Aetna Student Health

Plan Design and Benefits Summary
Preferred Provider Organization (PPO)

West Virginia University

Policy Year: 2020 - 2021
Policy Number: 474957
www.aetnastudenthealth.com
(866) 654-2338

The West Virginia University Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student HealthSM is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).
This is a brief description of the Student Health Plan. The plan is available for West Virginia University students. The plan is insured by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Certificate issued to you and may be viewed online at www.aetnastudenthealth.com. If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

Coverage Periods
Coverage will become effective at 12:01 AM (EST) on the Coverage Start Date indicated and will terminate at 12:00 AM (EST) on the Coverage End Date indicated.

<table>
<thead>
<tr>
<th>Coverage Period</th>
<th>Coverage Start Date</th>
<th>Coverage End Date</th>
<th>Waiver Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall Term</td>
<td>08/11/2020</td>
<td>12/31/2020</td>
<td>08/01/2020</td>
</tr>
<tr>
<td>Spring Term</td>
<td>01/01/2021</td>
<td>08/10/2021</td>
<td>Please monitor student insurance website for updates.</td>
</tr>
<tr>
<td>Summer Only Term</td>
<td>05/11/2021</td>
<td>08/10/2021</td>
<td>Please monitor student insurance website for updates.</td>
</tr>
</tbody>
</table>

Please visit www.studentinsurance.wvu.edu for updated Spring and Summer waiver deadlines when available.

Rates

<table>
<thead>
<tr>
<th>Coverage Period</th>
<th>2020-2021 Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fall Term</td>
<td>$1086</td>
</tr>
<tr>
<td>Spring/Summer Term</td>
<td>$1086</td>
</tr>
<tr>
<td>Summer Only Term</td>
<td>$546</td>
</tr>
</tbody>
</table>

All insurance coverage is subject to applicable state form and rate filing approval and, once approved to the terms of the Master Policy. We have not yet received approval from the state insurance department for the 2020-2021 benefits and rates described in this document. As part of the approval process, the State may require us to make changes to the benefits and/or rates. We will notify you if that happens.

Student Coverage

Who is eligible?

All domestic students who are enrolled in six or more credit hours and all international students enrolled in one or more credit hours at West Virginia University or West Virginia University Institute of Technology, including WVU students enrolled in fully online programs. Please Note: Dependents of students are not eligible to purchase the 2020/2021 West Virginia University Student Health Insurance Plan.

Students who fall below the credit hour requirement prior to the end of the add/drop period will be dis-enrolled from the plan and refunded the premium for that term. Students who fall below the credit hour requirement after the end of the add/drop period will remain enrolled in the plan and will not be refunded the premium.
**Enrollment**

Eligible students will be automatically enrolled in this Plan, unless the completed waiver application has been received and approved by the specified waiver deadline published online at www.studentinsurance.wvu.edu. Students who fall below the credit hour requirement prior to the end of the add/drop period will be dis-enrolled from the plan and refunded the premium for that term. Students who fall below the credit hour requirement after the end of the add/drop period will remain enrolled in the plan and will not be refunded the premium.

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

**Medicare Eligibility Notice**

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

**In-network Provider Network**

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

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

**Precertification**

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

**Precertification Call**

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

<table>
<thead>
<tr>
<th>Type of Admission</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-emergency admissions</td>
<td>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.</td>
</tr>
<tr>
<td>An emergency admission</td>
<td>You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.</td>
</tr>
<tr>
<td>An urgent admission</td>
<td>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.</td>
</tr>
<tr>
<td>Outpatient non-emergency services requiring precertification</td>
<td>You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.</td>
</tr>
</tbody>
</table>
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 days as long as you remain enrolled in the plan.

**Coordination of Benefits (COB)**

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

**Description of Benefits**

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

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

<table>
<thead>
<tr>
<th>Policy year deductible</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Student</strong></td>
<td>$500 per policy year</td>
<td>$5,000 per policy year</td>
</tr>
</tbody>
</table>

**Individual**

This is the amount you owe for in-network and out-of-network eligible health services each policy year before the plan begins to pay for eligible health services. This policy year deductible applies separately to you. After the amount you pay for eligible health services reaches the policy year deductible, this plan will begin to pay for eligible health services for the rest of the policy year.

**Policy year deductible waiver**

The policy year deductible is waived for all of the following eligible health services:

- Select and In-network care for Preventive care and wellness
- Select and In-network care for Pediatric Preventive Dental Benefits
- Select, In-network, and out-of-network care for Immunizations up to age 16, Pediatric Vision Services
- In-network Outpatient Office Visits

**Maximum out-of-pocket limit per policy year**

<table>
<thead>
<tr>
<th></th>
<th>$7,350 per policy year</th>
<th>None</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Student</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Referral penalty

You must get a referral from school health services for off-campus care. If you do not get a referral, then we will pay covered benefits at the out-of-network coverage cost sharing.

A referral is not required in the following circumstances:

Exceptions

- Care is provided by Designated Care Providers: WVU Healthcare, University Health Associates, Gateway Health Services Corp, WVU-Dental Corp., Berkeley Medical Center, Jefferson Memorial Hospital and University Medical Labs,
- Treatment is for an Emergency Medical Condition (a referral is required for follow up care),
- Obstetric and Gynecological Treatment,
- Pediatric Care,
- Preventive/Routine Services (services considered preventive according to Health Care Reform and/or services rendered not to diagnose or treat an Accident or Sickness)
- Physical Therapy
- The student is more than 20 miles away from WVU Student Health Services,
- Student Health Services is closed,
- Services rendered at another facility during vacation or break periods,
- Medical Care received when the student is no longer eligible to use WVU Student Health Services due to a change in Student Status,
- Maternity,
- Mental Health,
- Laboratory and X-Ray Expenses,
- Hospice Expense,
- Skilled Nursing Facility Expense,
- Rehabilitation Facility Expense,
- Private Duty Expense, and Licensed Nurse Expense.

