Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

Aetna Student Health
Plan Design and Benefits Summary
Nova Southeastern University

Policy Year: 2019 - 2020
Policy Number: 867897
www.aetnastudenthealth.com
(855)821-9720

This Plan Contains a Deductible

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

Nova Southeastern University

Covered medical services rendered at one of the **Nova Southeastern University Medical Health Care Centers will be covered at 100% with no plan deductible** (*subject to benefit limitations and exclusions as they relate to health care services*). The NSU clinics provide specialty care in Family Medicine, Occupational Therapy, Physical Therapy, Optometry, Dental, Dermatology, Internal Medicine, Obstetrics Gynecology, Pediatrics, Osteopathic Manipulative Medicine, and Sports Medicine. The NSU Student Health Center is staffed by board certified physicians who provide primary care services including: Physical Exams/Women's Health Care/Immunizations/Preventive Care/General Medical Care/Minor Surgical Procedures. Please call **(954) 262-1262** for more information or to schedule an appointment. Office visits for all other specialty Tier One providers will be paid at 100% with no deductible and any other medical services rendered during visit will be paid at 70% with no deductible.

These facilities provide primary care, women's health services, routine services, as well as a variety of other health care services.

Nova Southeastern University Student Health Center*
3200 S. University Drive
Davie, FL 33328
Phone: (954) 262-1262
Hours of Operation**:** For hours of operation please refer to the website www.nova.edu/smc

Sanford L. Ziff Health Care Center*
3200 S. University Drive
Davie, FL 33328
Phone: (954) 262-4100
Hours of Operation**:** Monday - Friday: 9:00 a.m. - 12:00 p.m. and 1:30 p.m. - 5:00 p.m. and Saturday: 9:00 a.m. - 1:00 p.m.

Nova Southeastern University Health Center at North Miami Beach*
1750 NE 167th St
North Miami Beach, FL 33162
Phone: (305) 949-4000
Hours of Operation**:** Monday - Friday: 9:00 a.m. - 12:00 p.m. and 1:30 p.m. - 5:00 p.m. and Saturday: 9:00 a.m. - 1:00 p.m.

Henderson Behavioral Health*
3440 S. University Drive
Davie, FL 33328
Phone: (954) 424-6911
Hours of Operation**:** Monday & Thursday: 8:30 a.m. - 6:00 p.m. Tuesday & Wednesday 8:30 a.m. - 8:00 p.m. Friday: 8:00 a.m. - 5:00 p.m.

*Referral is required if student is within 25 miles of these locations.

Satellite Campus Locations

Clearwater
Community Health Centers of Pinellas County
707 Druid Road East
Clearwater, FL 33756
Phone: (727) 824-8181

Fort Myers
Drs. Melwyn and Raynita D'Souza
14090 Metropolis Ave, Suite 102
Fort Myers, FL 33912
Phone: (239) 225-6304

Salus Care Mental Health Clinic
Evans Campus
3763 Evans Ave.
Fort Myers, FL 33901
Phone: (239) 931-9688 Ext 2240

Jacksonville
Fidel Garcia, MD
2014 University Blvd W
Jacksonville, FL 32217
Phone: (904) 733-9211
Hours of Operation**:** Monday - Friday: 9:00 a.m. - 4:30 p.m.

Michelle Volland, M., PhD
9951 Atlantic Blvd.
Suite 100b, Regency E. Office Pk.
Jacksonville, FL 32225
Phone: (904) 727-7778

Orlando
Dr. Ronald Burns
10055 University Blvd
Orlando, FL 32817
Phone: (407) 679-4800

Dr. Rafael Pinero
1720 S Orange Avenue, #500
Orlando, FL 32806
Phone: (407) 426-9693

Tampa Family Medical Care of Riverview, P.A.
7229 U.S. Highway 301 South
Riverview, FL 33578
Phone: (813) 677-8418 ext. *306

Psychologists (Student Health Center benefits apply)
Bruce F. Hertz, PhD
108 W. Citrus St
Altamonte Springs, FL 32714
Phone: (407) 682-6330

West Palm Beach
Dr. David Stern
4601 Congress Ave.
West Palm Beach, FL 33407
Phone: (561) 840-4600

Tier 1 Specialty Offices

Dr. Walter Ryan
Allergist
350 NW 84th Ave, Suite 205
Plantation, FL 33324
Phone: (954) 472-4848

Evelyn Berne, MD
Breast Surgeon
9960 Central Park Blvd North, Suite 100
Boca Raton, FL 33428
Phone: (561)482-1728

Kayvan Amini, DO
Cardiology
601 N. Flamingo Road, Suite 407
Pembroke Pines, FL 33028
Phone: (954) 499-9515

David Perloff
Cardiovascular Disease
2307 W Broward Blvd. Suite 101
Fort Lauderdale, FL 33312
Phone: (954) 523-3422

Narciso Gomez, MD
Colon & Rectal Surgeon
3475 Sheridan Street, Suite 201
Hollywood, FL 33021
Phone: (954) 369-5717

Chava Lustig, DO
Dermatology
2229 N. Commerce Pkwy Suite 210
Weston, FL 33326
Phone: (954) 908-3604

Elias Dermatology, DO
Dermatology
2301 N. University Dr. Suite 201
Pembroke Pines, FL 33024
Phone: (954) 961-5322

Akumin
Diagnostic Imaging Services
7301 NW 4th Street, Suite 107
Plantation, FL 33317
Phone: (954) 449-7023

