SIU
Southern Illinois University
CARBONDALE

Aetna Student Health

Plan Design and Benefits Summary
Southern Illinois University Carbondale

Policy Year: 2016 - 2017
Policy Number: 867930
Aetna Customer Service: (866) 746-6590
GSH Customer Service: (888) 538-0602

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www.aetnastudenthealth.com

This is a brief description of the Student Health Plan. The Plan is available for Southern Illinois University Carbondale students and their eligible dependents. The Plan is underwritten by Aetna Life Insurance Company (Aetna). The exact provisions governing this insurance, including definitions, are contained in the Master Policy issued to the Southern Illinois University Carbondale and may be viewed online at **www.aetnastudenthealth.com**. If any discrepancy exists between this Benefit Summary and the Policy, the Master Policy will govern and control the payment of benefits.

Student Health Services

Southern Illinois University Carbondale's Student Health Services is the on-campus health facility. Student Health Services offers prescription and allergy injections, immunizations, health education, in house laboratory services, confidential HIV testing, reproductive consultation including contraception, specialty consultation referral, treatment and screening for STDs, and women's and men's health care.

Student Health Services is open weekdays from 8:00 a.m. to 4:30 p.m. and is located at 374 East Grand Ave - MC6740.

For more information, call Student Health Services at **(618) 453-3311**.

Coverage Periods

Students: 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.

Coverage Period	Coverage Start Date	Coverage End Date	Waiver Deadline
Fall Semester	08/15/2016	01/15/2017	09/02/2016
Spring/Summer Semester	01/16/2017	08/14/2017	

Eligible Dependents: 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. Termination of coverage dates for insured dependents will coincide with student termination dates.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment Deadline
Fall Semester	08/15/2016	01/15/2017	09/02/2016
Spring/Summer Semester	01/16/2017	08/14/2017	

Rates

2016-2017 Rates*
Students and Dependents

	Fall Semester	Spring/Summer Semester
Student	**$650**	**$650**
Spouse	**$650**	**$650**
One Child	**$650**	**$650**
Two or More Children	**$1,300**	**$1,300**

*The rates listed above are inclusive of any fees that may be assessed by Gallagher Student Health and by your school.

Student Coverage

Eligibility

All students registered for on campus classes at the University of Southern Illinois Carbondale are enrolled in, and billed for, the Student Health Insurance Plan unless proof of comparable coverage is provided. Student Athletes will be automatically enrolled on a mandatory basis.

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

Enrollment

Eligible students are required to waive the Student Health Insurance Plan by the specified waiver deadline listed above.

Waiver/Enrollment Process:

1. Log onto **www.gallagherstudent.com/siu**.
2. Click on the "Student Waive/Enroll" tab.
3. New users will be required to create a unique User Account; Returning users will simply log in.
4. Once logged in, click on the red "I want to Waive" to waive or the green "I want to Enroll" button to enroll.

Immediately upon submitting a Form, you will receive a reference number indicating that the form has been successfully submitted. Print this reference number for your records. If you do not receive a reference number, you will need to correct any errors and resubmit the form. The online process is the only accepted process for waiving or enrolling in coverage.

Dependent Coverage

Eligibility

Covered students may also enroll their lawful spouse, same-sex domestic partner, and dependent children up to the age of 26.

Enrollment

To enroll the dependent(s) of a covered student, please refer to the Coverage Periods section of this document for coverage dates and deadline dates.

To Enroll Dependents Online:

1. Log onto **www.gallagherstudent.com/siu**.
2. Click on the "Dependent Enroll" tab.
3. New users will be required to create a unique User Account; Returning users will simply log in.
4. Once logged in, click on the "Dependent Enroll" button. Follow the online instructions to enroll.

Dependent enrollment applications will not be accepted after the enrollment deadline, unless there is a significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage under another health plan.) Students experiencing a significant life change will need to complete a Petition to Add form and return the form and documentation of the significant life event to Gallagher Student Health within 31 days of the significant life event.

Medicare Eligibility Notice

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

Preferred Provider Network

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

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

Pre-certification Program

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

Pre-certification for the following inpatient and outpatient services or supplies is needed*:

- All inpatient maternity and newborn care, after the initial 48 hours for a vaginal delivery or 96 hours for a cesarean section;
- Ambulance (emergency transportation by airplane);
- Autologous chondrocyte implantation, Carticel®;
- Bariatric surgery (bariatric surgery is not covered under the Policy unless specifically described in the Policy);
- BRCA genetic testing;
- Cardiac rhythm implantable devices;
- Cochlear device and/or implantation;
- Dental implants and oral appliances;
- Dorsal column (lumbar) neurostimulators: trial or implantation;
- Drugs and Medical Injectables;
- Electric or motorized wheelchairs and scooters;
- Gender Reassignment (Sex Change) Surgery;
- Home health care related services (i.e. private duty nursing);
- Hyperbaric oxygen therapy;