<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>Designated Care</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine physical exams</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed at a physician's office</td>
<td>100% (of the negotiated charge) per visit</td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>Policy year deductible applies</td>
</tr>
</tbody>
</table>

Maximum age and visit limits per policy year through age 21

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.

Maximum visits per policy year age 22 and over

1 visit
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>Designated Care</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive care immunizations</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed in a facility or at a physician’s office</td>
<td>100% (of the negotiated charge) per visit</td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>Policy year deductible applies</td>
</tr>
<tr>
<td>Maximums</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine gynecological exams (including Pap smears and cytology tests)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Performed at a physician’s, obstetrician (OB), gynecologist (GYN) or OB/GYN office</td>
<td>100% (of the negotiated charge) per visit</td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>Policy year deductible applies</td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td></td>
<td>1 visit</td>
<td></td>
</tr>
<tr>
<td>Preventive screening and counseling services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol &amp; drugs, Tobacco Products, Depression Screening, Sexually transmitted infection counseling &amp; Genetic risk counseling for breast and ovarian cancer</td>
<td>100% (of the negotiated charge) per visit</td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>Policy year deductible applies</td>
</tr>
<tr>
<td>Obesity/Healthy Diet maximum per policy year (Applies to covered persons age 22 and older)</td>
<td>26 visits (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)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Misuse of Alcohol maximum per policy year</td>
<td></td>
<td>5 visits</td>
<td></td>
</tr>
<tr>
<td>Tobacco Products Counseling maximum per policy year</td>
<td></td>
<td>8 visits</td>
<td></td>
</tr>
<tr>
<td>Depression screening maximum per policy year</td>
<td></td>
<td>1 visit</td>
<td></td>
</tr>
<tr>
<td>STI maximum per policy year</td>
<td></td>
<td>2 visits</td>
<td></td>
</tr>
<tr>
<td>Eligible health services</td>
<td>Designated Care</td>
<td>In-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>--------------------------------------------------------------</td>
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</tr>
<tr>
<td>Routine cancer screenings</td>
<td>100% (of the negotiated charge) per visit</td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>Policy year deductible applies</td>
</tr>
<tr>
<td>Maximums</td>
<td>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.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung cancer screening maximums</td>
<td>1 screening every 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prenatal care services</td>
<td>100% (of the negotiated charge) per visit</td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td>(Preventive care services only)</td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>Policy year deductible applies</td>
</tr>
<tr>
<td>Lactation support and counseling services</td>
<td>100% (of the negotiated charge) per visit</td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>Policy year deductible applies</td>
</tr>
<tr>
<td>Lactation counseling services maximum per policy year</td>
<td>6 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast pump supplies and accessories</td>
<td>100% (of the negotiated charge) per visit</td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>Policy year deductible applies</td>
</tr>
<tr>
<td>Female contraceptive counseling services office visit</td>
<td>100% (of the negotiated charge) per visit</td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>Policy year deductible applies</td>
</tr>
<tr>
<td>Contraceptive counseling services maximum per policy year</td>
<td>2 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female contraceptive prescription drugs and devices</td>
<td>100% (of the negotiated charge) per visit</td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>Policy year deductible applies</td>
</tr>
<tr>
<td>Female voluntary sterilization-Inpatient &amp; Outpatient provider services</td>
<td>100% (of the negotiated charge) per visit</td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>Policy year deductible applies</td>
</tr>
<tr>
<td>Eligible health services</td>
<td>Designated Care</td>
<td>In-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>---------------------------------------------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td><strong>Physicians and other health professionals</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist) includes telemedicine consultations</td>
<td>$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies</td>
<td>$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies</td>
<td>$70 copayment then the plan pays 50% (of the balance of the recognized charge) per visit thereafter Policy year deductible applies</td>
</tr>
<tr>
<td><strong>Allergy testing and treatment</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy testing &amp; Allergy injections treatment performed at a physician's or specialist's office</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td><strong>Physician and specialist - surgical services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)</td>
<td>80% (of the negotiated charge) Policy year deductible applies</td>
<td>80% (of the negotiated charge) Policy year deductible applies</td>
<td>50% (of the recognized charge) Policy year deductible applies</td>
</tr>
<tr>
<td>Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)</td>
<td>80% (of the negotiated charge) Policy year deductible applies</td>
<td>80% (of the negotiated charge) Policy year deductible applies</td>
<td>50% (of the recognized charge) Policy year deductible applies</td>
</tr>
<tr>
<td><strong>Alternatives to physician office visits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walk-in clinic visits (non-emergency visit)</td>
<td>$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies</td>
<td>$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter No policy year deductible applies</td>
<td>$70 copayment then the plan pays 50% (of the balance of the recognized charge) per visit thereafter Policy year deductible applies</td>
</tr>
</tbody>
</table>
### Eligible health services

