acid-based elemental formulas, if the covered person's physician has issued a written order stating that an amino acid-based elemental formula is medically necessary for the covered person's treatment after the covered person has been diagnosed with any of the following diseases or disorders:	80% of the Negotiated Charge	70% of the Recognized Charge

Additional Benefits (continued)	Preferred Care	Non-Preferred Care
Amino Acid-Based Elemental Formulas (continued) 1. immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins; 2. Severe food protein-induced enterocolitis syndrome; 3. Eosinophilic disorders, as evidenced by the results of a biopsy; and 4. Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract. Coverage includes any medically necessary services associated with the administration of the formula.	80% of the Negotiated Charge	70% of the Recognized Charge
Mastectomy and Reconstructive Surgery Expense To the extent that this Policy provides coverage for hospital room and board and surgery, Covered medical expenses includes expenses for charges incurred in connection with a mastectomy and lymph node dissection. Coverage includes: • a minimum of 48 of inpatient care following a mastectomy; • a minimum of 24 of inpatient care following a lymph node dissection; • reconstructive surgery on the breast on which surgery was performed and the non-diseased breast to achieve a symmetrical appearance; and • prostheses and treatment of physical complications including lymphedemas, at all states of mastectomy. A covered person may be discharged from inpatient care sooner if the covered person and the attending physician determine that a shorter period of inpatient care is appropriate.	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.	
Early Detection of Cardiovascular Disease Includes coverage for certain tests for the early detection of cardiovascular disease for any covered person who is: 1. male and older than 45 years of age and younger than 76 years of age; or 2. female and older than 55 years of age and younger than 76 years of age; and who is: • Diabetic; or • Has a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm that is intermediate or higher.	Payable in accordance with the type of expense incurred and the place where service is provided.	

Additional Benefits (continued)	Preferred Care	Non-Preferred Care
Early Detection of Cardiovascular Disease (continued) If performed by a laboratory that is certified by a national organization recognized by Texas for the purposes of this section, coverage will be provided for up to $200 every five years for one of the following non-invasive screening tests for atherosclerosis and abnormal artery structure and function: • computed tomography (CT) scanning measuring coronary artery calcification; or • ultrasonography measuring carotid intima-media thickness and plaque. Any reference in the plan to the exclusion or limitation of any of the above covered services and supplies, unless expressly outlined in this section, shall not apply.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Loss or Impairment of Speech or Hearing Includes expenses incurred by a covered person for medically necessary care and treatment of loss or impairment of speech or hearing on the same basis any other physical 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.	
Chiropractic Treatment Expense Covered medical expenses include 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	70% of the Recognized Charge
Short-Term Cardiac and Pulmonary Rehabilitation Therapy Services Expense Includes charges made by a hospital for short-term rehabilitation therapy services, as described below, when prescribed by a physician. The services have to be performed by: • A licensed or certified physical or occupational therapist; or • A physician. Charges for the following short term rehabilitation expenses are covered: • Cardiac and Pulmonary Rehabilitation Benefits • Cardiac rehabilitation benefits are available as part of an inpatient hospital stay. A course of outpatient cardiac rehabilitation appropriate for a covered person's condition is covered for a cardiac condition that can be changed. The 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 are available as part of an inpatient hospital stay. A course of outpatient pulmonary rehabilitation appropriate for a covered person's condition is covered for the treatment of reversible pulmonary disease states.		
Cardiac Rehabilitation	80% of the Negotiated Charge	70% of the Recognized Charge
Pulmonary Rehabilitation	80% of the Negotiated Charge	70% of the Recognized Charge

