Aetna Student Health
Plan Design and Benefits Summary
Preferred Provider Organization (PPO)

University of Miami
IEP – Intensive English Program

Policy Year: 2023–2024
Policy Number: 186130
www.aetnastudenthealth.com
(866) 639-1420

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

Student Health Service

The Aetna Student Insurance Plan includes a range of benefits that are designed specifically to provide you with excellent care, and minimize your out-of-pocket costs, wherever possible.

The Aetna Student Insurance Plan is designed to be used in conjunction with Student Health Services. To obtain the greatest level of benefits, (most are covered at 100%), you will need to initiate care at Student Health Services, where treatment will be administered, or a referral issued. Appointments can be scheduled online at MyUHealthChart.com.

Student Health Service provides an after-hours line. Students can reach the Student Health on call Provider by calling 305-284-9100. However, in the case of a medical emergency, when away from the campus or when Student Health Service is closed, you can seek care directly from any doctor in the **Aetna Student Health Network** by accessing Aetna **Docfind** or call **Aetna Student Health at 866-639-1420**. Call Aetna 24-Hour Nurse Line 1-800-556-1555. Please visit miami.edu/student-health for further information.

The Counseling Center

The Counseling Center offers a variety of services to students, including short-term psychotherapy, individual and group counseling, career and educational counseling and assessment services to assist students in their educational and career decisions. For appointments and more information, please call **305-284-5511**.

How to Obtain an Insurance Card

All enrollees can either print their insurance card by visiting aetnastudenthealth.com/um or use Aetna Health℠ app (text STUDENT to 90156 to download) to access an electronic ID on your phone. Students can request an insurance card to be mailed to their local address by contacting Aetna directly at 866-639-1420.

Eligibility

All Domestic students actively enrolled in 6 or more credit hours per semester or considered full time (in a program requiring documentation of health insurance coverage; exceptions listed at miami.edu/student-health), must purchase the student health insurance unless they show proof of comparable coverage to waive the insurance charge. All International students, regardless of credit hours, are required to be insured on the plan.

Students must actively attend classes for at least the first 31 days (unless an official medical withdraw has been approved by the Student Health Service) after the date for which coverage is purchased. Non-Degree seeking, non-credit courses, certificate programs, online-or weekend only programs or courses do not fulfill the eligibility requirements.

Waiver / Opt-out

Domestic students with adequate coverage of their own can waive the University-sponsored plan, however, international students are required to enroll in the University-sponsored plan (unless being sponsored by an embassy). exceptions listed at miami.edu/student-health. Eligible students are automatically charged the insurance premium along with their tuition fees**.** For more information please visit: miami.edu/student-health.

Coverage Dates / Rates

Coverage for all insured students 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 students terminates in accordance with the Termination Provisions described in the Certificate of Coverage.

Coverage Period	Coverage Start Date	Coverage End Date	Rates Student
IEP 6 week			
Session 1	**10/13/2023**	**12/02/2023**	**$655.00**
Session 2	**2/20/2024**	**4/20/2024**	**$655.00**
Session 3	**6/17/2024**	**8/14/2024**	**$655.00**
IEP 14 week			
Session 1	**8/15/2023**	**1/05/2024**	**$1510.00**
Session 2	**1/06/2024**	**4/20/2024**	**$1510.00**
Session 3	**4/21/2024**	**8/14/2024**	**$1510.00**

Dependent Eligibility

Dependents are not eligible to voluntarily enroll into the Aetna Student Health plan.

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

- A newborn child - Your newborn child is covered on your health plan for the first 31 days from the moment of birth.
  - 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, foster child or a child legally placed with you for adoption - A child that you, or that you and your spouse or domestic partner adopts or is placed with you for adoption or foster care is covered on your plan for the first 31 days after the adoption or the placement is complete. In the case of an adopted newborn child, the child is covered for the first 31 days from the moment of birth.
  - 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.

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.

Withdrawal from Classes – Other than Leave of Absence
If you withdraw from classes within 31 days after the policy effective date, you will be considered ineligible for coverage, your coverage will be terminated retroactively and any premium paid will be refunded.