Allan Golding, MD
Endocrine Surgery
17180 Royal Palm Blvd, Suite 1
Weston, FL 33326
Phone: (954) 265-0000

Fidel Henriquez, MD
Endocrinology
10796 Pines Blvd, Suite 103
Pembroke Pines, FL 33026
Phone: (954) 442-1402

Dr. Craig Shapiro
ENT Specialist
500 N Hiatus Rd
Pembroke Pines, FL 33026
Phone: (954) 438-7171

Michael B. Mekjian, DO
Gastroenterology
140 S.W. 84th Avenue, Suite C
Plantation, FL 33324
Phone: (954) 476-9350

Broward Surgical Associates
General Surgery
6405 N Federal Hwy, Suite 401
Fort Lauderdale, FL 33308
Phone: (954)-491-0900

Alberto Mestre, MD
Daniel Perez, MD
Infectious Disease
7353 NW 4th Street
Plantation, FL 33317
Phone: (954) 584-6320

Compass Health Systems
Mental Health
1601 North Palm Avenue, Suite 303
Pembroke Pines, FL 33026
Phone: (954) 447-0010

Jacob Radu, MD
Nephrology
722 Riverside Drive
Coral Springs, FL 33071
Phone: (954) 345-4333

Richard Singer, MD
Mayur Maniar, MD
Sunrise Medical Group
Neurology
3540 North Pine Island Road
Sunrise, FL 33351
Phone: (954) 797-7881

Harshad V. Amin, MD
Jason Tache, DO
Oncology/Hematology Specialist
260 N.W. 84th Avenue, Suite C
Plantation, FL 33324
Phone: (954) 370-8585

Ft. Lauderdale Eye Institute
Ophthalmology
850 S. Pine Island Road
Plantation, FL 33324
Phone: (954) 741-5555

Orthopedics Associates, USA
350 N Pine Island Road, Suite 200
Plantation, FL 33324
Phone (954) 476-8800

Carlos Messina, DPM & Robert Sheinberg, DPM
Orthopedic Sports Medicine, Podiatric Surgery
1600 Town Center Circle, Suite C
Weston, FL 33326
Phone: (954) 389-5900

Steven M. Spinner, DPM
Podiatry
201 N. University Drive, Suite 110
Plantation, FL 33324
Phone: (954) 370-2400

Neil H. Hornstein, PhD
Psychologist
4801 S University Drive, Suite 307
Davie, FL 33328
Phone: (954) 434-9192

Sandeep Jain, MD
Pulmonary Disease
7050 Northwest 4th Street, Suite 301
Plantation, FL 33317
Phone: (954) 530-0848

Guillermo J. Valenzuela, MD
Rheumatology Specialist
140 S.W. 84th Avenue, Suite B
Plantation, FL 33324
Phone: (954) 476-2338

Eli Friedman, MD
Sports Cardiology
1150 N 35th, Suite 605
Hollywood, FL 33021
Phone: (954) 265-7900

Chad Frank, D.O.
Sports Medicine- Physical
6710 W. Sunrise Blvd, Suite 110
Plantation, FL 33313
Phone: (954) 316-4905

Jeffrey Marks, MD
Urology
7390 NW 5th Street, Suite 7
Plantation, FL 33317
Phone: (954) 587-7010

Hospitals

Aventura Hospital and Medical Center
20900 Biscayne Boulevard
Aventura, FL 33180
Phone: (305) 682-7000

Plantation General Hospital
401 N.W. 42nd Avenue
Plantation, FL 33317
Phone: (954) 587-5010

Kendall Regional Medical Center
11750 Bird Road
Miami, FL 33175-3530
Phone: (305) 223-3000

Westside Regional Medical Center
8201 W. Broward Boulevard
Plantation, FL 33324
Phone: (954) 473-6600

Coverage Periods

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

Anesthesiology Assistant (M.S.)—except final year

Occupational Therapy (O.T.D., M.O.T.)

Medical and Cardiovascular Sonography (B.S., Concurrent B.S.)

Physical Therapy Doctoral PT

Physician Assistant (M.M.S., Concurrent M.M.S. and M.P.H.)—except final year

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	05/01/2019	04/30/2020	06/01/2019
Fall/Sum	05/01/2019	12/31/2019	06/01/2019
Winter	01/01/2020	04/30/2020	02/01/2020

Anesthesiology Assistant (M.S.)—final year

Physician Assistant (M.M.S., Concurrent M.M.S. and M.P.H.)—final year

International Program for Dental (DM) & Pharmacy (Advanced Standing) Graduates Pharmacy PHD, MS entry 2

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	05/01/2019	07/31/2020	06/01/2019
Fall/Sum	05/01/2019	12/31/2019	06/01/2019
Winter	01/01/2020	07/31/2020	02/01/2020

Clinical Vision, Research, Health Science (M.H.S., D.H.S.) Law Masters, Postdoctoral Dental Programs

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	06/01/2019	05/31/2020	07/01/2019
Fall	06/01/2019	12/31/2019	07/01/2019
Winter	01/01/2020	05/31/2020	02/01/2020

Health Sciences MS and Doctoral

Post Doc, Dental, Clinical Vision, Research with Optometry, Masters Law

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	07/01/2019	06/30/2020	08/01/2019
Fall	07/01/2019	12/31/2019	08/01/2019
Winter	01/01/2020	06/30/2020	02/01/2020

Abraham S. Fischler College of Education and School of Criminal Justice (all levels and programs)
College of Arts, Humanities, and Social Sciences (all levels and programs)
College of Engineering and Computing (all levels and programs)
Athletic Training (B.S.), Audiology (AuD) on campus residential program
Biomedical Science (M.B.S.), Dental Medicine (D.M.D.)