<table>
<thead>
<tr>
<th>Service</th>
<th>Designated Care</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive care immunizations</td>
<td>100% (of the negotiated charge) per visit</td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>Policy year deductible applies</td>
</tr>
<tr>
<td>Immunization limits</td>
<td>Subject to any age and frequency limits provided for in the comprehensive guidelines supported by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive screening and counseling services</td>
<td>100% (of the negotiated charge) per visit</td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>Policy year deductible applies</td>
</tr>
<tr>
<td>Preventive screening and counseling limits</td>
<td>Obesity and/or healthy diet: Maximum visits per policy year: 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)* (This maximum applies only to covered persons age 22 and older.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Misuse of alcohol and/or drugs: 5 Visits per policy year</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Use of tobacco products: 8 Visits per policy year</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Depression screening: 1 Visit per policy year</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sexually transmitted infection: 2 Visits per policy year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital and other facility care</td>
<td>Inpatient hospital (room and board) and other miscellaneous services and supplies)</td>
<td>$300 copayment plus 80% (of the balance of the negotiated charge) per admission</td>
<td>$300 copayment plus 80% (of the balance of the negotiated charge) per admission</td>
</tr>
<tr>
<td></td>
<td>Includes birthing center facility charges</td>
<td>Policy year deductible applies</td>
<td>Policy year deductible applies</td>
</tr>
<tr>
<td>In-hospital non-surgical physician services</td>
<td>80% (of the negotiated charge)</td>
<td>80% (of the negotiated charge)</td>
<td>50% (of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td>Policy year deductible applies</td>
<td>Policy year deductible applies</td>
<td>Policy year deductible applies</td>
</tr>
<tr>
<td>Alternatives to hospital stays</td>
<td>Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center</td>
<td>80% (of the negotiated charge)</td>
<td>80% (of the negotiated charge)</td>
</tr>
<tr>
<td></td>
<td>Policy year deductible applies</td>
<td>Policy year deductible applies</td>
<td>Policy year deductible applies</td>
</tr>
<tr>
<td>Eligible health services</td>
<td>Designated Care</td>
<td>In-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Home health Care</td>
<td>80% (of the negotiated charge)</td>
<td>80% (of the negotiated charge)</td>
<td>50% (of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td>Policy year deductible applies</td>
<td>Policy year deductible applies</td>
<td>Policy year deductible applies</td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td></td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>Hospice-Inpatient</td>
<td>80% (of the negotiated charge) per admission</td>
<td>80% (of the negotiated charge) per admission</td>
<td>50% (of the recognized charge) per admission</td>
</tr>
<tr>
<td></td>
<td>Policy year deductible applies</td>
<td>Policy year deductible applies</td>
<td>Policy year deductible applies</td>
</tr>
<tr>
<td>Hospice-Outpatient</td>
<td>80% (of the negotiated charge) per visit</td>
<td>80% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>Policy year deductible applies</td>
<td>Policy year deductible applies</td>
<td>Policy year deductible applies</td>
</tr>
<tr>
<td>Skilled nursing facility-</td>
<td>$300 copayment plus 80% (of the balance of the negotiated charge) per admission</td>
<td>$300 copayment plus 80% (of the balance of the negotiated charge) per admission</td>
<td>$300 copayment plus 50% (of the balance of the recognized charge) per admission</td>
</tr>
<tr>
<td>Inpatient</td>
<td>Policy year deductible applies</td>
<td>Policy year deductible applies</td>
<td>Policy year deductible applies</td>
</tr>
<tr>
<td>Maximum days of confinement per</td>
<td></td>
<td>100</td>
<td></td>
</tr>
<tr>
<td>policy year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligible health services</td>
<td>Designated Care</td>
<td>In-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------</td>
</tr>
<tr>
<td>Hospital emergency room</td>
<td>$300 copayment (waived if admitted) plus 80% (of the balance of the negotiated charge) per admission</td>
<td>$300 copayment (waived if admitted) plus 80% (of the balance of the negotiated charge) per admission</td>
<td>Paid the same as in-network coverage</td>
</tr>
<tr>
<td></td>
<td>Policy year deductible applies</td>
<td>Policy year deductible applies</td>
<td></td>
</tr>
<tr>
<td>Non-emergency care in a hospital emergency room</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Urgent Care</th>
<th>$50 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter</th>
<th>$50 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter</th>
<th>$50 copayment then the plan pays 50% (of the balance of the recognized charge) per visit thereafter</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Policy year deductible applies</td>
<td>Policy year deductible applies</td>
<td>Policy year deductible applies</td>
</tr>
<tr>
<td>Non-urgent use of urgent care provider</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Eligible health services</td>
<td>Designated Care</td>
<td>In-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
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<td>---------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td><strong>Pediatric dental care</strong> (Limited to covered persons through the end of the month in which the person turns age 19)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type A services</td>
<td>100% (of the negotiated charge) per visit</td>
<td>100% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Type B services</td>
<td>75% (of the negotiated charge) per visit</td>
<td>75% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Type C services</td>
<td>75% (of the negotiated charge) per visit</td>
<td>75% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Orthodontic services</td>
<td>75% (of the negotiated charge) per visit</td>
<td>75% (of the negotiated charge) per visit</td>
<td>50% (of the recognized charge) per visit</td>
</tr>
<tr>
<td></td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>Dental emergency treatment</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>