- Infertility treatment (Comprehensive and ART infertility treatment is not covered under the plan unless specifically described in the Policy);
- Inpatient Confinements (surgical and non-surgical); hospital, skilled nursing facility, rehabilitation facility, residential treatment facility for mental disorders and substance abuse, hospice care;
- Inpatient mental disorders treatment;
- Inpatient substance abuse treatment;
- Kidney dialysis;
- Knee surgery;
- Limb Prosthetics;
- Non-Preferred Care freestanding ambulatory surgical facility services when referred by a Preferred Care Provider;
- Oncotype DX;
- Orthognatic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint;
- Osseointegrated implant;
- Osteochondral allograft/knee;
- Outpatient back surgery not performed in a physician's office;
- Pediatric Congenital Heart Surgery;
- Pre-implantation genetic testing;
- Procedures that may be considered cosmetic. Cosmetic services and supplies are not covered under the plan unless specifically described in the Policy;
- Proton beam radiotherapy;
- Referral or use of Non-Preferred Care Providers for non-emergency services, unless the covered person understands and consents to the use of a Non-Preferred Care Provider under their under Non-Preferred Care benefits when available in their plan;
- Spinal Procedures;
- Transplant Services;
- Uvulopalatopharyngoplasty, including laser-assisted procedures; and
- Ventricular assist devices.

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

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

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

Pre-certification of non-emergency admissions

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

Pre-certification of emergency admissions

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

Pre-certification of urgent admissions

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

Pre-certification of outpatient non-emergency medical services

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

Pre-certification of prenatal care and delivery

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

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

Description of Benefits

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

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

Metallic Level: Platinum, Tested at 91.73%

DEDUCTIBLE	Preferred Care	Non-Preferred Care
The policy year deductible is waived for preferred care covered medical expenses that apply to Preventive Care Expense benefits. In compliance with Illinois State mandate(s) the policy year deductible is also waived for: • victims of sexual assault or abuse. Per visit or admission Deductibles do not apply towards satisfying the Policy Year Deductible. In addition to state and federal requirements for waiver of the policy year deductible, the plan will waive the policy year deductible for: Preferred Care Pediatric Preventive Dental Services and Pediatric preventive Vision Services. ***Annual Deductible does not apply to these services**	Individual: $100 per Policy Year	Individual: $150 per Policy Year

COINSURANCE	Preferred Care	Non-Preferred Care
Coinsurance is both the percentage of covered medical expenses that the plan pays, and the percentage of covered medical expenses that you pay. The percentage that the plan pays is referred to as "plan coinsurance" or the "payment percentage," and varies by the type of expense. Please refer to the Schedule of Benefits for specific information on coinsurance amounts.	Covered Medical Expenses are payable at the plan coinsurance percentage specified below, after any applicable Deductible.	
OUT-OF-POCKET MAXIMUMS	**Preferred Care**	**Non-Preferred Care**
Once the Individual or Family Out-of-Pocket Limit has been satisfied, Covered Medical Expenses will be payable at 100% for the remainder of the Policy Year. The following expenses do not apply toward meeting the plan's out-of-pocket limits: • Non-covered medical expenses; and • Referral penalties because a required referral for the service(s) or supply was not obtained.	Individual Out-of-Pocket: $1,100 per Policy Year Family Out-of-Pocket: $2,200 per Policy Year	Individual Out-of-Pocket: $2,000 per Policy Year Family Out-of-Pocket: $4,000 per Policy Year

REFERRAL REQUIREMENT

The covered student must contact the school health services before receiving any medical care. If the covered student does not obtain a referral from school health services; the non-preferred care level of benefits will apply to that care.

Exceptions:

- Treatment for an emergency medical condition.
- Obstetric and gynecological treatment.
- Pediatric care.
- The covered student is more than 50 miles away from the school health center.
- The school health center is closed.
- Preventive/Routine Services (services considered preventive according to Health Care Reform and/or services rendered not to diagnose or treat an Accident or Sickness).

Dependents are not eligible to use the services of the school health center and are therefore not subject to the referral requirements and penalties.

INPATIENT HOSPITALIZATION BENEFITS	Preferred Care	Non-Preferred Care
Room and Board Expense The covered room and board expense does not include any charge in excess of the daily room and board maximum.	80% of the Negotiated Charge	60% of the Recognized Charge for a semi-private room
Intensive Care The covered room and board expense does not include any charge in excess of the daily room and board maximum.	80% of the Negotiated Charge	60% of the Recognized Charge
Miscellaneous Hospital Expense Includes but not limited to: operating room, laboratory tests/ X rays, oxygen tent, drugs, medicines and dressings.	80% of the Negotiated Charge	60% of the Recognized Charge
Licensed Nurse Expense Includes charges incurred by a covered person who is confined in a hospital as a resident bed patient and requires the services of a registered nurse or licensed practical nurse.	80% of the Negotiated Charge	60% of the Recognized Charge

