Quality Health Plans & Benefits
Healthier Living
Financial Well-Being
Intelligent Solutions

Aetna Student Health
Plan Design and Benefits Summary

University of Notre Dame

Policy Year: 2017 - 2018
Policy Number: 474916

www.aetnastudenthealth.com
(888) 294-7406

This is a brief description of the Student Health Plan. The Plan is available for University of Notre Dame 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 Policy issued to you and may be viewed online at **www.aetnastudenthealth.com.** If there is a difference between this Benefit Summary and Policy, the Policy will control.

Health Services

The University Health Services is the University's on-campus health facility. Staffed by physicians and registered nurses, it is open during the Fall and Spring semesters. Physicians hold clinic hours Monday through Friday.

Hours of operation are:

Mon., Tues., Wed.	8 a.m. to 7 p.m.
Thursday	9 a.m. to 5 p.m.
Friday	8 a.m. to 5 p.m.
Saturday	8 a.m. to 12 p.m.

Coverage Periods

Students: Coverage will become effective at 12:01 AM on the Coverage Start Date indicated below, and will terminate at 11:59 PM on the Coverage End Date indicated.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Early Start Annual	08/01/2017	08/14/2018	10/01/2017
Annual	08/15/2017	08/14/2018	10/01/2017
Spring/Summer	01/01/2018	08/14/2018	02/15/2018
Summer	05/15/2018	08/14/2018	06/15/2018

Eligible Dependents:. Coverage will become effective at 12:01 AM on the Coverage Start Date indicated below, and will terminate at 11:59 PM on the Coverage End Date indicated. Coverage for insured dependents terminates in accordance with the Termination Provisions described in the Master Policy.

Coverage Period	Coverage Start Date	Coverage End Date	Enrollment/Waiver Deadline
Early Start Annual	08/01/2017	08/14/2018	10/01/2017
Annual	08/15/2017	08/14/2018	10/01/2017
Spring/Summer	01/01/2018	08/14/2018	02/15/2018
Summer	05/15/2018	08/14/2018	06/15/2018

Rates

The rates below include premiums for the Plan underwritten by Aetna Life Insurance Company (Aetna.)

Rates Undergraduates and Graduate Students				
	Early Start	Annual	Spring/Summer Semester	Summer Semester
Student	**$2,352.00**	**$2,265.00**	**$1,402.00**	**$ 571.00**
Spouse	**$2,352.00**	**$2,265.00**	**$1,402.00**	**$ 571.00**
Child	**$2,352.00**	**$2,265.00**	**$1,402.00**	**$ 571.00**
Child(ren)	**$4,704.00**	**$4,453.00**	**$2,804.00**	**$1,142.00**

Student Coverage

Eligibility

All Registered International and all graduate nonresident and degree seeking students will be automatically enrolled in this plan, unless the waiver has been completed by the specified enrollment deadline dates. Students who are enrolled at the University of Notre Dame, and who actively attend classes for at least the first **31 days**, after the date when coverage becomes effective.

Voluntary Enrollment:

- All registered Domestic undergraduate students taking 3 or more credit hours
- Non-degree seeking graduate students taking credit hours
- ROTC students taking credit hours
- Dependents – Spouse and Children

Enrollment

To enroll online or obtain an enrollment application for voluntary coverage, log on to **www.aetnastudenthealth.com** and search for your school, then click on Enroll to download the appropriate form.

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.

Dependent Coverage

Eligibility

Covered students may also enroll their lawful spouse and dependent children up to the age of **26**.

Enrollment

To enroll the dependent(s) of a covered student, please complete the Enrollment Form by visiting **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 **(888) 294-7406** and requesting that an Enrollment Form be sent in the mail. Please refer to the Coverage Periods section of this document for coverage dates and deadline dates. 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.

Medicare Eligibility

You are not eligible for health coverage under this student policy if you have Medicare at the time of enrollment in this student plan.

If you obtain Medicare after you enrolled in this student plan, your health coverage under this plan will not end.

As used here, "have Medicare" means that you are entitled to benefits under Part A (receiving free Part A) or enrolled in Part B or Premium Part A.

