Aetna Student Health

Plan Design and Benefits Summary

Preferred Provider Organization (PPO)

The Catholic University of America

Basic Plan

Policy Year: 2024 - 2025
Policy Number: 474963
https://www.aetnastudenthealth.com
(866) 577-6692

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

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

The Catholic University of America Health Services

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

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

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

For questions about:
- Enrollment
- Waiver Process
- Insurance Benefits
- Claims Processing
- Pre-Certification Requirements

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

For questions about:
- Plan Eligibility
- Registration Status

Please contact:
The Catholic University of America Student Medical Plan Administrator
Email: cua-studentmedins@cua.edu

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

For questions about:

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

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

Coverage Periods

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

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
2024/2025 Annual Plan	08/14/2024	08/13/2025	09/13/2024
New Spring 2025 Semester Students/Dependents	01/01/2025	08/13/2025	02/07/2025
New Summer 2025 Semester Students/Dependents	05/08/2025	08/13/2025	06/01/2025

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

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment Deadline
2024/2025 Annual Plan	08/14/2024	08/13/2025	09/13/2024
New Spring 2025 Semester Students/Dependents	01/01/2025	08/13/2025	02/07/2025

Rates

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

The Catholic University of America Students & Dependents			
	Annual 08/14/2024 - 08/13/2025	**Spring Semester*** 01/01/2025 - 08/13/2025	**Summer Semester*** 05/08/2025 – 08/13/2025
Student Only	**$3,116**	**$1920.83**	**$836.62**
Spouse Only	**$3,073**	**$1894.32**	**$825.08**
Child Only	**$3,073**	**$1,894.32**	**$825.08**
Children	**$6,146**	**$3,788.63**	**$1,650.16**

**Students new to the University for Spring 2025 or Summer 2025 Semester only*

John Paul II Institute Students, Dominican House of Studies Students and Washington Theological Union Students & Dependents		
	Annual 08/14/2024 - 08/13/2025	**Spring Semester*** 01/01/2025 - 08/13/2025
Student Only	**$3,323**	**$2,048.43**
Spouse Only	**$3,073**	**$1,894.32**
Child Only	**$3,073**	**$1,894.32**
Children	**$6,146**	**$3,788.63**

**Students new to the University for Spring 2025 Semester only*

Student Coverage

Eligibility

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

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

All International Students Holding an F1 or J1 Visa (regardless of billed credit hours): are automatically enrolled in The Catholic University of America Student Medical Insurance Plan unless proof of other comparable coverage is submitted online and by **September 13, 2024**. **All waiver submissions submitted by C students holding a J1 Visa** will be audited by The Catholic University of America, Aetna Student Health, and/or their contractors or representatives. You may be required to provide, upon request, any coverage documents and/or other records demonstrating that you meet the school's requirements for waiving the student health insurance plan. By submitting the waiver request, you agree that your current insurance plan may be contacted for confirmation that your coverage is in force for the applicable **policy year** and that it meets waiver requirements.

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

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

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

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

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

In the event that you do not enroll during the initial Enrollment/Waiver period that ends on 9/13/24, then you are not eligible to come onto The Catholic University of America Student Medical Plan **unless** you have a qualifying event.

A qualifying event would include the following:
- Loss of coverage due to change in job status when coverage is provided by your employer.
- Loss of coverage due to a change in marital status.

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

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

Enrollment

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

To enroll the dependent(s) of a covered student, please complete the Enrollment Form by visiting https://www.aetnastudenthealth.com, selecting the school name, and clicking on the "Plans & Products Offered to You" link on the left hand side of the screen, or by calling customer service at 866-577-6692 and requesting that an Enrollment Form be sent in the mail. Dependent enrollment applications will not be accepted after the enrollment deadline, unless there is a significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage under another health plan.) The completed Enrollment Form and premium must be sent to Aetna Student Health.

