



**Aetna Student Health  
Plan Design and Benefits Summary  
Preferred Provider Organization (PPO)**

**The Catholic University of America  
Basic Plan**

Policy Year: 2025 - 2026

Policy Number: 474963

<https://www.aetnastudenthealth.com>

(866) 577-6692



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

**The Catholic University of America is involved in pending litigation challenging the federal requirement to provide contraceptive coverage. In connection with that litigation, a federal court issued a stay that temporarily exempts The Catholic University of America from providing contraceptive coverage. As long as this stay is in place, the plan will not provide contraceptive coverage. We are not able to estimate when (or if) the stay will be vacated.**

## The Catholic University of America Health Services

The Catholic University of America Student Health Services is the University's on-campus health facility located behind Centennial Village in the Eugene I. Kane Student Health and Fitness Center.

For more information, please visit <http://health.cua.edu>, contact the Alliant Call Center at 800-489-1390, or email: [benefithelp@alliant.com](mailto:benefithelp@alliant.com). If this is an emergency, please call **911** or the Campus Department of Public Safety at **(202) 319-5111**.

The Catholic University of America offers an assistance program for students that may need help with coordinating care or understanding their medical insurance. For information about The Catholic University of America Health Advocate Program please visit <http://studentinsurance.cua.edu>.

### For questions about:

- Enrollment
- Waiver Process
- Insurance Benefits
- Claims Processing
- Pre-Certification Requirements

### Please contact:

Aetna Student Health  
P.O. Box 981106  
El Paso, TX 79998  
**(866) 577-6692**

### For questions about:

- Plan Eligibility
- Registration Status

### Please contact:

The Catholic University of America Student Medical Plan Administrator  
**Email: [cua-studentmedins@cua.edu](mailto:cua-studentmedins@cua.edu)**

### For questions about:

Aetna Participating Provider Listings a complete list of providers can be found by using Aetna's electronic on line directory DocFind® Service at <https://www.aetnastudenthealth.com> (search The Catholic University of America).

**For questions about:**

- Status of Pharmacy Claim
- Pharmacy Claim Forms
- Excluded Drugs and Pre-Authorization

**Please contact:**

Aetna Pharmacy Management  
**(888) RX-AETNA** or **(888) 792-3862** (Available **24** hours)

## Coverage Periods

**Students:** Coverage for all insured students and their dependents enrolled for coverage in the Plan for the following Coverage Periods. Coverage will become effective at 12:01 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicated. **You may choose to select this plan as an alternative to the Premium Plan. This plan has a high deductible, please review plan documents prior to selection.**

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
<b>2025/2026 Annual Plan</b>	08/14/2025	08/13/2026	09/12/2025
<b>New Spring 2026 Semester Students/Dependents</b>	01/01/2026	08/13/2026	01/30/2026
<b>New Summer 2026 Semester Students/Dependents</b>	05/08/2026	08/13/2026	06/01/2026

Coverage for students attending **John Paul II Institute, Dominican House of Studies** or **Washington Theological Union** and their dependents who are eligible under the Plan for the following Coverage Periods. Coverage will become effective at 12:01 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment Deadline
<b>2025/2026 Annual Plan</b>	08/14/2025	08/13/2026	09/12/2025
<b>New Spring 2026 Semester Students/Dependents</b>	01/01/2026	08/13/2026	01/30/2026

## Rates

The rates below include both premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna), The Catholic University of America's administrative fee and the cost of the Health Advocate Program.

### The Catholic University of America Students & Dependents

	Annual 08/14/2025 - 08/13/2026	Spring Semester* 01/01/2026 - 08/13/2026	Summer Semester* 05/08/2026 - 08/13/2026
<b>Student Only</b>	<b>\$2,970</b>	<b>\$1,830.82</b>	<b>\$797.43</b>
<b>Spouse Only</b>	<b>\$2,927</b>	<b>\$1,804.31</b>	<b>\$785.88</b>
<b>Child Only</b>	<b>\$2,927</b>	<b>\$1,804.31</b>	<b>\$785.88</b>
<b>Children</b>	<b>\$5,854</b>	<b>\$3,608.62</b>	<b>\$1,571.76</b>

*\*Students new to the University for Spring 2026 or Summer 2026 Semester only*

### John Paul II Institute Students, Dominican House of Studies Students and Washington Theological Union Students & Dependents

