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

Virginia Tech

Policy Year: 2026–2027
Policy Number: 474968
www.aetnastudenthealth.com
(866) 577-7027

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

Virginia Tech Health Services

The Schiffert Health Center is the University's on-campus health facility. Staffed by physicians, nurse practitioners and registered nurses, it is open weekdays from 8:00 a.m. to 5:00 p.m., during the Fall and Spring semesters. A Physician and nurse practitioner are on call at all times, and conduct clinics during the week.

For more information, call the Health Services at **(540) 231-6444**. In the event of an emergency, call **911**.

Coverage Periods

Students/Eligible Dependents: Coverage will become effective at 12:00 AM on the Coverage Start Date indicated below and will terminate at 11:59 PM on the Coverage End Date indicated. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Certificate of Coverage.

Coverage Period	Coverage Start Date	Coverage End Date	Open Enrollment Deadline
Annual	08/01/2026	07/31/2027	08/31/2026
Spring /Summer	01/01/2027	07/31/2027	01/31/2027

Rates

	Annual	Spring Semester
Student	$3,993.00	$2,320.00
Spouse/Domestic Partner	$3,993.00	$2,320.00
Child	$3,993.00	$2,320.00
2+ Children	$7,986.00	$4,640.00

Coverage

Eligibility

Students must be enrolled as **full-time** students at the university on the first day that coverage will be effective. Students in Cooperative Education and serving approved internships off-campus or performing credited research hours are considered to be full-time students of the university. However, if the student takes fewer than full-time hours but is enrolled in the maximum number of hours allowed toward graduation (i.e. working on a dissertation), the student may obtain a statement to this effect in writing on the department's letterhead and with the signature of the department head. This confirmation should be sent to the Student Medical Insurance office. The student shall then be considered as full-time and shall be eligible to enroll in the university's insurance plans.

- Undergraduate Eligibility: 9 or more credit hours
- Graduate Eligibility: 6 or more credit hours

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- International Students with an F1 or J1 Visa, School of Medicine (VTCSOM) & Veterinary Medicine (DVM) Students are required to maintain health insurance either through the school sponsored plan or a comparable plan.
- Eligible Graduate Assistants wishing to use the health care subsidy must in enroll in the Virginia Tech sponsored plan.
- Visiting Scholars are required to maintain health insurance either though the schools sponsored plan or a comparable plan during their stay at Virginia Tech.
- Language and Culture Institute VT Advantage students.

Students must actively attend classes for at least the first **31 days**, after the date when coverage becomes effective.

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.

Enrollment

To enroll online, visit **risk.vt.edu/smi,** click on Enroll and follow the steps. Enrollment 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.)

ID Cards: To print an ID card, log on to **www.aetnastudenthealth.com**, search for your school, click on Get your ID card and follow the steps. Please note that the ID card will be available within 7-10 business days after enrollment is completed.

Please note: Visiting Scholar students must enroll through the Virginia Tech Student Medical Insurance office.

Waiver Process/Procedure

International Students with an F1 or J1 Visa, School of Medicine (VTCSOM) & Veterinary Medicine (DVM) Students are required to maintain health insurance either through the school sponsored plan or a comparable plan.

International Students

To meet the criteria of a comparable insurance plan, coverage must meet or exceed all of the following:

1. The policy must offer adequate provider care within a 50-mile/80-kilometer radius of the campus of enrollment.
2. The policy must have no annual or lifetime limits on medical, mental health, substance abuse, and prescription medication benefits, and have no internal limits on major coverages.
3. The policy must have an annual deductible of **$500** or less.
4. The policy must have no annual or lifetime limits on medical, mental health, substance abuse, and prescription medication benefits, and have no internal limits on major coverages.
5. The policy must provide a minimum of **$25,000** for repatriation of remains and **$50,000** medical evacuation to the home country.
6. Medical expenses for pregnancy, childbirth and complications of pregnancy must be treated as any other illness under the policy, regardless of gender.

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7. Coverage term date requirements:
    a. For student entering in the Summer: The policy must be valid from the student's first day of classes or mandatory program participation (varies by program) with coverage through July 31, the following year, if graduating, the last day of the month of the student's graduation.

    b. For students entering in the Fall: The policy must be valid from the first day of classes with coverage through July 31 the following year or, if graduating, the last day of the month of the student's graduation.
    c. For students entering in the Spring: The policy must be valid from the first day of classes with coverage through July 31 or, if graduating, the last day of the month of the student's graduation.

VTCSOM & Veterinary Medicine DVM Students
To meet the criteria of a comparable insurance plan, coverage must meet or exceed all of the following:

1. The policy must have at least $500,000 each in coverage for medical, prescription, mental health, and substance abuse coverage benefits with no exclusion for club, intramural, or extramural sports.
2. The policy annual deductible must be $2500 or less.
3. Medical expenses for pregnancy, childbirth, and complications of pregnancy must be treated as any other illness under the policy, regardless of gender.
4. The policy must cover pre-existing conditions for the entire policy term with no waiting period.
5. The policy must be valid from the student's first day of classes or mandatory program participation (varies by program) with coverage through July 31 the following year or, if graduating, the last day of the month of the student's graduation.

Waiver submissions will be audited by Virginia Tech, 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.

All International, School of Medicine (VTCSOM), and Veterinary Medicine (DVM) Students will automatically be enrolled in the university-sponsored insurance plan if the requirement is not met by the deadline. There are no exemptions from this requirement. Waivers must be remitted by the deadlines listed below.

Waiver Deadline Dates
1. Students enrolling for the Fall Semester- 08/31/2026
2. Students enrolling for the Spring Semester- 01/31/2027

Dependent Coverage

Eligibility

If your plan includes dependent coverage, you can enroll the following family members on your plan:

- Your legal spouse that resides with you
- Your domestic partner who meets the rules set by the policyholder and requirements under state law
- Your dependent children – your own or those of your spouse or domestic partner
    - The children must be under 26 years of age, and they include:
        - Biological children
        - Stepchildren
        - Legally adopted children
        - A child legally placed with you for adoption (including a foster child)
        - Foster children

Verification of Dependent status may be required.

If a child is covered based on being a full-time student and he/she can't attend school because of a medical condition, the plan must allow the child to stay on the plan, if certified by a physician as medically necessary, until the earlier of 12 months or when coverage would otherwise terminate for the dependent.

Enrollment

To enroll the dependent(s) of a covered student, please complete the Enrollment by visiting **www.aetnastudenthealth.com**, selecting the school name, and clicking on Enroll. Please refer to the Coverage Periods section of this document for coverage dates and deadline dates. Dependent enrollment 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 and premium must be sent to Aetna Student Health.