INPATIENT HOSPITALIZATION BENEFITS (continued)	Preferred Care	Non-Preferred Care
Well Newborn Nursery Care	80% of the Negotiated Charge	60% of the Recognized Charge
Non-Surgical Physicians Expense Includes hospital charges incurred by a covered person who is confined as an inpatient in a hospital for a surgical procedure for the services of a physician who is not the physician who may have performed surgery on the covered person.	80% of the Negotiated Charge	60% of the Recognized Charge
SURGICAL EXPENSES	**Preferred Care**	**Non-Preferred Care**
Surgical Expense (Inpatient and Outpatient) When injury or sickness requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, covered medical expenses only include expenses incurred for the most expensive procedure.	80% of the Negotiated Charge	60% of the Recognized Charge
Anesthesia Expense (Inpatient and Outpatient) If, in connection with such operation, the covered person requires the services of an anesthetist who is not employed or retained by the hospital in which the operation is performed, the expenses incurred will be Covered Medical Expenses.	80% of the Negotiated Charge	60% of the Recognized Charge
Assistant Surgeon Expense (Inpatient and Outpatient)	50% of the Negotiated Charge	50% of the Recognized Charge
OUTPATIENT EXPENSES	**Preferred Care**	**Non-Preferred Care**
Physician or Specialist Office Visit Expense Includes the charges made by the physician or specialist if a covered person requires the services of a physician or specialist in the physician's or specialist's office while not confined as an inpatient in a hospital.	80% of the Negotiated Charge	60% of the Recognized Charge
Laboratory and X-ray Expense	80% of the Negotiated Charge	60% of the Recognized Charge
Hospital Outpatient Department Expense	80% of the Negotiated Charge	60% of the Recognized Charge
Therapy Expense Covered medical expenses include charges incurred by a covered person for the following types of therapy provided on an outpatient basis: • Radiation therapy; • Inhalation therapy; • Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy; • Kidney dialysis; and • Respiratory therapy.	80% of the Negotiated Charge	60% of the Recognized Charge
Pre-Admission Testing Expense Includes charges incurred by a covered person for pre-admission testing charges made by a hospital, surgery center, licensed diagnostic lab facility, or physician, in its own behalf, to test a person while an outpatient before scheduled surgery.	Payable in accordance with the type of expense incurred and the place where service is provided.	

OUTPATIENT EXPENSES (continued)	Preferred Care	Non-Preferred Care
Ambulatory Surgical Expense Covered medical expenses include expenses incurred by a covered person for outpatient surgery performed in an ambulatory surgical center. Covered medical expenses must be incurred on the day of the surgery or within 24 hours after the surgery.	80% of the Negotiated Charge	60% of the Recognized Charge
Walk-in Clinic Visit Expense	80% of the Negotiated Charge	60% of the Recognized Charge
Emergency Room Expense Covered medical expenses incurred by a covered person for services received in the emergency room of a hospital while the covered person is not a full-time inpatient of the hospital. The treatment received must be emergency care for an emergency medical condition. There is no coverage for elective treatment, routine care or care for a non-emergency sickness. As to emergency care incurred for the treatment of an emergency medical condition or psychiatric condition, any referral requirement will not apply & any expenses incurred for non-preferred care will be paid at the same cost-sharing level as if they had been incurred for preferred care. **Important Notice:** Covered medical expenses that are applied to the emergency room visit benefit deductible or copay cannot be applied to any other benefit deductible or copay under the plan. Likewise, covered medical expenses that are applied to any of the plan's other benefit deductibles or copays cannot be applied to the emergency room visit benefit deductible or copay. Separate benefit deductibles or copays may apply for certain services rendered in the emergency room that are not included in the hospital emergency room visit benefit. These benefit deductibles or copays may be different from the hospital emergency room visit benefit deductible or copay, and will be based on the specific service rendered. Similarly, services rendered in the emergency room that are not included in the hospital emergency room visit benefit may be subject to coinsurance rates that are different from the coinsurance rate applicable to the hospital emergency room visit benefit. Important Note: Please note that Non-Preferred Care Providers do not have a contract with Aetna; the provider may not accept payment of your cost share (your deductible and coinsurance) as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. Please send Aetna the bill at the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.	80% of the Negotiated Charge	80% of the Recognized Charge

OUTPATIENT EXPENSES (continued)	Preferred Care	Non-Preferred Care
Sexual Criminal Assault Examination and testing of a covered person who has been the victim of a sexual criminal assault.	100% No policy year deductible applies	Paid the same as the Preferred Care level of benefits.
Durable Medical and Surgical Equipment Expense Durable medical and surgical equipment would include: Artificial arms and legs; including accessories; • Arm, back, neck braces, leg braces; including attached shoes (but not corrective shoes); • Surgical supports; • Scalp hair prostheses required as the result of hair loss due to injury; sickness; or treatment of sickness; and • Head halters.	80% of the Negotiated Charge	60% of the Recognized Charge

PREVENTIVE CARE EXPENSES

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

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

PREVENTIVE CARE EXPENSES	Preferred Care	Non-Preferred Care
Routine Physical Exam Includes routine vision & hearing screenings given as part of the routine physical exam.	100% of the Negotiated Charge*	60% of the Recognized Charge
Preventive Care Immunizations	100% of the Negotiated Charge*	60% of the Recognized Charge
Well Woman Preventive Visits Routine well woman preventive exam office visit, including Pap smears.	100% of the Negotiated Charge*	60% of the Recognized Charge
Preventive Care Screening and Counseling Services for Sexually Transmitted Infections Includes the counseling services to help a covered person prevent or reduce sexually transmitted infections.	100% of the Negotiated Charge*	60% of the Recognized Charge
Preventive Care Screening and Counseling Services for Obesity and/or Healthy Diet Screening and counseling services to aid in weight reduction due to obesity. Coverage includes: • Preventive counseling visits and/or risk factor reduction intervention; • Nutritional counseling; and • Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.	100% of the Negotiated Charge*	60% of the Recognized Charge