Preferred Provider Network

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

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

Pre-certification Program

Some services have to be pre-certified by Aetna beforehand if you want the Plan to cover them. Preferred Providers are responsible for requesting pre-certification for their services. You are responsible for requesting pre-certification if you seek care from a Non-Preferred Provider for any of the services listed in the Schedule of Benefits section of the Certificate.

If you want the Plan to cover a service from a Non-Preferred Provider that requires pre-certification, you must call Aetna at the number on your ID card. After Aetna receives a request for pre-certification, we will review the reasons for your planned treatment and determine if benefits are available.

If you do not secure pre-certification for the below listed inpatient and outpatient covered medical services and supplies obtained from a non-preferred provider your covered medical expenses will be subject to a **$500** per service, treatment, procedure, visit, or supply penalty.

Pre-certification for the following inpatient and outpatient services or supplies may be needed:

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

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

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

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

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

Pre-certification of non-emergency admissions

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

Pre-certification of emergency admissions

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

Pre-certification of urgent admissions

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

Pre-certification of outpatient non-emergency medical services

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

Pre-certification of prenatal care and delivery

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

Description of Benefits

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

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

Next Closest Metallic Level: Gold, Tested at 82.61%.

DEDUCTIBLE	Preferred Care	Non- Preferred Care
The policy year deductible is waived for Preferred Care covered medical expenses that apply to Preventive Care Expense benefits. In addition to state and federal requirements for waiver of the Policy Year Deductible, this Plan will waive the Deductible for: expenses incurred at the University Health Services, South Bend Medical Foundation, MIC (Medical Imaging Center), Rad, Inc. and McDonald Physical Therapy, Preferred Care Pediatric Dental Services and Preferred Care and Non Preferred Pediatric Vision Services. Per visit or admission Deductibles do not apply towards satisfying the Policy Year Deductible. ***Annual Deductible does not apply to these services**	Individual: $500 per Policy Year	
COINSURANCE		
Coinsurance is both the percentage of covered medical expenses that the plan pays, and the percentage of covered medical expenses that you pay. The percentage that the plan pays is referred to as "plan coinsurance" or the "payment percentage," and varies by the type of expense. Please refer to the Schedule of Benefits for specific information on coinsurance amounts.	Covered Medical Expenses are payable at the plan coinsurance percentage specified below, after any applicable Deductible.	

OUT-OF-POCKET MAXIMUMS	Preferred Care	Non-Preferred Care
Once the Individual or Family Out-of-Pocket Limit has been satisfied, Covered Medical Expenses will be payable at 100% for the remainder of the Policy Year. The following expenses do not apply toward meeting the plan's preferred care and non-preferred care out-of-pocket limits: • Non-covered medical expenses; • Referral penalties because a required referral for the service(s) or supply was not obtained; and • Expenses that are not paid or precertification benefit reductions or penalties because a required precertification for the service(s) or supply was not obtained from Aetna.	Individual Out-of-Pocket: $6,000 Per Policy Year Family Out-of-Pocket: $12,000 Per Policy Year	N/A
REFERRAL REQUIREMENTS	**Preferred Care**	**Non-Preferred Care**
If you do not obtain a referral from the Student Health Center, your benefits will be payable at the Non-preferred benefit level. A referral is not required in the following circumstances: • Treatment is for an Emergency Medical Condition. • Obstetric and Gynecological Treatment. • Pediatric Care. • Preventive/Routine Services (services considered preventive according to Health Care Reform and/or services rendered not to diagnose or treat an Accident or Sickness). • Medical care obtained when the student is no longer able to use the UHS due to a change in the student's status. • The student is more than **25** miles away from the University Health Services. • The Student Health Center is closed. • Chiropractic Services. • High Cost Procedures and X-ray Services. • Services related to Dental Injury, and impacted Wisdom teeth. Dependents are not eligible to use the services of the University Health Services and are therefore not subject to the referral requirements and penalties.	If no referral is obtained, preferred care is reduced to non-preferred care.	N/A
INPATIENT HOSPITALIZATION BENEFITS	**Preferred Care**	**Non-Preferred Care**
Room and Board Expense The covered room and board expense does not include any charge in excess of the daily room and board maximum.	80% of the Negotiated Charge	60% of the Recognized Charge for a semi-private room
Intensive Care The covered room and board expense does not include any charge in excess of the daily room and board maximum.	80% of the Negotiated Charge	60% of the Recognized Charge
Miscellaneous Hospital Expense Includes but not limited to: operating room, laboratory tests/X rays, oxygen tent, drugs, medicines and dressings.	80% of the Negotiated Charge	60% of the Recognized Charge
Licensed Nurse Expense Includes charges incurred by a covered person who is confined in a hospital as a resident bed patient and requires the services of a registered nurse or licensed practical nurse.	80% of the Negotiated Charge	60% of the Recognized Charge