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

Newborn child

- Your newborn child is covered on your health plan for the first 60 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 60-day period.
- You must still enroll the child within 60 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 60 days.
- If your coverage ends during this 60-day period, then your newborn's coverage will end on the same date as your coverage. This applies even if the 60-day period has not ended.

Adopted child or a child legally placed with you for adoption

A child that you, or you and your spouse or domestic partner adopt, or that is placed with you for adoption is covered on your plan for the first 60 days after the adoption or the placement is complete.

- To keep your child covered, we must receive your completed enrollment information within 60 days after the adoption or placement for adoption.
- You must still enroll the child within 60 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 60 days.
- If your coverage ends during this 60-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 60-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 60 days from the court order.

- To keep your dependent covered, we must receive your completed enrollment information within 60 days of the court order.
- You must still enroll the dependent within 60 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 60 days.
- If your coverage ends during this 60-day period, then your dependent's coverage will end on the same date as your coverage. This applies even if the 60-day period has not ended.

Foster child

A foster child is covered on your plan for the first 60-day period after obtaining legal responsibility as a foster parent. A foster child is a child whose care, comfort, education, and upbringing are left to persons other than the natural parents.

- To keep your foster child covered, we must receive your completed enrollment information within 60 days after the date the child is placed with you.
- If you miss this deadline, your foster child will not have health benefits after the first 60-day period.
- If your coverage ends during this 60-day period, then your foster child's coverage will end on the same date as your coverage. This applies even if the 60-day period has not ended.

For information or general questions on dependent enrollment, contact Student Medical Insurance at **(540) 231-6226**

Medicare Eligibility Notice

You are not eligible to enroll in the student health plan if you have Medicare at the time of enrollment in this student plan. 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 payment has been received and no premiums will be refunded.

Withdrawal from Classes – Other than Leave of Absence

If you withdraw from classes other than under a school-approved leave of absence within 31 days after the policy effective date, you will be considered ineligible for coverage, your coverage will be terminated retroactively and any premiums collected will be refunded. If the withdrawal is more than 31 days after the policy effective date, your coverage will remain in force through the end of the period for which payment has been received and no premiums will be refunded. If you withdraw from classes to enter the armed forces of any country, coverage will terminate as of the effective date of such entry and a pro rata refund of premiums will be made if you submit a written request within 90 days of withdrawal from classes.

Preferred Provider Network

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

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

Precertification

You need pre-approval from us for some eligible health services. Pre-approval is also called precertification. Your Preferred Care physician is responsible for obtaining any necessary precertification before you get the care. When you go to an Non-Preferred Care provider, it is your responsibility to obtain precertification from us for any services and supplies on the precertification list. If you do not precertify when required, there is a **$200** penalty for each type of eligible health service that was not precertified. For a current listing of the health services or prescription drugs that require precertification, contact Member Services or go to **www.aetna.com**.

Precertification Call

Precertification should be secured within the timeframes specified below. For emergency services, precertification is not required, but you should still notify us within the timeframes listed below. That includes an emergency interhospital transfer for a life-threatening condition for a newborn and for the mother to accompany the newborn.

Non-emergency admissions:	You, your physician or the facility will need to call and request precertification at least 15 days before the date you are scheduled to be admitted.
An emergency admission:	You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
An urgent admission:	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.
Outpatient non-emergency services requiring precertification:	You or your physician must call at least 15 days before the outpatient care is provided, or the treatment or procedure is scheduled.
Delivery:	You, your physician, or the facility must call within 48 hours of the birth or as soon thereafter as possible. No penalty will be applied for the first 48 hours after delivery for a routine delivery and 96 hours for a cesarean delivery.

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 precertified services are approved, the approval is valid for 60 days as long as you remain enrolled in the plan.

What if you don't obtain the required pre-certification?

If you don't obtain the required pre-certification:

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

What types of services and supplies require pre-certification?

Pre-certification is required for the following types of services and supplies:

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

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

Coordination of Benefits (COB)

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB). 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 **www.aetnastudenthealth.com**. If any discrepancy exists between this Benefit Summary and the Certificate of Coverage, the Certificate will control.

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

	Preferred Care Coverage	Non-Preferred Care Coverage

Policy year deductibles		
You have to meet your policy year deductible before this plan pays for benefits.		
Student	$450 per policy year	$1,000 per policy year
Spouse or domestic partner	$450 per policy year	$1,000 per policy year
Each child	$450 per policy year	$1,000 per policy year
Family	$900 per policy year	$2,000 per policy year

Policy year deductible waiver

The policy year deductible is waived for Preferred Care covered medical expenses that apply to Preventive Care Expense benefits.

In addition to federal requirements for waiver of the policy year deductible, this Plan will waive the Deductible for:

- Preferred and Non-Preferred Care Emergency Room Services
- Preferred and Non-Preferred Care Emergency ground, air, and water ambulance (includes non-emergency ambulance),
- Non-Preferred Care Preventive Health Care Services up to age 7,
- Preferred and Non-Preferred Care Pediatric Care Vision Benefit Expenses,
- Preferred Care Pediatric Dental Services Expenses,
- Preferred Care Nutritional support,
- Preferred Care Adult Vision Exam and Vision Supplies Expense,
- Preferred Care Office Visit Expense,
- Preferred Care Walk-in Clinic Visit Expense
- Preferred Care Hearing aids for minors
- Preferred Care Outpatient Treatment of Mental Disorders Expense,
- Preferred Care Outpatient Treatment of Substance Abuse Expense,
- Preferred Care Urgent Care Expense, and
- Preferred Care Non-Elective Second Surgical Opinion Expense.

Per visit or admission deductibles do not apply towards satisfying the policy year deductible.

Individual Deductible

This is the amount you are obliged to pay for Preferred Care and Non-Preferred Care eligible health services each policy year before the plan begins to pay for eligible health services. This policy year deductible applies separately to you and each of your covered dependents. After the amount you pay for eligible health services reaches the policy year deductible, this plan will begin to pay for eligible health services for the rest of the policy year. Refer to the schedule of benefits section of this document for coverage percentages of individual services.

Family Deductible

This is the amount you and your covered dependents are obliged to pay for Preferred Care and Non-Preferred Care eligible health services each policy year before the plan begins to pay for eligible health services. After the amount you and your covered dependents pay for eligible health services reaches this family policy year deductible, this plan will begin to pay for eligible health services that you and your covered dependents incur for the rest of the policy year. Refer to the schedule of benefits section of this document for coverage percentages of individual services.