Dr. Kiran C. Patel College of Allopathic Medicine, Exercise and Sports Science (B.S.)
H. Wayne Huizenga College of Business and Entrepreneurship (all levels and programs)
Halmos College of Natural Sciences and Oceanography (all levels and programs)
Health Science (Ph.D.), Law Full-time Day Program (J.D.)

Ron and Kathy Assaf College of Nursing (all levels and programs)
Pharmacy (Pharm.D., Ph.D.), Physical Therapy (Ph.D. and Transitional), Public Health (M.P.H)
Residential Students (all levels and programs),

Respiratory Therapy First-Professional Program (B.S.)
Speech-Language and Communication Disorders (B.S.)
Speech-Language Pathology (M.S., SLP.D.), Occupational Therapy (Dr. O.T., Ph.D.)

Optometry (O.D.),Osteopathic Medicine

College of Psychology (all graduate and doctoral programs), Undergraduate Students

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Annual	08/01/2019	07/31/2020	09/01/2019
Fall	08/01/2019	12/31/2020	09/01/2019
Winter	01/01/2020	07/30/2020	02/01/2020

Rates

Rates may vary depending on your program's term start and end date. Please check with the Nova Southeastern University Student Health Insurance Department or visit **www.aetnastudenthealth.com/nsu** for information about your insurance cost if not showing on the price sheet above. Fall /Winter Term rates include a school administrative fee.

Rates

Anesthesiology Assistant (M.S.)—except final year

Occupational Therapy (O.T.D., M.O.T.)

Medical and Cardiovascular Sonography (B.S., Concurrent B.S.)

Physical Therapy Doctoral PT

Physician Assistant (M.M.S., Concurrent M.M.S. and M.P.H.)—except final year

	Annual	Fall	Winter
Student	$2295	$1534	$761

Rates

Anesthesiology Assistant (M.S.)—final year

Physician Assistant (M.M.S., Concurrent M.M.S. and M.P.H.)—final year

International Program for Dental (DM) & Pharmacy (Advanced Standing) Graduates Pharmacy PHD, MS entry 2

	Annual	Fall	Winter
Student	$2867	$1532	$1335

Rates

Clinical Vision, Research, Health Science (M.H.S., D.H.S.) Law Masters,

Postdoctoral Dental Programs

	Annual	Fall	Winter
Student	$2295	$1342	$953

Rates

Health Sciences MS and Doctoral

Post Doc, Dental, Clinical Vision, Research with Optometry, Masters Law

	Annual	Fall	Winter
Student	$2295	$1152	$1143

Rates

Abraham S. Fischler College of Education and School of Criminal Justice

College of Arts, Humanities, and Social Sciences (all levels and programs)
College of Engineering and Computing (all levels and programs)
Athletic Training (B.S.), Audiology (AuD) on campus residential program
Biomedical Science (M.B.S.), Dental Medicine (D.M.D.)

Dr. Kiran C. Patel College of Allopathic Medicine, Exercise and Sports Science (B.S.)
H. Wayne Huizenga College of Business and Entrepreneurship (all levels and programs)
Halmos College of Natural Sciences and Oceanography (all levels and programs)
Health Science (Ph.D.), Law Full-time Day Program (J.D.)

Ron and Kathy Assaf College of Nursing (all levels and programs)
Pharmacy (Pharm.D., Ph.D.), Physical Therapy (Ph.D. and Transitional), Public Health (M.P.H)
Residential Students (all levels and programs),

Respiratory Therapy First-Professional Program (B.S.)
Speech-Language and Communication Disorders (B.S.)
Speech-Language Pathology (M.S., SLP.D.), Occupational Therapy (Dr. O.T., Ph.D.)

Optometry (O.D.),Osteopathic Medicine

College of Psychology (all graduate and doctoral programs), Undergraduate Students

	Annual	Fall	Winter
Student	$2295	$959	$1336

	Continuation Plan*
	3-Months
Student	$570

Student Coverage

Eligibility

Mandatory Student Requirement

Nova Southeastern University (NSU) takes its institutional responsibility to provide for a safe learning environment seriously and is committed to the health and well-being of all enrolled students. As the recent outbreaks of communicable diseases in many parts of the country illustrate, the physical health of a community can quickly become compromised with lapses in precautions. To safeguard the physical and mental health of all NSU Sharks, the university requires all students regardless of level, campus location, or modality, to carry adequate medical insurance. If you have adequate health care coverage and do not need the NSU Student Health Insurance Plan, you must opt out of this plan each academic year by the given waiver deadline for your program. Students not enrolled in classes the first 31 days of the semester are not eligible for coverage.

Enrollment

All students will be automatically enrolled in this Plan, unless the completed waiver application has been received by Nova Southeastern University by the specified enrollment deadline dates listed in the next section of this Plan Design and Benefits Summary.

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

***Three-Month Continuation Option for Expiring 2019-2020 Insurance**

Students graduating or otherwise leaving school whose 2019-2020 student health insurance coverage is terminating may elect to purchase a continuation option that will provide an additional three months of coverage based on the 2019-2020 policy year benefits. Please note you can only enroll one time into the continuation option plan.