PREVENTIVE CARE EXPENSES (continued)	Preferred Care	Non-Preferred Care
Preventive Care Screening and Counseling Services for Misuse of Alcohol and/or Drugs Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.	100% of the Negotiated Charge*	60% of the Recognized Charge
Preventive Care Screening and Counseling Services for Use of Tobacco Products Screening and counseling services to aid a covered person to stop the use of tobacco products. Coverage includes: • Preventive counseling visits; • Treatment visits; and • Class visits; to aid a covered person to stop the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: • Cigarettes; • Cigars; • Smoking tobacco; • Snuff; • Smokeless tobacco; and • Candy-like products that contain tobacco.	100% of the Negotiated Charge*	60% of the Recognized Charge
Preventive Care Screening and Counseling Services for Depression Screening Screening or test to determine if depression is present.	100% of the Negotiated Charge*	60% of the Recognized Charge
Preventive Care Routine Cancer Screenings Covered expenses include but are not limited to: Pap smears; Mammograms; Fecal occult blood tests; Digital rectal exams; Prostate specific antigen (PSA) tests; Sigmoidoscopies; Double contrast barium enemas (DCBE); Colonoscopies (anesthesia and the removal of polyps performed during a screening procedure are **covered medical expenses**); and Lung cancer screenings.	100% of the Negotiated Charge*	60% of the Recognized Charge
Preventive Care Screening and Counseling Services for Genetic Risk for Breast and Ovarian Cancer Covered medical expenses include the counseling and evaluation services to help assess a covered person's risk of breast and ovarian cancer susceptibility.	100% of the Negotiated Charge*	60% of the Recognized Charge
Preventive Care Prenatal Care Coverage for prenatal care under this Preventive Care Expense benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check, and fundal height). Refer to the Maternity Expense benefit for more information on coverage for maternity expenses under the Policy, including other prenatal care, delivery and postnatal care office visits.	100% of the Negotiated Charge*	60% of the Recognized Charge

PREVENTIVE CARE EXPENSES (continued)	Preferred Care	Non-Preferred Care
Preventive Care Lactation Counseling Services Lactation support and lactation counseling services are covered medical expenses when provided in either a group or individual setting.	100% of the Negotiated Charge*	60% of the Recognized Charge
Preventive Care Breast Pumps and Supplies	100% of the Negotiated Charge*	60% of the Recognized Charge
Preventive Care Female Contraceptive Counseling Services, Preventive Care Female Contraceptive Generic, Brand Name, Biosimilar Prescription Drugs and Devices provided, administered, or removed, by a Physician during an Office Visit, Preventive Care Female Voluntary Sterilization (Inpatient), Preventive Care Female Voluntary Sterilization (Outpatient) Includes counseling services on contraceptive methods provided by a physician, obstetrician or gynecologist. Such counseling services are covered medical expenses when provided in either a group or individual setting. **Voluntary Sterilization** Includes charges billed separately by the provider for female voluntary sterilization procedures & related services & supplies including, but not limited to, tubal ligation and sterilization implants. Covered medical expenses under this benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement. **Contraceptive**s can be paid either under this benefit or the prescribed medicines expense depending on the type of expense and how and where the expense is incurred. Benefits are paid under this benefit for female contraceptive prescription drugs and devices (including any related services and supplies) when they are provided, administered, or removed, by a physician during an office visit.	100% of the Negotiated Charge*	60% of the Recognized Charge
OTHER FAMILY PLANNING SERVICES EXPENSE	**Preferred Care**	**Non-Preferred Care**
Voluntary Sterilization for Males (Outpatient)	Payable in accordance with the type of expense incurred and the place where service is provided.	
Voluntary Termination of Pregnancy (Outpatient)	80% of the Negotiated Charge	60% of the Recognized Charge
AMBULANCE EXPENSE	**Preferred Care**	**Non-Preferred Care**
Ground, Air, Water and Non-Emergency Ambulance Includes charges incurred by a covered person for the use of a professional ambulance in an emergency. Covered medical expenses for the service are limited to charges for ground transportation to the nearest hospital equipped to render treatment for the condition. Air transportation is covered only when medically necessary.	80% of the Negotiated Charge	80% of the Recognized Charge