To satisfy this family policy year deductible limit for the rest of the policy year, the following must happen:

- The combined eligible health services that you and each of your covered dependents incur towards the individual policy year deductibles must reach this family policy year deductible limit in a policy year.

When this occurs in a policy year, the individual policy year deductibles for you and your covered dependents will be considered met for the rest of the policy year.

Eligible health services applied to the Non-Preferred Care policy year deductibles will not be applied to satisfy

the Preferred Care policy year deductibles. Eligible health services applied to the Preferred Care policy year deductibles will not be applied to satisfy the Non-Preferred Care policy year deductibles.

The medical policy year deductibles will not be applied to satisfy the prescription drug policy year deductibles. The prescription drug policy year deductibles will not be applied to satisfy the medical policy year deductibles.

Maximum out-of-pocket limits		
	Preferred Care Coverage	**Non-Preferred Care Coverage**
Student	$6,250 per policy year	
Spouse or domestic partner	$6,250 per policy year	
Each child	$6,250 per policy year	
Family	$12,500 per policy year	

Once the Individual or Family Out-of-Pocket Limit has been satisfied, Covered Medical Expenses will be payable at **100%** for the remainder of the policy year.

The following expenses do not apply toward meeting the plan's out-of-pocket limits:

- Non-covered medical expenses; and
- Expenses that are not paid or pre-certification benefit reductions or penalties because a required pre-certification for the service(s) or supply was not obtained from Aetna.

Referral requirement

Students who have initiated care at Schiffert Health Center prior to seeking care in the community and have been referred to an outside provider for treatment are eligible to receive enhanced benefits for services when care is provided by a preferred care provider shown as preferred coverage with Referral in the below schedule of benefits. **A new referral must be obtained each policy year**.

If a referral is received, preferred care coinsurance increases from 80% to 90% for services rendered at a hospital. A referral is not required in the following circumstances:

- Emergency Room Services
- Treatment received when Schiffert Health Center is closed.
- Care received outside a 20-mile radius from the Blacksburg Campus
- Maternity
- Satellite Campus enrolled students
- Treatment is for an Emergency Medical Condition
- Obstetric and Gynecological Treatment
- Pediatric Care
- Preventive/Routine Services (services considered preventive according to Health Care Reform and/or services rendered not to diagnosis or treat an Accident or Sickness).

*Dependents and Visiting Scholars are not eligible to use the services of the School Health Service and therefore cannot received enhanced benefits shown in tier 1 of the schedule of benefits.

All labs and services provided at Schiffert Health Center are covered at **100%**. Students should submit their itemized paid statements to Aetna Student Health for reimbursement. Retroactive referral requests will not be accepted or processed.

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.

Tier I: When a Schiffert Health Center referral is obtained, benefits will be paid at the **Tier I** Level when rendered by a **Preferred Care** provider.

Tier II: When a referral is not obtained but care is rendered by a **Preferred Care** provider, benefits will be paid at the **Tier II** Level.

Tier III: When care is rendered by a **Non-Preferred Care** provider, benefits will be paid at the **Tier III** Level.

Eligible health services	**Tier I Preferred Care Coverage with Referral**	**Tier II Preferred Care Coverage without Referral**	**Tier III Non-Preferred Care Coverage**
Physician and specialist services			
Physician and specialist services (non-surgical and non-preventive) - Office hours visits (non-surgical and non-preventive care by a physician and specialist, includes telemedicine consultations)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	65% (of the recognized charge) per visit
Urgent care			
Urgent care provided by an urgent care provider – visit charge *For coverage of complex imaging services, lab work, and radiological services performed during an urgent medical care visit, refer to the "outpatient diagnostic testing" section.*	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$25 copayment then the plan pays 65% (of the balance of the recognized charge) per visit
Urgent care facility: A facility licensed as a freestanding medical facility by applicable state and federal laws to treat an urgent condition. **Urgent condition:** An illness or injury that requires prompt medical attention but is not an emergency medical condition. An urgent condition includes earache, sore throat, and fever (not above 104 degrees).			
Non-urgent use of an urgent care provider	Not covered	Not covered	Not covered

The following is not covered under this benefit:

- Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)

If you go to an urgent care facility for what is not an urgent condition, the plan will not cover your expenses.

Examples of non-urgent care are:

- Routine or preventive care (this includes immunizations)
- Follow-up care
- Physical therapy
- Elective treatment
- Any diagnostic lab work and radiological services which are not related to the treatment of the urgent condition

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Alternatives to physician office visits			
Walk-in clinic visits (non-emergency visit)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	65% (of the recognized charge) per visit
Consultant services (non-surgical and non-preventive)			
Consultant services - Office hours visits (non-surgical and non-preventive care) Includes telemedicine consultations	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	80% (of the recognized charge) per visit
Routine physical exams			
Performed at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Under 7 years of age – 100% of the recognized charge per visit, no copayment or deductible applies 7 years of age or older - 100% of the recognized charge per visit, policy year 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. For details, contact your physician or Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.		
Routine physical exam limits for covered persons age 22 and over: maximum visits per policy year	1 visit		

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Preventive care immunizations			
Performed in a facility or at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	Under 7 years of age – 100% of the recognized charge per visit, no copayment or deductible applies 7 years of age or older - 100% of the recognized charge per visit, policy year 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. For details, contact your physician or Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.		
The following is not covered under this benefit: • Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment.			
Routine gynecological exams (including Pap smears and cytology tests)			
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	65% (of the recognized charge) per visit
Maximum visits per policy year	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.		
Preventive screening and counseling services In figuring the maximum visits, each session of up to 60 minutes is equal to one visit			
Preventive screening and counseling services for obesity and/or healthy diet counseling	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	65% (of the recognized charge) per visit
Obesity and/or healthy diet counseling - Maximum visits	Age 0-22: unlimited visits. Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.		