	Annual 08/14/2025 - 08/13/2026	Spring Semester* 01/01/2026 - 08/13/2026
<b>Student Only</b>	<b>\$3,177</b>	<b>\$1,958.42</b>
<b>Spouse Only</b>	<b>\$2,927</b>	<b>\$1,804.31</b>
<b>Child Only</b>	<b>\$2,927</b>	<b>\$1,804.31</b>
<b>Children</b>	<b>\$5,854</b>	<b>\$3,608.62</b>

*\*Students new to the University for Spring 2026 Semester only*

## Student Coverage

### Eligibility

All Catholic University of America students with billed credit hours and their dependents are eligible to enroll in The Catholic University of America Medical Insurance Plan. Please contact Catholic University Student Accounts at **(202) 319-5300** if you are unsure of your registration status. Eligible students will be automatically enrolled in this Plan, unless the completed waiver application has been received by The Catholic University of America by the specified enrollment deadline dates listed in the previous section of this Plan Design and Benefits Summary.

**Domestic Students (billed for 12 or more credit hours):** are automatically enrolled in the insurance plan unless an online waiver is submitted and accepted by the posted deadline.

**All International Students Holding an F1 or J1 Visa (regardless of billed credit hours):** are automatically enrolled in The Catholic University of America Student Medical Insurance Plan unless proof of other comparable coverage is submitted online and by **September 12, 2025**. **All waiver submissions submitted by C students holding a J1 Visa** will be audited by The Catholic University of America, 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 waiver requirements.

**Voluntary Enrollment:** Domestic Students (**billed for at least 6 credit hours**) and their dependents are eligible to purchase The Catholic University of America Student Medical Insurance Plan on a voluntary basis. To enroll for voluntary coverage, log on to <https://www.aetnastudenthealth.com> and search for your school.

**John Paul II Institute, The Dominican House of Studies and Washington Theological Union Students:** are eligible to purchase The Catholic University of America Student Medical Insurance Plan on a voluntary basis. To enroll for voluntary coverage, log on to <https://www.aetnastudenthealth.com> and search for your school.

**Note:** Default enrollment into The Catholic University of America student medical insurance will occur a few days after the deadline. We recommend if you wish to have coverage, you should proactively enroll yourself through Aetna Student Health's Website <https://www.aetnastudenthealth.com>.

Domestic students billed at least 6 credit hours but less than 12 credit hours must complete an online enrollment application to have coverage under The Catholic University of America student medical plan. If an online enrollment application is not completed before the deadline you will not be enrolled in The Catholic University of America student medical insurance. This applies even if the student medical insurance charge appears on your account as it will be automatically removed.

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.

In the event that you do not enroll during the initial Enrollment/Waiver period that ends on 9/12/25, then you are not eligible to come onto The Catholic University of America Student Medical Plan **unless** you have a qualifying event.

A qualifying event would include the following:

- Loss of coverage due to change in job status when coverage is provided by your employer.
- Loss of coverage due to a change in marital status.

The following are **NOT** considered qualifying events:

- If you voluntarily choose to cancel your own private, exchange policy or employer provided coverage during the plan year, you may not request to be added to The Catholic University of America Student Medical plan mid-year.
- If you become a full-time student during the academic year, you may not request to be added to The Catholic University of America Student Medical plan mid-year.

The Catholic University of America reserves the right to request documentation to verify a qualifying event in order to determine plan eligibility.

## Enrollment

To enroll online or obtain an enrollment application for voluntary coverage, log on to <https://www.aetnastudenthealth.com> and search for your school. **You may choose to select this plan as an alternative to the Premium Plan. This plan has a high deductible, please review plan documents prior to selection.**

To enroll the dependent(s) of a covered student, please complete the Enrollment Form by visiting <https://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 866-577-6692 and requesting that an Enrollment Form be sent in the mail. Dependent enrollment applications will not be accepted after the enrollment deadline, unless there is a significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage under another health plan.) The completed Enrollment Form and premium must be sent to Aetna Student Health.

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

- A newborn child - Your newborn child is covered on your health plan for the first 31 days from the moment of birth.
  - To keep your newborn covered, you must notify us (or our agent) of the birth and pay any required premium contribution during that 31 day period.
  - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional premium contribution for the newborn.
  - If you miss this deadline, your newborn will not have health benefits after the first 31 days.
  - If your coverage ends during this 31 day period, then your newborn's coverage will end on the same date as your coverage. This applies even if the 31 day period has not ended.
  