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

- A newborn child - Your newborn child is covered on your health plan for the first 31 days from the moment of birth.
    - To keep your newborn covered, you must notify us (or our agent) of the birth and pay any required premium contribution during that 31 day period.
    - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional premium contribution for the newborn.
    - If you miss this deadline, your newborn will not have health benefits after the first 31 days.
    - If your coverage ends during this 31day period, then your newborn's coverage will end on the same date as your coverage. This applies even if the 31 day period has not ended.

- An adopted child or a child legally placed with you for adoption - A child that you, or your spouse adopts or is placed with you for adoption, is covered on your plan for the first 31 days after the adoption or the placement is complete.
    - To keep your child covered, we must receive your completed enrollment information within 31days after the adoption or placement for adoption.
    - You must still enroll the child within 31days of the adoption or placement for adoption even when coverage does not require payment of an additional premium contribution for the child.
    - If you miss this deadline, your adopted child or child placed with you for adoption will not have health benefits after the first 31days.
    - If your coverage ends during this 31day period, then coverage for your adopted child or child placed with you for adoption will end on the same date as your coverage. This applies even if the 31day period has not ended.

- Dependent coverage due to a court order - If you must provide coverage to a dependent because of a court order, your dependent is covered on your health plan for the first 31 days from the court order.
    - To keep your dependent covered, we must receive your completed enrollment information within 31 days of the court order.
    - You must still enroll the dependent within 31 days of the court order even when coverage does not require payment of an additional premium contribution for the dependent.
    - If you miss this deadline, your dependent will not have health benefits after the first 31 days.
    - If your coverage ends during this 31 day period, then your dependent's coverage will end on the same date as your coverage. This applies even if the 31 day period has not ended.

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

Medicare Eligibility Notice

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

Termination and Refunds

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

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

In-network Provider Network

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

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

Precertification

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

Precertification call

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

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

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

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

Coordination of Benefits (COB)

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

Description of Benefits

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

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

Policy year deductible	**In-network coverage**	**Out-of-network coverage**
You have to meet your policy year deductible before this plan pays for benefits.		
Student	$7,000 per policy year	$7,000 per policy year
Spouse	$7,000 per policy year	$7,000 per policy year
Each child	$7,000 per policy year	$7,000 per policy year
Policy year deductible waiver		
The policy year deductible is waived for all of the following eligible health services: • In-network care for *Preventive care and wellness* • Emergency Department HIV Screenings, and • Mammograms and Pap Smears including cervical cytological screenings. • Pediatric Preventive Vision Services; and • Preferred Care Pediatric Dental Services.		
Maximum out-of-pocket limit per policy year		
Student	$8,700 per policy year	$17,400 per policy year
Spouse	$8,700 per policy year	$17,400 per policy year
Each child	$8,700 per policy year	$17,400 per policy year
Family	$17,400 per policy year	$34,800 per policy year

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

Eligible health services	In-network coverage	Out-of-network coverage
Preventive care and wellness		
Routine Physical exam	100% (of the negotiated charge) per visit No Deductible applies	50% (of the recognized charge) per visit Deductible applies
Routine physical exam limits for covered persons through age 21: maximum age and visit limits per policy year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents.	
Routine physical exam limits for covered persons age 22 and over: maximum visits per policy year	1 visit	
Preventive care immunizations **Performed in a facility or at a physician's office**		
Preventive care immunizations	100% (of the negotiated charge) per visit No Deductible applies	50% (of the recognized charge) per visit Deductible applies
Preventive care immunization maximums	Subject to any age limits provided for in the comprehensive guidelines supported by Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.	
The following is not covered under this benefit: • Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment or travel		
Well woman preventive visits **Routine gynecological exams (including Pap smears and cytology tests)**		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No Deductible applies	100% (of the recognized charge) per visit Deductible applies
Maximum visits per policy year	1 visit	