Medicare Eligibility Notice

You are <u>not</u> eligible for health coverage under this student policy if you have Medicare at the time of enrollment in this student plan. If you obtain Medicare after you enrolled in this student plan, your health coverage under this plan will not end. As used here, “have Medicare” means that you are entitled to benefits under Part A (receiving free Part A) or enrolled in Part B or Premium Part A.

In-network Provider Network

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

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

Precertification

You need pre-approval from us for some eligible health services. Pre-approval is also called precertification.

Precertification for medical services and supplies

In-network care

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

Out-of-network care

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

Precertification call

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

Non-emergency admissions:	You, your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.
An emergency admission:	You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
An urgent admission:	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.
Outpatient non-emergency services requiring precertification:	You or your physician must call at least 14 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. If your precertified services are approved, the approval is valid for 30 as long as you remain enrolled in the plan.

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

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

What if you don't obtain the required precertification?
If you don't obtain the required precertification:

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

What types of services and supplies require precertification?
Precertification is required for the following types of services and supplies:

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

Coordination of Benefits (COB)

Some people have health coverage under more than one health plan. If you do, we will work together with your other plan(s) to decide how much each plan pays. This is called coordination of benefits (COB).

Here's how COB works

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

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

Description of Benefits

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

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

Metallic Level: Gold, Tested at 80.11%

Policy year deductible	**In-network coverage**	**Out-of-network coverage**
You have to meet your policy year deductible before this plan pays for benefits.		
Student	$400 per policy year	$800 per policy year
Policy year deductible waiver		
The policy year deductible is waived for all of the following eligible health services: • In-network care for Preventive care and wellness • In-network care for Pediatric Preventive Dental Services • In-network and out-of-network care for Prescribed Medicines Expense, Routine Mammograms, and Pediatric Preventive Vision Services		
Maximum out-of-pocket limits **Maximum out-of-pocket limit** per **policy year**		
Student	$5,750 per policy year	None

Precertification covered benefit penalty

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

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

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

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

Referral penalty

You must get a referral from school health services for off-campus care.

If you do not get a referral, then we won't pay the provider.

Exceptions

- Treatment for an emergency medical condition
- Obstetric and gynecological care
- Pediatric care
- The school health services is closed
- You are more than 25 miles from the school health service
- Chiropractic care
- Dermatology
- Preventive/Routine Services (services considered preventive according to Health Care Reform and/or services rendered not to diagnosis or treat an accident or sickness).

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

Eligible health services	In-network coverage	Out-of-network coverage
Preventive care and wellness		
Routine physical exams		
Performed at a physician's office	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Covered persons through age 21: Maximum age and visit limits per policy year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging onto your Aetna Navigator® secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Covered persons age 22 and over: Maximum visits per policy year	1 visit	
Preventive care immunizations		
Performed in a facility or at a physician's office	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention For details, contact your physician or Member Services by logging onto your Aetna Navigator® secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Well woman preventive visits **Routine gynecological exams (including Pap smears and cytology tests)**		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.	

Eligible health services	In-network coverage	Out-of-network coverage
Preventive screening and counseling services		
Obesity and/or healthy diet counseling office visits	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Maximum visits per policy year (This maximum applies only to covered persons age 22 and older.)	26 visits (however, of these only 10 visits will be allowed under the plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)	
Misuse of alcohol and/or drugs counseling office visits	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Maximum visits per policy year	5 visits	
Use of tobacco products counseling office visits	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Maximum visits per policy year	8 visits	
Depression screening counseling office visits	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Maximum visits per policy year	1 visit	
Sexually transmitted infection counseling office visits	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Maximum visits per policy year	2 visits	
Genetic risk counseling for breast and ovarian cancer counseling office visits	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Routine cancer screenings performed at a physician's office, specialist's office or facility.		
Routine cancer screenings	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician or Member Services by logging onto your Aetna Navigator® secure website at www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Lung cancer screening maximums	1 screening every 12 months*	
***Important note:** Any lung cancer screenings that exceed the lung cancer screening maximum above are covered under the *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 policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
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 support and counseling services		
Lactation counseling services - facility or office visits	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits	
Important note: Any visits that exceed the lactation counseling services maximum are covered under the *Physicians and other health professionals* section.		