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Preventive screening and counseling services (continued)			
Preventive screening and counseling services for misuse of alcohol & drugs	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	65% (of the recognized charge) per visit
Misuse of alcohol and/or drugs counseling - Maximum visits per policy year	5 visits		
Preventive screening and counseling services for use of tobacco products	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	65% (of the recognized charge) per visit
Use of tobacco products counseling - Maximum visits per policy year	8 visits		
Preventive screening and counseling services for sexually transmitted infection counseling	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	65% (of the recognized charge) per visit
Sexually transmitted infection counseling - Maximum visits per policy year	2 visits		
Preventive screening and counseling services genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	65% (of the recognized charge) per visit
Genetic risk counseling for breast and ovarian cancer limitations	Not subject to any age or frequency limitations		
Routine cancer screenings ***(continued on next page)***	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	65% (of the recognized charge) per visit

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Preventive screening and counseling services (continued)			
Routine cancer screenings - Maximum:	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, refer to the *Routine cancer screenings* section of your certificate of coverage, or contact your physician or Member Services by logging in to your Aetna website at **www.aetnastudenthealth.com** or calling the toll-free number on your ID card.		
Lung cancer screening maximum	1 screening every 12 months*		
***Important note:** Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *Outpatient diagnostic testing* section.			
Prenatal care services (provided by a physician, an obstetrician (OB), gynecologist (GYN), and/or OB/GYN)			
Preventive care services only	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	65% (of the recognized charge) per visit
Important note: You should review the *Maternity care and Well newborn nursery care* sections. They will give you more information on coverage levels for maternity care under this plan.			
Comprehensive lactation counseling services			
Lactation counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	65% (of the recognized charge) per visit
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits		
Important note: Any visits that exceed the lactation counseling services maximum are covered under the *Physicians and other health professionals* section.			

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Comprehensive lactation support and counseling services (continued)			
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	100% (of the negotiated charge) per item No copayment or policy year deductible applies	80% (of the recognized charge) per item
Maximums	An electric breast pump (non-hospital grade, cost is covered by your plan once every three years) or a manual breast pump (cost is covered by your plan once per pregnancy) If an electric breast pump was purchased within the previous three-year period, the purchase of another electric breast pump will not be covered until a three-year period has elapsed since the last purchase.		
Family planning services – female contraceptives			
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	65% (of the recognized charge) per visit
Contraceptives (prescription drugs and devices)			
Female contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit (a 12-month supply of hormonal contraceptives will be covered under the plan when dispensed or furnished at one time)	100% (of the negotiated charge) per item No copayment or policy year deductible applies	100% (of the negotiated charge) per item No copayment or policy year deductible applies	65% (of the recognized charge) per item
Female voluntary sterilization			
Female Voluntary sterilization - Inpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	100% (of the negotiated charge) No copayment or policy year deductible applies	65% (of the recognized charge)
Female Voluntary sterilization - Outpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	100% (of the negotiated charge) No copayment or policy year deductible applies	65% (of the recognized charge)
The following are not covered under this benefit: • Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care • Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA • Male contraceptive methods, sterilization procedures or devices, except for male condoms prescribed by a provider			

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Family planning services – other			
Voluntary sterilization for males - surgical services	90% (of the negotiated charge)	80% (of the negotiated charge)	65% (of the recognized charge)
The following are not covered under this benefit: • Reversal of voluntary sterilization procedures, including related follow-up care			
Abortion			
Inpatient physician or specialist surgical services	90% (of the negotiated charge)	80% (of the negotiated charge)	65% (of the recognized charge)
Outpatient physician or specialist surgical services	90% (of the negotiated charge)	80% (of the negotiated charge)	65% (of the recognized charge)
Maternity care			
Maternity care (includes delivery and postpartum care services in a hospital or birthing center) Coverage is provided under the same terms, conditions as any other **illness**.	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
The following are not covered under this benefit: • Any services and supplies related to births that take place in the home, except for home delivery by a certified nurse midwife, or in any other place not licensed to perform deliveries			
Well newborn nursery care in a hospital or birthing center	90% (of the negotiated charge) No policy year deductible applies	90% (of the negotiated charge) No policy year deductible applies	65% (of the recognized charge) No policy year deductible applies
Note: *The per admission copayment amount and/or policy year deductible for newborns will be waived for nursery charges for the duration of the newborn's initial routine facility stay. The nursery charges waiver will not apply for non-routine facility stays.*			
Care and treatment for the newborn to correct functional impairment caused by congenital defects and birth abnormalities (including inpatient and outpatient dental services, dental appliances, oral surgical, and orthodontic services that are medically necessary for the treatment of cleft lip, cleft palate or ectodermal dysplasia)	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

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Physician and specialist -inpatient surgical services			
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthesiologist, anesthetist and surgical assistant expenses)	90% (of the negotiated charge)	80% (of the negotiated charge)	65% (of the recognized charge)
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • Services of another physician for the administration of a local anesthetic unless approved by the plan as **medically necessary**			
Physician and specialist -outpatient surgical services			
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthesiologist, anesthetist and surgical assistant expenses)	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic unless approved by the plan as medically necessary			
Outpatient surgery (facility charges)			
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
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 unless approved by the plan as medically necessary			

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Hospital and other facility care			
Inpatient hospital (room and board and other miscellaneous services and supplies) Includes birthing center facility charges	$300 copayment then the plan pays 90% (of the balance of the negotiated charge) per admission	$300 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission	$300 copayment then the plan pays 65% (of the balance of the recognized charge) per admission
The following are not eligible health services: • All services and supplies provided in: - Rest homes - Any place considered a person's main residence or providing mainly custodial or rest care - Health resorts - Spas - Schools or camps			
Room and board for intensive care	$300 copayment then the plan pays 90% (of the balance of the negotiated charge) per admission	$300 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission	$300 copayment then the plan pays 65% (of the balance of the recognized charge) per admission
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	Covered according to the type of benefit and the place where the service is received
In-hospital non-surgical physician services			
In-hospital non-surgical physician services	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
Adult vision care - Limited to covered persons age 19 and over			
Adult routine vision exams (including refraction) performed by a legally qualified ophthalmologist or therapeutic optometrist, or any other providers acting within the scope of their license	$15 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$15 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	65% (of the recognized charge) per visit
Maximum visits per policy year	1 visit		
Vision correction after surgery or accident	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

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Adult vision care - Limited to covered persons age 19 and over (continued)			
Eyeglass frames, prescription lenses or prescription contact lenses*	$15 copayment then the plan pays 100% (of the balance of the negotiated charge) per item No policy year deductible applies	$15 copayment then the plan pays 100% (of the balance of the negotiated charge) per item No policy year deductible applies	$15 copayment then the plan pays 65% (of the balance of the recognized charge) per item
Maximum per policy year eyeglass frames, prescription lenses or prescription contact lenses	$120		
***Important note**: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. **Coverage does not include the office visit for the fitting of prescription contact lenses.**			
The following are not covered under this benefit: Adult vision care • Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes Adult vision care services and supplies • Special supplies such as non-prescription sunglasses • Special vision procedures, such as orthoptics or vision therapy • Eye exams during your stay in a hospital or other facility for health care • Replacement of lenses or frames that are lost or stolen or broken • Acuity tests • Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures • Services to treat errors of refraction			
Behavioral Health & Substance Use Related Disorders Treatment			
Inpatient hospital mental health disorders treatment (room and board) Inpatient residential treatment facility mental health disorders treatment (room and board) Coverage is provided under the same terms, conditions as any other illness	$300 copayment then the plan pays 90% (of the balance of the negotiated charge) per admission	$300 copayment then the plan pays 90% (of the balance of the negotiated charge) per admission	$300 copayment then the plan pays 65% (of the balance of the recognized charge) per admission