Additional Benefits (continued)	Preferred Care	Non-Preferred Care
Short-Term Rehabilitation Therapies Expense Includes charges for short-term rehabilitation services, as described below, when prescribed by a physician. Short-term rehabilitation services must follow a specific treatment plan that: • Details the treatment, and specifies frequency and duration; • Provides for ongoing reviews and is renewed only if continued therapy is appropriate; and • Allows therapy services, provided in a covered person's home, if the covered person is homebound. Inpatient rehabilitation benefits for the services listed will be paid as part of the inpatient hospital and skilled nursing facility benefits.		
Short-Term Rehabilitation Therapies Expense Outpatient Cognitive, Physical, Occupational and Speech Rehabilitation Therapy Services (combined)	80% of the Negotiated Charge	70% of the Recognized Charge
Hearing Aids	**Preferred Care**	**Non-Preferred Care**
Hearing Aid Expenses Covered medical expenses for hearing care includes charges for prescribed hearing aids and hearing aid expenses. Maximum of 1 hearing aid per ear per 12 consecutive month period.	75% of the Negotiated Charge	75% of the Recognized Charge
Cochlear Implants	75% of the Negotiated Charge	75% of the Recognized Charge
Treatment Of Mental Disorders Expense	**Preferred Care**	**Non-Preferred Care**
Inpatient Mental Health Expense Covered medical expenses include charges made by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider for the treatment of mental disorders for Inpatient room and board at the semi-private room rate, and other services and supplies related to a covered person's condition that are provided during a covered person's stay in a hospital, psychiatric hospital, or residential treatment facility.	80% of the Negotiated Charge	70% of the Recognized Charge
Outpatient Mental Health Expense	80% of the Negotiated Charge	70% of the Recognized Charge
Outpatient Mental Health Partial Hospitalization Expense	80% of the Negotiated Charge	70% of the Recognized Charge
Alcoholism and Drug Addiction Treatment	**Preferred Care**	**Non-Preferred Care**
Inpatient Substance Abuse Treatment Covered medical expenses include charges made by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider for the treatment of mental disorders for Inpatient room and board at the semi-private room rate, and other services and supplies related to a covered person's condition that are provided during a covered person's stay in a hospital, psychiatric hospital, or residential treatment facility.	80% of the Negotiated Charge	70% of the Recognized Charge
Outpatient Substance Abuse Treatment	80% of the Negotiated Charge	70% of the Recognized Charge

Transplant Services Expense	Preferred Care	Non-Preferred Care
Transplant Services Expense Benefits may vary if an Institute of Excellence™ (IOE) facility or non-IOE or non-preferred care provider is used. Through the IOE network, the covered person will have access to a provider network that specializes in transplants. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure the covered person requires. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Transplant Travel and Lodging Expense The plan will reimburse a covered person for some of the cost of their travel and lodging expenses. Maximum Benefit payable for Travel and Lodging Expenses for any one transplant, including tandem transplants	$10,000 per transplant	
Pediatric Dental Services Expense **(Coverage is limited to covered persons through age 18)**	**Preferred Care**	**Non-Preferred Care**
Type A Expense (Pediatric Routine Dental Exam Expense) Limited to 1 exam every 6 months.	100% of the Negotiated Charge*	70% of the Recognized Charge
Type B Expense (Pediatric Basic Dental Care Expense)	70% of the Negotiated Charge*	50% of the Recognized Charge
Type C Expense (Pediatric Major Dental Care Expense)	50% of the Negotiated Charge*	50% of the Recognized Charge
Pediatric Orthodontia Expense Orthodontics Medically necessary comprehensive treatment • Replacement of retainer (limit one per lifetime).	50% of the Negotiated Charge*	50% of the Recognized Charge
Pediatric Routine Vision **(Coverage is limited to covered persons through age 18)**	**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.	100% of the Negotiated Charge*	70% of the Recognized Charge
Pediatric Visit for the fitting of prescription contact lenses, Pediatric Eyeglass Frames, Prescription Lenses or Prescription Contact Lenses Includes charges for the following vision care services and supplies: • Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses. • Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a preferred care provider. • Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a non-preferred care provider.	100% of the Negotiated Charge *	70% of the Recognized Charge

Pediatric Routine Vision (continued) (Coverage is limited to covered persons through age 18)	Preferred Care	Non-Preferred Care
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.		

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

PRESCRIBED MEDICINES EXPENSE

*The prescription drug plan covered percentage is the percentage of prescription drug covered medical expenses that the plan pays.

Generic and Brand Prescription Drugs	Preferred Care
For each 30 day supply filled at a retail pharmacy. **You must pay out of pocket and then submit your receipt to Aetna Student Health for reimbursement.**	70% of the Actual Charge after the Policy Year Deductible

Copay and Deductible Waiver
Waiver for Risk-Reducing Breast Cancer Prescription Drugs

Risk-reducing breast cancer generic prescription drugs will be paid at 100%.