Eligible health services	In-network coverage	Out-of-network coverage
Breast pump supplies and accessories	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
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 policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Contraceptives (prescription drugs and devices)		
Female contraceptive prescription drugs and devices provided, administered, or removed, by a physician during an office visit	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Female voluntary sterilization		
Inpatient provider services	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Outpatient provider services	100% (of the negotiated charge) per visit No policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Physicians and other health professionals		
Physician and specialist services		
Office hours visits (non-surgical and non-preventive care by a physician and specialist)	$30 copayment then the plan pays 70% (of the balance of the negotiated charge) per visit thereafter Policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Telemedicine consultation By a physician or specialist	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
Allergy testing and treatment		
Allergy testing performed at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Allergy injections treatment performed at a physician's, or specialist office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Allergy sera and extracts administered via injection at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Physician and specialist - inpatient surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon	70% (of the negotiated charge) per visit Policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Anesthetist	70% (of the negotiated charge) per visit Policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Surgical assistant	70% (of the negotiated charge) per visit Policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Physician and specialist - outpatient surgical services		
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon	70% (of the negotiated charge) per visit Policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
In-hospital non-surgical physician services		
In-hospital non-surgical physician services	70% (of the negotiated charge) per visit Policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Consultant services (non-surgical and non-preventive)		
Office hours visits (non-surgical and non-preventive care)	$30 copayment then the plan pays 70% (of the balance of the negotiated charge) per visit thereafter Policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Telemedicine consultation by a consultant	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Second surgical opinion	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Alternatives to physician office visits		
Walk-in clinic visits(non-emergency visit)	70% (of the negotiated charge) per visit Policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Hospital and other facility care		
Inpatient hospital (room and board) and other miscellaneous services and supplies) Subject to semi-private room rate unless intensive care unit required Room and board includes intensive care For physician charges, refer to the Physician and specialist – inpatient surgical services benefit	70% (of the negotiated charge) per admission Policy year deductible applies	50% (of the recognized charge) per admission Policy year deductible applies
Preadmission testing	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Alternatives to hospital stays		
Outpatient surgery (facility charges)		
Facility charges for surgery performed in the outpatient department of a hospital or surgery center For physician charges, refer to the *Physician and specialist - outpatient surgical services* benefit	70% (of the negotiated charge) per visit Policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Home health care		
Outpatient	70% (of the negotiated charge) per visit Policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Maximum visits per policy year	unlimited	
Hospice care		
Inpatient facility (room and board and other miscellaneous services and supplies)	70% (of the negotiated charge) per admission Policy year deductible applies	50% (of the recognized charge) per admission Policy year deductible applies
Maximum days per confinement per policy year	unlimited	
Outpatient	70% (of the negotiated charge) per visit Policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Maximum visits per policy year	unlimited	
Skilled nursing facility		
Inpatient facility (room and board and miscellaneous inpatient care services and supplies) Subject to semi-private room rate unless intensive care unit is required Room and board includes intensive care	70% (of the negotiated charge) per visit Policy year deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Maximum days of confinement per policy year	60	

Eligible health services	In-network coverage	Out-of-network coverage
Emergency services and urgent care		
Emergency services		
Hospital emergency room *Includes complex imaging services, lab work and radiological services performed during a hospital emergency room visit, and any surgery which results from the hospital emergency room visit	$300 copayment then the plan pays 70% (of the balance of the negotiated charge) per visit Policy year deductible applies	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered

Important note:

- As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment/coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill.
- A separate hospital emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived and your inpatient copayment/coinsurance will apply.
- Covered benefits that are applied to the hospital emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment/coinsurance.
- Separate copayment/coinsurance amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment/coinsurance amounts may be different from the hospital emergency room copayment/coinsurance. They are based on the specific service given to you.
- Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment/coinsurance amounts that are different from the hospital emergency room copayment/coinsurance amounts.

Eligible health services	In-network coverage	Out-of-network coverage
Urgent care		
Urgent medical care provided by an urgent care provider Does not include complex imaging services, lab work and radiological services performed during an urgent medical care visit	$150 copayment then the plan pays 70% (of the balance of the negotiated charge) per visit thereafter Policy year deductible applies	$150 copayment then the plan pays 50% (of the balance of the negotiated charge) per visit thereafter Policy year deductible applies
Non-urgent use of urgent care provider 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.	Not covered	Not covered
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 deductible applies	70% (of the recognized charge) per visit Policy year deductible applies
Type B services	70% (of the negotiated charge) per visit No deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Type C services	50% (of the negotiated charge) per visit No deductible applies	50% (of the recognized charge) per visit Policy year deductible applies
Orthodontic services	50% (of the negotiated charge) per visit No deductible applies	50% (of the recognized charge) per visit Policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Dental emergency treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received.
Specific conditions		
Birthing center (facility charges)		
Inpatient (room and board and other miscellaneous services and supplies)	Paid at the same cost-sharing as hospital care.	Paid at the same cost-sharing as hospital care.
Diabetic services and supplies (including equipment and training)		
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Impacted wisdom teeth		
Impacted wisdom teeth	70% (of the negotiated charge) Policy year deductible applies	70% (of the recognized charge) Policy year deductible applies
Accidental injury to sound natural teeth		
Accidental injury to sound natural teeth	70% (of the negotiated charge) Policy year deductible applies	70% (of the recognized charge) Policy year deductible applies
Anesthesia and related facility charges for oral surgery or **a dental procedure**		
Anesthesia and related facility charges for oral surgery or a dental procedure Coverage is subject to certain conditions. See the benefit description in the certificate of coverage for details.	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 and joints of the facial region		
Bones and joints of the facial region	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.
Cleft lip/cleft palate		
Cleft lip/cleft palate	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
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.
Temporomandibular joint dysfunction (TMJ)		
TMJ treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Dermatological treatment		
Dermatological treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maternity care		
Maternity care (includes delivery and postpartum care services in a hospital or birthing center)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Well newborn nursery care in a hospital or birthing center	70% (of the negotiated charge) No policy year deductible applies	50% (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.*		
Pregnancy complications		
Inpatient (room and board and other miscellaneous services and supplies) Subject to semi-private room rate unless intensive care unit required Room and board includes intensive care	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
Family planning services – other		
Voluntary sterilization for male Inpatient physician or specialist surgical services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Voluntary sterilization for males Outpatient physician or specialist surgical services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Gender reassignment (sex change) treatment		
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Tracheal shave	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Electrolysis of face and neck	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 Aetna Navigator® 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.		
Autism spectrum disorder		
Autism spectrum disorder treatment (includes physician and specialist office visits, diagnosis and testing)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Applied behavior analysis*	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
***Important note**: Applied behavior analysis requires precertification by Aetna. Your in-network provider is responsible for obtaining precertification. You are responsible for obtaining precertification when you use an out-of-network provider.		