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

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

OUTPATIENT EXPENSES (continued)	Preferred Care	Non-Preferred Care
Durable Medical and Surgical Equipment Expense Durable medical and surgical equipment would include: Artificial arms and legs; including accessories; • Arm, back, neck braces, leg braces; including attached shoes (but not corrective shoes); • Surgical supports; • Scalp hair prostheses required as the result of hair loss due to injury; sickness; or treatment of sickness; and • Head halters.	80% of the Negotiated Charge	60% of the Recognized Charge

PREVENTIVE CARE EXPENSES

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

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

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

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

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

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Skilled Nursing Facility Expense	80% of the Negotiated Charge	60% of the Recognized Charge
Rehabilitation Facility Expense Includes charges incurred by a covered person for confinement as a full time inpatient in a rehabilitation facility.	80% of the Negotiated Charge	60% of the Recognized Charge
Home Health Care Expense Covered medical expenses **will not** include: • Services by a person who resides in the covered person's home, or is a member of the covered person's immediate family • Homemaker or housekeeper services; • Maintenance therapy; • Dialysis treatment; • Purchase or rental of dialysis equipment; • Food or home delivered services; or • Custodial care.	80% of the Negotiated Charge	60% of the Recognized Charge
Dermatological Expense Includes physician's charges incurred by a covered person for the diagnosis and treatment of skin disorders. Related laboratory expenses are covered under the Lab and X-ray Expense benefit. Unless specified above, not covered under this benefit are charges incurred for: • Cosmetic treatment and procedures; and Laboratory fees	Payable in accordance with the type of expense incurred and the place where service is provided.	
Prosthetic and Orthotic Devices Expense Covered medical expenses include charges made for orthotic and prosthetic devices including repairs or replacements that are determined by your physician to be medically necessary to restore or maintain your ability to perform activities of daily living or essential job related activity and are not solely for comfort or conveniences. An orthotic device means a medically necessary custom fabricated brace or support that is designed as a component of a prosthetic device. Coverage provided will be equal to the coverage that is provided for the same device, repair or replacement under the federal Medicare program. Coverage is provided under the same terms and conditions as for any other illness. **Limitations** Unless specified above, not covered under this benefit are charges for: • Eye exams; • Eyeglasses; • Vision aids; • Hearing aids; • Communication aids; • Trusses, corsets and other support items; and • Orthopedic shoes; foot orthotics; or other devices to support the feet unless required for the treatment of, or to prevent complications of, diabetes.	80% of the Negotiated Charge	60% of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Podiatric Expense Includes charges incurred by a covered person for podiatric services; provided on an outpatient basis following an injury. Unless specified above, not covered under this benefit are charges incurred for routine foot care, such as trimming of corns, calluses, and nails.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Hypodermic Needles Expense Includes expenses incurred by a covered person for hypodermic needles and syringes.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Maternity Expense Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other Sickness. In the event of an inpatient confinement, such benefits would be payable for inpatient care of the Covered Person, and any newborn child, for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother and done in accordance with the rules and regulations promulgated by State Mandate. Covered medical expenses may include home visits, parent education, and assistance and training in breast or bottle-feeding.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Non-Prescription Enteral Formula Expense Includes charges incurred by a covered person, for non-prescription enteral formulas for which a physician has issued a written order, and are for the treatment of malabsorption caused by: • Crohn's Disease; • Ulcerative colitis; • Gastroesophageal reflux; • Gastrointestinal motility; • Chronic intestinal pseudo obstruction; and • Inherited diseases of amino acids and organic acids. • Covered medical expenses for inherited diseases of amino acids; and organic acids; will also include food products modified to be low protein.	80% of the Negotiated Charge	60% of the Recognized Charge
