



# Aetna Student Health Plan Design and Benefits Summary

Preferred Provider Organization (PPO)

## University of Notre Dame

Policy Year: 2023 - 2024

Policy Number: 474916

<https://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 Certificate issued to you and may be viewed online at <https://www.aetnastudenthealth.com>. If there is a difference between this Plan Summary and Certificate, the Certificate will control.

## Health Services

The University Health Services is the University's on-campus health facility. Staffed by providers and registered nurses, it is open year-round. Please see [www.uhs.nd.edu](http://www.uhs.nd.edu) for hours of operation.

The University Health Services also offers an on-campus pharmacy with smaller prescription copays than pharmacies off-campus. Copays are as followed:

- \$5 for Generic prescription drugs
- \$30 for Brand Name prescription drugs
- \$70 for Specialty drugs

For more details on copays at off-campus pharmacies, please review the benefit grid below.

## 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
<b>Early Start Annual</b>	08/01/2023	08/14/2024	09/15/2023
<b>Annual</b>	08/15/2023	08/14/2024	09/15/2023
<b>Spring/Summer</b>	01/01/2024	08/14/2024	02/15/2024
<b>Summer</b>	05/15/2024	08/14/2024	06/15/2024

**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
<b>Early Start Annual</b>	08/01/2023	08/14/2024	09/15/2023
<b>Annual</b>	08/15/2023	08/14/2024	09/15/2023
<b>Spring/Summer</b>	01/01/2024	08/14/2024	02/15/2024
<b>Summer</b>	05/15/2024	08/14/2024	06/15/2024

## 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	\$2,944	\$2,836	\$1,759	\$713
Spouse	\$2,944	\$2,836	\$1,759	\$713
Child	\$2,944	\$2,836	\$1,759	\$713
Child(ren)	\$5,888	\$5,672	\$3,518	\$1,426

## Student Coverage

### Eligibility

All Registered International and all graduate resident 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 are eligible.

### 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 <https://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 <https://www.aetnastudenthealth.com>, selecting the school's 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.

### Important note regarding coverage for a newborn infant or newly adopted 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 31 day 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 that you and your spouse adopts or is placed with you for adoption is covered from the earlier of:

- The date you have been granted custody as the adoptive parent
- The date the child is placed for adoption
- The date the adoption is complete

An adopted child or a child legally placed with you for adoption is covered on your plan for the first 31 days

- To keep your child covered, we must receive your completed enrollment information within 31 days after the adoption or placement for adoption.
  - o The date of adoption
  - o You were granted custody or
  - o The date the child was placed for adoption
- You must still enroll the child within 31 days 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 [31-90 days].
- If your coverage ends during this 31-day 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 31-day period has not ended.

If you need information or have general questions on dependent enrollment, call Member Services at (888) 294-7406

### **Medicare Eligibility Notice**

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

### **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 payment has been received and no premiums will be refunded.

If you withdraw from classes other than under a school-approved leave of absence within 31 days after the policy effective date, you will be considered ineligible for coverage, your coverage will be terminated retroactively and any premiums collected will be refunded. If the withdrawal is more than 31 days after the policy effective date, your coverage will remain in force through the end of the period for which payment has been received and no premiums will be refunded. If you withdraw from classes to enter the armed forces of any country, coverage will terminate as of the effective date of such entry and a pro rata refund of premiums will be made if you submit a written request within 90 days of withdrawal from classes.

### **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.aetnastudenthealth.com](http://www.aetnastudenthealth.com).

## Precertification call

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

Non-emergency admissions:	You, your physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.
An emergency admission:	You, your physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
An urgent admission:	You, your physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.
Outpatient non-emergency services requiring precertification:	You or your physician must call at least 14 days before the outpatient care is provided, or the treatment or procedure is scheduled.

We will provide a written notification to you and your physician of the precertification decision, where required by state law. If your precertified services are approved, the approval is valid for 30 days as long as you remain enrolled in the plan.