Eligible health services	In-network coverage	Out-of-network coverage
Mental health treatment		
Mental health treatment – inpatient		
Inpatient hospital mental disorders treatment (room and board and other miscellaneous hospital services and supplies) Inpatient residential treatment facility mental disorders treatment (room and board and other miscellaneous residential treatment facility services and supplies) Subject to semi-private room rate unless intensive care unit is required Mental disorder room and board intensive care	70% (of the negotiated charge) Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies
Mental health treatment - outpatient		
Outpatient mental disorders treatment office visits to a physician or behavioral health provider (includes telemedicine consultations)	$30 copayment then the plan pays 70% (of the balance of the negotiated charge) per visit thereafter Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Other outpatient mental disorders treatment (includes skilled behavioral health services in the home) Partial hospitalization treatment (at least 6 hours, but less than 24 hours per day of clinical treatment) Intensive Outpatient Program (at least 2 hours per day and at least 8 hours per week of clinical treatment)	70% (of the negotiated charge) Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Substance abuse related disorders treatment-inpatient		
Inpatient hospital substance abuse detoxification (room and board and other miscellaneous hospital services supplies) Inpatient hospital substance abuse rehabilitation (room and board and other miscellaneous hospital services supplies) Inpatient residential treatment facility substance abuse (room and board and other miscellaneous residential treatment facility services and supplies) Subject to semi-private room rate unless intensive care unit is required Substance abuse room and board intensive care	70% (of the negotiated charge) Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies
Substance abuse related disorders treatment-outpatient: detoxification and rehabilitation		
Outpatient substance abuse office visits to a physician or behavioral health provider (includes telemedicine consultations)	$30 copayment then the plan pays 70% (of the balance of the negotiated charge) per visit thereafter Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies
Other outpatient substance abuse services (includes skilled behavioral health services in the home) Partial hospitalization treatment (at least 6 hours, but less than 24 hours per day of clinical treatment) Intensive Outpatient Program (at least 2 hours per day and at least 8 hours per week of clinical treatment)	70% (of the negotiated charge) Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Reconstructive surgery and supplies		
Reconstructive surgery and supplies (includes reconstructive breast 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.

Eligible health services	In-network coverage (IOE facility)	In-network coverage (Non-IOE facility)	Out-of-network coverage
Transplant services			
Inpatient and outpatient transplant facility services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Inpatient and outpatient transplant physician and specialist services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
Treatment of infertility		
Basic infertility services Inpatient and outpatient care - basic infertility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Specific therapies and tests		
Outpatient diagnostic testing		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	70% (of the negotiated charge) Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies
Diagnostic lab work and radiological services performed in a physician's office, the outpatient department of a hospital or other facility	70% (of the negotiated charge) Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies
Chemotherapy		
Chemotherapy	70% (of the negotiated charge) Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient infusion therapy		
Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Outpatient radiation therapy		
Outpatient radiation therapy	70% (of the negotiated charge) Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies
Outpatient respiratory therapy		
Respiratory therapy	70% (of the negotiated charge) Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies
Transfusion or kidney dialysis of blood		
Transfusion or kidney dialysis of blood	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Short-term cardiac and pulmonary rehabilitation services		
Cardiac rehabilitation	70% (of the negotiated charge) Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies
Pulmonary rehabilitation	70% (of the negotiated charge) Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies
Short-term rehabilitation and habilitation therapy services		
Outpatient physical, occupational, speech, and cognitive therapies Combined for short-term rehabilitation services and habilitation therapy services	70% (of the negotiated charge) Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies
Acupuncture therapy		
Acupuncture therapy	70% (of the negotiated charge) Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies
Maximum per **policy year**	unlimited	