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Behavioral Health & Substance Use Related Disorders Treatment (continued)			
Outpatient office visits (includes telemedicine consultations)	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	65% (of the recognized charge) per visit
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program) (includes skilled behavioral health services in the home)	90% (of the negotiated charge)	80% (of the negotiated charge)	65% (of the recognized charge)
Transplant services			
Inpatient and outpatient transplant facility services	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		
Transplant services – travel and lodging	Covered		

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	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19)			
Type A services	100% (of the negotiated charge) per visit No copayment or deductible applies	100% (of the negotiated charge) per visit No copayment or deductible applies	65% (of the recognized charge) per visit
Type B services	70% (of the negotiated charge) per visit No policy year deductible applies	70% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Type C services	50% (of the negotiated charge) per visit No policy year deductible applies	50% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Orthodontic services	50% (of the negotiated charge) per visit No policy year deductible applies	50% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit
Dental emergency **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

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
- Crowns to alter vertical dimension
- Dental implants and braces (that are determined not to be medically necessary) and mouth guards (not including an occlusal guard for grinding and clenching of teeth)

(continued on next page)

Pediatric dental care exclusions (continued)

The following are not covered under this benefit:

- Orthodontic treatment except as covered above and in the *Pediatric dental care* section of the schedule of benefits
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs or pre-medication
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically provided in the *Pediatric dental care* section of the schedule of benefits
- 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, except when medically necessary
- Treatment by other than a dental provider

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)			
Pediatric routine vision exams (including refraction) performed by a legally qualified ophthalmologist or optometrist (includes comprehensive low vision evaluations)	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the negotiated charge) per visit No policy year deductible applies	65% (of the recognized charge) per visit No policy year deductible applies
Office visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the negotiated charge) per visit No policy year deductible applies	65% (of the recognized charge) per visit No policy year deductible applies
Maximum visits per policy year Low vision Maximum Fitting of contact Maximum	1 visit One comprehensive low vision evaluation every policy year 1 visit		
Vision correction after surgery or accident	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
Pediatric vision care services & supplies - Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item No policy year deductible applies	100% (of the negotiated charge) per item No policy year deductible applies	65% (of the recognized charge) per item No policy year 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 frames One pair of standard single vision, bifocal, trifocal, or progressive prescription lenses Daily disposables: up to 3-month supply Extended wear disposable: up to 6-month supply Non-disposable lenses: one set		
Optical devices	100% (of the negotiated charge) per item No policy year deductible applies	100% (of the negotiated charge) per item No policy year deductible applies	65% (of the recognized charge) per item No policy year deductible applies
Maximum number of optical devices per policy year	One optical device		

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Pediatric vision care (continued) (Limited to covered persons through the end of the month in which the person turns age 19)			
***Important note**: 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: • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes • Non-elective contact lenses if you have undergone prior elective corneal surgery, such as radial keratotomy (RK), photorefractive keratectomy (PRK), or LASIK			
Allergy testing and treatment			
Allergy testing performed at a physician's or specialist's office	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
Allergy injections treatment performed at a physician's or specialist's office	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
Allergy sera and extracts administered via injection at a physician's or specialist's office	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
Alternatives to hospital stays			
Home Health Care			
Outpatient	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	80% (of the recognized charge) per visit
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			

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Hospice Care			
Hospice - Inpatient	80% (of the negotiated charge) per admission	80% (of the negotiated charge) per admission	65% (of the recognized charge) per admission
Hospice - Outpatient	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
The following are not covered under this benefit: • Funeral arrangements • Pastoral counseling • Financial or legal counseling which includes estate planning and the drafting of a will • Services which are not related to your care and may include: - Sitter or companion services for either you or other family members except for respite care - Transportation - Maintenance of the house			
Private Duty Nursing			
Outpatient	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	80% (of the recognized charge) per visit
Maximum per policy year	64 hours		
Skilled Nursing Facility			
Inpatient	$300 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission	$300 copayment then the plan pays 80% (of the balance of the negotiated charge) per admission	$300 copayment then the plan pays 65% (of the balance of the recognized charge) per admission

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Emergency Services			
Emergency room	$300 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$300 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	Paid the same as Preferred Care coverage

The following are not covered under this benefit:

- Non-emergency services in a hospital emergency room facility or an independent freestanding emergency department

If you go to an emergency room for what is not an emergency medical condition, the plan will not cover your expenses. We will consider a medical condition an "emergency medical condition" based upon whichever one of the following is most favorable to you as they are reported to us by the hospital emergency room provider:

- The presenting symptoms, or
- The final diagnosis of the medical condition

Important note:

- As Non-Preferred Care 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 or call Member Services for an address at 1-866-577-7027 and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill.
- A separate emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived and your inpatient copayment/coinsurance will apply.
- Covered benefits that are applied to the 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.
- 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.
- 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.

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Adult dental care for cancer treatments and dental injuries			
Adult dental care for cancer treatments	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	80% (of the actual charge) per visit
Accidental injury to sound natural teeth	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	80% (of the actual charge) per visit
Covered services do not include an injury that results from chewing or biting.			
The following are not covered under this benefit: • The care, filling, removal or replacement of teeth and treatment of diseases of the teeth • Dental services related to the gums • Apicoectomy (dental root resection) • Orthodontics • 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			
Specific conditions			
Diabetic services and supplies (including equipment and training)			
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Impacted wisdom teeth			
Impacted wisdom teeth	80% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	80% (of the actual charge) per visit
Blood and body fluid exposure			
Blood and body fluid exposure	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
Bones or joints of the head, neck, face or jaw treatment			
Jaw joint disorder, temporomandibular joint dysfunction (TMJ) and craniomandibular disorders (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	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			

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Dermatological treatment			
Dermatological treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	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			
Gender affirming treatment			
Surgical, hormone replacement therapy, and counseling treatment* **Pre-certification needed for some services. See important note below.*	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
***Important Note**: Just log into your secure website at **www.aetnastudenthealth.com** for detailed information about this covered benefit, including eligibility requirements in Aetna's clinical policy bulletin #0615. You can also call *Member Services* at the toll-free number on the back of your ID card.			
All other cosmetic services and supplies not listed under eligible health services above are not covered under this benefit. This includes, but is not limited to the following: • Rhinoplasty • Face-lifting • Lip enhancement • Facial bone reduction • Blepharoplasty • Liposuction of the waist (body contouring) • Reduction thyroid chondroplasty (tracheal shave) • Nipple reconstruction • Hair removal (including electrolysis of face and neck) • Voice modification surgery (laryngoplasty or shortening of the vocal cords), and skin resurfacing, which are used in feminization • Voice and communication therapy • Chest binders • Chin implants, nose implants, and lip reduction, which are used to assist masculinization, are considered cosmetic			