Eligible health services	In-network coverage	Out-of-network coverage
Preventive screening and counseling services		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No Deductible applies	50% (of the recognized charge) per visit Deductible applies
Obesity and/or healthy diet counseling Maximum visits	Age 22 and older: 26 visits per 12 months, of which up to 10 visits may be used for healthy diet counseling.	
Misuse of alcohol and/or drugs counseling Maximum visits per policy year	5 visits	
Use of tobacco products counseling Maximum visits per policy year	8 visits	
Sexually transmitted infection counseling Maximum visits per policy year	2 visits	
Genetic risk counseling for breast and ovarian cancer limitations	Not subject to any age or frequency limitations	
Genetic risk counseling for breast and ovarian cancer Maximum visits per policy year	1 visit	
Routine cancer screenings Deductible does not apply to routine mammography	100% (of the negotiated charge) per visit No Deductible applies	100% (of the recognized charge) per visit Deductible applies
Routine cancer screening maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • 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.	
Lung cancer screening maximums	1 screening every 12 months	

Eligible health services	In-network coverage	Out-of-network coverage
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit No Deductible applies	50% (of the recognized charge) per visit Deductible applies
Lactation counseling services	100% (of the negotiated charge) per visit No Deductible applies	50% (of the recognized charge) per visit Deductible applies
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits	
Breast pump supplies and accessories	100% (of the negotiated charge) per item No Deductible applies	50% (of the recognized charge) per item Deductible applies
Physicians and other health professionals		
Physician, specialist including Consultants Office visits (non-surgical**/**non-preventive care by a physician and specialist) includes telemedicine consultations)	80% (of the negotiated charge) per visit Deductible applies	50% (of the recognized charge) per visit Deductible applies
Allergy testing and treatment		
Allergy testing performed at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Allergy injections treatment including Allergy sera and extracts administered via injection performed at a physician's or specialist's office	80% (of the negotiated charge) per visit Deductible applies	50% (of the recognized charge) per visit Deductible applies
Physician and specialist - surgical services		
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) per visit Deductible applies	50% (of the recognized charge) per visit Deductible applies
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the Eligible health services and exclusions – Hospital and other facility care section) • Services of another physician for the administration of a local anesthetic		

Eligible health services	In-network coverage	Out-of-network coverage
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)	80% (of the negotiated charge) per visit Deductible applies	50% (of the recognized charge) per visit Deductible applies
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the Eligible health services and exclusions – Hospital and other facility care section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		
Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)	80% (of the negotiated charge) per visit Deductible applies	50% (of the recognized charge) per visit Deductible applies
Hospital and other facility care		
Inpatient hospital (room and board) and other miscellaneous services and supplies) Includes birthing center facility charges	80% (of the negotiated charge) per visit Deductible applies	50% (of the recognized charge) per visit Deductible applies
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit Deductible applies	50% (of the recognized charge) per visit Deductible applies
Preadmission testing	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Alternatives to hospital stays		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	80% (of the negotiated charge) per visit Deductible applies	50% (of the recognized charge) per visit Deductible applies
The following are not covered under this benefit: • A stay in a hospital (See the Hospital care – facility charges benefit in this section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		

Eligible health services	In-network coverage	Out-of-network coverage
Home health care	80% (of the negotiated charge) per admission Deductible applies	50% (of the recognized charge) per admission Deductible applies
Maximum visits per episode per policy year	unlimited	
The following are not covered under this benefit: • Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities) • Transportation • Homemaker or housekeeper services • Food or home delivered services • Maintenance therapy		
Hospice-Inpatient	80% (of the negotiated charge) per admission Deductible applies	50% (of the recognized charge) per admission Deductible applies
Maximum days per confinement per policy year	unlimited	
Hospice-Outpatient	80% (of the negotiated charge) per admission Deductible applies	50% (of the recognized charge) per admission Deductible applies
Maximum outpatient hospice visits per policy year	unlimited	
The following are not covered under this benefit: • Funeral arrangements • Pastoral counseling • Respite care • Financial or legal counseling which includes estate planning and the drafting of a will • Homemaker or caretaker services that are services which are not solely related to your care and may include: - Sitter or companion services for either you or other family members - Transportation - Maintenance of the house		
Skilled nursing facility-Inpatient	80% (of the negotiated charge) per admission Deductible applies	50% (of the recognized charge) per admission Deductible applies
Maximum days of confinement per policy year	unlimited	