Eligible health services	In-network coverage	Out-of-network coverage
Chiropractic services		
Chiropractic services	70% (of the negotiated charge) Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies
Maximum visits per policy year	unlimited	
Diagnostic testing for learning disabilities		
Diagnostic testing for learning disabilities	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Specialty prescription drugs (Purchased and injected or infused by your provider in an outpatient setting)		
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit or the place where the service is received.	Covered according to the type of benefit or the place where the service is received.
Other services and supplies		
Acupuncture in lieu of anesthesia	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Emergency ground, air, and water ambulance (includes non-emergency ambulance)	70% (of the negotiated charge) per trip	Paid the same as in-network coverage
Clinical trial 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.
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Durable medical and surgical equipment	70% (of the negotiated charge) Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies
Enteral formulas and nutritional supplements	70% (of the negotiated charge) Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Osteoporosis (non-preventive care)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Prosthetic devices		
All other prosthetic devices	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum per policy year	unlimited	
Orthotic devices	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum per policy year	unlimited	
Cochlear implants Coverage is limited to covered persons age 18 and over	70% (of the negotiated charge) Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies
Maximum per policy year	unlimited	
Hearing aids and exams		
Hearing aid exams	$30 copayment then the plan pays 70% (of the balance of the negotiated charge) per visit thereafter Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies
Hearing aids	70% (of the negotiated charge) Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies
Podiatric (foot care) treatment		
Physician and Specialist non-routine foot care treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Vision care		
Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)		
Pediatric routine vision exams (including refraction)		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Performed by a legally qualified ophthalmologist or optometrist	100% (of the negotiated charge) No policy year deductible applies	50% (of the recognized charge) No policy year deductible applies
Maximum visits per policy year	1 visit	
Pediatric comprehensive low vision evaluations		
Performed by a legally qualified ophthalmologist or optometrist	100% (of the negotiated charge) No policy year deductible applies	50% (of the recognized charge) No policy year deductible applies
Maximum	One comprehensive low vision evaluation every policy year	
Pediatric vision care services and supplies		
Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) No policy year deductible applies	50% (of the recognized charge) No policy year deductible applies
Maximum number of eyeglass frames per policy year. Maximum number of prescription lenses per policy year	One set of eyeglass frames One pair of prescription lenses	
Maximum number of prescription contact lenses per policy year (includes non-conventional prescription contact lenses and aphakic lenses prescribed after cataract surgery)	Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set	
Office visit for fitting of contact lenses	100% (of the negotiated charge) No policy year deductible applies	50% (of the recognized charge) No policy year deductible applies
Optical devices Maximum number of optical devices per policy year One optical device	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__: 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.
Coverage does not include the office visit for the fitting of prescription contact lenses.

Adult vision care Limited to covered persons age 19 and over		
Adult routine vision exams (including refraction) Performed by a legally qualified ophthalmologist or optometrist Limited to covered persons age 19 and over	$30 copayment then the plan pays 70% (of the balance of the negotiated charge) per visit thereafter Policy year deductible applies	50% (of the recognized charge) Policy year deductible applies

Outpatient prescription drugs

Policy year deductible and copayment/coinsurance waiver for risk reducing breast cancer

The policy year deductible and the per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network, pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.

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

The policy year deductible and the per prescription copayment/coinsurance will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a retail in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%.

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

Policy year deductible and copayment/coinsurance waiver for contraceptives

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

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

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

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

Preferred Generic prescription drugs			
Per prescription copayment/coinsurance			
	Nova Southeastern University Pharmacy ONLY	**In-network coverage**	**Out-of-network coverage**
For each fill up to a 30 day supply filled at a retail pharmacy	$15 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$20 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$20 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies
Preferred brand-name prescription drugs			
Per prescription copayment/coinsurance			
For each fill up to a 30 day supply filled at a retail pharmacy	$50 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$50 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$50 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies
Non-preferred generic prescription drugs			
Per prescription copayment/coinsurance			
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 negotiated charge) No policy year deductible applies	$75 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$75 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies
Non-preferred brand-name prescription drugs			
Per prescription copayment/coinsurance			
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 negotiated charge) No policy year deductible applies	$75 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies	$75 copayment per supply then the plan pays 100% (of the negotiated charge) No policy year deductible applies

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

For each 30 day supply		
Maximums:	Coverage is permitted for two 90-day treatment regimens only. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure website at www.aetnastudenthealth.com or calling the toll-free number on the back of your ID card.	

A covered person, a covered person's designee or a covered person's prescriber may seek an expedited medical exception process to obtain coverage for non-covered drugs in exigent circumstances. An "exigent circumstance" exists when a covered person is suffering from a health condition that may seriously jeopardize a covered person's life, health, or ability to regain maximum function or when a covered person is undergoing a current course of treatment using a non-formulary drug.

The request for an expedited review of an exigent circumstance may be submitted by contacting Aetna's *Pre-certification Department* at **1-855-240-0535**, faxing the request to **1-877-269-9916**, or submitting the request in writing to:

CVS Health
ATTN: Aetna PA
1300 E Campbell Road
Richardson, TX 75081

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

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

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

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

General exceptions and exclusions

Acupuncture therapy
• Maintenance treatment
• Acupuncture when provided for the following conditions:
- Acute low back pain
- Addiction
- AIDS

- Amblyopia
- Allergic rehinitis
- Asthma
- Autism spectrum disorders
- Bell’s Palsy
- Burning mouth syndrome
- Cancer-related dyspnea
- Carpal tunnel syndrome
- Chemotherapy-induced leukopenia
- Chemotherapy-induced neuopathic pain
- Chronic pain syndrome (e.g., RSD, facial pain)
- Chronic obstructive pulmonary disease
Diabetic peripheral neuropathy
Dry eyes
- Erectile dysfunction
- Facial spasm
- Fetal breech presentation
- Fibromyalgia
- Fibrotic contractures
- Glaucoma
- Hypertension
- Induction of labor
- Infertility(e.g., to assist oocyte retrieval and embryo transfer during IVF treatment cycle)
- Insomnia
- Irritable bowel syndrome
- Menstrual cramps/dysmenorrhea
- Mumps
- Myofascial pain
- Myopia
- Neck pain/cervical spondylosis
- Obesity
- Painful neuropathies
- Parkinson’s disease
- Peripheral arterial disease (e.g., intermittent claudication)
- Phantom leg pain
- Polycystic ovary syndrome
- Post-herpetic neuralgia
- Psoriasis
- Psychiatric disorders (e.g., depression)
- Raynaud’s disease pain
- Respiratory disorders
- Rheumatoid arthritis
- Rhinitis
- Sensorineural deafness
- Shoulder pain (e.g., bursitis)
- Stroke rehabilitation (e.g., dysphagia)
- Tennis elbow/ epicondylitis
- Tension headache
- Tinnitus