- An adopted child or a child legally placed with you for adoption - A child that you, or your spouse adopts or is placed with you for adoption, is covered on your plan for the first 31 days after the adoption or the placement is complete.
  - To keep your child covered, we must receive your completed enrollment information within 31 days after the adoption or placement for adoption.
  - You must still enroll the child within 31 days of the adoption or placement for adoption even when coverage does not require payment of an additional premium contribution for the child.
  - If you miss this deadline, your adopted child or child placed with you for adoption will not have health benefits after the first 31 days.
  - If your coverage ends during this 31 day period, then coverage for your adopted child or child placed with you for adoption will end on the same date as your coverage. This applies even if the 31 day period has not ended.
  
- Dependent coverage due to a court order - If you must provide coverage to a dependent because of a court order, your dependent is covered on your health plan for the first 31 days from the court order.
  - To keep your dependent covered, we must receive your completed enrollment information within 31 days of the court order.
  - You must still enroll the dependent within 31 days of the court order even when coverage does not require payment of an additional premium contribution for the dependent.
  - If you miss this deadline, your dependent will not have health benefits after the first 31 days.
  - If your coverage ends during this 31 day period, then your dependent's coverage will end on the same date as your coverage. This applies even if the 31 day period has not ended.

If you need information or have general questions on dependent enrollment, call Member Services at 866-577-6692

## Medicare Eligibility Notice

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

## Termination and Refunds

Withdrawal from Classes – Leave of Absence:

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

Withdrawal from Classes – Other than Leave of Absence:

If you withdraw from classes within 31 days after the policy effective date, you will be considered ineligible for coverage. Your coverage will be terminated retroactively, and any premium paid will be refunded. If you withdraw from classes more than 31 days after the policy effective date, your coverage will remain in force through the end of the period for which premium payment has been received. No premium will be refunded. If you withdraw from classes to enter the armed forces of any country, your coverage will end as of the date of such entry. We will refund your premium, on a pro-rata basis, if you submit a written request within 90 days from the date you withdraw.

## In-network Provider Network

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

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

## Precertification

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

### Precertification call

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

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

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

We will provide a written notification to you and your physician of the precertification decision, where required by state law and within the timeframe specified by state law. If your pre-certified services are approved, the approval is valid for 60 days as long as you remain enrolled in the plan.

## Coordination of Benefits (COB)

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB). A complete description of the Coordination of Benefits provision is contained in the certificate issued to you.

## Description of Benefits

The Plan excludes coverage for certain services and has limitations on the amounts it will pay. While this Plan Summary document will tell you about some of the important features of the Plan, other features that may be important to you are defined in the Certificate. To look at the full Plan description, which is contained in the Certificate issued to you, go to <https://www.aetnastudenthealth.com>.

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

Policy year deductible	In-network coverage	Out-of-network coverage
You have to meet your policy year deductible before this plan pays for benefits.		
<b>Student</b>	\$7,000 per policy year	\$7,000 per policy year
<b>Spouse</b>	\$7,000 per policy year	\$7,000 per policy year
<b>Each child</b>	\$7,000 per policy year	\$7,000 per policy year
<b>Policy year deductible waiver</b>		
The policy year deductible is waived for all of the following eligible health services: <ul style="list-style-type: none"> <li>• In-network care for <i>Preventive care and wellness</i></li> <li>• Emergency Department HIV Screenings, and</li> <li>• Mammograms and Pap Smears including cervical cytological screenings.</li> <li>• Pediatric Preventive Vision Services; and</li> <li>• Preferred Care Pediatric Dental Services.</li> </ul>		
<b>Maximum out-of-pocket limit per policy year</b>		
<b>Student</b>	\$8,700 per policy year	\$17,400 per policy year
<b>Spouse</b>	\$8,700 per policy year	\$17,400 per policy year
<b>Each child</b>	\$8,700 per policy year	\$17,400 per policy year
<b>Family</b>	\$17,400 per policy year	\$34,800 per policy year

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

Eligible health services	In-network coverage	Out-of-network coverage
<b>Preventive care and wellness</b> <b>Routine physical exams</b> <b>Performed at a physician's office</b>		
Routine Physical exam	100% (of the negotiated charge) per visit  No Deductible applies	50% (of the recognized charge) per visit  Deductible applies
Routine physical exam limits for covered persons through age 21: maximum age and visit limits per policy year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents.	
Routine physical exam limits for covered persons age 22 and over: maximum visits per policy year	1 visit	
<b>Preventive care immunizations</b> <b>Performed in a facility or at a physician's office</b>		
Preventive care immunizations	100% (of the negotiated charge) per visit  No Deductible applies	50% (of the recognized charge) per visit  Deductible applies
Preventive care immunization maximums	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	
The following is not covered under this benefit: <ul style="list-style-type: none"> <li>Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment or travel</li> </ul>		
<b>Well woman preventive visits</b> <b>Routine gynecological exams (including Pap smears and cytology tests)</b>		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit  No Deductible applies	100% (of the recognized charge) per visit  Deductible applies
Maximum visits per policy year	1 visit	