If you withdraw from classes more than 31 days after the policy effective date, your coverage will remain in force through the end of the period for which premium payment has been received and no premium will be refunded.

If you withdraw from classes to enter the armed forces of any country, your coverage will end as of the date of such entry. We will refund any unearned premium, on a pro rata basis, if you submit a written request within 90 days from the date you withdraw.

In-network Provider Network

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

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

Precertification

You need pre-approval from us for some eligible health services. Pre-approval is also called precertification. Your in-network physician is responsible for obtaining any necessary precertification before you get the care. When you go to an out-of-network provider, it is your responsibility to obtain precertification from us for any services and supplies on the precertification list. For a current listing of the health services or prescription drugs that require precertification, contact Member Services or go to www.aetna.com.

Precertification Call

Precertification should be secured within the timeframes specified below. To obtain precertification, call Member Services at the toll-free number on your ID card. 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 24 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.
Delivery:	You, your physician, or the facility must call within 24 hours of the birth or as soon thereafter as possible. No penalty will be applied for the first 48 hours after delivery for a routine delivery and 96 hours for a cesarean delivery.

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 Florida Insurance Law(s).

Policy year deductibles			
	Designated care coverage	**In-network coverage**	**Out-of-network coverage**
You have to meet your policy year deductible before this plan pays for benefits.			
Student	$300 per policy year		$750 per policy year
Policy year deductible waiver			
The policy year deductible is waived for all of the following eligible health services: • In-network care for Preventive care and wellness, Pediatric Dental Type A services, Pediatric Vision care services, and Diagnostic lab work and radiological services performed in a physician's office, the outpatient department of a hospital or other facility • In-network care and out-of-network care for Child health supervision services through age 16, Well newborn nursery care, and Outpatient prescription drugs Designated Care The policy year deductible is waived for all of the following eligible health services: • Preventive care and wellness • Consultant visits • Durable medical equipment • Office Visits (including walk-in clinic and nutritional counseling) • Routine adult vision exams • Diagnostic lab work and radiological services performed in a physician's office, the outpatient department of a hospital or other facility • Mental Health and Substance Abuse All Other Outpatient Treatment • Well newborn nursery care			
This is the amount you owe for in-network and out-of-network eligible health services each policy year before the plan begins to pay for eligible health services. After the amount you pay for eligible health services reaches the policy year deductible, this plan will begin to pay for eligible health services for the rest of the policy year.			
Eligible health services applied to the out-of-network policy year deductibles will not be applied to satisfy the in-network policy year deductibles. Eligible health services applied to the in-network policy year deductibles will not be applied to satisfy the out-of-network policy year deductibles.			

Designated Care Providers:
University of Miami Hospital
Anne Bates Leach Eye Hospital
University of Miami Hospital & Clinics
Sylvester Comprehensive Cancer Center

Maximum out-of-pocket limits			
	Designated care coverage	**In-network coverage**	**Out-of-network coverage**
Student	$5,500 per policy year		$6,000 per policy year
Eligible health services applied to the out-of-network maximum out-of-pocket limit will not be applied to satisfy the in-network maximum out-of-pocket limit and eligible health services applied to the in-network maximum out-of-pocket limit will not be applied to satisfy the out-of-network maximum out-of-pocket limit.			

Eligible health services	**Designated care coverage**	**In-network coverage**	**Out-of-network coverage**
Preventive care and wellness			
Routine physical exam	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
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. For details, contact your physician or Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card		
Routine physical exam limits for covered persons age 22 and over: maximum visits per policy year	1 visit		
Preventive care immunizations	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
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 For details, contact your physician or Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card		
The following is not covered under this benefit: • Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment or travel			

Eligible health services	Designated care coverage	In-network coverage	Out-of-network coverage
Well woman preventive visits			
Routine gynecological exams (including Pap smears and cytology tests) performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Well woman routine gynecological exam maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.		
Maximum visits per policy year	1 visit		
Preventive screening and counseling services In figuring the maximum visits, each session of up to 60 minutes is equal to one visit			
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	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Obesity and/or healthy diet - counseling Maximum visits	Age 0-22: unlimited 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		
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		