ADDITIONAL BENEFITS	Preferred Care	Non-Preferred Care
Allergy Testing and Treatment Expense Includes charges incurred by a covered person for diagnostic testing and treatment of allergies and immunology services.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Diagnostic Testing For Learning Disabilities Expense Covered medical expenses include charges incurred by a covered person for diagnostic testing for: • Attention deficit disorder; or • Attention deficit hyperactive disorder.	Payable in accordance with the type of expense incurred and the place where service is provided.	
High Cost Procedures Expense Includes charges incurred by a covered person as a result of certain high cost procedures provided on an outpatient basis. Covered medical expenses for high cost procedures include; but are not limited to; charges for the following procedures and services: • Computerized Axial Tomography (C.A.T.) scans; • Magnetic Resonance Imaging (MRI); and • Positron Emission Tomography (PET) Scans.	80% of the Negotiated Charge	60% of the Recognized Charge
Urgent Care Expense	80% of the Negotiated Charge	60% of the Recognized Charge
Dental Expense for Impacted Wisdom Teeth Includes charges incurred by a covered person for services of a dentist or dental surgeon for removal of one or more impacted wisdom teeth. Includes expenses for the treatment of: the mouth; teeth; and jaws; but only those for services rendered and supplies needed for the following treatment of; or related to conditions; of the: • mouth; jaws; jaw joints; or • supporting tissues; (this includes: bones; muscles; and nerves).	80% of the Negotiated Charge	80% of the Recognized Charge
Accidental Injury to Sound Natural Teeth Expense Covered medical expenses include charges incurred by a covered person for services of a dentist or dental surgeon as a result of an injury to sound natural teeth.	80% of the Negotiated Charge	80% of the Recognized Charge
Non-Elective Second Surgical Opinion Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	
Consultant Expense Includes the charges incurred by covered person in connection with the services of a consultant. The services must be requested by the attending physician to confirm or determine a diagnosis. Coverage may be extended to include treatment by the consultant.	80% of the Negotiated Charge	60% of the Recognized Charge
Skilled Nursing Facility Expense	80% of the Negotiated Charge	60% of the Recognized Charge
Rehabilitation Facility Expense Includes charges incurred by a covered person for confinement as a full time inpatient in a rehabilitation facility.	80% of the Negotiated Charge	60% of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Home Health Care Expense Covered medical expenses **will not** include: • Services by a person who resides in the covered person's home, or is a member of the covered person's immediate family • Homemaker or housekeeper services; • Maintenance therapy; • Dialysis treatment; • Purchase or rental of dialysis equipment; • Food or home delivered services; or • Custodial care.	80% of the Negotiated Charge	60% of the Recognized Charge
Temporomandibular Joint Dysfunction Expense Covered medical expenses include physician's charges incurred by a covered person for treatment of Temporomandibular Joint (TMJ) Dysfunction.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Dermatological Expense Includes physician's charges incurred by a covered person for the diagnosis and treatment of skin disorders. Related laboratory expenses are covered under the Lab and X-ray Expense benefit. Unless specified above, not covered under this benefit are charges incurred for: • Treatment for acne; • Cosmetic treatment and procedures; and Laboratory fees.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Prosthetic and Customized Orthotic Devices Expense Covered medical expenses include charges made for internal and external prosthetic devices customized orthotic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by sickness, injury or congenital defect. Covered medical expenses also include instruction and incidental supplies needed to use a covered prosthetic device. A customized orthotic device means a supportive device for the body or a part of the body, the head, neck or extremities. **Limitations:** Unless specified above, not covered under this benefit are charges for: • Eye exams; • Eyeglasses; • Vision aids; • Hearing aids; • Communication aids.	80% of the Negotiated Charge	60% of the Recognized Charge
Podiatric Expense Includes charges incurred by a covered person for podiatric services; provided on an outpatient basis following an injury. Unless specified above, not covered under this benefit are charges incurred for routine foot care, such as trimming of corns, calluses, and nails.	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Hypodermic Needles Expense Includes expenses incurred by a covered person for hypodermic needles and syringes.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Maternity Expense Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other Sickness. In the event of an inpatient confinement, such benefits would be payable for inpatient care of the Covered Person, and any newborn child, for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother and done in accordance with the rules and regulations promulgated by State Mandate. Covered medical expenses may include home visits, parent education, and assistance and training in breast or bottle-feeding.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Non-Prescription Enteral Formula Expense Includes charges incurred by a covered person, for non-prescription enteral formulas for which a physician has issued a written order, and are for the treatment of malabsorption caused by: • Crohn's Disease; • Ulcerative colitis; • Gastroesophageal reflux; • Gastrointestinal motility; • Chronic intestinal pseudo obstruction; and • Inherited diseases of amino acids and organic acids. Covered medical expenses for inherited diseases of amino acids; and organic acids; will also include food products modified to be low protein.	80% of the Negotiated Charge	60% of the Recognized Charge
Acupuncture in Lieu of Anesthesia Expense Includes charges incurred by a covered person for acupuncture therapy when acupuncture is used in lieu of other anesthesia for a surgical or dental procedure covered under this Plan. The acupuncture must be administered by a health care provider who is a legally qualified physician; practicing within the scope of their license.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Transfusion or Kidney Dialysis of Blood Expense Includes charges incurred by a covered person for the transfusion or kidney dialysis of blood, including the cost of: Whole blood; blood components; and the administration of whole blood and blood components.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Hospice Expense	80% of the Negotiated Charge	60% of the Recognized Charge
Osteoporosis Care Covered medical expenses include the diagnosis and treatment of osteoporosis on the same basis as any other covered medical expense.	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