### Specific Conditions

<table>
<thead>
<tr>
<th>Diabetic services and supplies (including equipment and training)</th>
<th>Covered according to the type of benefit and the place where the service is received</th>
<th>Covered according to the type of benefit and the place where the service is received</th>
<th>Covered according to the type of benefit and the place where the service is received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impacted wisdom teeth</td>
<td>100% (of the negotiated charge)</td>
<td>100% (of the negotiated charge)</td>
<td>100% (of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td>Policy year deductible applies</td>
<td>Policy year deductible applies</td>
<td>Policy year deductible applies</td>
</tr>
<tr>
<td>Accidental injury to sound natural teeth</td>
<td>100% (of the negotiated charge)</td>
<td>100% (of the negotiated charge)</td>
<td>100% (of the recognized charge)</td>
</tr>
<tr>
<td></td>
<td>Policy year deductible applies</td>
<td>Policy year deductible applies</td>
<td>Policy year deductible applies</td>
</tr>
<tr>
<td>Obesity bariatric Surgery</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Eligible health services</td>
<td>Designated Care</td>
<td>In-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Maternity care</strong></td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
</tbody>
</table>
| Maternity care (includes delivery and postpartum care services in a hospital or birthing center) | 80% of the negotiated charge  
No policy year deductible applies | 80% of the negotiated charge  
No policy year deductible applies | 50% of the recognized charge  
No policy year deductible applies |
| Well newborn nursery care in a hospital or birthing center                                | 80% of the negotiated charge  
No policy year deductible applies | 80% of the negotiated charge  
No policy year deductible applies | 50% of the recognized charge  
No policy year deductible applies |
| **Family planning services – other**                                                     | 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. |
| Voluntary sterilization for males-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. | Covered according to the type of benefit and the place where the service is received. |
| **Gender reassignment (sex change) treatment**                                          | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| 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. | Covered according to the type of benefit and the place where the service is received. |
| **Autism spectrum disorder**                                                            | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| Autism spectrum disorder treatment, diagnosis and testing and Applied behavior analysis | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| **Mental Health & Substance Abuse Treatment**                                           | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| Inpatient hospital (room and board and other miscellaneous hospital services and supplies) | $300 copayment plus 80% of the balance of the negotiated charge  
Policy year deductible applies | $300 copayment plus 80% of the balance of the negotiated charge  
Policy year deductible applies | $300 copayment plus 50% of the balance of the recognized charge  
Policy year deductible applies |
| Outpatient office visits (includes telemedicine consultations)                          | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program) | 80% of the negotiated charge  
Policy year deductible applies | 80% of the negotiated charge  
Policy year deductible applies | 50% of the recognized charge  
Policy year deductible applies |
<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>In-network coverage</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplant services Inpatient and outpatient facility services</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Transplant services Inpatient and outpatient physician and specialist services</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Transplant services-travel and lodging</td>
<td>Covered</td>
<td>Covered</td>
<td>Covered</td>
</tr>
<tr>
<td>Lifetime Maximum Travel and Lodging Expenses for any one transplant</td>
<td>$10,000</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Maximum Lodging Expenses per IOE patient</td>
<td>$50 per night</td>
<td>$50 per night</td>
<td>$50 per night</td>
</tr>
<tr>
<td>Maximum Lodging Expenses per companion</td>
<td>$50 per night</td>
<td>$50 per night</td>
<td>$50 per night</td>
</tr>
<tr>
<td>Eligible health services</td>
<td>Designated Care</td>
<td>In-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>Basic infertility services</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Specific therapies and tests</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient diagnostic testing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility</td>
<td>$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter</td>
<td>$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter</td>
<td>$70 copayment then the plan pays 50% (of the balance of the recognized charge) per visit thereafter Policy year deductible applies</td>
</tr>
<tr>
<td>Diagnostic lab work and radiological services performed in a physician's office, the outpatient department of a hospital or other facility</td>
<td>$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter</td>
<td>$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter</td>
<td>$70 copayment then the plan pays 50% (of the balance of the recognized charge) per visit thereafter Policy year deductible applies</td>
</tr>
<tr>
<td>Eligible health services</td>
<td>Designated Care</td>
<td>In-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>--------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Chemotherapy</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Chemotherapy, Radiation &amp; Respiratory Therapy</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy)</td>
<td>$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter. No policy year deductible applies.</td>
<td>$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter. No policy year deductible applies.</td>
<td>$70 copayment then the plan pays 50% (of the balance of the recognized charge) per visit thereafter. Policy year deductible applies.</td>
</tr>
<tr>
<td>Combined for short-term rehabilitation services and habilitation therapy services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic services</td>
<td>$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter. No policy year deductible applies.</td>
<td>$25 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit thereafter. No policy year deductible applies.</td>
<td>$70 copayment then the plan pays 50% (of the balance of the recognized charge) per visit thereafter. Policy year deductible applies.</td>
</tr>
<tr>
<td>Maximum visits per policy year</td>
<td>30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency ground, air, and water ambulance</td>
<td>100% (of the negotiated charge) per trip</td>
<td>100% (of the negotiated charge) per trip</td>
<td>Paid the same as in-network coverage</td>
</tr>
<tr>
<td>Durable medical and surgical equipment</td>
<td>80% (of the negotiated charge) Policy year deductible applies</td>
<td>80% (of the negotiated charge) Policy year deductible applies</td>
<td>50% (of the recognized charge) Policy year deductible applies</td>
</tr>
<tr>
<td>Enteral formulas and nutritional supplements</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
<td>Covered according to the type of benefit and the place where the service is received.</td>
</tr>
<tr>
<td>Coverage is limited to covered persons age 20 and under</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prosthetic Devices &amp; Orthotics</td>
<td>80% (of the negotiated charge) Policy year deductible applies</td>
<td>80% (of the negotiated charge) Policy year deductible applies</td>
<td>50% (of the recognized charge) Policy year deductible applies</td>
</tr>
<tr>
<td>Eligible health services</td>
<td>Designated Care</td>
<td>In-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>-----------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
<td>-------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **Pediatric vision care** (Limited to covered persons through the end of the month in which the person turns 19) | **100% (of the negotiated charge) per visit**  
No policy year deductible applies | **100% (of the negotiated charge) per visit**  
No policy year deductible applies | **50% (of the recognized charge) per visit**  
No policy year deductible applies |
| Pediatric routine vision exams (including refraction)-  
Performed by a legally qualified ophthalmologist or optometrist  
Includes comprehensive low vision evaluations  
Includes visit for fitting of contact lenses | | | |
| Maximum visits per policy year  
Low vision Maximum | 1 visit  
One comprehensive low vision evaluation every policy year | | |
| Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses | **100% (of the negotiated charge) per visit**  
No policy year deductible applies | **100% (of the negotiated charge) per visit**  
No policy year deductible applies | **50% (of the recognized charge) per visit**  
No policy year deductible applies |
| Maximum number Per year:  
Eyeglass frames  
Prescription lenses  
Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery) | One set of eyeglass frames  
One pair of prescription lenses  
Daily disposables: up to 3 month supply  
Extended wear disposable: up to 6 month supply  
Non-disposable lenses: one set | | |