## Coordination of Benefits (COB)

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

## Description of Benefits

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

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

<b>Policy year deductible</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
You have to meet your policy year deductible before this plan pays for benefits.		
<b>Student</b>	\$350 per policy year	\$1,500 per policy year
<b>Spouse</b>	\$350 per policy year	\$1,500 per policy year
<b>Each child</b>	\$350 per policy year	\$1,500 per policy year
<b>Family</b>	None	None
<b>Policy year deductible waiver</b>		
The policy year deductible is waived for all of the following eligible health services: <ul style="list-style-type: none"> <li>• In-network care for <i>Preventive care and wellness</i></li> <li>• Expenses incurred at the University Health Services</li> <li>• LabCorp</li> <li>• MIC (Medical Imaging Center)</li> <li>• XRC</li> <li>• McDonald Physical Therapy (\$105 per visit per day)</li> <li>• Preferred Care Pediatric Dental Services and</li> <li>• Preferred Care and Non-Preferred Pediatric Vision Services.</li> </ul>		
<b>Maximum out-of-pocket limits</b>		
<b>Maximum out-of-pocket limit per policy year</b>		
<b>Student</b>	\$6,000 per policy year	None
<b>Spouse</b>	\$6,000 per policy year	None
<b>Each child</b>	\$6,000 per policy year	None
<b>Family</b>	\$12,000 per policy year	None

## Referral penalty

You must get a referral from school health services for off-campus care prior to your appointment off-campus.

If you do not get a referral, then we will pay covered benefits at the out-of-network coverage cost sharing.

### Exceptions

- Treatment is for an Emergency Medical Condition.
- Obstetric and Gynecological Treatment.
- Pediatric Care.
- 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.

Your covered dependents may use the Notre Dame Wellness Center

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

Eligible health services	In-network coverage	Out-of-network coverage
<b>Preventive care and wellness</b>		
<b>Routine physical exams</b>		
Routine Physical exam	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit policy year 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	



Eligible health services	In-network coverage	Out-of-network coverage
<b>Preventive care immunizations</b> <b>Performed in a facility or at a physician's office</b>		
Preventive care immunizations	100% (of the negotiated charge) per visit.  No copayment or policy year deductible applies	60% (of the recognized charge) per visit  policy year 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.	
<p>The following is not covered under this benefit:</p> <ul style="list-style-type: none"> <li>Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment or travel</li> </ul>		
<b>Well woman preventive visits</b> <b>Routine gynecological exams (including Pap smears and cytology tests)</b>		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	60% (of the recognized charge) per visit  policy year deductible applies
Maximum visits per policy year	1 visit	
<b>Preventive screening and counseling services</b>		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Depression Screening, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	60% (of the recognized charge) per visit  policy year 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	

Eligible health services	In-network coverage	Out-of-network coverage
Depression screening counseling Maximum visits per policy year	1 visit	
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	
Routine cancer screenings	100% (of the negotiated charge) per visit  No copayment or policy year deductible applies	60% (of the recognized charge) per visit  policy year deductible applies
Additional Maximum:	Subject to any age; family history; and frequency guidelines as set forth in the most current: <ul style="list-style-type: none"> <li>• 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</li> <li>• The comprehensive guidelines supported by the Health Resources and Services Administration.</li> </ul>	
Lung cancer screening maximums	1 screening every 12 months	
Mammograms	At least one baseline mammogram if you are at least age 35, but less than age 40. At least one mammogram per year if you are: Less than age 40 and at risk, or at least age 40	
Prostate specific antigen (PSA) tests	At least one Prostate specific antigen (PSA) test per year if you are: Less than age 50, but at a high risk, or at least age 50	
Colorectal screening tests: <ul style="list-style-type: none"> <li>- Digital rectal</li> <li>- Fecal occult blood tests</li> <li>- Sigmoidoscopies</li> <li>- Double contrast barium enemas (DCBE)</li> <li>- Colonoscopies which include the removal of polyps performed during a screening procedure</li> </ul>	Colorectal screening tests if you are: Less than age 50, but at high risk or at least age 50	

and a pathology exam on any polyp		
<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
High breast density	Screening, testing or examinations if you are: At least age 40	
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit policy year deductible applies
Lactation counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit policy year deductible applies
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits	
Breast pump supplies and accessories	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit policy year deductible applies
<b>Family planning services – female contraceptives Counseling services</b>		
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit policy year deductible applies
Contraceptive counseling services maximum visits per policy year either in a group or individual setting	2 visits	
Female contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
<b>Female Voluntary sterilization</b>		
Inpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit policy year deductible applies
Outpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit policy year deductible applies
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care</li> <li>• Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA</li> <li>• Male contraceptive methods, sterilization procedures or devices, except for male condoms prescribed by a provider</li> </ul>		
<b>Physicians and other health professionals</b>		
Physician, specialist including Consultants Office visits (non-surgical/ non-preventive care by a physician and specialist) includes telehealth consultations)	80% (of the negotiated charge) per visit policy year deductible applies	60% (of the recognized charge) per visit policy year deductible applies
<b>Allergy testing and treatment</b>		
Allergy testing performed at a physician's or specialist's office	80% (of the negotiated charge) per visit policy year deductible applies	60% (of the recognized charge) per visit policy year deductible applies
Allergy injections treatment performed at a physician's or specialist's office	80% (of the negotiated charge) per visit policy year deductible applies	60% (of the recognized charge) per visit policy year deductible applies
Allergy sera and extracts administered via injection at a physician or specialist office	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