End Stage Renal Disease Treatment Covered medical expenses include inpatient and outpatient treatment, subject to medical necessity.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Private Duty Nursing Includes private duty nursing services provided by an R.N. or L.P.N. if the covered person's condition requires skilled nursing care and visiting nursing care is not adequate.	80% of the Negotiated Charge	60% of the Recognized Charge
Diabetes Benefit Expense Includes charges for services, supplies, equipment, & training for the treatment of insulin and non-insulin dependent diabetes & elevated blood glucose levels during pregnancy. Self-management training provided by a licensed health care provider certified in diabetes self-management training.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Autism Spectrum Disorder Expense Includes charges incurred for services and supplies required for the diagnosis & treatment of autism spectrum disorder when ordered by a physician or behavioral health provider as part of a treatment plan.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Basic Infertility Expense Covered medical expenses include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Comprehensive Infertility Expenses Comprehensive Infertility Services Benefits • Ovulation induction with menotropins is subject to the maximum benefit of 4 cycles per lifetime. • Intrauterine insemination is subject to the maximum benefit of 4 cycles per lifetime.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Advanced Reproductive Technology (ART) Expenses Advanced Reproductive Technology is defined as: • In vitro fertilization (IVF); • Zygote intrafallopian transfer (ZIFT); • Gamete intra-fallopian transfer (GIFT); • Cryopreserved embryo transfers; and • Intracytoplasmic sperm injection (ICSI); or ovum microsurgery. • Up to 4 cycles of any combination of the following ART services per lifetime which only include: IVF; GIFT; ZIFT; or cryopreserved embryo transfers; • IVF; GIFT; ZIFT; or cryopreserved embryo transfers subject to the maximum benefit, if any shown on the Schedule of Benefits while covered under an Aetna plan; • ICSI or ovum microsurgery; • Payment for charges associated with the care of an eligible • covered person under this Plan who is participating in a donor IVF program, including fertilization and culture; and • Charges associated with obtaining the spouse's sperm for ART, when the spouse is also covered under the Policy.	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Advanced Reproductive Technology (ART) Expenses (continued) For treatments that include egg retrieval, benefits will not be paid for more than 4 completed egg retrievals per lifetime. However, if the live birth follows a completed egg retrieval, 2 additional egg retrievals will be covered. **Limitations:** Unless otherwise specified above, the following charges will not be payable as covered medical expenses under the Policy: • ART services for a female attempting to become pregnant who has not had at least 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination (for covered persons under 35 years of age), or 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination (for covered persons 35 years of age or older) prior to enrolling in the infertility program; • ART services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal; • Reversal of sterilization surgery; • Infertility Services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle; • The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier; • Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, hospital, ultrasounds, laboratory tests, etc.); • Home ovulation prediction kits; • Drugs related to the treatment of non-covered medical expenses or related to the treatment of infertility that are not medically necessary; • Injectable infertility medications, including but not limited to, menotropins, and hCG, GnRH agonists; • Any service or supply provided without pre-certification from Aetna's infertility case management unit; • Infertility Services that are not reasonably likely to result in success; • Ovulation induction and intrauterine insemination services if a covered person is not infertile; • Any ART procedures or services related to such procedures, including but not limited to in vitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), zygote intra-fallopian transfer ("ZIFT"), and intra-cytoplasmic sperm injection ("ICSI"); • Any charges associated with care required to obtain ART services (e.g., office, hospital, ultrasounds, laboratory tests, etc.); and any charges associated with obtaining sperm for any ART procedures.	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Bariatric Surgery Expense Covered medical expenses for the treatment of morbid obesity include one bariatric surgical procedure including related outpatient services, within a two-year period, beginning with the date of the first bariatric surgical procedure, unless a multi-stage procedure is planned.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Gender Reassignment (Sex Change) Treatment Expense Includes charges made in connection with a medically necessary gender reassignment surgery (sometimes called sex change surgery) as long the covered student or their covered dependent has obtained pre-certification from Aetna. The covered student or their covered dependent must be at least 18 years of age or older to be eligible for this benefit. Covered medical expenses include: • Charges made by a physician for: - Performing the surgical procedure; and - Pre-operative and post-operative hospital and office visits. • Charges made by a hospital for inpatient and outpatient services (including outpatient surgery). • Charges made by a Skilled Nursing Facility for inpatient services and supplies. • Charges made for the administration of anesthetics. • Charges for outpatient diagnostic laboratory and x-rays. • Charges for blood transfusion and the cost of unreplaced blood and blood products. • Charges made by a behavioral health provider for gender reassignment counseling. • Charges incurred for injectable and non-injectable hormone replacement therapy. No benefits will be paid for covered medical expenses under this benefit unless they have been pre-certified by Aetna. Refer to the Pre-certification section for more information.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Chiropractic Osteopathic Manipulation Treatment Expense Covered medical expenses include charges made by a physician on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine. Benefits limited to 20 visits per policy year.	50% of the Negotiated Charge	50% of the Recognized Charge
Naparathic Services Covered medical expenses include naparathic services (massage, nutritional counseling, and manipulations) provided by a physician for the treatment of a medical condition.	Payable in accordance with the type of expense incurred and the place where service is provided.	