Eligible health services	Designated care coverage	In-network coverage	Out-of-network coverage
Preventive screening and counseling services (continued) In figuring the maximum visits, each session of up to 60 minutes is equal to one visit			
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Maximum:	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; and • The comprehensive guidelines supported by the Health Resources and Services Administration. For details, contact your physician or Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.		
Lung cancer screening maximum	1 screening every 12 months		
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Lactation counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits		
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	100% (of the negotiated charge) per item No copayment or policy year deductible applies	60% (of the recognized charge) per item
Family planning services – female contraceptives - counseling services			
Female contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
Contraceptive counseling services maximum visits per policy year either in a group or individual setting	2 visits		

Eligible health services	Designated care coverage	In-network coverage	Out-of-network coverage
Family planning services – female contraceptives - counseling services (continued)			
Female contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit	100% (of the negotiated charge) per item No copayment or policy year deductible applies	100% (of the negotiated charge) per item No copayment or policy year deductible applies	60% (of the recognized charge) per item
Female Voluntary sterilization - Inpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	100% (of the negotiated charge) No copayment or policy year deductible applies	60% (of the recognized charge)
Female Voluntary sterilization - Outpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	60% (of the recognized charge) per visit
The following are not covered under this benefit: • Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care • Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA • Male contraceptive methods, sterilization procedures or devices			
Physicians and other health professionals			
Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist, includes telemedicine consultations)	100% (of the negotiated charge) per visit No policy year deductible applies	$40 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	60% (of the recognized charge) per visit
Allergy testing and treatment			
Allergy testing performed at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received		
Allergy injections treatment performed at a physician's, or specialist office	100% (of the negotiated charge) No policy year deductible applies	100% (of the negotiated charge)	60% (of the recognized charge) per visit
Allergy sera and extracts administered via injection at a physician's or specialist's office	Covered according to the type of benefit and the place where the service is received		

Eligible health services	Designated care coverage	In-network coverage	Out-of-network coverage
Physician and specialist surgical services			
Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses)	90% (of the negotiated charge)	70% (of the negotiated charge)	60% (of the recognized charge)
The following are not covered under this benefit: • The services of any other physician who helps the operating physician • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • Services of another physician for the administration of a local anesthetic			
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)	90% (of the negotiated charge) per visit	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: • The services of any other physician who helps the operating physician • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic			
Alternatives to physician office visits			
Walk-in clinic visits (non-emergency visit)	100% (of the negotiated charge) per visit No policy year deductible applies	$40 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	60% (of the recognized charge) per visit
Hospital and other facility care			
Inpatient hospital (room and board including intensive care and other miscellaneous services and supplies) Includes birthing center facility charges	90% (of the negotiated charge) per admission	70% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Preadmission testing	Covered according to the type of benefit and the place where the service is received		
In-hospital non-surgical physician services	90% (of the negotiated charge) per visit	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

Eligible health services	Designated care coverage	In-network coverage	Out-of-network coverage
Alternatives to hospital stays			
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	90% (of the negotiated charge)	70% (of the negotiated charge)	60% (of the recognized charge)
The following are not covered under this benefit: • The services of any other physician who helps the operating physician • A stay in a hospital (See the *Hospital care – facility charges* benefit in this section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic			
Home health care	90% (of the negotiated charge) per visit	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum visits per policy year	60 visits		
The following are not covered under this benefit: • Services for infusion therapy • Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities) • Transportation • Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present • Homemaker or housekeeper services • Food or home delivered services • Maintenance therapy			
Hospice - Inpatient	90% (of the negotiated charge) per admission	70% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Hospice - Outpatient	90% (of the negotiated charge) per visit	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: • Funeral arrangements • Pastoral counseling • Respite care • Bereavement counseling • Financial or legal counseling which includes estate planning and the drafting of a will • Homemaker or caretaker services that are services which are not solely related to your care and may include: - Sitter or companion services for either you or other family members - Transportation - Maintenance of the house			
Skilled nursing facility - Inpatient	90% (of the negotiated charge) per admission	70% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Maximum days of confinement per policy year	60 days		