Acupuncture in Lieu of Anesthesia Expense Includes charges incurred by a covered person for acupuncture therapy when acupuncture is used in lieu of other anesthesia for a surgical or dental procedure covered under this Plan. The acupuncture must be administered by a health care provider who is a legally qualified physician; practicing within the scope of their license.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Transfusion or Kidney Dialysis of Blood Expense Includes charges incurred by a covered person for the transfusion or kidney dialysis of blood, including the cost of: Whole blood; blood components; and the administration of whole blood and blood components.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Hospice Expense	80% of the Negotiated Charge	60% of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Blood and Body Fluid Exposure/ Needle Stick Coverage Expense Limited to those charges related to a clinical related injury. Any expense related to the treatment of any sickness resulting from a clinical related injury is not covered under this benefit. Incidents include, but are not limited to needle sticks, unprotected exposure to blood and body fluid, and unprotected exposure to highly contagious pathogens.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Private Duty Nursing Includes private duty nursing services provided by an R.N. or L.P.N. if the covered person's condition requires skilled nursing care and visiting nursing care is not adequate. Includes private duty nursing services provided by an R.N. or L.P.N. if the covered person's condition requires skilled nursing care and visiting nursing care is not adequate. However, covered medical expenses will not include private duty nursing for any hours shifts during a policy year in excess of the Private Duty Nursing Care Maximum Shifts Hours. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift. Private Duty Nursing Services Maximum Shifts per policy year: 35 shifts.	80% of the Negotiated Charge	60% of the Recognized Charge
Diabetes Benefit Expense Includes charges for services, supplies, equipment, & training for the treatment of insulin and non-insulin dependent diabetes &elevated blood glucose levels during pregnancy. Self-management training provided by a licensed health care provider certified in diabetes self-management training.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Autism Spectrum Disorder Expense Includes charges incurred for services and supplies required for the diagnosis & treatment of autism spectrum disorder when ordered by a physician or behavioral health provider as part of a treatment plan.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Basic Infertility Expense Covered medical expenses include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Anesthesia and Associated Hospitalization For Certain Dental Care Covered Medical Expenses include charges made for general anesthesia and associated hospital charges in connection with dental care for a child or an individual with a disability if any of the following applies: • the child is less than 19 years of age; • the child or individual with a disability has a physical or mental condition that requires hospitalization or general anesthesia for dental care; or • the individual with a disability has a record of; or is regarded as; having a physical or mental impairment that substantially limits one (1) or more of the major life activities of the individual.	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Clinical Trials Expense (Experimental or Investigational Treatment) Includes charges made by a provider for experimental or investigational drugs, devices, treatments or procedures "under an approved clinical trial" only when a covered person has cancer or a terminal illness.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Clinical Trials Expense Routine Patient Costs Covered Percentage Includes charges made by a provider for "routine patient costs" furnished in connection with a covered person's participation in an "approved clinical trial" for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Chiropractic Treatment Expense Includes charges made by a physician on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.	80% of the Negotiated Charge	60% of the Recognized Charge
SHORT-TERM CARDIAC AND PULMONARY REHABILITATION THERAPY SERVICES EXPENSE Inpatient rehabilitation benefits for the services listed will be paid as part of the Hospital Expense and Skilled Nursing Facility Expense benefits. **Cardiac Rehabilitation Benefits** Cardiac rehabilitation benefits received at a hospital, skilled nursing facility, or physician's office. This Plan will cover charges in accordance with a treatment plan as determined by a covered person's risk level when recommended by a physician. **Pulmonary Rehabilitation Benefits** Pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states.		
Cardiac Rehabilitation	80% of the Negotiated Charge	60% of the Recognized Charge
Pulmonary Rehabilitation	80% of the Negotiated Charge	60% of the Recognized Charge
SHORT-TERM REHABILITATION SERVICES EXPENSE Includes charges for short-term rehabilitation services, as described below, when prescribed by a physician. Short-term rehabilitation services must follow a specific treatment plan that: • Details the treatment, and specifies frequency and duration; • Provides for ongoing reviews and is renewed only if continued therapy is appropriate; and • Allows therapy services, provided in a covered person's home, if the covered person is homebound. Inpatient rehabilitation benefits for the services listed will be paid as part of the inpatient hospital and skilled nursing facility benefits.		
Short-Term Rehabilitation Services Expense **Outpatient Cognitive, Physical, Occupational and Speech Rehabilitation and Habilitation Therapy Services (combined)**	80% of the Negotiated Charge	60% of the Recognized Charge
HEARING AIDS	**Preferred Care**	**Non-Preferred Care**
Cochlear Implants	80% of the Negotiated Charge	60% of the Recognized Charge