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Autism spectrum disorder There are no visit limits for any eligible health services to diagnose or treat autism spectrum disorder.			
Autism spectrum disorder treatment, diagnosis and testing. Includes Applied behavior analysis** and Physical, occupational, and speech therapy associated with dinosis of autism spectrum disorder	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
****Important note**: Applied behavior analysis requires pre-certification by Aetna. Your Preferred Care provider is responsible for obtaining pre-certification. You are responsible for obtaining pre-certification when you use a Non-Preferred Care provider.			
Obesity surgery and services			
Obesity surgery and 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
Obesity surgery and services The following are not eligible health services: • Weight management treatment. • Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the certificate. • Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes: - 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.			
Oral Surgery			
Oral surgery	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

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Infertility services			
Treatment of basic infertility	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Infertility services exclusions The following are not covered under the infertility services benefit: • 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. • Infertility medication. • Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue. • Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue. • All charges associated with or in support of surrogacy arrangements for you or the surrogate when the surrogate is not a covered person under your plan. 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.			
Specific therapies and tests			
Outpatient diagnostic testing			
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	90% (of the negotiated charge)	80% (of the negotiated charge)	65% (of the recognized charge)
Diagnostic lab work and radiological services performed in a physician's office, the outpatient department of a hospital or other facility	90% (of the negotiated charge)	80% (of the negotiated charge)	65% (of the recognized charge)

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Outpatient Chemotherapy, Radiation, Respiratory & Outpatient infusion therapy (including medical formulas)			
Outpatient Chemotherapy, Radiation, Respiratory & Outpatient infusion therapy (including medical formulas)	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
Outpatient infusion therapy (including medical formulas) 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	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			
Rehabilitation and habilitation therapy services			
Outpatient physical, occupational, speech (including speech language therapies) and cognitive therapies (including Cardiac and Pulmonary Therapy)	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
The following are not covered services: • Home programs, other than home health care services, on-going conditioning, or maintenance care.			
Early intervention services			
Early intervention services include speech and language therapy, physical and occupational therapies and assistive technology services and devices Limited to covered dependents to age 3 No visit limit applies for physical, occupational or speech therapy 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

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Spinal manipulation (chiropractic, osteopathic and manipulation therapy services)			
Spinal manipulation chiropractic, osteopathic, and manipulation services Includes rehabilitation and habilitation services	90% (of the negotiated charge) per visit	80% (of the negotiated charge) per visit	65% (of the recognized charge) per visit
Specialty prescription drugs (Purchased and injected or infused by your provider in an outpatient setting)			
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit 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
Other services and supplies			
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	$300 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	$300 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	Paid the same as Preferred Care coverage
The following are not covered under this benefit: • Non-emergency fixed wing air ambulance from a Non-Preferred Care provider • Ambulance services for routine transportation to receive outpatient or inpatient services			
Clinical trial - Routine patient costs	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Clinical trial - 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	Covered according to the type of benefit and the place where the service is received
The following are not eligible health services: • Services and supplies related to data collection and record-keeping needed only for the clinical trial • Services and supplies provided by the trial sponsor for free • 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)			

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Other services and supplies (continued)			
Durable medical and surgical equipment including supplies and equipment needed for the use of DME	80% (of the negotiated charge) per item	80% (of the negotiated charge) per item	65% (of the recognized charge) per item
The following are not covered under this benefit: • Whirlpools • Portable whirlpool pumps • Sauna baths • Massage devices • Over bed tables • Elevators • Communication aids • Vision aids • Telephone alert systems • Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician			
Nutritional support	100% (of the negotiated charge) per item No policy year deductible applies	100% (of the negotiated charge) per item No policy year deductible applies	65% (of the recognized charge) per item
Enteral formulas and nutritional supplements Eligible health services include enteral formulas and nutritional supplements used to treat malabsorption of food caused by: • Crohn's Disease • Ulcerative colitis • Gastroesophageal reflux • Gastrointestinal motility • Chronic intestinal pseudo-obstruction • Phenylketonuria • Eosinophilic gastrointestinal disorders • Inherited diseases of amino acids and organic acids ***(continued on next page)***			

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Enteral formulas and nutritional supplements (continued) Covered benefits also include food products modified to be low in protein for inherited diseases of amino acids and organic acids. For purposes of this benefit, "low protein modified food product" means foods that are specifically formulated to have less than one gram of protein per serving and are intended to be used under the direction of a physician for the dietary treatment of any inherited metabolic illness. Low protein modified food products do not include foods that are naturally low in protein. Your physician must give you a written order for these supplies.			
Enteral formulas and nutritional supplements The following are not covered under this benefit: • Any other 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, except as described above, if the item can be obtained over-the-counter and without a written prescription.			
Lymphedema	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
Prosthetic devices			
Orthotics	80% (of the negotiated charge) per item	80% (of the negotiated charge) per item	80% (of the recognized charge) per item
Prosthetic Devices & Cranial prosthetics (medical wigs) after cancer treatment	80% (of the negotiated charge) per item	80% (of the negotiated charge) per item	80% (of the recognized charge) per item
The following are not covered under this benefit: • Services covered under any other benefit • Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace • Trusses, corsets, and other support items • Repair and replacement due to loss, misuse, abuse or theft • Communication aids			
Cochlear implants			
Cochlear implants	80% (of the negotiated charge) per item	80% (of the negotiated charge) per item	80% (of the recognized charge) per item

Eligible health services	Tier I Preferred Care Coverage with Referral	Tier II Preferred Care Coverage without Referral	Tier III Non-Preferred Care Coverage
Hearing aids for minors			
Hearing aids for minors	100% (of the negotiated charge) per item No copayment or policy year deductible applies	100% (of the negotiated charge) per item No copayment or policy year deductible applies	80% (of the recognized charge) per item
Hearing aids for minors - maximum	Coverage is limited to 1 hearing aid per hearing-impaired ear every 24 months up to $1,500 per hearing aid. Covered services are for children 18 years of age or younger.		
The following are not covered services: • Replacement of a hearing aid that is lost, stolen, or damaged through neglect • Replacement parts or repairs for a hearing aid • Batteries after the initial is provided or cords • A hearing aid that does not meet the specifications prescribed for correction of hearing loss			
Podiatric (foot care) treatment			
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	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Services and supplies for: - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working, or wearing shoes - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet			
Outpatient prescription drugs			
Outpatient prescription drug policy year deductibles **A separate policy year deductible applies to prescription drugs**			
You have to meet your prescription drug policy year deductibles below before this plan pays for outpatient prescription drug benefits.			
Student	$100 per policy year		
Spouse or domestic partner	$100 per policy year		
Each child	$100 per policy year		
Policy year deductible and copayment/coinsurance waiver for risk reducing breast cancer drugs			
The outpatient prescription drug policy year deductible and the prescription drug copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs filled at a retail Preferred Care pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.			