SHORT-TERM CARDIAC AND PULMONARY REHABILITATION THERAPY SERVICES EXPENSE

Inpatient rehabilitation benefits for the services listed will be paid as part of the Hospital Expense and Skilled Nursing Facility Expense benefits.

Cardiac Rehabilitation Benefits

Cardiac rehabilitation benefits received at a hospital, skilled nursing facility, or physician's office. This Plan will cover charges in accordance with a treatment plan as determined by a covered person's risk level when recommended by a physician.

Pulmonary Rehabilitation Benefits

Pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of pulmonary disease states.

Cardiac Rehabilitation	80% of the Negotiated Charge	60% of the Recognized Charge
Pulmonary Rehabilitation	80% of the Negotiated Charge	60% of the Recognized Charge

SHORT-TERM REHABILITATION SERVICES EXPENSE

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

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

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

Short-Term Rehabilitation Services Expense Outpatient Cognitive, Physical, Occupational and Speech Rehabilitation and Habilitation Therapy Services (combined)	80% of the Negotiated Charge	60% of the Recognized Charge
HEARING AIDS	**Preferred Care**	**Non-Preferred Care**
Hearing Aid Exams and Hearing Aid Expenses Covered medical expenses for hearing care includes charges for hearing exams, prescribed hearing aids and hearing aid expenses. Coverage is limited to covered persons through age 25. One hearing exam every 12 month consecutive period. One hearing aid per impaired ear every 12 month consecutive period.	80% of the Negotiated Charge	60% of the Recognized Charge

Cochlear Implants
Limitations:
No benefits are payable under this benefit for charges incurred for:
• A service or supply which is received while the person is not a covered person under this Plan;
• A replacement of:
  ○ a hearing aid that is lost, stolen or broken; or
  ○ a hearing aid installed within the prior 12 month period.
• Replacement parts or repairs for a hearing aid;
• Batteries or cords;
• 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;
	80% of the Negotiated Charge	60% of the Recognized Charge

HEARING AIDS (continued)	Preferred Care	Non-Preferred Care

Cochlear Implants (continued)
• Any hearing aid furnished or ordered because of a hearing exam that was done before the date the person became covered under this Plan;
• Any hearing care service or supply which is a covered medical expense in whole or in part under any other part of this Plan;
• Any hearing care service or supply which does not meet professionally accepted standards;
• Any hearing exam:
  ○ required by an employer as a condition of employment; or
  ○ which an employer is required to provide under a labor agreement; or
  ○ which is required by any law of government.
• Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay; and
• Any tests, appliances and devices for the improvement of hearing including hearing aid batteries and auxiliary equipment or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech.
	80% of the Negotiated Charge	60% of the Recognized Charge

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

ALCOHOLISM AND DRUG ADDICTION TREATMENT (continued)	Preferred Care	Non-Preferred Care
Inpatient & Residential Substance Abuse Physician Services per Admission Expense	80% of the Negotiated Charge	60% of the Recognized Charge
Outpatient Substance Abuse Treatment	80% of the Negotiated Charge	60% of the Recognized Charge
TRANSPLANT SERVICE EXPENSE	**Preferred Care**	**Non-Preferred Care**
Transplant Services Expense Benefits may vary if an Institute of Excellence™ (IOE) facility or non-IOE or non-preferred care provider is used. Through the IOE network, the covered person will have access to a provider network that specializes in transplants. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure the covered person requires. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Transplant Travel and Lodging Expense The plan will reimburse a covered person for some of the cost of their travel and lodging expenses.	$50 per night Maximum Benefit for Lodging Expenses per IOE patient & $50 per night Maximum Benefit for Lodging Expenses per companion up to 10,000 per transplant.	
PEDIATRIC DENTAL SERVICES EXPENSE **(Coverage is limited to covered persons until the end of the month in which the covered person turns 19)**	**Preferred Care**	**Non-Preferred Care**
Type A Expense (Pediatric Routine Dental Exam Expense) Benefit maximum of 1 visit every 6 months	100% of the Negotiated Charge*	60% of the Recognized Charge
Type B Expense (Pediatric Basic Dental Care Expense)	70% of the Negotiated Charge*	50% of the Recognized Charge
Type C Expense (Pediatric Major Dental Care Expense)	50% of the Negotiated Charge*	50% of the Recognized Charge
Pediatric Orthodontia Expense Orthodontics Medically necessary comprehensive treatment • Replacement of retainer (limit one per lifetime).	50% of the Negotiated Charge*	50% of the Recognized Charge
PEDIATRIC ROUTINE VISION **(Coverage is limited to covered persons until the end of the month in which the covered person turns 19)**	**Preferred Care**	**Non-Preferred Care**
Pediatric Routine Vision Exams (including refractions) Includes charges made by a legally qualified ophthalmologist or optometrist for a routine vision exam. The exam will include refraction & glaucoma testing. Benefit Maximum of 1 visit per Policy Year.	100% of the Negotiated Charge*	60% of the Recognized Charge*

PEDIATRIC ROUTINE VISION (continued) (Coverage is limited to covered persons until the end of the month in which the covered person turns 19)	Preferred Care	Non-Preferred Care
Pediatric Visit for the fitting of prescription contact lenses, Pediatric Eyeglass Frames, Prescription Lenses or Prescription Contact Lenses Includes charges for the following vision care services and supplies: • Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses. • Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a preferred care provider. Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a non-preferred care provider. Coverage includes charges incurred for: • Non-conventional prescription contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses. Aphakic prescription lenses prescribed after cataract surgery has been performed. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.	100% of the Negotiated Charge*	60% of the Recognized Charge*

PRESCRIBED MEDICINES EXPENSE

COVERED PERCENTAGE*	Preferred Care	Non-Preferred Care
Preventive Care Drugs and Supplements **Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.**		
Risk Reducing Breast Cancer Prescription Drugs For each 30 day supply filled at a retail pharmacy.	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits	100% of the Recognized Charge
Tobacco Cessation Prescription Drugs and Over-the-Counter Drugs. (for two 90-day treatment regimens only)	Refer to the Copay and Deductible Waiver Provision	100% of the Recognized Charge
Other preventive care drugs and supplements For each 30 day supply filled at a retail pharmacy.	100% per supply	100% of the Recognized Charge
CONTRACEPTIVES	**Preferred Care**	**Non-Preferred Care**
FDA-Approved Female Generic Over-the-Counter Contraceptives (Non-Emergency) for each 30 day Supply	100% per supply	100% of the Recognized Charge
FDA-Approved Female Generic Emergency Contraceptives	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits	100% of the Recognized Charge
All OTHER PRESCRIPTION DRUGS	**Preferred Care**	**Non-Preferred Care**
For each 30 day supply filled at a retail pharmacy.	100% of the Negotiated Charge	100% of the Recognized Charge