Eligible health services	Designated care coverage	In-network coverage	Out-of-network coverage
Emergency services and urgent care			
Hospital emergency room	$200 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	$200 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not covered	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 or call Member Services for an address at 1-866-639-1420 and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill. • A separate hospital emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived and your inpatient copayment/coinsurance will apply. • Covered benefits that are applied to the hospital emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment/coinsurance. • Separate copayment/coinsurance amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment/coinsurance amounts may be different from the hospital emergency room copayment/coinsurance. They are based on the specific service given to you. • Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment/coinsurance amounts that are different from the hospital emergency room copayment/coinsurance amounts.			
The following are not covered under this benefit: • Non-emergency services in a hospital emergency room facility, freestanding emergency medical care facility or comparable emergency facility			
Urgent care	$50 copayment then the plan pays 100% (of the balance of the negotiated charge per visit	$50 copayment then the plan pays 100% (of the balance of the negotiated charge per visit	60% (of the recognized charge) per visit
Non-urgent use of an urgent care provider	Not covered	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	Designated care coverage	In-network coverage	Out-of-network coverage
Pediatric dental care Limited to covered persons through the end of the month in which the person turns age 19.			
Type A services	Not available	100% (of the negotiated charge) per visit No copayment or deductible applies	60% (of the recognized charge) per visit
Type B services	Not available	70% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Type C services	Not available	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Orthodontic services	Not available	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Dental emergency services	Not applicable	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

(continued on next page)

Eligible health services	Designated care coverage	In-network coverage	Out-of-network coverage
Pediatric dental care exclusions (continued) The following are not covered under this benefit: • Mail order and at-home kits for orthodontic treatment • Orthodontic treatment except as covered 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 • Work related: Any illness or injury related to employment or self-employment including any injuries that arise out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law and submit proof that you are not covered for a particular illness or injury under such law, that illness or injury will be considered "non-occupational" regardless of cause.			
Specific conditions			
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received		
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		
The following are not covered under this benefit: • Services and supplies for: - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet			
Impacted wisdom teeth	Not available	70% (of the negotiated charge)	60% (of the recognized charge)

Eligible health services	Designated care coverage	In-network coverage	Out-of-network coverage
Specific conditions (continued)			
Accidental injury to sound natural teeth	Not available	70% (of the negotiated charge)	60% (of the recognized charge)
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		
The following are not covered under this benefit: • Dental implants			
Bones and joints of the facial region	Covered according to the type of benefit and the place where the service is received		
The following are not covered under this benefit: • Care or treatment of the teeth or gums • Intraoral prosthetic device • Surgical procedures for cosmetic purposes			
Cleft lip and palate - Treatment for a congenital cleft lip or cleft palate	Covered according to the type of benefit and the place where the service is received		
Age limit	Covered persons through age 18		
The following are not covered under this benefit: • Oral prosthesis, dentures or bridgework ordered before the covered dependent child becomes covered or ordered while covered but installed or delivered more than 60 days after termination of coverage • Services given to treat speech development unless his/her speech is impaired because of a cleft lip or cleft palate or any condition developed because of cleft lip or cleft palate • Services performed before the covered dependent child becomes covered or after termination of coverage: - Hearing aid evaluation tests - Oral or facial surgery - Cleft orthodontic therapy - Diagnostic or rehabilitative - Special education for a covered dependent child whose ability to speak or hear is lost or impaired including lessons in sign language - Hearing examinations required as a condition of employment			