Eligible health services	In-network coverage	Out-of-network coverage
<b>Preventive screening and counseling services</b>		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit  No Deductible applies	50% (of the recognized charge) per visit  Deductible applies
Obesity and/or healthy diet counseling Maximum visits	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	
Misuse of alcohol and/or drugs counseling Maximum visits per policy year	5 visits	
Use of tobacco products counseling Maximum visits per policy year	8 visits	
Sexually transmitted infection counseling Maximum visits per policy year	2 visits	
Genetic risk counseling for breast and ovarian cancer limitations	Not subject to any age or frequency limitations	
Genetic risk counseling for breast and ovarian cancer Maximum visits per policy year	1 visit	
Routine cancer screenings  Deductible does not apply to routine mammography	100% (of the negotiated charge) per visit  No Deductible applies	100% (of the recognized charge) per visit  Deductible applies
Routine cancer screening maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> <li>• Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and</li> <li>• The comprehensive guidelines supported by the Health Resources and Services Administration.</li> </ul>	
Lung cancer screening maximums	1 screening every 12 months	

<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit  No Deductible applies	50% (of the recognized charge) per visit  Deductible applies
Lactation counseling services	100% (of the negotiated charge) per visit  No Deductible applies	50% (of the recognized charge) per visit  Deductible applies
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits	
Breast pump supplies and accessories	100% (of the negotiated charge) per item  No Deductible applies	50% (of the recognized charge) per item  Deductible applies
<b>Physicians and other health professionals</b>		
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist) includes telemedicine consultations)	80% (of the negotiated charge) per visit  Deductible applies	50% (of the recognized charge) per visit  Deductible applies
<b>Allergy testing and treatment</b>		
Allergy testing performed at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Allergy injections treatment including Allergy sera and extracts administered via injection performed at a physician's or specialist's office	80% (of the negotiated charge) per visit  Deductible applies	50% (of the recognized charge) per visit  Deductible applies
<b>Physician and specialist - surgical services</b>		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) per visit  Deductible applies	50% (of the recognized charge) per visit  Deductible applies
The following are not covered under this benefit:		
<ul style="list-style-type: none"> <li>• A stay in a hospital (Hospital stays are covered in the Eligible health services and exclusions – Hospital and other facility care section)</li> <li>• Services of another physician for the administration of a local anesthetic</li> </ul>		

<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthesiologist and surgical assistant expenses)	80% (of the negotiated charge) per visit  Deductible applies	50% (of the recognized charge) per visit  Deductible applies
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• A stay in a hospital (Hospital stays are covered in the Eligible health services and exclusions – Hospital and other facility care section)</li> <li>• A separate facility charge for surgery performed in a physician's office</li> <li>• Services of another physician for the administration of a local anesthetic</li> </ul>		
<b>Alternatives to physician office visits</b>		
Walk-in clinic visits (non-emergency visit)	80% (of the negotiated charge) per visit  Deductible applies	50% (of the recognized charge) per visit  Deductible applies
<b>Hospital and other facility care</b>		
Inpatient hospital (room and board) and other miscellaneous services and supplies) Includes birthing center facility charges	80% (of the negotiated charge) per visit  Deductible applies	50% (of the recognized charge) per visit  Deductible applies
<p>The following are not eligible health services:</p> <ul style="list-style-type: none"> <li>• All services and supplies provided in: <ul style="list-style-type: none"> <li>- Rest homes</li> <li>- Any place considered a person's main residence or providing mainly custodial or rest care</li> <li>- Health resorts</li> <li>- Spas</li> <li>- Schools or camps</li> </ul> </li> </ul>		
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit  Deductible applies	50% (of the recognized charge) per visit  Deductible applies
Preadmission testing	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<b>Alternatives to hospital stays</b>		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	80% (of the negotiated charge) per visit  Deductible applies	50% (of the recognized charge) per visit  Deductible applies

The following are not covered under this benefit:

- A stay in a hospital (See the Hospital care – facility charges benefit in this section)
- A separate facility charge for surgery performed in a physician’s office
- Services of another physician for the administration of a local anesthetic

<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
Home health care	80% (of the negotiated charge) per admission  Deductible applies	50% (of the recognized charge) per admission  Deductible applies
Maximum visits per episode per policy year	unlimited	

The following are not covered under this benefit:

- Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities)
- Transportation
- Homemaker or housekeeper services
- Food or home delivered services
- Maintenance therapy