Eligible health services	In-network coverage	Out-of-network coverage
Hospital emergency room	80% (of the negotiated charge) per visit Deductible applies	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered
Important note: • As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment/coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill. • A separate hospital emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived, and your inpatient copayment/coinsurance will apply. • Covered benefits that are applied to the hospital emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment/coinsurance. • Separate copayment/coinsurance amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment/coinsurance amounts may be different from the hospital emergency room copayment/coinsurance. They are based on the specific service given to you. • Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment/coinsurance amounts that are different from the hospital emergency room copayment/coinsurance amounts.		
The following are not covered under this benefit: • Non-emergency services in a hospital emergency room facility, freestanding emergency medical care facility or comparable emergency facility		
Urgent care	80% (of the negotiated charge) per visit Deductible applies	50% (of the recognized charge) per visit Deductible applies
Non-urgent use of urgent care provider	Not covered	Not covered
The following is not covered under this benefit: • Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)		

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

Pediatric dental care exclusions

The following are not covered under this benefit:

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

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

Eligible health services	**In-network coverage**	**Out-of-network coverage**
Specific conditions		
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Podiatric (foot care) treatment Physician and specialist non-routine foot care treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Services and supplies for: • The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches • The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes • Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies • Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet		
Impacted wisdom teeth	80% (of the negotiated charge) Deductible applies	80% (of the recognized charge) Deductible applies
Accidental injury to sound natural teeth	80% (of the negotiated charge) Deductible applies	80% (of the recognized charge) Deductible applies
The following are not covered under this benefit: • The care, filling, removal or replacement of teeth and treatment of diseases of the teeth • Dental services related to the gums • Apicoectomy (dental root resection)		

• Orthodontics • Root canal treatment • Soft tissue impactions • Bony impacted teeth • Alveolectomy • Augmentation and vestibuloplasty treatment of periodontal disease • False teeth • Prosthetic restoration of dental implants • Dental implants		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: Dental implants		
Clinical trial (routine patient costs)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Coverage is limited to routine patient services from in-network providers. The following are not covered under this benefit: • Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs) • Services and supplies provided by the trial sponsor without charge to you • The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna's claim policies)		
Dermatological treatment	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: Cosmetic treatment and procedures		
Maternity care		
Maternity care (includes delivery and postpartum care services in a hospital or birthing center)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries		
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) No deductible applies	50% (of the recognized charge) No deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
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
Behavioral Health		
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	80% (of the negotiated charge) per admission Deductible applies	50% (of the recognized charge) per admission Deductible applies
Outpatient treatment office visits (includes telemedicine cognitive behavioral therapy consultations)	80% (of the negotiated charge) per visit Deductible applies	50% (of the recognized charge) per visit Deductible applies
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	80% (of the negotiated charge) per visit Deductible applies	50% (of the recognized charge) per visit Deductible applies

Eligible health services	In-network coverage Network (IOE facility)	In-network coverage Network (Non-IOE facility)	Out-of-network coverage Network Non-IOE facility and out-of-network facility
Inpatient and outpatient transplant facility services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Inpatient and outpatient transplant physician and specialist services	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Transplant services-travel and lodging	Covered	Covered	Covered
Lifetime Maximum Travel and Lodging Expenses for any one transplant	$10,000	$10,000	$10,000
Maximum Lodging Expenses per **IOE** patient	$50 per night	$50 per night	$50 per night
Maximum Lodging Expenses per companion	$50 per night	$50 per night	$50 per night

The following are not covered under this benefit:

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

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

The following are not covered under this benefit:

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

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for short-term rehabilitation services and habilitation therapy services	80% (of the negotiated charge) Deductible applies	50% (of the recognized charge) Deductible applies
Chiropractic services	80% (of the negotiated charge) Deductible applies	50% (of the recognized charge) Deductible applies
Emergency ground, air, and water ambulance	80% (of the negotiated charge) per trip Deductible applies	Paid the same as in-network coverage
The following are not covered under this benefit: • Ambulance services for routine transportation to receive outpatient or inpatient care		
Durable medical and surgical equipment	80% (of the negotiated charge) per item Deductible applies	50% (of the recognized charge) per item Deductible applies
The following are not covered under this benefit: • Whirlpools • Portable whirlpool pumps • Sauna baths • Massage devices • Over bed tables • Elevators • Communication aids • Vision aids • Telephone alert systems • Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician		
Nutritional support	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
The following are not covered under this benefit: • Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition		

Eligible health services	In-network coverage	Out-of-network coverage
Osteoporosis (non-preventive care) Physician's or specialist's office visits	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Prosthetic Devices & Orthotics Includes Cranial prosthetics *(Medical wigs)*	80% (of the negotiated charge) per item Deductible applies	50% (of the recognized charge) per item Deductible applies
The following are not covered under this benefit: • Services covered under any other benefit • Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace • Trusses, corsets, and other support items • Repair and replacement due to loss, misuse, abuse or theft • Communication aids • Cochlear implants		
Cochlear implants	80% (of the negotiated charge) per item Deductible applies	50% (of the recognized charge) per item Deductible applies
Hearing aid exams	80% (of the negotiated charge) per visit Deductible applies	50% (of the recognized charge) per visit Deductible applies
Hearing aid exam maximum	One hearing exam every policy year	
The following are not covered under this benefit: • Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay		
Hearing aids	80% (of the negotiated charge) per item Deductible applies	50% (of the recognized charge) per item Deductible applies
Hearing aids maximum per ear	One hearing aid per ear every policy year	
The following are not covered under this benefit: • 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		

Pediatric vision care **(Limited to covered persons through the end of the month in which the person turns age 19)**		
Eligible health services	**In-network coverage**	**Out-of-network coverage**
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	100% (of the negotiated charge) per visit No deductible applies	50% (of the recognized charge) per visit Deductible applies
Maximum visits per policy year Low vision Maximum Fitting of contact Maximum	1 visit One comprehensive low vision evaluation every policy year 2 visits	
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per visit No deductible applies	50% (of the recognized charge) per visit Deductible applies
Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	 One set of eyeglass frame One pair of prescription lense 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.		
The following are not covered under this benefit: • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes		

Outpatient prescription drugs

Policy year deductible and copayment 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 filled at a retail in-network pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.

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

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

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

Outpatient prescription drug policy year deductibles

A separate policy year deductible applies to prescription drugs

	In-network coverage	**Out-of-network coverage**
Student	$500 per policy year	
Spouse	$500 per policy year	
Each Child	$500 per policy year	

Eligible health services	**In-network coverage**	**Out-of-network coverage**
Preferred generic prescription drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	20% copayment per supply	20% copayment per supply then the plan pays 60% (of the balance of the recognized charge)
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	20% copayment per supply	Not covered
Preferred brand-name prescription drugs		
For each fill up to a 30 day supply filled at a retail pharmacy	35% copayment per supply	35% copayment per supply then the plan pays 60% (of the balance of the recognized charge)
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	35% copayment per supply	Not covered

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

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

Outpatient prescription drugs exclusions

The following are not eligible health services:

- Any services related to providing, injecting or application of a drug]
- Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Contraceptives (birth control)
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as an eligible health service
- Drugs or medications:
  - Administered or entirely consumed at the time and place they are prescribed or provided
  - Which do not require a prescription by law, even if a prescription is written, unless we have approved a medical exception
  - That are therapeutically the same or an alternative to a covered prescription drug, unless we approve a medical exception
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility
  - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as an eligible health service
  - That are used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, 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 covered person meets one or more clinical criteria detailed in our precertification and clinical policies
- Duplicative drug therapy; for example, two antihistamines for the same condition
- Genetic care including:
  - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as an eligible health service
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
- Implantable drugs and associated devices except as specifically stated in the schedule of benefits or the certificate
- Infertility:
  - Prescription drugs used primarily for the treatment of infertility
- Injectables including:
  - Any charges for the administration or injection of prescription drugs
  - Needles and syringes except for those used for insulin administration
  - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting
- Off-label drug use except for indications recognized through peer-reviewed medical literature
- Prescription drugs:
  - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or prescription drugs for the treatment of a dental condition
  - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's drug guide
  - That are used for the purpose of improving visual acuity or field of vision
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card
- Replacement of lost or stolen prescriptions
- Test agents except diabetic test agents

A covered person, a covered person's designee or a covered person's prescriber may seek an expedited medical exception process to obtain coverage for non-covered drugs in exigent circumstances. An "exigent circumstance" exists when a covered person is suffering from a health condition that may seriously jeopardize a covered person's life, health, or ability to regain maximum function or when a covered person is undergoing a current course of treatment using a non-formulary drug. The request for an expedited review of an exigent circumstance may be submitted by contacting Aetna's *Pre-certification Department* at **1-855-240-0535**, faxing the request to **1-877-269-9916**, or submitting the request in writing to:

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

Exclusions

Abortion

- Services and supplies provided for an abortion

Acupuncture

- Acupuncture
- Acupressure

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 based on categories, conditions, diagnoses or equivalent terms as listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association:
- 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
- Sexual deviations and disorders except as described in the Eligible health services and exclusions section
- Tobacco use disorders except as described in the *Eligible health services and exclusions – Preventive care and wellness* section

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 donated blood to the hospital, other than blood derived clotting factors
- Any related services for donated blood including processing, storage or replacement expenses
- The services of blood donors, including yourself, apheresis or plasmapheresis
- The blood you donate for your own use, excluding administration and processing expenses and except where described in the Eligible health services and exclusions – Transplant services section

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 and exclusions- Clinical trial therapies (experimental or investigational)* section in the certificate

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.

This exclusion does not apply to:

- Surgery after an accidental injury when performed as soon as medically feasible. (Injuries that occur during medical treatments are not considered accidental injuries even if unplanned or unexpected.)

Court-ordered testing

- Court-ordered testing or care unless medically necessary

Custodial care

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

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/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
- For behavioral health (mental health treatment and substance related disorders treatment):
  - Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
  - Services given mainly to:
    - Maintain, not improve, a level of function
    - Provide a place free from conditions that could make your physical or mental state worse

Dental care for adults

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

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

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 and exclusions– Diabetic services and supplies (including equipment and training)* section in the certificate. This includes:
  - Special education
  - Remedial education

- Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
- Job training
- Job hardening programs

- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Examinations

Any health or dental examinations needed:

- Because a third party requires the exam. Examples 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.

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

Felony

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

Gender Affirming Treatment

Gene-based, cellular and other innovative therapies (GCIT)
Therapies and treatments including:

- Cellular immunotherapies.
- Genetically modified viral therapy.
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for treatment of certain conditions.
- All human gene therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
  - Luxturna® (Voretigene neparvovec)
  - Zolgensma® (Onasemnogene abeparvovec-xioi)
  - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9.
- Oligonucleotide-based therapies. Examples include:
  - Antisense. An example is Spinraza® (Nusinersen).
  - siRNA.
  - mRNA.
  - microRNA therapies.

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

The services have a basis in genetic/molecular medicine and are not covered under the **Institutes of Excellence™ (IOE)** programs.