Eligible health services	Designated care coverage	In-network coverage	Out-of-network coverage
Specific conditions (continued)			
Clinical trial (routine patient costs)	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 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)			
Dermatological treatment	Covered according to the type of benefit and the place where the service is received		
The following are not covered under this benefit: • Cosmetic treatment and procedures			
Maternity care (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		
The following are not covered under this benefit: • Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries			
Well newborn nursery care in a hospital or birthing center	90% (of the negotiated charge) No policy year deductible applies	70% (of the negotiated charge) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
Family planning services – other			
Voluntary sterilization for males - inpatient surgical services	Covered according to the type of benefit and the place where the service is received		
Voluntary sterilization for males - outpatient surgical services	Covered according to the type of benefit and the place where the service is received		
The following are not covered under this benefit: • Reversal of voluntary sterilization procedures, including related follow-up care • Services provided as a result of complications resulting from a male voluntary sterilization procedure and related follow-up care			
Gender affirming treatment			
Surgical, hormone replacement therapy, and counseling treatment	Covered according to the type of benefit and the place where the service is received		
The following are not eligible health services under this benefit: • Any treatment, surgery, service or supply that is not in the list above of eligible health services			
Autism spectrum disorder			
Autism spectrum disorder treatment, diagnosis and testing, includes Applied behavior analysis and Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder	Covered according to the type of benefit and the place where the service is received		

Eligible health services	Designated care coverage	In-network coverage	Out-of-network coverage
Behavioral health and substance-related disorders treatment			
Inpatient hospital (room and board and other miscellaneous hospital services and supplies)	90% (of the negotiated charge) per admission	70% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
Outpatient office visits (includes telemedicine consultations)	100% (of the negotiated charge) per visit No policy year deductible applies	$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	60% (of the recognized charge) per visit
Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program)	100% (of the negotiated charge) per visit No policy year deductible applies	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit

Description	Select care coverage	In-network coverage (IOE facility)	Out-of-network coverage (Includes providers who are otherwise part of Aetna's network but are non-IOE providers)
Transplant services			
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		
The following are not covered under this benefit: • Services and supplies furnished to a donor when the recipient is not a covered person • Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness • Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness			

Eligible health services	Designated care coverage	In-network coverage	Out-of-network coverage
Treatment of infertility			
Basic infertility services - Inpatient and outpatient care	Covered according to the type of benefit and the place where the service is received		
The following are not covered under the infertility treatment benefit: • Injectable infertility medication, including but not limited to menotropins, hCG, and GnRH agonists. • All charges associated with: - Surrogacy for you or the surrogate. A surrogate is a female carrying her own genetically related child where the child is conceived with the intention of turning the child over to be raised by others, including the biological father - Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue - Thawing of cryopreserved (frozen) eggs, embryos or sperm, or reproductive tissue - The care of the donor in a donor egg cycle which includes, but is not limited to, any payments to the donor, donor screening fees, fees for lab tests, and any charges associated with care of the donor required for donor egg retrievals or transfers - The use of a gestational carrier for the female acting as the gestational carrier. A gestational carrier is a female carrying an embryo to which the person is not genetically related - Obtaining sperm for ART services - Home ovulation prediction kits or home pregnancy tests - The purchase of donor embryos, donor oocytes, or donor sperm - Reversal of voluntary sterilizations, including follow-up care • Ovulation induction with menotropins, Intrauterine insemination and any related services, products or procedures • In vitro fertilization (IVF), Zygote intrafallopian transfer (ZIFT), Gamete intrafallopian transfer (GIFT), Cryopreserved embryo transfers and any related services, products or procedures (such as Intracytoplasmic sperm injection (ICSI) or ovum microsurgery)			
Specific therapies and tests			
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	90% (of the negotiated charge)	70% (of the negotiated charge)	60% (of the recognized charge)
Diagnostic lab work performed in a physician's office, the outpatient department of a hospital or other facility	100% (of the negotiated charge) No policy year deductible applies	100% (of the negotiated charge) No policy year deductible applies	60% (of the recognized charge)
Diagnostic radiological services performed in a physician's office, the outpatient department of a hospital or other facility	100% (of the negotiated charge) No policy year deductible applies	100% (of the negotiated charge) No policy year deductible applies	60% (of the recognized charge)
Outpatient Chemotherapy, Radiation & Respiratory Therapy	90% (of the negotiated charge) per visit	70% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