TREATMENT OF MENTAL DISORDER EXPENSE	Preferred Care	Non-Preferred Care
Inpatient Mental Health Expense & Residential Mental Health Treatment Facility Expense Covered medical expenses include charges made by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider for the treatment of mental disorders for Inpatient room and board at the semi-private room rate, and other services and supplies related to a covered person's condition that are provided during a covered person's stay in a hospital, psychiatric hospital, or residential treatment facility.	80% of the Negotiated Charge	60% of the Recognized Charge
Inpatient Mental Health Physician Services per Admission Expense &Residential Mental Health Treatment Physician Services Expense	80% of the Negotiated Charge	60% of the Recognized Charge
Outpatient Mental Health Expense Includes Telemedicine services.	After a $25 Copay per visit, 100% of the Negotiated Charge	60% of the Recognized Charge
Outpatient Mental Health Partial Hospitalization Expense	80% of the Negotiated Charge	60% of the Recognized Charge
ALCOHOLISM AND DRUG ADDICTION TREATMENT	**Preferred Care**	**Non-Preferred Care**
Inpatient Substance Abuse Treatment Covered medical expenses include charges made by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider for the treatment of mental disorders for Inpatient room and board at the semi-private room rate, and other services and supplies related to a covered person's condition that are provided during a covered person's stay in a hospital, psychiatric hospital, or residential treatment facility.	80% of the Negotiated Charge	60% of the Recognized Charge
Inpatient Substance Abuse Physician Services per Admission Expense	80% of the Negotiated Charge	60% of the Recognized Charge
Outpatient Substance Abuse Treatment	80% of the Negotiated Charge	60% of the Recognized Charge
TRANSPLANT SERVICES EXPENSE	**Preferred Care**	**Non-Preferred Care**
Transplant Services Expense Benefits may vary if an Institute of Excellence™ (IOE) facility or non-IOE or non-preferred care provider is used. Through the IOE network, the covered person will have access to a provider network that specializes in transplants. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure the covered person requires. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Transplant Travel and Lodging Expense The plan will reimburse a covered person for some of the cost of their travel and lodging expenses. **Benefit maximum of $10,000 per transplant.**	100% of the Actual Charge	

PEDIATRIC DENTAL SERVICES EXPENSE (Coverage is limited to covered persons until the end of the month in which the covered person turns 19)	**Preferred Care**	**Non-Preferred Care**
Type A Expense (Pediatric Routine Dental Exam Expense) Benefit Maximum of 1 visit every 6 months	100% of the Negotiated Charge*	70% of the Recognized Charge
Type B Expense (Pediatric Basic Dental Care Expense)	70% of the Negotiated Charge*	50% of the Recognized Charge
Type C Expense (Pediatric Major Dental Care Expense)	50% of the Negotiated Charge*	50% of the Recognized Charge
Pediatric Orthodontia Expense **Orthodontics** Medically necessary comprehensive treatment • Replacement of retainer (limit one per lifetime).	50% of the Negotiated Charge*	50% of the Recognized Charge
PEDIATRIC ROUTINE VISION (Coverage is limited to covered persons until the end of the month in which the covered person turns 19)	**Preferred Care**	**Non-Preferred Care**
Pediatric Routine Vision Exams (including refractions) Includes charges made by a legally qualified ophthalmologist or optometrist for a routine vision exam. The exam will include refraction & glaucoma testing. Benefits are limited to 1 exam per policy year.	100% of the Negotiated Charge*	60% of the Recognized Charge*
Pediatric Visit for the fitting of prescription contact lenses, Pediatric Eyeglass Frames, Prescription Lenses or Prescription Contact Lenses Includes charges for the following vision care services and supplies: • Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses. • Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a preferred care provider. Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a non-preferred care provider. Coverage includes charges incurred for: • Non-conventional prescription contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses. Aphakic prescription lenses prescribed after cataract surgery has been performed. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.	100% of the Negotiated Charge *	60% of the Recognized Charge*