*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.*

**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%.

**Outpatient prescription drug policy year deductible and copayment waiver for tobacco cessation prescription and over-the-counter drugs**

The outpatient prescription drug policy year deductible and the prescription drug copayment 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 or mail order in-network and out-of-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%.

Your policy year deductible and any prescription drug copayment will apply after those two regimens per policy year have been exhausted.
The outpatient prescription drug policy year deductible and the prescription drug copayment will not apply to female contraceptive methods when obtained at an in-network and out-of-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 outpatient prescription drug policy year deductible and the prescription drug copayment continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at an in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.

<table>
<thead>
<tr>
<th>Eligible health services</th>
<th>Designated Care</th>
<th>In-network coverage</th>
<th>Out-of-network coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Preferred generic prescription drugs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For each fill up to a 30 day supply filled at a retail pharmacy</td>
<td>$15 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies</td>
<td>$15 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies</td>
<td>$15 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies</td>
</tr>
<tr>
<td>More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy</td>
<td>$30 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies</td>
<td>$30 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Preferred brand-name prescription drugs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For each fill up to a 30 day supply filled at a retail pharmacy</td>
<td>$40 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies</td>
<td>$40 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies</td>
<td>$40 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies</td>
</tr>
<tr>
<td>More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy</td>
<td>$80 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies</td>
<td>$80 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Eligible health services</td>
<td>Designated Care</td>
<td>In-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Non-preferred generic prescription drugs</strong></td>
<td></td>
<td>$75 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>$75 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
</tr>
<tr>
<td>For each fill up to a 30 day supply filled at a retail pharmacy</td>
<td>$75 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy</td>
<td>$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>No policy year deductible applies</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Non-preferred brand-name prescription drugs</strong></td>
<td></td>
<td>$75 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>$75 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
</tr>
<tr>
<td>For each fill up to a 30 day supply filled at a retail pharmacy</td>
<td>$75 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>No policy year deductible applies</td>
<td>No policy year deductible applies</td>
</tr>
<tr>
<td>More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy</td>
<td>$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)</td>
<td>No policy year deductible applies</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Eligible health services</td>
<td>Designated Care</td>
<td>In-network coverage</td>
<td>Out-of-network coverage</td>
</tr>
<tr>
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<tr>
<td><strong>Specialty drugs</strong></td>
<td></td>
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<tr>
<td>For each fill up to a 30 day supply filled at a retail pharmacy</td>
<td>$100 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies</td>
<td>$100 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies</td>
<td>$100 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies</td>
</tr>
<tr>
<td>More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy</td>
<td>$200 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies</td>
<td>$200 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Orally administered anti-cancer prescription drugs- For each fill up to a 30 day supply filled at a retail pharmacy</td>
<td>100% (of the negotiated charge) No policy year deductible applies</td>
<td>100% (of the negotiated charge) No policy year deductible applies</td>
<td>100% (of the recognized charge) No policy year deductible applies</td>
</tr>
<tr>
<td>Preventive care drugs and supplements filled at a retail pharmacy</td>
<td>100% (of the negotiated charge per prescription or refill No copayment policy year deductible applies</td>
<td>100% (of the negotiated charge per prescription or refill No copayment policy year deductible applies</td>
<td>Paid according to the type of drug per the schedule of benefits, above</td>
</tr>
<tr>
<td>Risk reducing breast cancer prescription drugs filled at a pharmacy</td>
<td>100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies</td>
<td>Paid according to the type of drug per the schedule of benefits, above</td>
<td></td>
</tr>
<tr>
<td>Maximums:</td>
<td>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.</td>
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</tr>
<tr>
<td>Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy</td>
<td>100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies</td>
<td>Paid according to the type of drug per the schedule of benefits, above</td>
<td></td>
</tr>
<tr>
<td>Maximums:</td>
<td>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.</td>
<td></td>
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</tr>
</tbody>
</table>
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

**Exclusions**

**Acupuncture therapy**
- Maintenance treatment
- Acupuncture when provided for the following conditions:
  - Acute low back pain
  - Addiction
  - AIDS
  - Amblyopia
  - Allergic rhinitis
  - Asthma
  - Autism spectrum disorders
  - Bell’s Palsy
  - Burning mouth syndrome
  - Cancer-related dyspnea
  - Carpal tunnel syndrome
  - Chemotherapy-induced leukopenia
  - Chemotherapy-induced neuropathic 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.