- Tobacco Cessation
- Urinary incontinence
- Uterine fibroids
- Xerostomia
- Whiplash

Air or space travel

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

  This exclusion does not apply if:
  - You are traveling solely as a fare-paying passenger
  - You are traveling on a licensed, commercial, regularly scheduled non-military aircraft
  - You are traveling solely in a civil aircraft with a current valid "Standard Federal Aviation Agency Airworthiness Certificate" and:
    - The civil aircraft is piloted by a person with a current valid pilot's certificate with proper ratings for the type of flight and aircraft involved
    - You are as a passenger with no duties at all on an aircraft used only to carry passengers or you are a pilot or a part of the flight crew on an aircraft owned or leased by the policyholder performing duties for the policyholder

Alternative health care

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

Armed forces

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

Beyond legal authority

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

Breasts

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

Custodial care

Examples 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/changing containers and clamping tubing)
- Watching or protecting you
- Respite care, adult (or child) day care, or convalescent care except In connection with hospice care,
- Institutional care. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training

Dental care for adults

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

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

Durable medical equipment (DME)

Examples of these items are:

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

Early intensive behavioral interventions

Examples of these services are:

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

Educational services

Examples of these services are:

- Any service or supply for education, training or retraining services or testing. This includes:

- Special education
- Remedial education
- Wilderness treatment program
- Job training
- Job hardening programs

- Services provided by a governmental school district

Elective treatment or elective surgery

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

Experimental or investigational

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

Family planning services - other

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

Felony

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

Foot care

- Services and supplies for:
  - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches
  - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
  - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
  - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet

Gender reassignment (sex change) treatment

- Cosmetic services and supplies such as:
  - Rhinoplasty
  - Face-lifting
  - Lip enhancement
  - Facial bone reduction
  - Lepharoplasty
  - Breast augmentation
  - Liposuction of the waist (body contouring)
  - Reduction thyroid chondroplasty (tracheal shave)
  - 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

- Chin implants, nose implants, and lip reduction, which are used to assist masculinization, are considered cosmetic

Genetic care

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

Growth/Height care

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

Hearing aids and exams

The following services or supplies:

- A replacement of:
  - A hearing aid that is lost, stolen or broken
  - A hearing aid installed within the prior 24 month period
- Replacement parts or repairs for a hearing aid
- Batteries or cords
- Cochlear implants
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss
- Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist
- Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay
- Any tests, appliances and devices to:
  - Improve your hearing. This includes hearing aid batteries, amplifiers, and auxiliary equipment
  - Enhance other forms of communication to make up for hearing loss or devices that simulate speech

Home health care

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

Hospice care

- Funeral arrangements
- Pastoral counseling
- Respite care
- Bereavement counseling
- Financial or legal counseling which includes estate planning and the drafting of a will

- Homemaker or caretaker services that are services which are not solely related to your care and may include:
  - Sitter or companion services for either you or other family members
  - Transportation
  - Maintenance of the house

Incidental surgeries

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

Judgment or settlement

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

Mandatory no-fault laws

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

Medical supplies – outpatient disposable

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

Medicare

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

Mental health treatment

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

Motor vehicle accidents

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

Non-medically necessary services and supplies

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

Non-U.S .citizen

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

Obesity (bariatric) surgery

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

Organ removal

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

Private duty nursing (outpatient only)

Prosthetic devices

- Services covered under any other benefit
- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items

- Repair and replacement due to loss, misuse, abuse or theft
- Communication aids
- Cochlear implants

Riot

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

Routine exams

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

School health services

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

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

Services provided by a family member

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

Sinus surgery

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

Sleep apnea

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

Students in mental health field

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

Therapies and tests

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

Tobacco cessation

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

Treatment in a federal, state, or governmental entity

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

Treatment of infertility

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

Intracytoplasmic sperm injection (ICSI) or ovum microsurgery)

Use of drugs, alcohol or intoxicants

- Services and supplies to treat an injury resulting from the use of:
  - Drugs (except as prescribed by a physician)
  - Alcohol
  - Intoxicants

Vision Care

Pediatric vision care services and supplies

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

Adult vision care

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

Adult vision care services and supplies

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

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

Exceptions and exclusions that apply to outpatient prescription drugs

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

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

Drugs or medications

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

Nova Southeastern University 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**.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.
If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).

TTY: 711

To access language services at no cost to you, call 1-855-821-9720.

Para acceder a los servicios de idiomas sin costo, llame al 1-855-821-9720. (Spanish)

如欲使用免費語言服務，請致電 1-855-821-9720。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-855-821-9720. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-855-821-9720 . (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie an 1-855-821-9720. (German)

Pou jwenn sèvis lang gratis, rele 1-855-821-9720. (French Creole-Haitian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-855-821-9720. (Italian)

言語サービスを無料でご利用いただくには、 までお電話ください1-855-821-9720。(Japanese)

무료 언어 서비스를 이용하려면 번으로 전화해 주십시오1-855-821-9720. (Korean)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-855-821-9720. (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-855-821-9720. (Portuguese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-855-821-9720. (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-855-821-9720. (Vietnamese)

9720-821-855-1 ى الرقم للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال عل (Arabic)