PRESCRIBED MEDICINES EXPENSE

Covered Percentage*	Preferred Care	Non-Preferred Care
Preventive Care Drugs and Supplements **Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.**		
Risk Reducing Breast Cancer Prescription Drugs For each 30 day supply filled at a retail pharmacy.	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits	Not Covered
Tobacco Cessation Prescription Drugs and Over-the-Counter Drugs. **(**for two 90-day treatment regimens only)	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits	Not Covered
Other preventive care drugs and supplements For each 30 day supply filled at a retail pharmacy.	100% per supply	Not Covered
All OTHER PRESCRIPTION DRUGS	**Preferred Care**	**Non-Preferred Care**
For each 30 day supply filled at a retail pharmacy.	100% of the Negotiated Charge	Not Covered

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

Per Prescription Copay/Deductible	Preferred Care	Non-Preferred Care
Generic Prescription Drugs For each 30 day supply filled at a retail pharmacy.	Copay per supply of 20% of the Negotiated Charge	Not Covered
Preferred Brand-Name Prescription Drug	**Preferred Care**	**Non-Preferred Care**
For each 30 day supply filled at a retail pharmacy.	Copay per supply of 40% of the Negotiated Charge	Not Covered
Non-Preferred Brand-Name Prescription Drugs	**Preferred Care**	**Non-Preferred Care**
For each 30 day supply filled at a retail pharmacy.	Copay per supply of 40% of the Negotiated Charge	Not Covered
Risk Reducing Breast Cancer Prescription Drugs For each 30 day supply filled at a retail pharmacy.	Refer to the Copay and Deductible Waiver Provision later in this Schedule of Benefits	Not Covered
Tobacco Cessation Prescription Drugs and Over-the-Counter Drugs. (for two 90-day treatment regimens only)	No copay or deductible applies	Not Covered
Other preventive care drugs and supplements For each 30 day supply filled at a retail pharmacy.	No copay or deductible applies	Not Covered
Orally Administered Anti-Cancer Prescription Drugs (including Chemotherapy Drugs)	Payable on the same basis as covered cancer chemotherapy medications that are administered intravenously or by injection.	

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

Aetna will make a coverage determination within 24 hours after receipt of the request and will notify the covered person, the covered person's designee or the covered person's prescriber of Aetna's decision.

Copay and Deductible Waiver

Waiver for Risk-Reducing Breast Cancer Prescription Drugs

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

Any prescription copayment/coinsurance will apply after those two regimens have been exhausted.

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

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

Exclusions

This Plan does not cover nor provide benefits for:

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

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

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

4. Expense incurred as a result of an accident occurring in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation; except as a fare paying passenger in an aircraft operated by a scheduled airline maintaining regular published schedules on a regularly established route.

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

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

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

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

   This exclusion does not apply to reconstructive surgery or prosthetic devices for a covered person who has undergone a mastectomy.

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

10. Expense incurred for voluntary or elective abortions unless specifically covered under the Policy.

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

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

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

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

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

16. Expense incurred for the male or female reversal of voluntary sterilizations, including related follow-up care and treatment of complications of such procedures.

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

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

19. Expense incurred for custodial care.

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

21. Expenses incurred for the repair or replacement of existing artificial limbs; orthopedic braces; or orthotic devices except as specifically covered in the Policy.

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

23. Expenses incurred for gastric bypass; and any restrictive procedures; for weight loss except screening and counseling services specifically covered under the Policy.