Hospice-Inpatient	80% (of the negotiated charge) per admission  Deductible applies	50% (of the recognized charge) per admission  Deductible applies
Maximum days per confinement per policy year	unlimited	
Hospice-Outpatient	80% (of the negotiated charge) per admission  Deductible applies	50% (of the recognized charge) per admission  Deductible applies
Maximum outpatient hospice visits per policy year	unlimited	

The following are not covered under this benefit:

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

Eligible health services	In-network coverage	Out-of-network coverage
Skilled nursing facility- Inpatient	80% (of the negotiated charge) per admission  Deductible applies	50% (of the recognized charge) per admission  Deductible applies
Maximum days of confinement per policy year	unlimited	
Emergency room	80% (of the negotiated charge) per visit  Deductible applies	Paid the same as in-network coverage
Non-emergency care in an emergency room	Not covered	Not covered
<p><b>Important note:</b></p> <ul style="list-style-type: none"> <li>As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment/coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill.</li> <li>A separate emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived, and your inpatient copayment/coinsurance will apply.</li> <li>Covered benefits that are applied to the emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the emergency room copayment/coinsurance.</li> <li>Separate copayment/coinsurance amounts may apply for certain services given to you in the emergency room that are not part of the emergency room benefit. These copayment/coinsurance amounts may be different from the emergency room copayment/coinsurance. They are based on the specific service given to you.</li> <li>Services given to you in the emergency room that are not part of the emergency room benefit may be subject to copayment/coinsurance amounts that are different from the emergency room copayment/coinsurance amounts.</li> </ul>		
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>Non-emergency services in a hospital emergency room or an independent freestanding emergency department</li> </ul>		
Urgent care	80% (of the negotiated charge) per visit  Deductible applies	50% (of the recognized charge) per visit  Deductible applies
Non-urgent use of urgent care provider	Not covered	Not covered
<p>The following is not covered under this benefit:</p> <ul style="list-style-type: none"> <li>Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)</li> </ul>		

Eligible health services	In-network coverage	Out-of-network coverage
<b>Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19)</b>		
Type A services	100% (of the negotiated charge) per visit No deductible applies	70% (of the recognized charge) per visit Deductible applies
Type B services	70% (of the negotiated charge) per visit No deductible applies	50% (of the recognized charge) per visit policy year Deductible applies
Type C services	50% (of the negotiated charge) per visit No deductible applies	50% (of the recognized charge) per visit policy year Deductible applies
Orthodontic services	50% (of the negotiated charge) per visit No deductible applies	50% (of the recognized charge) per visit policy year Deductible applies
Dental emergency treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

**Pediatric dental care exclusions**

The following are not covered under this benefit:

- Any instruction for diet, plaque control and oral hygiene
- Cosmetic services and supplies including:
  - Plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
  - Augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the *Eligible health services and exclusions* section
  - Facings on molar crowns and pontics will always be considered cosmetic
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants and braces (that are determined not to be medically necessary mouth guards, and other devices to protect, replace or reposition teeth)
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services and exclusions – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in

- connection with another eligible health service
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered above and in the *Pediatric dental care* section of the Policy
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication or analgesia (nitrous oxide)
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a provider
  - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a dental provider

Eligible health services	In-network coverage	Out-of-network coverage
<b>Specific conditions</b>		
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Podiatric (foot care) treatment Physician and specialist non-routine foot care treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Services and supplies for:</li> <li>• The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches</li> <li>• The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes</li> <li>• Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies</li> <li>• Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet</li> </ul>		
Impacted wisdom teeth	80% (of the negotiated charge)  Deductible applies	80% (of the recognized charge)  Deductible applies
Accidental injury to sound natural teeth	80% (of the negotiated charge)  Deductible applies	80% (of the recognized charge)  Deductible applies
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• The care, filling, removal or replacement of teeth and treatment of diseases of the teeth</li> <li>• Dental services related to the gums</li> <li>• Apicoectomy (dental root resection)</li> <li>• Orthodontics</li> </ul>		

- Root canal treatment
- Soft tissue impactions
- Bony impacted teeth
- Alveolectomy
- Augmentation and vestibuloplasty treatment of periodontal disease
- False teeth
- Prosthetic restoration of dental implants
- Dental implants