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

Per Prescription Copay/Deductible	Preferred Care	Non-Preferred Care
Generic Prescription Drugs For each 30 day supply filled at a retail pharmacy.	$10 Copay per supply	$10 Deductible per supply
Preferred Brand-Name Prescription Drug	**Preferred Care**	**Non-Preferred Care**
For each 30 day supply filled at a retail pharmacy.	$25 Copay per supply	$25 Deductible per supply
Non-Preferred Brand-Name Prescription Drugs	**Preferred Care**	**Non-Preferred Care**
For each 30 day supply filled at a retail pharmacy.	$50 Copay per supply	$50 Deductible per supply
Orally Administered Anti-Cancer Prescription Drugs (including Chemotherapy Drugs)	Payable on the same basis as covered cancer chemotherapy medications that are administered intravenously or by injection.	
Risk Reducing Breast Cancer Prescription Drugs For each 30 day supply filled at a retail pharmacy.	100% per supply	$50 Deductible per supply
Tobacco Cessation Prescription Drugs and Over-the-Counter Drugs. (for two 90-day treatment regimens only)	100% per supply	$50 Deductible per supply
Other preventive care drugs and supplements For each 30 day supply filled at a retail pharmacy.	100% per supply	100% of the Recognized Charge

Per Prescription Copay filled at Southern Illinois University Carbondale Student Health Services:

- Generic Prescription Drugs: $10 Copay per supply
- Preferred Brand-Name Prescription Drugs: $25 Copay per supply

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

Copay and Deductible Waiver

Waiver for Risk-Reducing Breast Cancer Prescription Drugs

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

Waiver for Prescription Drug Contraceptives

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

- Female contraceptives that are:
  - Oral prescription drugs that are generic prescription drugs.
  - Injectable prescription drugs that are generic prescription drugs.
  - Vaginal ring prescription drugs that are generic prescription drugs, brand-name prescription drugs and biosimilar prescription drugs.
  - Transdermal contraceptive patch prescription drugs that are generic prescription drugs, brand-name prescription drugs, and biosimilar prescription drugs.
- Female contraceptive devices.
- FDA-approved female:
  - generic emergency contraceptives; and
  - generic over-the-counter (OTC) emergency contraceptives.

when obtained at a preferred care pharmacy. This means that such contraceptive methods will be paid at 100%.

The per prescription copay/deductible and policy year deductible continue to apply:

- When the contraceptive methods listed above are obtained at a non-preferred pharmacy.
- To female contraceptives that are:
  - Oral prescription drugs that are brand-name prescription drugs and biosimilar prescription drugs.
  - Injectable prescription drugs that are brand-name prescription drugs and biosimilar prescription drugs.
- To female contraceptive devices that are brand-name devices.
- To FDA-approved female:
  - brand-name and biosimilar emergency contraceptives; and
  - brand-name over-the-counter (OTC) emergency contraceptives.
- To FDA-approved female brand-name over-the-counter (OTC) contraceptives.
- To FDA-approved male brand-name over-the-counter (OTC) contraceptives.

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

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

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

Exclusions

This Plan does not cover nor provide benefits for:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15. Expense for or related to artificial insemination; in-vitro fertilization; or embryo transfer procedures; male elective sterilization; or elective abortion unless specifically covered under the Policy.

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

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

18. Expense incurred for custodial care, except for respite care covered under hospice care.

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

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

21. Expenses incurred for breast reduction/mammoplasty.

22. Expenses incurred for gynecomastia (male breasts).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

41. 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).

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

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

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

45. Expenses incurred for orthodontic treatment except as specifically covered in the Orthodontic Treatment Rule.

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

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

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

Notice of Non-Discrimination:

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

Sanctioned Countries:

If coverage provided by this 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).

TTY: 711

For language assistance in your language call the number listed on your ID card at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación. (Spanish)

欲取得繁體中文語言協助，請撥打您 ID 卡上所列的號碼，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le numéro indiqué sur votre carte d'identité sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang nakalistang numero sa iyong ID card nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen auf Deutsch? Rufen Sie kostenlos die auf Ihrer Versicherungskarte aufgeführte Nummer an. (German)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني المذكور في بطاقتك التعريفية. (Arabic)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo a yo endike nan kat idantifikasyon ou gratis. (French Creole)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente il numero riportato sulla Sua scheda identificativa. (Italian)

日本語で援助をご希望の方は、IDカードに記載されている番号まで無料でお電話ください。(Japanese)

한국어로 언어 지원을 받고 싶으시면 보험 ID 카드에 수록된 무료 통화번호로 전화해 주십시오. (Korean)

برای راهنمایی به زبان فارسی، بدون هیچ هزینه ای با شماره ای که بر روی کارت شناسایی شما آمده است تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer podany na karcie ID. (Polish)

Para obter assistência linguística em português ligue para o número grátis listado no seu cartão de identificação. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру, указанному в вашей ID-карте удостоверения личности. (Russian)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số được ghi trên thẻ ID của quý vị. (Vietnamese)