Eligible health services	Designated care coverage	In-network coverage	Out-of-network coverage
Specific therapies and tests (continued)			
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		
The following are not covered under this benefit: • Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan • Enteral nutrition • Blood transfusions and blood products • Dialysis			
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for short-term rehabilitation services and habilitation therapy services	$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	60% (of the recognized charge) per visit
Chiropractic services	$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit	60% (of the recognized charge) per visit
Maximum visits per policy year	24 visits		
Specialty prescription drugs purchased and injected or infused by your provider in an outpatient setting	Covered according to the type of benefit or the place where the service is received		
Other services and supplies			
Emergency ground, air, and water ambulance	90% (of the negotiated charge) per trip	70% (of the negotiated charge) per trip	Paid the same as in-network coverage
The following are not covered under this benefit: • Ambulance services for routine transportation to receive outpatient or inpatient care			
Durable medical and surgical equipment	90% (of the negotiated charge) per item	70% (of the negotiated charge) per item	60% (of the recognized charge) per item
The following are not covered under this benefit: • Whirlpools • Portable whirlpool pumps • Sauna baths • Massage devices • Over bed tables • Elevators • Communication aids • Vision aids • Telephone alert systems • Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician			

Eligible health services	Designated care coverage	In-network coverage	Out-of-network coverage
Other services and supplies (continued)			
Nutritional support	Covered according to the type of benefit or the place where the service is received		
The following are not covered under this benefit: • Any food item, including infant formulas, nutritional supplements, vitamins, plus prescription vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition			
Prosthetic Devices & Orthotics	90% (of the negotiated charge) per item	70% (of the negotiated charge) per item	60% (of the recognized charge) per item
The following are not covered under this benefit: • Services covered under any other benefit • Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace • Trusses, corsets, and other support items • Repair and replacement due to loss, misuse, abuse or theft • Communication aids • Cochlear implants			
Pediatric vision care Limited to covered persons through the end of the month in which the person turns age 19			
Pediatric routine vision exams (including refraction) performed by a legally qualified ophthalmologist or optometrist	Not available	100% (of the negotiated charge) per visit No policy year deductible applies	60% (of the recognized charge) per visit
Maximum visits per policy year Low vision Maximum Fitting of contact Maximum	1 visit One comprehensive low vision evaluation every policy year 1 visit		
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	Not available	100% (of the negotiated charge) per item No policy year deductible applies	60% (of the recognized charge) per item
Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery) ***Refer to Important Note on next page***	One set of eyeglass frames One pair of prescription lenses Daily disposables: up to 3-month supply Extended wear disposable: up to 6-month supply Non-disposable lenses: one set		

Eligible health services	Designated care coverage	In-network coverage	Out-of-network coverage
Pediatric vision care (continued) Limited to covered persons through the end of the month in which the person turns age 19			
Optical devices	Not available	Covered according to the type of benefit and the place where the service is received	
Maximum number of optical devices per policy year	One optical device		
***Important note**: Refer to the Vision care section in the certificate of coverage for the explanation of these vision care supplies. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.			
The following are not covered under this benefit: • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes			
Adult vision care - Limited to covered persons age 19 and over			
Adult routine vision exams (including refraction) performed by a legally qualified ophthalmologist or therapeutic optometrist, or any other providers acting within the scope of their license ***Eye Examinations covered only at Student Health Service-designated facility for one visit annually at a $20 Copayment.***	$20 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	Not covered	
Maximum visits per policy year	1 visit	Not covered	
The following are not covered under this benefit: Adult vision care • Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes Adult vision care services and supplies • Special supplies such as non-prescription sunglasses • Special vision procedures, such as orthoptics or vision therapy • Eye exams during your stay in a hospital or other facility for health care • Eye exams for contact lenses or their fitting • Eyeglasses or duplicate or spare eyeglasses or lenses or frames • Replacement of lenses or frames that are lost or stolen or broken • Acuity tests • Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures • Services to treat errors of refraction			