Eligible health services	In-network coverage	Out-of-network coverage
Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: Dental implants		
Clinical trials		
Experimental or investigational therapies	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Routine patient costs	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not eligible health services: <ul style="list-style-type: none"> <li>• Services and supplies related to data collection and record-keeping needed only for the clinical trial</li> <li>• Services and supplies provided by the trial sponsor for free</li> <li>• The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with our policies)</li> </ul>		
Dermatological treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: Cosmetic treatment and procedures		
<b>Maternity care</b>		
Maternity care (includes delivery and postpartum care services in a hospital or birthing center)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries		

<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>	
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge)  No deductible applies	50% (of the recognized charge)  No deductible applies	
Autism spectrum disorder treatment, diagnosis and testing and Applied behavior analysis	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	
<b>Behavioral Health</b>			
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	80% (of the negotiated charge) per admission  Deductible applies	50% (of the recognized charge) per admission  Deductible applies	
Outpatient treatment office visits  (includes telemedicine cognitive behavioral therapy consultations)	80% (of the negotiated charge) per visit  Deductible applies	50% (of the recognized charge) per visit  Deductible applies	
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	80% (of the negotiated charge) per visit  Deductible applies	50% (of the recognized charge) per visit  Deductible applies	
<b>Eligible health services</b>	<b>In-network coverage Network (IOE facility)</b>	<b>In-network coverage Network (Non-IOE facility)</b>	<b>Out-of-network coverage Network Non-IOE facility and out-of-network facility</b>
Inpatient and outpatient transplant facility services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Inpatient and outpatient transplant physician and specialist services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Transplant services-travel and lodging	Covered	Covered	Covered
Lifetime Maximum Travel and Lodging Expenses for any one transplant	\$10,000	\$10,000	\$10,000
Maximum Lodging Expenses per <b>IOE</b> patient	\$50 per night	\$50 per night	\$50 per night
Maximum Lodging Expenses per companion	\$50 per night	\$50 per night	\$50 per night

The following are not covered under this benefit:

- Services and supplies furnished to a donor when the recipient is not a covered person
- Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
- Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness

Eligible health services	In-network coverage	Out-of-network coverage
<b>Specific therapies and tests</b>		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge) Deductible applies	50% (of the recognized charge) Deductible applies
Diagnostic lab work performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge) Deductible applies	50% (of the recognized charge) Deductible applies
Diagnostic radiological services performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge) Deductible applies	50% (of the recognized charge) Deductible applies
Outpatient Chemotherapy, Radiation & Respiratory Therapy	80% (of the negotiated charge) Deductible applies	50% (of the recognized charge) Deductible applies
Hormone replacement therapy	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

The following are not covered under this benefit:

- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan
- Enteral nutrition
- Blood transfusions and blood products
- Dialysis

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy)  Combined for short-term rehabilitation services and habilitation therapy services	80% (of the negotiated charge)  Deductible applies	50% (of the recognized charge)  Deductible applies
Chiropractic services	80% (of the negotiated charge)  Deductible applies	50% (of the recognized charge)  Deductible applies
Emergency ground, air, and water ambulance	80% (of the negotiated charge) per trip  Deductible applies	Paid the same as in-network coverage
The following are not covered under this benefit: <ul style="list-style-type: none"> <li>Ambulance services for routine transportation to receive outpatient or inpatient services</li> </ul>		
Durable medical and surgical equipment	80% (of the negotiated charge) per item  Deductible applies	50% (of the recognized charge) per item  Deductible applies
The following are not covered under this benefit: <ul style="list-style-type: none"> <li>Whirlpools</li> <li>Portable whirlpool pumps</li> <li>Sauna baths</li> <li>Massage devices</li> <li>Over bed tables</li> <li>Elevators</li> <li>Communication aids</li> <li>Vision aids</li> <li>Telephone alert systems</li> <li>Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician</li> </ul>		
Nutritional support	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: <ul style="list-style-type: none"> <li>Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition</li> </ul>		

Eligible health services	In-network coverage	Out-of-network coverage
Osteoporosis (non-preventive care) Physician's or specialist's office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Prosthetic Devices & Orthotics Includes Cranial prosthetics ( <i>Medical wigs</i> )	80% (of the negotiated charge) per item  Deductible applies	50% (of the recognized charge) per item  Deductible applies
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Services covered under any other benefit</li> <li>• Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace</li> <li>• Trusses, corsets, and other support items</li> <li>• Repair and replacement due to loss, misuse, abuse or theft</li> <li>• Communication aids</li> <li>• Cochlear implants</li> </ul>		
Cochlear implants	80% (of the negotiated charge) per item  Deductible applies	50% (of the recognized charge) per item  Deductible applies
Hearing aid exams	80% (of the negotiated charge) per visit  Deductible applies	50% (of the recognized charge) per visit  Deductible applies
Hearing aid exam maximum	One hearing exam every policy year	
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay</li> </ul>		
Hearing aids	80% (of the negotiated charge) per item  Deductible applies	50% (of the recognized charge) per item  Deductible applies
Hearing aids maximum per ear	One hearing aid per ear every policy year	
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• A replacement of: <ul style="list-style-type: none"> <li>- A hearing aid that is lost, stolen or broken</li> <li>- A hearing aid installed within the prior 12 month period</li> </ul> </li> <li>• Replacement parts or repairs for a hearing aid</li> <li>• Batteries or cords</li> <li>• Cochlear implants</li> <li>• A hearing aid that does not meet the specifications prescribed for correction of hearing loss</li> <li>• Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist</li> </ul>		