Behavioral health treatment

- 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):
  - Stay in a facility for treatment for dementias and amnesia without a behavioral disturbance that necessitates mental health treatment
  - School and/or education service including special education, remedial education, wilderness treatment programs, or any such related or similar programs
  - Services provided in conjunction with school, vocation, work or recreational activities
  - Transportation

Beyond legal authority

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

Blood, blood plasma, synthetic blood, blood derivatives or substitutes

Examples of these are:
- The provision of blood to the hospital, other than blood derived clotting factors
- Any related services including processing, storage or replacement expenses
- The services of blood donors, apheresis or plasmapheresis
- For autologous blood donations, only administration and processing expenses are covered

Breasts

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

Clinical trial therapies (experimental or investigational)

- Your plan does not cover clinical trial therapies (experimental or investigational), except as described in the Eligible health services under your plan - Clinical trial therapies (experimental or investigational) section

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

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

- Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body. Whether or not for psychological or emotional reasons. Injuries that occur during medical treatments are not considered accidental injuries even if unplanned or unexpected.

This exclusion does not apply to:
- Surgery after an accidental injury when performed as soon as medically feasible
- Coverage that may be provided under the Eligible health services under your plan - Gender reassignment (sex change) treatment section.

Court-ordered services and supplies

- This includes court-ordered services and supplies, or those required as a condition of parole, probation, release or as a result of any legal proceeding, unless they are a covered benefit under your plan

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/jejunalostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a stable gastrostomy catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care except in connection with hospice care, adult (or child) day care, or convalescent care
- Institutional care. 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 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

Educational services
Examples of these services are:
- Any service or supply for education, training or retraining services or testing, except where described in the Eligible health services under your plan – Diabetic services and supplies (including equipment and training) section. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

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

Enteral formulas and nutritional supplements
- Any food item, including infant formulas, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition, except as covered in the Eligible health services under your plan – Enteral formulas and nutritional supplements section

Examinations
Any health or dental examinations needed:
- Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract
- Because a law requires it
- To buy insurance or to get or keep a license
- To travel
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity

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.
Emergency services and urgent care
- Non-emergency services in a hospital emergency room facility
- Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)

Facility charges
For care, services or supplies provided in:
- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons’ main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

Family planning services - other
- Voluntary sterilization for males
- 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
Gene-based, cellular and other innovative therapies (GCIT)
The following are not eligible health services unless you receive prior written approval from us:
- GCIT services received at a facility or with a provider that is not a GCIT-designated facility/provider
- All associated services when GCIT services are not covered. Examples include infusion, laboratory, radiology, anesthesia, and nursing services.

Please refer to the Medical necessity, referral and precertification requirements section.

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 12 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.

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

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

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

Maintenance care
- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services. See the Eligible health services under your plan – Habilitation therapy services section

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 and substance abuse related disorders treatment
- 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) are not covered:
  - 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
  - Specific developmental disorders of scholastic skills (learning disorders/learning disabilities)
  - Specific developmental disorder of motor functions
  - Specific developmental disorders of speech and language
  - Other disorders of psychological development

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 and weight management
- 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:
- 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.

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

Outpatient surgery
- The services of any other physician who helps the operating physician
- A stay in a hospital (Hospital stays are covered in the Eligible health services under your plan – Hospital and other facility care section)
- A separate facility charge for surgery performed in a physician's office
- Services of another physician for the administration of a local anesthetic

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

Preventive care and wellness
- Services for diagnosis or treatment of a suspected or identified illness or injury
- Exams given during your stay for medical care
- Services not given by or under a physician's direction
- Psychiatric, psychological, personality or emotional testing or exams
- Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA
- Male contraceptive devices
- The reversal of voluntary sterilization procedures, including any related follow-up care
- Female voluntary sterilization procedures that were not billed separately by the provider or were not the primary purpose of a confinement

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

Sexual dysfunction and enhancement
• Any treatment, prescription drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services
• Not eligible for coverage are prescription drugs in 30 day supplies

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

Specialty prescription drugs
• Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug benefit
Sports
- Any services or supplies given by providers as a result from play or practice of collegiate or intercollegiate sports, not including intercollegiate club sports and intramurals

Strength and performance
- Services, devices and supplies such as drugs or preparations designed primarily for enhancing your:
  - Strength
  - Physical condition
  - Endurance
  - Physical performance

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

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

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

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).
- ART services are not provided for out-of-network care.

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.
Wilderness treatment programs
See Educational services within this section

Work related illness or injuries
- Coverage available to you under worker’s compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers’ compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered “non-occupational” regardless of cause.

Exceptions that apply to outpatient prescription drugs

Biological sera

Cosmetic drugs
- Medications or preparations used for cosmetic purposes

Devices, products and appliances, except those that are specially covered

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
Immunization or immunological agents

Injectables
- Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by us
- Needles and syringes, except for those used for self-administration of an injectable drug
- Any drug, which due to its characteristics as determined by us must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting. This exception does not apply to Depo Provera and other injectable drugs used for contraception.

Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps except as specifically provided in the Eligible health services under your plan – Diabetic services and supplies (including equipment and training) section

Refills
- Refills dispensed more than one year from the date the latest prescription order was written.

Replacement of lost or stolen prescriptions

Test agents except diabetic test agents

West Virginia University Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student HealthSM is the brand name for products and services provided by Aetna Life Insurance Company and its applicable affiliated companies (Aetna).
Sanctioned Countries

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

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call the number listed on your ID card at no cost.