Genetic care

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

Growth/Height care

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

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

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 and exclusions – Habilitation therapy service*s section in the certificate

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

Non-U.S. citizen

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

Obesity (bariatric) surgery

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

- Hypnosis or other forms of therapy
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Other primary payer

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

Personal care, comfort or convenience items

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

Routine exams

- 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 not permitted by law

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

Services provided by a family member

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

Sexual dysfunction and enhancement

Except as required by law, 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 60 day supplies

Sinus surgery

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

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

Telemedicine

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

Therapies and tests

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

Tobacco cessation

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

Treatment in a federal, state, or governmental entity

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

Treatment of infertility

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

Vision care for adults

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

Wilderness treatment programs

See *Educational services* within this section

Work related illness or injuries

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

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

Sanctioned Countries

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

Assistive Technology

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

Smartphone or Tablet

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

Non-Discrimination

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

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

These aids and services include:

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

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

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

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

Language accessibility statement

Interpreter services are available for free.

Attention: If you speak English, language assistance service, free of charge, are available to you. Call **1-877-480-4161** (TTY: **711**).

Español/Spanish

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-480-4161** (TTY: **711**).

አማርኛ/Amharic

ልብ ይበሉ: አማርኛ ቋንቋ የሚናገሩ ከሆነ፣ የትርጉም ድጋፍ ሰጪ ድርጅቶች፣ ያለምንም ክፍያ እርስዎን ለማገልገል ተዘጋጅተዋል። የሚከተለው ቁጥር ላይ ይደውሉ **1-877-480-4161** (መስማት ለተሳናቸው: **711**).

العربية/Arabic

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-480-4161** (رقم الهاتف النصي: **711**).

Bàsɔ̀ɔ̀ Wùɖù/Bassa

Dè dɛ nìà kɛ dyeɖeˈ gbo: ɔ juˇ keˈ m̀ dyi Bàsɔ̀ɔ̀-wùɖù-po-nyɔ̀ juˇ niˈ, nìiˈ à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ m̀ gbo kpaˈa. Ɓaˈ **1-877-480-4161** (TTY: **711**).

中文/Chinese

注意：如果您说中文，我们可为您提供免费的语言协助服务。请致电 **1-877-480-4161** (TTY: **711**)。

فارسی/Farsi

توجه: اگر به زبان فارسی صحبت می کنید، خدمات زبانی رایگان به شما ارایه میگردد، با شماره **1-877-480-4161** (TTY: **711**) تماس بگیرید.

Français/French

Attention : Si vous parlez français, vous pouvez disposer d’une assistance gratuite dans votre langue en composant le **1-877-480-4161** (TTY: **711**).

ગુજરાતી/Gujarati

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો ભાષાકીય સહાયતા સેવા તમને નિ:શુલ્ક ઉપલબ્ધ છે. કૉલ કરો **1-877-480-4161** (TTY: **711**).

Kreyòl Ayisyen/Haitian Creole

Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-877-480-4161** (TTY: **711**).

Igbo

Nrụbama: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n’efu, dịrị gị. Kpọọ **1-877-480-4161** (TTY: **711**).

한국어/Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스가 무료로 제공됩니다. **1-877-480-4161**(TTY: **711**)번으로 전화해 주십시오.

Português/Portuguese

Atenção: a ajuda está disponível em português por meio do número **1-877-480-4161** (TTY: **711**). Estes serviços são oferecidos gratuitamente.

Русский/Russian

Внимание: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Звоните по телефону **1-877-480-4161** (TTY: **711**).

Tagalog

Paunawa: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-480-4161** (TTY: **711**).

Urdu/اردو

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت دستیاب ہیں ۔ (**1-877-480-4161** (TTY: **711**) پر کال کریں.

Tiếng Việt/Vietnamese

Lưu ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị.
Gọi số **1-877-480-4161** (TTY: **711**).

Yorùbá/Yoruba

Àkíyèsí: Bí o bá nsọ èdè Yorùbá, ìrànlọ́wọ́ lórí èdè, lófẹ̀ẹ́, wà fún ọ. Pe **1-877-480-4161** (TTY: **711**).

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