<b>Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)</b>		
<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
Pediatric routine vision exams (including refraction)- Performed by a legally qualified ophthalmologist or optometrist Includes comprehensive low vision evaluations.	100% (of the negotiated charge) per visit  No deductible applies	50% (of the recognized charge) per visit  Deductible applies
Office visit for fitting of contact lenses	100% (of the negotiated charge) per visit  No deductible applies	50% (of the recognized charge) per visit  Deductible applies
Maximum visits per policy year Low vision Maximum Fitting of contact Maximum	1 visit  One comprehensive low vision evaluation every policy year 2 visits	
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per visit  No deductible applies	50% (of the recognized charge) per visit  Deductible applies
Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	One set of eyeglass frame One pair of prescription lens Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set	
* <b>Important note:</b> Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.		
The following are not covered under this benefit:		
<ul style="list-style-type: none"> <li>• Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes</li> </ul>		

<b>Outpatient prescription drugs</b>		
<b>Policy year deductible and copayment waiver for risk reducing breast cancer</b>		
The policy year deductible and the per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs filled at a retail in-network pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.		
<b>Policy year deductible and copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs</b>		
The policy year deductible and the per prescription copayment/coinsurance will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a retail in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%. Your policy year deductible and any prescription copayment/coinsurance will apply after those two regimens per policy year have been exhausted.		
<b>Outpatient prescription drug policy year deductibles</b>		
<b>A separate policy year deductible applies to prescription drugs</b>		
	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>Student</b>		\$500 per policy year
<b>Spouse</b>		\$500 per policy year
<b>Each Child</b>		\$500 per policy year
<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>Preferred generic prescription drugs</b>		
For each fill up to a 30 day supply filled at a retail pharmacy	20% copayment per supply	20% copayment per supply then the plan pays 60% (of the balance of the recognized charge)
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	20% copayment per supply	Not covered
<b>Preferred brand-name prescription drugs</b>		
For each fill up to a 30 day supply filled at a retail pharmacy	35% copayment per supply	35% copayment per supply then the plan pays 60% (of the balance of the recognized charge)
More than a 30 day supply but less than a 91 day supply	35% copayment per supply	Not covered

filled at a mail order pharmacy		
<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>Non-preferred brand-name prescription drugs</b>		
For each fill up to a 30 day supply filled at a retail pharmacy	50% copayment per supply	50% copayment per supply then the plan pays 60% (of the balance of the recognized charge)
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	50% copayment per supply	Not covered
<b>Preferred specialty prescription drugs</b>		
For each fill up to a 30 day supply filled at a retail pharmacy	50% copayment per supply	50% copayment per supply then the plan pays 60% (of the balance of the recognized charge)
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	50% copayment per supply	Not covered
<b>Important note:</b> Your cost share will not exceed \$150 per 30 day supply and \$300 per 90 day supply of a covered specialty drug.		
<b>Diabetic insulin &amp; supplies</b>		
30 day supply at retail pharmacy	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above
90 day supply at mail order pharmacy	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above
<b>Diabetic insulin important note:</b> Your cost share will not exceed \$25 per 30 day supply of a covered prescription insulin drug filled at a network pharmacy. No deductible applies for preferred insulin.		
Anti-cancer drugs taken by mouth- For each fill up to a 30 day supply	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
Preventive care drugs and supplements filled at a retail pharmacy For each 30 day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above

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

### Outpatient prescription drugs exclusions

The following are not eligible health services:

- Any services related to providing, injecting or application of a drug]
- Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Contraceptives (birth control)
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as an eligible health service
- Drugs or medications:
  - Administered or entirely consumed at the time and place they are prescribed or provided
  - Which do not require a prescription by law, even if a prescription is written, unless we have approved a medical exception
  - That are therapeutically the same or an alternative to a covered prescription drug, unless we approve a medical exception
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility
  - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as an eligible health service
  - That are indicated or used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food

supplements, non-prescription appetite suppressants or other medications except as described in the certificate