Smartphone or Tablet

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

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  ○ Qualified sign language interpreters
  ○ Written information in other formats (large print, audio, accessible electronic formats, other formats)

• Provides free language services to people whose primary language is not English, such as:
  ○ Qualified interpreters
  ○ Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Aetna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 14462, Lexington, KY 40512, 1-800-648-7817, TTY 711, Fax 859-425-3379, CRCoordinator@aetna.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 800-537-7697 (TDD)

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.
<table>
<thead>
<tr>
<th>Language</th>
<th>Service Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albanian</td>
<td><code>Për shërbose për kthimi falas për ju, telefononi në numrin që gjendet në kartën tuaj të identitetit.</code></td>
</tr>
<tr>
<td>Amharic</td>
<td><code> phóng የል洨 እንዳንድ ፈለስ ለእንዳንድ እንዳንድ ያለማ ያለ Mongo ለእንዳንድ ያለ ዲ ከማር ያለ ፈለስ ይችላል።</code></td>
</tr>
<tr>
<td>Arabic</td>
<td><code>للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقة اشتراكك.</code></td>
</tr>
</tbody>
</table>
| Armenian          | `Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեν` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայերեն` Հայեր
<table>
<thead>
<tr>
<th>Language</th>
<th>Text</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hawaiian</td>
<td>No ka wala'au 'ana me ka lawelawe 'ōlelo e kahea aku i ka helu kelepona ma kāu kāleka ID. Kāki 'ōle 'ia kēia kōkua nei.</td>
</tr>
<tr>
<td>Hindi</td>
<td>बिना किसी खोज के भाषा सेवाओं का उपयोग करने के लिए, अपने आईडी कार्ड पर दिए नंबर पर कॉल करें।</td>
</tr>
<tr>
<td>Hmong</td>
<td>Yuav kom tau kev pab txhais lus tsis muaj nqi them rau koj, hu tus naj npawb ntawm koj dalim npav ID.</td>
</tr>
<tr>
<td>Igbo</td>
<td>Inweta enyemaka asusy na akwughi ugwọ obula, kpọọ nomba nọ na kaadi njirimara gi</td>
</tr>
<tr>
<td>Ilocano</td>
<td>Tapno maakses dagiti serbisio ti pagsasao nga awanan ti bayadna, awagan ti numero nga adda ayan ti ID kardmo.</td>
</tr>
<tr>
<td>Indonesian</td>
<td>Untuk mengakses layanan bahasa tanpa dikenakan biaya, silakan hubungi nomor telepon di kartu asuransi Anda.</td>
</tr>
<tr>
<td>Italian</td>
<td>Per accedere ai servizi linguistici senza alcun costo per lei, chiami il numero sulla tessera identificativa.</td>
</tr>
<tr>
<td>Japanese</td>
<td>無料の言語サービスは、IDカードにある番号にお電話ください。</td>
</tr>
<tr>
<td>Karen</td>
<td>ლაშქრობით ნაცვლად ქართული დაწესებულების გარეშე და უკავშირებლად სერვისები, გამოიყენეთ დამოკიდებული იდ-კარტით.</td>
</tr>
<tr>
<td>Korean</td>
<td>무료 다국어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오.</td>
</tr>
<tr>
<td>Kru-Bassa</td>
<td>I nyuu kosna mahola ni language services ngui nsaa wogui wo, sebel i nsinga i ye ntilga i kat yong matibila</td>
</tr>
<tr>
<td>Kurdish</td>
<td>بوع دسوبيغ اكويشن بى خزماناگوزارى زممان بىيى تيختون بو تو، بىوويندى بكى بى زمارى سىى سىى (ID) دىى ناكلوى بىوى.</td>
</tr>
<tr>
<td>Lao</td>
<td>ບໍລິສັດຂັ້ນໜ້າສາມາດແກ່ບໍລິການ. ລາຍການບໍລິການເປັນບໍລິການທີ່ຈັກດັບ.</td>
</tr>
<tr>
<td>Marathi</td>
<td>आपल्याच्या कोणत्याही शुल्कावर्धक भाषा सेवांप्रमाणे पोषणथर्यासाठी, आपल्या ID कार्डवरील क्रमांकांक फोन करा.</td>
</tr>
<tr>
<td>Marshallese</td>
<td>Nan bōk jipaŋ kön kajin ilo an eijelok wōnean ḳan kwe, kwōn kallok nōmba eo ilo kaat in ID ḳo aṃ.</td>
</tr>
<tr>
<td>Micronesian-Ponapean</td>
<td>Pwehn alehdi sawas en lokaia kan ni sohte pweipwei, koahlil nempe nan amhw doaropwe en ID.</td>
</tr>
<tr>
<td>Mon-Khmer, Cambodian</td>
<td>សូមប្រើប្រាស់សេវាកម្មទាំងនេះដោះស្រាយបញ្ហាដែលមាន ដ៏លឿននឹងការរៀបចំ្រូតខ្លួនឯង៖ T'aā ni nizaad k'ehjí bee niká a'doowol doo bāgh ilinígóo naaltsoos bee atañ niljíjyu nanitiniígíi bee néélhú'dolínígíi béésh bee hane'i bikí'i qíjí' holnê'.</td>