Waiver for Prescription Drug Contraceptives

The per prescription coinsurance will not apply to:
Female contraceptives that are:

- Oral prescription drugs that are generic prescription drugs.
- Injectable prescription drugs that are generic 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 coinsurance will 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 coinsurance 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 Precertification Department. Any waiver granted as a result of a medical exception shall be based upon an individual, case by case medically necessary determination and coverage will not apply or extend to other covered persons.

Exclusions

This Plan does not cover nor provide benefits for:

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

1. 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.
2. 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.
3. 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.
4. 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.
5. 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.
6. 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.
7. Expense incurred for elective treatment or elective surgery except as specifically covered under the Policy and provided while the Policy is in effect.
8. Expense incurred for cosmetic surgery; reconstructive surgery; or other services and supplies which improve; alter; or enhance appearance; whether or not for psychological or emotional reasons; except to the extent needed to: Improve the function of a part of the body that: is not a tooth or structure that supports the teeth; and is malformed: This exclusion will not apply to reconstructive surgery for craniofacial abnormalities performed on a dependent child who is under 18 years of age. As used here, "reconstructive surgery for craniofacial abnormalities" means reconstructive surgery:

- To improve the function of; or
- To attempt to create a normal appearance of;
- An abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections or disease; or as a result of a severe birth defect; including harelip; webbed fingers; or toes; or as direct result of: disease; or surgery performed to treat a disease or injury. Repair an injury 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.

9. Expense incurred as a result of commission of a felony.
10. Expense incurred for voluntary or elective abortions unless specifically covered under the Policy.
11. Expense incurred after the date insurance terminates for a covered person except as may be specifically provided in the Extension of Benefits provision.
12. Expense incurred for services normally provided without charge by the school and covered by the school fee for services.
13. 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.
14. Expense incurred for the male or female reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.
15. 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).
16. Expense incurred for which no member of the covered person's immediate family has any legal obligation for payment.
17. Expense incurred for custodial care.
18. 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.
19. Expenses incurred for blood or blood plasma; except charges made by a hospital for the processing or administration of blood.
20. Expenses incurred for the repair or replacement of existing artificial limbs; orthopedic braces; or orthotic devices except as specifically covered in the Policy.
21. 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.
22. Expenses incurred for gastric bypass; and any restrictive procedures; for weight loss except screening and counseling services specifically covered under the Policy.
23. Expenses incurred for breast reduction/mammoplasty.
24. Expenses incurred for gynecomastia (male breasts).
25. 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.
26. Expense incurred for acupuncture except as specifically covered under the Policy.
27. Expense incurred for alternative; holistic medicine; and/or therapy; including but not limited to; yoga and hypnotherapy unless specifically covered under the Policy.

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

29. 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.

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

31. Expense for the cost of supplies used in the performance of any occupational therapy.

32. 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.

33. 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.

34. 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.

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

36. Expense incurred for any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum except as specifically covered under the Policy.

37. 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.

38. Expenses incurred for massage therapy.

39. Expense incurred for; or related to; gender reassignment (sex change) surgery.

40. Expense incurred for non-preferred care charges that are above the recognized charges.

41. 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.

42. 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.

43. 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.

44. 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 orthotics or vision training;
    - Eye exams during a stay in a hospital or other facility for health care;
    - Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
    - Replacement of lenses or frames that are lost or stolen or broken;
        - Acuity tests; and
        - Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
        - Services to treat errors of refraction.

45. 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.

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

47. 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:
    - Dementias and amnesias without behavioral disturbances;
    - Sexual deviations and disorders except for gender identity disorders;
    - 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.

48. Expense incurred in a facility for care, services or supplies provided in:
    - Rest homes;
    - Assisted living facilities (this does not apply to assisted living facilities for the treatment of Acquired Brain Injuries);
    - 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.

49. 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).

50. 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.

51. Expense incurred for therapies and tests: Any of the following treatments or procedures including but not limited to:
    - Aromatherapy;
    - Bio-feedback and bioenergetic therapy except this does not apply to the treatment of acquired brain injury;
    - 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

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

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

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

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

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

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