24. Expenses incurred for breast reduction/mammoplasty.

25. Expenses incurred for gynecomastia (male breasts).

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

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

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

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

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

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

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

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

34. Expense for services or supplies provided for the treatment of obesity and/or weight control except screening and counseling services as specifically covered under the Policy. Not covered is any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including morbid obesity, regardless of the existence of comorbid conditions, including but not limited to:
    - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery;

- surgical procedures, medical treatments, weight control/loss programs and other services and supplies that are 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 or food supplements, appetite suppressants and other medications;
- Counseling, coaching, training, hypnosis, or other forms of therapy; and
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy, or other forms of activity or activity enhancement.

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

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

37. Expense incurred for injury resulting from the plan or practice of intercollegiate sports (participating in sports clubs; or intramural athletic activities; is not excluded).

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

39. Expenses incurred for massage therapy.

40. Expense incurred for; or related to; gender reassignment (sex change) surgery.

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

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

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

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

45. Expenses incurred for vision-related services and supplies, except as specifically covered in the Policy. In addition, the plan does not cover:
    - Special supplies such as non-prescription sunglasses;
    - Vision service or supply which does not meet professionally accepted standards;
    - Special vision procedures, such as orthoptics or vision training;
    - Eye exams during a stay in a hospital or other facility for health care;
    - Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
    - Replacement of lenses or frames that are lost or stolen or broken;
    - Acuity tests; and
    - Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
    - Services to treat errors of refraction.

46. 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).

47. Expense incurred for educational services:
    - Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
    - Evaluation or treatment of learning disabilities, attention deficit disorder, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and
    - Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills;
    - Services eligible under the Individuals with Disabilities in Education Act (IDEA).

48. Expense incurred in relation to genetics: Except as specifically covered in the Policy, the plan does not cover 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.

49. Expense incurred for therapies and tests: Any of the following treatments or procedures including but not limited to:
    - Aromatherapy;
    - Bio-feedback and bioenergetic therapy;
    - Carbon dioxide therapy;
    - Chelation therapy (except for heavy metal poisoning);
    - Computer-aided tomography (CAT) scanning of the entire body;
    - Early intensive behavioral interventions (including Applied Behavior Analysis, Denver, LEAP, TEACHH, Rutgers programs) except as specifically covered in the What the Medical Plan Covers Section;
    - Educational therapy;
    - Gastric irrigation;
    - Hair analysis;
    - Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
    - Hypnosis, and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with covered surgery;
    - Lovaas therapy;
    - Massage therapy;
    - Megavitamin therapy;
    - Primal therapy;
    - Psychodrama;
    - Purging;
    - Recreational therapy;
    - Rolfing;
    - Sensory or auditory integration therapy;
    - Sleep therapy;
    - Thermograms and thermography

The Pediatric Dental Services benefit is subject to the following additional exclusions and limitations:

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

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

52. Expenses incurred for orthodontic treatment except as specifically covered in the Orthodontic Treatment Rule section of the Policy.

53. Expenses incurred for jaw joint disorder treatment, services and supplies, except as specifically covered in the Policy, to alter bite or the alignment or operation of the jaw, including temporomandibular joint disorder (TMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment.

54. Expenses incurred for orthodontic treatment except as specifically covered in the Policy.

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

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

IMPORTANT NOTICES:

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**.

The University of Notre Dame 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).

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

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

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-888-294-7406.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), CRCoordinator@aetna.com.

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

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

TTY: 711

To access language services at no cost to you, call 1-888-294-7406.

Para acceder a los servicios de idiomas sin costo, llame al 1-888-294-7406. (Spanish)

如欲使用免費語言服務，請致電 1-888-294-7406。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-888-294-7406. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-294-7406. (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-294-7406 an. (German)

(Arabic) .1-888-294-7406 # للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم

Pou jwenn sèvis lang gratis, rele 1-888-294-7406. (French Creole-Haitian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-294-7406. (Italian)

言語サービスを無料でご利用いただくには、1-888-294-7406 までお電話ください。(Japanese)

무료 언어 서비스를 이용하려면 1-888-294-7406 번으로 전화해 주십시오. (Korean)

(Persian-Farsi) .برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-888-294-7406 تماس بگیرید

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-294-7406. (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-294-7406. (Portuguese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-294-7406. (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-294-7406. (Vietnamese)