Policy year deductible and copayment/coinsurance waiver for tobacco cessation prescription and over-the-counter drugs

The outpatient prescription drug policy year deductible and the prescription drug 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 Preferred Care pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%.

Your outpatient prescription drug policy year deductible and any prescription drug copayment/coinsurance will apply after those two regimens per policy year have been exhausted.

Policy year deductible and copayment/coinsurance waiver for contraceptives

The outpatient prescription drug policy year deductible and the prescription drug copayment/coinsurance will not apply to female contraceptive methods when obtained at a Preferred Care pharmacy.

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

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

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

Eligible health services	Preferred Care coverage	Non-Preferred Care coverage
Preferred generic prescription drugs		
For each fill up to a 30-day supply filled at a retail pharmacy	$15 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	$15 copayment per supply then the plan pays 100% (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	$45 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	Not covered
Preferred brand-name prescription drugs		
For each fill up to a 30-day supply filled at a retail pharmacy	$45 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	$45 copayment per supply then the plan pays 100% (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	$135 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	Not covered
Non-preferred generic prescription drugs		
For each fill up to a 30-day supply filled at a retail pharmacy	$75 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	$75 copayment per supply then the plan pays 100% (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	$225 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	Not covered

Eligible health services	Preferred Care coverage	Non-Preferred Care coverage
Outpatient prescription drugs (continued)		
Non-preferred brand-name prescription drugs		
For each fill up to a 30-day supply filled at a retail pharmacy	$75 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	$75 copayment per supply then the plan pays 100% (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	$225 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)	Not covered
Specialty drugs		
For each fill up to a 30-day supply filled at a **specialty pharmacy** or a retail pharmacy	Copayment is the greater of $250 or 20% (of the negotiated charge) but will be no more than $500 per supply	Copayment is the greater of $250 or 20% (of the recognized charge) but will be no more than $500 per supply
Diabetic insulin		
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
91-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
Important note: Your cost share will not exceed $50 per 30-day supply of a covered prescription insulin drug filled at a network pharmacy. No deductible applies for 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
Preventive care drugs and supplements maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.	

Eligible health services	Preferred Care coverage	Non-Preferred Care coverage
Outpatient prescription drugs (continued)		
Risk reducing breast cancer prescription drugs filled at a pharmacy For each 30–day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Risk reducing breast cancer prescription drugs maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered risk reducing breast cancer prescription drugs, contact Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each 30–day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Tobacco cessation prescription drugs and OTC drugs maximums	Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Contraceptives (birth control)		
For each fill up to a 12-month supply of generic and OTC drugs and devices filled at a retail or mail order pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
For each fill up to a 12-month supply of brand name prescription drugs and devices filled at a retail or 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
Outpatient prescription drugs important note: If you or your provider requests a covered brand-name prescription drug when a covered generic prescription drug equivalent is available, you will be responsible for the cost share that applies to the brand-name drug plus the cost difference between the generic drug and the brand-name drug. The cost difference does not apply toward your policy year deductible or maximum out-of-pocket limit.		

Outpatient prescription drug exclusions

The following are not eligible health services:

- Allergy sera and extracts given by injection, except as covered in the Physician services section
- Any services related to providing, injecting or application of a drug
- Any treatment, device, drug, service, or supply to alter the body's genes, genetic make-up, or the expression of the body's genes unless listed as a covered service
- Compounded prescriptions when there is not at least one ingredient for which a prescription is needed, when there is a copy of a commercially available drug product and compounds containing bulk chemicals not approved by the FDA
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as an eligible health service
- Dietary supplements including medical foods, except where described in the Nutritional support section
- 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, except where stated above
  - 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
  - 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
- Immunizations related to travel or work
- 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 with the exception of Depo Provera and other injectable drugs for contraception
- Off-label drug use except as specifically provided for in the Off-label use section
- 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

(continued on next page)

Outpatient prescription drug exclusions (continued)

The following are not eligible health services:

- Prescription drugs:
  - 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
- Tobacco cessation drugs, unless recommended by the USPSTF
- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's drug guide
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's drug guide

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

Out of Country Claims

Out of Country claims should be submitted with appropriate medical service and payment information from the provider of service. Covered services received outside the United States will be considered at the Non-Preferred Care level of benefits.

General Exclusions

Acupuncture

- Acupuncture
- Acupressure

Blood and blood products

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

Cardiac rehabilitation

- Services for home programs, on-going conditioning, and maintenance 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

This exclusion does not apply to medically necessary services according to non-discriminatory criteria consistent with current medical standards.

Court-ordered testing

- Court-ordered testing or care unless medically necessary

Custodial care

Except as described in the Hospice care section 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 use disorder treatment):
  - Services provided when you have reached the greatest level of function expected with the current level of care,
  - Services given mainly to 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 exclusion does not apply to services under the *Adult dental care*, *Oral surgery*, and *Additional dental care for children and adults* sections.

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). This exclusion does not include therapy by a licensed therapist for behavioral health services if provided on an outpatient basis as part of a wilderness treatment program.
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Examinations

Except as covered under the *Preventive care* section, 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

Gene-based, cellular and other innovative therapies

Growth/Height care
Unless there is evidence that the member meets one or more clinical criteria detailed in our precertification and clinical policies:
- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
- Surgical procedures, devices and growth hormones to stimulate growth

Hearing aids
Except as covered in the *Durable medical equipment (DME)* and *Hearing aids for minors* sections, any tests, appliances and devices to:
- Improve your hearing
- Enhance other forms of communication to make up for hearing loss or devices that simulate speech

Hearing exams
- Hearing exams performed for the evaluation and treatment of illness, injury or hearing loss

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. and services for the treatment of autism spectrum disorder.

Medical supplies – outpatient disposable over-the-counter items
- Any outpatient disposable supply or device. Examples of these include:
  - Sheaths
  - Bags
  - Elastic garments
  - Support hose
  - Bandages
  - Bedpans
  - Home test kits not related to diabetic testing
  - Compresses
  - Over-the-counter convenience and hygienic items

Non-medically necessary services
- Services we determine are not medically necessary. This includes services that do not meet our clinical policy bulletin guidelines.