Eligible health services	In-network coverage	Out-of-network coverage
<b>Physician and specialist - surgical services</b>		
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 admission  policy year deductible applies	60% (of the recognized charge) per admission  policy year deductible applies
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• The services of any other physician who helps the operating physician</li> <li>• A stay in a hospital (Hospital stays are covered in the <i>Eligible health services and exclusions – Hospital and other facility care</i> section)</li> <li>• Services of another physician for the administration of a local anesthetic</li> </ul>		
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 admission  policy year deductible applies	60% (of the recognized charge) per admission  policy year deductible applies
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• The services of any other physician who helps the operating physician</li> <li>• A stay in a hospital (Hospital stays are covered in the <i>Eligible health services and exclusions – Hospital and other facility care</i> section)</li> <li>• A separate facility charge for surgery performed in a physician’s office</li> <li>• Services of another physician for the administration of a local anesthetic</li> </ul>		
<b>Alternatives to physician office visits</b>		
Walk-in clinic visits (non-emergency visit)	80% (of the negotiated charge) per visit  policy year deductible applies	60% (of the recognized charge) per visit  policy year deductible applies
<b>Hospital and other facility care</b>		
Inpatient hospital (room and board) and other miscellaneous services and supplies)  Includes birthing center facility charges	80% (of the negotiated charge) per admission  policy year deductible applies	60% (of the recognized charge) per admission  policy year deductible applies

<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
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
In-hospital non-surgical physician services	80% (of the negotiated charge) per admission policy year deductible applies	60% (of the recognized charge) per admission policy year deductible applies
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	80% (of the negotiated charge) per admission policy year deductible applies	60% (of the recognized charge) per admission policy year deductible applies
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• The services of any other physician who helps the operating physician</li> <li>• A stay in a hospital (See the <i>Hospital care - facility charges</i> benefit in this section)</li> <li>• A separate facility charge for surgery performed in a physician's office</li> <li>• Services of another physician for the administration of a local anesthetic</li> </ul>		
Home health care	80% (of the negotiated charge) per visit policy year deductible applies	60% (of the recognized charge) per visit policy year deductible applies
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Services for infusion therapy</li> <li>• 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)</li> <li>• Transportation</li> <li>• Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present</li> <li>• Homemaker or housekeeper services</li> <li>• Food or home delivered services</li> <li>• Maintenance therapy</li> </ul>		
Hospice-Inpatient	80% (of the negotiated charge) per admission policy year deductible applies	60% (of the recognized charge) per admission policy year deductible applies
Hospice-Outpatient	80% (of the negotiated charge) per visit policy year deductible applies	60% (of the recognized charge) per visit policy year deductible applies
Skilled nursing facility-Inpatient	80% (of the negotiated charge) per admission policy year deductible applies	60% (of the recognized charge) per admission policy year deductible applies

<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
Hospital emergency room	\$100. Co-pay then 80% (of the negotiated) per visit policy year deductible applies	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered

**Important note:**

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

The following are not covered under this benefit:

- Non-emergency services in a hospital emergency room facility

Urgent medical care provided by an urgent care provider	80% (of the negotiated charge) per visit policy year deductible applies	60% (of the recognized charge) per visit policy year 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
<b>Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19)</b>		
Type A services	100% (of the negotiated charge) per visit No copayment or deductible applies	70% (of the recognized charge) per visit policy year deductible applies
Type B services	70% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit policy year deductible applies
Type C services	50% (of the negotiated charge) per visit No copayment or deductible applies	50% (of the recognized charge) per visit policy year deductible applies
Orthodontic services	50% (of the negotiated charge) per visit No copayment or 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
- Asynchronous dental treatment
- 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 or
  - 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) and craniomandibular joint dysfunction disorder (CMJ) 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 schedule of benefits
- 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 the [*Pediatric*] *dental care* section of the schedule of benefits
- 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