Outpatient prescription drugs
Copayment waiver for risk reducing breast cancer drugs
The per prescription copayment/coinsurance will not apply to risk reducing breast cancer prescription drugs when obtained at a retail in-network pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.
Copayment waiver for tobacco cessation prescription and over-the-counter drugs
The outpatient prescription drug copayment will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a retail in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%. Your outpatient prescription drug copayment will apply after those two regimens per policy year have been exhausted.
Copayment waiver for contraceptives
The outpatient prescription drug copayment will not apply to female contraceptive methods when obtained at an in-network pharmacy. This means that such contraceptive methods are paid at 100% for: • Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%. • If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug or device for that method paid at 100%. The outpatient prescription drug copayment will continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at an in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.

Eligible health services	Designated care coverage	In-network coverage	Out-of-network coverage
Preferred generic prescription drugs			
For each fill up to a 30-day supply filled at a retail pharmacy	$10 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$20 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$20 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy	Not available	$25 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered

Eligible health services	Designated care coverage	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)			
Preferred brand-name prescription drugs			
For each fill up to a 30-day supply filled at a retail pharmacy	$35 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$45 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$45 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy	Not available	$87.50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
Non-preferred generic prescription drugs			
For each fill up to a 30-day supply filled at a retail pharmacy	$70 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$85 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$85 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy	Not available	$125 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered

Eligible health services	Designated care coverage	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)			
Non-preferred brand-name prescription drugs			
For each fill up to a 30-day supply filled at a retail pharmacy	$70 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$85 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$85 copayment per supply then the plan pays 100% (of the balance of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 90-day supply filled at a mail order pharmacy	Not available	$125 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
Specialty drugs			
For each fill up to a 30-day supply filled at a specialty pharmacy or a retail pharmacy	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$150 copayment per supply then the 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 specialty pharmacy or a retail pharmacy	Not available	$250 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	Not covered
Orally administered anti-cancer prescription drugs 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 negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies

Eligible health services	Designated care coverage	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)			
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	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
Preventive care drugs and supplements maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.		
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	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 USPSTF. For details on the guidelines and the current list of covered risk reducing breast cancer prescription drugs, contact Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.		
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	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 is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.		

Eligible health services	Designated care coverage	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)			
Contraceptives (birth control)			
For each fill up to a 30-day supply of generic and OTC drugs and devices filled at a retail or mail order pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
For each fill up to a 30-day supply of brand name prescription drugs and devices filled at a retail or mail order pharmacy	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above	Paid according to the type of drug per the schedule of benefits, above

If a prescriber prescribes a covered brand-name prescription drug where a generic prescription drug equivalent is available and specifies "Dispense As Written" (DAW), you will pay the cost sharing for the brand-name prescription drug. If a prescriber does not specify DAW and you request a covered brand-name prescription drug where a generic prescription drug equivalent is available, you will be responsible for the cost difference between the brand-name prescription drug and the generic prescription drug, plus the cost sharing that applies to the brand-name prescription drug. The cost difference related to a prescription drug that is not specified as DAW is not applied towards your policy year deductible or maximum out-of-pocket limit.

Outpatient prescription drugs exclusions

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

- Abortion drugs
- Allergy sera and extracts administered via injection
- Any services related to the dispensing, injecting or application of a drug
- Biological sera unless specified on the preferred drug guide
- Compounded prescriptions containing bulk chemicals not approved by the U.S. Food and Drug Administration (FDA) including compounded bioidentical hormones
- Cosmetic drugs including medications and preparations used for cosmetic purposes
- Devices, products and appliances, except those that are specially covered
- Dietary supplements including medical foods
- 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

(continued on next page)

Outpatient prescription drugs exclusions (continued)

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

- Drugs or medications
  - 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
- Duplicative drug therapy (e.g. two antihistamine drugs)
- 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
- Immunizations related to travel or work
- 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
- Infertility
  - Prescription drugs used primarily for the treatment of infertility
- 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

Out of Country claims

Out of Country claims should be submitted with appropriate medical service and payment information from the provider of service. Covered services received outside the United States will be considered at the Out-of-network level of benefits.