Other non-covered services
- 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

Other primary payer
- Payment for a portion of the charge that Medicare or another party is responsible for as the primary payer This exclusion does not apply to laws that make the government program the secondary payer after benefits under this policy have been paid. See the *Coordination of benefits (COB)* section for details.

Outpatient prescription or non-prescription drugs and medicines
- Specialty prescription drugs except as stated in the *Eligible health services and exclusions* section

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 and exclusions* section

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

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.

Sexual dysfunction and enhancement
- 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, or other counseling or advisory services

Strength and performance
- Health club memberships, workout equipment, charges from a physical fitness or personal trainer, or any other charges for activities, equipment, services, devices, supplies or facilities used for physical fitness, even if ordered by a physician.

Therapies and tests
- Full body CT scans, unless medically necessary
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for 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 and exclusions – Preventive care and wellness* section
  - Hypnosis and other therapies
  - Medications, except as specifically provided in the *Eligible health services and exclusions – 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 as part of your training
- Any services and supplies provided to a covered student who receives treatment from a provider as part of their training

Wilderness treatment programs
See *Educational services* in this section

Work related illness or injuries
- Coverage available to you under workers' compensation or a similar program under local, state or federal law for any illness or injury related to employment or self-employment

Important note:
A source of coverage or reimbursement is 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 Virginia Tech Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health℠ 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 1-866-577-7027.

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.

Discrimination is Against the Law

Aetna Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with 45 CFR § 92.101(a)(2)). Aetna Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Aetna Inc.:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, call 1-866-577-7027 (TTY: 711) or the number on the back of your ID card.

If you believe that Aetna Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Civil Rights Coordinator
Attn: 1557 Coordinator
CVS Pharmacy, Inc.
1 CVS Drive, MC 2332
Woonsocket, RI 02895
Phone: 1-800-648-7817, TTY: 711
Email: CRCoordinator@aetna.com

You can file a grievance in person, by mail, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
This notice is available at Aetna Inc.'s website: https://www.aetnastudenthealth.com

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.

TTY: **711**

English	To access language services at no cost to you, call the number on your ID card.
Amharic	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በመታወቂያዎት ላይ ያለውን ቁጥር ይደውሉ።
Arabic	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.
Armenian	Ձեր նախընտրած լեզվով ավվճար խորհրդատվություն ստանալու համար զանգահարեք ձեր բժշկական ապահովագրության քարտի վրա նշված հէրախոսահամարով հէրախոսահամարով
Carolinian (Kapasal Falawasch)	Ngir mëna am sarwis lakk yi te doo fay, woo nimero bi am ci sa kàrt.
Chamorro	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang i numiru gi iyo-mu kard aidentifikasion.
Chinese Traditional	如欲使用免費語言服務，請撥打您健康保險卡上所列的電話號碼
Cushitic-Oromo	Tajaajiiloota afaanii gatii bilisaa ati argaachuuf, lakkoofsa fuula waraaqaa eenyummaa (ID) kee irraa jiruun bilbili.
French	Pour accéder gratuitement aux services linguistiques, veuillez composer le numéro indiqué sur votre carte d'assurance santé.
French Creole (Haitian)	Pou ou jwenn sèvis gratis nan lang ou, rele nimewo telefòn ki sou kat idantifikasyon asirans sante ou.
German	Um auf den für Sie kostenlosen Sprachservice auf Deutsch zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an.
Greek	Για πρόσβαση στις υπηρεσίες γλώσσας χωρίς χρέωση, καλέστε τον αριθμό στην κάρτα ασφάλισής σας.
Gujarati	તમારે કોઇ પણ જાતના ખર્ચ વિના ભાષા સેવાઓ મેળવવા માટે, તમારા આઇડી કાર્ડ પર રહેલ નંબર પર કૉલ કરવો.
Hindi	बिना किसी कीमत के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।
Hmong	Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj daim npav ID.
Italian	Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.
Japanese	無料の言語サービスは、IDカードにある番号にお電話ください。
Karen	လၫ်တၢ်ကမ္ၢၤကျိာတၢ်မၤစၫၤအတၢ်ဖံးတၢ်မၤတဖၣ လၫ်တအိၣ်ဒီးအပှၤလၫ်နကဘၣ်ဟ့ၣ်အီၤအဂီၢ်ကီးဘၣ်လီတဲစိနီၣ်ဂ့ၢ်လၫ်အအိၣ်လၫ်နခိၣ်ဂီၤ ၈ (ၪ) အလိၢ်ၣ်တက့ၢ်၍
Korean	무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.
Laotian	ເພື່ອເຂົ້າເຖິງບໍລິການພາສາທີ່ບໍ່ເສຍຄ່າ, ໃຫ້ໂທຫາເບີໂທຢູ່ໃນບັດປະຈຳຕົວຂອງທ່ານ.
Mon-Khmer, Cambodian	ដើម្បីទទួលបានសេវាកម្មភាសាដែលឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរសព្ទទៅកាន់លេខដែលមាននៅលើបណ្ណសម្គាល់ខ្លួនរបស់លោកអ្នក។
Navajo	T’áá ni nizaad k’ehjí bee níká a’doowoł doo bą́ą́h ílínígóó naaltsoos bee atah nílı̨́go nanitinígíí bee néého’dólzinígíí béésh bee hane’í biká’ígíí áajı̨’ hólne’.
Pennsylvanian-Dutch	Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff dei ID Kaart.
Persian-Farsi	برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید.
Polish	Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.
Portuguese	Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.
Punjabi	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਪੰਜਾਬੀ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, ਆਪਣੇ ਆਈਡੀ ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Russian	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.
Samoan	Mō le mauaina o 'au'aunaga tau gagana e aunoa ma se totogi, vala'au le numera i luga o lau pepa ID.
Serbo-Croatian	Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.
Spanish	Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.
Syriac-Assyrian	ܠܡܬܚܫܒ ܒܫܘܬܐ ܕܠܫܢܐ ܕܠܝܬ ܠܗ ܥܠܘܬܐ ܒܠܚܘܕ، ܒܥܝ ܠܡܬܚܙܐ ܠܡܝܠܐ ܕܒܬܪ ܡܣܦܪܐ ܕܐܝܬ ܥܠ ܟܪܛܝܣ ܕܐܝܕܝ ܕܝܠܟ.
Tagalog	Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.
Thai	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน
Ukrainian	Щоб безкоштовнj отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікайній картці.
Vietnamese	Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.