- That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature, unless there is evidence that the covered person meets one or more clinical criteria detailed in our precertification and clinical policies
- Duplicative drug therapy; for example, two antihistamines for the same condition
- Genetic care including:
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as an eligible health service
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
- Implantable drugs and associated devices except as specifically stated in the schedule of benefits or the certificate
- Infertility:
  - Prescription drugs used primarily for the treatment of infertility
- Injectables including:
  - Any charges for the administration or injection of prescription drugs
  - Needles and syringes except for those used for insulin administration
  - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- Prescription drugs:
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or prescription drugs for the treatment of a dental condition
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's drug guide
  - That are used for the purpose of improving visual acuity or field of vision
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card
- Prescription drugs indicated for the purpose of weight loss.
- Replacement of lost or stolen prescriptions
- Test agents except diabetic test agents

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

## General Exclusions

The following are not eligible health services under your plan:

### Abortion

- Services and supplies provided for an abortion

### Acupuncture

- Acupuncture
- Acupressure

### Behavioral health treatment

Services for the following based on categories, conditions, diagnoses or equivalent terms as listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association:

- School and/or education service including special education, remedial education, wilderness treatment programs, or any such related or similar programs
- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation

### Blood and blood products

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

### Contraceptive methods, procedures, services, and supplies for contraceptive purposes

- Contraceptive methods, procedures, services, and supplies for contraceptive purposes as elected by [the policyholder] due to an exemption or accommodation in accordance with applicable federal or state law and regulation
- Services provided as a result of complications resulting from voluntary sterilization procedure and related follow-up care

### Cosmetic services and plastic surgery

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

## **Court-ordered testing**

- Court-ordered testing or care unless medically necessary

## **Custodial care**

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

Examples of these are:

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

## **Dental care for adults**

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

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

## **Educational services**

Examples of these are:

- Any service or supply for education, training or retraining services or testing. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

## **Examinations**

Any health or dental examinations needed:

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

## **Experimental, investigational, or unproven**

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

## **Family planning services - other**

- Voluntary sterilization for males
- Abortion
- Reversal of voluntary sterilization procedures, including related follow-up care
- Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care

## **Gender Affirming Treatment**

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

## **Growth/Height care**

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

## **Jaw joint disorder**

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

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

#### **Maintenance care**

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

#### **Medical supplies – outpatient disposable**

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

#### **Non-U.S. citizen**

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

#### **Obesity surgery**

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

#### **Other primary payer**

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

#### **Personal care, comfort or convenience items**

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

### **Routine exams and preventive services and supplies**

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

### **School health services**

- Services and supplies normally provided by the policyholder's:
  - School health services
  - Infirmary
  - Hospital
  - Pharmacy
- Services and supplies provided by health professionals who the policyholder:
  - Employs
  - Is affiliated with
  - Has an agreement or arrangement with
  - Otherwise designates

### **Services not permitted by law**

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

### **Services provided by a family member**

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

### **Sexual dysfunction and enhancement**

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

### **Sports**

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

### **Strength and performance**

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

### **Students in mental health field**

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

## Telemedicine

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

## Therapies and tests

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

## Tobacco cessation

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

## Treatment in a federal, state, or governmental entity

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

## Treatment of infertility

- All infertility services associated with or in support of an ovulation induction cycle while on medication to stimulate the ovaries. This includes, but is not limited to, imaging, laboratory services, and professional services.
- Limited infertility services including Advanced Reproductive Technology (ART) and Fertility preservation services
- Infertility medication.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- Obtaining sperm from a person not covered under this plan.
- Infertility treatment when a successful pregnancy could have been obtained through less costly treatment.
- Infertility treatment when either partner has had voluntary sterilization surgery, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- Infertility treatment when infertility is due to a natural physiologic process such as age related ovarian insufficiency (e.g., perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period [or other abnormal testing results as outlined in Aetna's

infertility clinical policy

**Vision care for adults**

- Routine vision exam provided by an ophthalmologist or optometrist, including refraction and glaucoma testing
- Vision care services and supplies

**Wilderness treatment programs**

See *Educational services* within this section

**Work related illness or injuries**

- Coverage available to you under worker’s compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.

**Important Note:**

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

The Catholic University of America Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health<sup>SM</sup> is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).

## **Sanctioned Countries**

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

## **Assistive Technology**

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

## **Smartphone or Tablet**

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

## **Non-Discrimination**

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

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

These aids and services include:

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

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

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

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