</tr>
<tr>
<td>Navajo</td>
<td>T’áa ní nizaad k’ehjí bee niká a’doowol doo bágh ilínígóó naaltsoos bee atah niljíjyu nanitiniígíi bee néélhú’ dolítiniígíi béésh bee hane’i bikí’i qíjí’ hólne’.</td>
</tr>
<tr>
<td>Nepali</td>
<td>आमाको भवनले सेवाहरूकाई नीः शुल्क पहुँच राख्न आपनो काउडिमा रहेको नम्बरमा कल गर्नुहोस्।</td>
</tr>
<tr>
<td>Nilotic-Dinka</td>
<td>Tē koor yin ran de wĕer de thokic ke cīn wēu kōr keek tēnōn yin. Ke yin col ran ye kōk kuunny nē namba de abac tō nē ID kard dùn de tīf de nyin de panakim kōu.</td>
</tr>
<tr>
<td>Norwegian</td>
<td>For tilgang til kostnadsfri språktjenester, ring nummeret på ID-kortet ditt.</td>
</tr>
<tr>
<td>Language</td>
<td>Translation</td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>English</td>
<td>Um Schprooch Services zu griege mitaus Koscht, ruff die Nummer uff del ID Kaart.</td>
</tr>
<tr>
<td>Persian Farsi</td>
<td>پرای دسترسی به خدمات زبان به طور رایگان، با شماره قد شده روی کارت شناسایی خود تماس بگیرید.</td>
</tr>
<tr>
<td>Polish</td>
<td>Aby uzyskać dostęp do bezpłatnych usług językowych, należy zadzwonić pod numer podany na karcie identyfikacyjnej.</td>
</tr>
<tr>
<td>Portuguese</td>
<td>Para aceder aos serviços linguísticos gratuitamente, ligue para o número indicado no seu cartão de identificação.</td>
</tr>
<tr>
<td>Punjabi</td>
<td>ਉਸ ਤੋਂ ਲਈ ਕਾਫੀ ਦਿਨ ਲੈ ਨਾਲ ਸੀਧਾ ਦੀਖਾਵਾ ਹੋਵੇਗਾ ਕਿਸੇ ਸੇਵਾ ਲਈ ਲਗਨ ਲੋਕਾਂ, ਅਜਿਹੇ ਆਧਾਰ ਵਿੱਚ ਹੋਵੇਗਾ।</td>
</tr>
<tr>
<td>Romanian</td>
<td>Pentru a accesa gratuit serviciile de limbă, apelați numărul de pe cardul de membru.</td>
</tr>
<tr>
<td>Russian</td>
<td>Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону, приведенному на вашей идентификационной карте.</td>
</tr>
<tr>
<td>Samoan</td>
<td>Mō le maua i o 'au'aunaga tau gaga e aunoa ma se toto gi, vala'au le numera i luga o lau pepa ID.</td>
</tr>
<tr>
<td>Serbo-Croatian</td>
<td>Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacijnoj kartici.</td>
</tr>
<tr>
<td>Spanish</td>
<td>Para acceder a los servicios lingüísticos sin costo alguno, llame al número que figura en su tarjeta de identificación.</td>
</tr>
<tr>
<td>Sudanic Fulfulde</td>
<td>Heeba a naasta nder ekkitolg jaangirde woldeji walla yobogo, ewnu lamba je don windi ha do dorowol maada.</td>
</tr>
<tr>
<td>Swahili</td>
<td>Kupata huduma za lugha bila malipo kwako, piga nambari iliyo kwene kadi yako ya kitambulisho.</td>
</tr>
<tr>
<td>Syriac-Assyrian</td>
<td>ܐܢܓܠܝܐ ܒܠܫܢܐ ܚܝܬܐ ܚܫܝܚܐ ܬܘܡܢܐ ܝܠܝܬܐ ܫܠܡܐ ܒܒܠܝܬܐ ܙܚܝܚܐ ܬܘܡܢܐ ܝܠܝܬܐ</td>
</tr>
<tr>
<td>Tagalog</td>
<td>Upang ma-access ang mga serbisyo sa wika nang walang bayad, tawagan ang numero sa iyong ID card.</td>
</tr>
<tr>
<td>Telugu</td>
<td>తెలుగు లో తెలుగు పాఠకాలకు అయితే థండం ఉండతాం, ఆంగ్లంలో పాఠకాలకు అయితే థండం ఉండతాం.</td>
</tr>
<tr>
<td>Thai</td>
<td>ภาษาไทยเป็นภาษาที่ใช้ในการสื่อสารทางการค้าโดยไม่มีกีฬาใจราย โปรดให้หมายเลขที่แสดงอยู่บนหนังสือประจำตัวของคุณ</td>
</tr>
<tr>
<td>Tongan</td>
<td>Kapau ‘oku ke fiema’u ta’etötöngi ‘a e ngaahi sëvesi kotoa pê he ngaahi lea kotoa, telefoni ki he fika ‘oku ha atu ‘i hō’o ID kaati.</td>
</tr>
<tr>
<td>Turkish</td>
<td>Dil hizmetlerine ücretsiz olarak erişmek için kimlik kartınızdaki numarayı arayın.</td>
</tr>
<tr>
<td>Ukrainian</td>
<td>Щоб безкоштовно отримати мовні послуги, задзвоніть за номером, вказаним на вашій ідентифікаційний картці.</td>
</tr>
<tr>
<td>Urdu</td>
<td>لسانی خدمات تک مفت رسنی کے لیے اپنے بھی کے کارڈ پر درج نمبر پر کال کریں</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>Để sử dụng các dịch vụ ngôn ngữ miễn phí, vui lòng gọi số điện thoại ghi trên thẻ ID của quý vị.</td>
</tr>
<tr>
<td>Yiddish</td>
<td>יא באקוקס ביערא טראפהאמעס ערעי פון אַפּארט. לְךֶד נאָסְן אַך יאָט אינער אַרְעאָל.</td>
</tr>
<tr>
<td>Yoruba</td>
<td>Láti ráyésí awon ṣeṣẹ ède fún ọ lọfẹ, pe nömọ̀̀ba to wà ìlóri kààdì idànìmọ̀ rẹ̀.</td>
</tr>
</tbody>
</table>