Eligible health services	In-network coverage	Out-of-network coverage
<b>Specific conditions</b>		
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

Eligible health services	In-network coverage	Out-of-network coverage
Impacted wisdom teeth	80% (of the negotiated charge) policy year deductible applies	80% (of the recognized charge) policy year deductible applies
Accidental injury to sound natural teeth	80% (of the negotiated charge) policy year deductible applies	80% (of the recognized charge) policy year 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

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
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Maximum per policy year	\$2,000	
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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
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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 and investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna's claim policies)

<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
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.
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Cosmetic treatment and procedures</li> </ul>		
<b>Maternity care</b>		
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.
<p>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</p>		
Well newborn nursery care in a hospital or birthing center	80% (of the negotiated charge) per policy year deductible applies	60% (of the recognized charge) per policy year deductible applies
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.
<b>Mental Health &amp; Substance Abuse Treatment</b>		
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	80% (of the negotiated charge) per admission per policy year deductible applies	60% (of the recognized charge) per admission per policy year deductible applies
Outpatient office visits (includes telehealth consultations)	80% (of the negotiated charge) per visit per policy year deductible applies	60% (of the recognized charge) per visit per policy year deductible applies
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	80% (of the negotiated charge) per visit per policy year deductible applies	60% (of the recognized charge) per visit per policy year deductible applies

<b>Eligible health services</b>	<b>In-network coverage (IOE facility)</b>	<b>In-network coverage (Non-IOE facility)</b>	<b>Out-of-network coverage</b>
Inpatient and outpatient transplant facility services	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.		
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 <b>IOE</b> patient	\$50 per night	\$50 per night	\$50 per night
Maximum Lodging Expenses per companion	\$50 per night	\$50 per night	\$50 per night
<ul style="list-style-type: none"> <li>• The following are not covered under this benefit:</li> <li>• Services and supplies furnished to a donor when the recipient is not a covered person</li> <li>• Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness</li> <li>• 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</li> </ul>			
<b>Treatment of infertility</b>			
Basic infertility services Inpatient and outpatient care	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.	
<b>Specific therapies and tests</b>			
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit policy year deductible applies	60% (of the recognized charge) per visit policy year deductible applies	
Diagnostic lab work and radiological services performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge) per visit policy year deductible applies	60% (of the recognized charge) per visit policy year deductible applies	

<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
Outpatient Chemotherapy, Radiation & Respiratory Therapy	80% (of the negotiated charge) per visit policy year deductible applies	60% (of the recognized charge) per visit policy year deductible applies
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
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan</li> <li>• Enteral nutrition</li> <li>• Blood transfusions and blood products</li> <li>• Dialysis</li> </ul>		
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) per visit policy year deductible applies	60% (of the recognized charge) per visit policy year deductible applies
Chiropractic services	80% (of the negotiated charge) per visit policy year deductible applies	60% (of the recognized charge) per visit policy year deductible applies
<b>Other services and supplies</b>		
Emergency ground, air, and water ambulance  (includes non-emergency ambulance)	80% (of the negotiated charge) per trip policy year deductible applies	Paid the same as in-network coverage
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Ambulance services for routine transportation to receive outpatient or inpatient care</li> </ul>		
Durable medical and surgical equipment	80% (of the negotiated charge) per item policy year deductible applies	60% (of the recognized charge) per item policy year deductible applies
<p>The following are not covered under this benefit:</p>		

- 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

Eligible health services	In-network coverage	Out-of-network coverage
Nutritional support	80% (of the negotiated charge) per item policy year deductible applies	60% (of the recognized charge) per item policy year deductible applies
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• 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</li> </ul>		
Prosthetic Devices & Orthotics Includes Cranial prosthetics ( <i>Medical wigs</i> )	80% (of the negotiated charge) per item policy year deductible applies	60% (of the recognized charge) per item policy year deductible applies
<p>The following are not covered under this benefit:</p> <ul style="list-style-type: none"> <li>• Services covered under any other benefit</li> <li>• 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</li> <li>• Trusses, corsets, and other support items</li> <li>• Repair and replacement due to loss, misuse, abuse or theft</li> <li>• Communication aids</li> <li>• Cochlear implants</li> </ul>		
Cochlear implants Coverage is limited to covered persons age 18 and over	80% (of the negotiated charge) per item policy year deductible applies	60% (of the recognized charge) per item policy year deductible applies

<b>Vision care</b>		
<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
<b>Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)</b>		
<b>Pediatric routine vision exams (including refraction)</b>		
Performed by a legally qualified ophthalmologist or optometrist	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit No policy year deductible applies
Maximum visits per policy year	1 visit	
<b>Pediatric comprehensive low vision evaluations</b>		
Performed by a legally qualified ophthalmologist or optometrist	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Maximum	One comprehensive low vision evaluation every policy year	
<b>Pediatric vision care services and supplies</b>		
Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit No policy year deductible applies
Maximum number of eyeglass frames per policy year Maximum number of prescription lenses per policy year	One set of eyeglass frames One pair of prescription lenses	
Maximum number of prescription contact lenses per policy year (includes non-conventional prescription contact lenses and aphakic lenses prescribed after cataract surgery)	Daily disposables: up to 3 month supply Extended wear disposable: up to 6 month supply Non-disposable lenses: one set	
Office visit for fitting of contact lenses	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit No policy year deductible applies
Optical devices Maximum number of optical devices per policy year One optical device	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.

**\*Important note:** Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies.

As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.

Coverage does not include the office visit for the fitting of prescription contact lenses.

**Outpatient prescription drugs**

**Policy year deductible and copayment waiver for risk reducing breast cancer**

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

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

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

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

**Preferred Generic prescription drugs**

**Per prescription copayment**

For each fill up to a 30 day supply filled at a retail pharmacy	Greater of \$15 Copayment or 20% coinsurance (of the negotiated charge) then plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	Greater of \$45 Copayment or 20% coinsurance (of the negotiated charge) then plan pays 100% (of the balance of the negotiated charge)	Not covered

<b>Eligible health services</b>	<b>In-network coverage</b>	<b>Out-of-network coverage</b>
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**Preferred brand-name prescription drugs**

**Per prescription copayment**

For each fill up to a 30 day supply filled at a retail pharmacy	Greater of \$40 Copayment or 40% coinsurance (of the negotiated charge) then plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	Greater of \$120 Copayment or 40% coinsurance (of the negotiated charge) then plan pays 100% (of the balance of the negotiated charge)	



<b>Non-Preferred brand-name prescription drugs</b>		
<b>Per prescription copayment</b>		
For each fill up to a 30 day supply filled at a retail pharmacy	Greater of \$75 Copayment or 40% coinsurance (of the negotiated charge) then plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
More than a 30 day supply but less than a 91 day supply filled at a mail order pharmacy	Greater of \$225 Copayment or 40% coinsurance (of the negotiated charge) then plan pays 100% (of the balance of the negotiated charge)	
<b>Orally administered anti-cancer prescription drugs</b>		
<b>Per prescription copayment</b>		
For each fill up to a 30 day supply filled at a retail pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
<b>Preventive care drugs and supplements</b>		
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
Maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging onto your Aetna Navigator® secure website at <a href="http://www.aetnastudenthealth.com">www.aetnastudenthealth.com</a> or calling the toll-free number on the back of your ID card.	
<b>Risk reducing breast cancer prescription drugs</b>		
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 copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Maximums:	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered risk reducing breast cancer prescription drugs, contact Member Services by logging onto your Aetna Navigator® secure website at <a href="http://www.aetnastudenthealth.com">www.aetnastudenthealth.com</a> or calling the toll-free number on the back of your ID card.	

### **Tobacco cessation prescription and over-the-counter drugs**

Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy 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
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Maximums:	Coverage is permitted for two 90-day treatment regimens only. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging onto your Aetna Navigator® secure website at <a href="http://www.aetnastudenthealth.com">www.aetnastudenthealth.com</a> or calling the toll-free number on the back of your ID card.  Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits
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### **Outpatient prescription drugs exclusions**

The following are not covered under the outpatient prescription drugs benefit:

- Biological sera unless specified on the [preferred] drug guide
- Cosmetic drugs including medications and preparations used for cosmetic purposes
- Devices, products and appliances, except those that are specially covered
- Drugs or medications
  - Administered or entirely consumed at the time and place it is prescribed or provided
  - Which do not, by federal or state law, require a prescription order i.e. over-the-counter (OTC) drugs), even if a prescription is written except as specifically provided above
  - That are therapeutically equivalent or therapeutically alternative to a covered prescription drug (unless a medical exception is approved)
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while an inpatient of a healthcare facility
  - Recently approved by the U.S. Food and Drug Administration (FDA), but which have not yet been reviewed by our Pharmacy and Therapeutics Committee
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - For which the cost is covered by a federal, state, or government agency (for example: Medicaid or Veterans Administration)
  - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - That are used for the purpose of weight gain or reduction, including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications

- That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the covered person meets one or more clinical criteria detailed in our precertification and clinical policies
- Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
- Implantable drugs and associated devices [except as specifically provided above]
- Injectables
  - Any charges for the administration or injection of prescription drugs or injectable insulin and other injectable drugs covered by us.
  - Needles and syringes, except for those used for 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. This exception does not apply to Depo Provera and other injectable drugs used for contraception.
- 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 preferred drug guide.
  - 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
- Tobacco cessation drugs, unless recommended by the United States Preventive Services Task Force (USPSTF)
- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (that is, a drug with the same active ingredient or same therapeutic effect), supply or equipment is on the preferred drug guide
  - Any dosage or form of a drug when the same drug is available in a different dosage or form on our preferred drug guide

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

## General Exclusions

### Abortion

- Abortion except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger

### 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.

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

### **Clinical trial therapies (experimental or investigational)**

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

### **Cosmetic services and plastic surgery**

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

This exclusion does not apply to:

- Surgery after an accidental injury when performed as soon as medically feasible

- Coverage that may be provided under the Eligible health services under your plan - Gender reassignment (sex change) treatment section.

### **Court-ordered 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, accidental injury to the jaw,

sound natural teeth, mouth or face, 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

### **Felony**

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

### **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

### **Gene-based, cellular and other innovative therapies (GCIT)**

The following are not eligible health services unless you receive prior written approval from us:

- GCIT services received at a facility or with a provider that is not a GCIT-designated facility/provider
- All associated services when GCIT services are not covered. Examples include infusion, laboratory, radiology, anesthesia, and nursing services.

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

### **Growth/Height care**

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

### **Hearing aids**

Any tests, appliances and devices to:

- Improve your hearing
- Enhance other forms of communication to make up for hearing loss or devices that simulate speech

### **Hearing exams**

- Hearing exams performed for the evaluation and treatment of illness, injury or hearing loss.

### **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 under your plan – Habilitation therapy services section

### **Medical supplies – outpatient disposable**

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

### **Medicare**

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

### **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:

- 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

### **Private duty nursing**

#### **Riot**

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

#### **Routine exams**

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

#### **School health services**

- Services and supplies normally provided by the policyholder’s:
  - School health services
  - Infirmary
  - Hospital
  - Pharmacy orby health professionals who
  - Are employed by
  - Are Affiliated with
  - Have an agreement or arrangement with, or
  - Are otherwise designated by the policyholder.

#### **Services provided by a family member**

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

#### **Services, supplies and drugs received outside of the United States**

- Non-emergency services, outpatient prescription drugs or supplies received outside of the United States. They are not covered even if they are covered in the United States under this certificate of coverage.

## **Sexual dysfunction and enhancement**

- Any treatment, prescription drug, service, or supply to enhance sexual performance or increase sexual desire or any treatment, drug, service or supply to treat sexual dysfunction not secondary to organic disease, 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 not caused by organic disease
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services
- Not eligible for coverage are prescription drugs in 30 day supplies

## **Sinus surgery**

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

## **Specialty prescription drugs**

- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug benefit.

## **Strength and performance**

- Services, devices and supplies such as drugs or preparations designed primarily for the purpose of enhancing your strength, physical condition, endurance, or 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

## **Telehealth**

- Services given when you are not present at the same time as the provider
- Services including:
  - Telephone calls
  - Telehealth 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

### **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.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers’ compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered “non-occupational” regardless of cause.

University of Notre Dame Student Health Insurance Plan is underwritten by Aetna Life Insurance Company. Aetna Student Health<sup>SM</sup> 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

ለብ 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**).

### Bàsò̀̀ Wùdù̀̀/Bassa

Dè dè nìà kè dyèdè gbo: ɔ jù kè m̀̀ d̀̀yi Bàsò̀̀̀- wùdù̀̀̀- po-nyò̀̀̀ jù nì, nìi à wuɖu kà kò d̀̀ò po-poò̀̀̀ b̀̀é m̀̀ gbo kpáa. Ɖá **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.  
કોલ 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, dijiri gi. Krọọ **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**).

#### **اردو/Urdu**

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, lófẹ́, wà fún ọ. Pe **1-877-480-4161** (TTY: **711**).

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