General Exclusions

Acupuncture

- Acupuncture
- Acupressure

Alternative health care

- Services and supplies given by a provider for alternative health care. This includes but is not limited to aromatherapy, naturopathic medicine, herbal remedies, homeopathy, energy medicine, Christian faith-healing medicine, Ayurvedic medicine, yoga, hypnotherapy, and traditional Chinese medicine.

Armed forces

- Services and supplies received from a provider as a result of an injury sustained, or illness contracted, while in the service of the armed forces of any country. When you enter the armed forces of any country, we will refund any unearned pro rata premium.

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

Cornea or cartilage transplants
- Cornea (corneal graft with amniotic membrane)
- Cartilage (autologous chondrocyte implant or osteochondral allograft or autograft) transplants

Cosmetic services and plastic surgery
- Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body.

This exclusion does not apply to:
- Surgery after an accidental injury when performed as soon as medically feasible. (Injuries that occur during medical treatments are not considered accidental injuries even if unplanned or unexpected.)
- Coverage that may be provided under the *Eligible health services and exclusions - Gender affirming 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, 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 diseases of the teeth
  - Dental services related to the gums
  - Apicoectomy (dental root resection)
  - Orthodontics
  - Root canal treatment
  - Soft tissue impactions
  - Alveolectomy
  - Augmentation and vestibuloplasty treatment of periodontal disease
  - False teeth
  - Prosthetic restoration of dental implants
  - Dental implants

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

Educational services

Examples of these services are:

- Any service or supply for education, training or retraining services or testing, except where described in the *Eligible health services and exclusions – Diabetic services and supplies (including equipment and training)* section. 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 and exclusions – 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.

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 and precertification requirements* section.

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

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

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

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 disorder 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 and exclusions – Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment* section.

Judgment or settlement

- Services and supplies for the treatment of an injury or illness to the extent that payment is made as a judgment or settlement by any person deemed responsible for the injury or illness (or their insurers)

Mandatory no-fault laws

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

Maintenance care

- Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services. See the *Eligible health services and exclusions – 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 and services

- 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 and exclusions – Preventive care and wellness* section, including preventive services for obesity screening and weight management interventions. This is regardless of the existence of other medical conditions. Examples of these are:
  - Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery
  - Surgical procedures, medical treatments and weight control/loss programs primarily intended to treat, or are related to the treatment of obesity, including morbid obesity
  - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
  - Hypnosis or other forms of therapy
  - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

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

Outpatient prescription or non-prescription drugs and medicines
- Outpatient prescription drugs or non-prescription drugs and medicines provided by the policyholder
- Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan

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

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 and exclusions* section

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

Sexual dysfunction and enhancement
- Any treatment, prescription drug, service, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:
  - Surgery, prescription drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ
  - Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services
- Not eligible for coverage are prescription drugs in 60-day supplies

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
  - Physical performance

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

Telemedicine
- Services given when you are not present at the same time as the provider
- Services including:
  - Telephone calls
  - Telemedicine kiosks
  - Electronic vital signs monitoring or exchanges, (e.g. Tele-ICU, Tele-stroke)

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

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

Voluntary sterilization
- Reversal of voluntary sterilization procedures, including related follow-up care

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.

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

Sanctioned Countries

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

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-866-639-1420.

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 1-866-639-1420.

If you have questions about our nondiscrimination policy or have a discrimination-related concern that you would like to discuss, please call us at 1-866-639-1420.

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 **1-866-639-1420** (TTY: **711**).

Español/Spanish

Atención: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-866-639-1420** (TTY: **711**).

አማርኛ**/Amharic**

ልብ ይበሉ: አማርኛ ቋንቋ የሚናገሩ ከሆነ፥ የትርጉም ድጋፍ ሰጪ ድርጅቶች፣ ያለምንም ክፍያ እርስዎን ለማገልገል ተዘጋጅተዋል። የሚከተለው ቁጥር ላይ ይደውሉ **1-866-639-1420** (መስማት ለተሳናቸው: **711**).

العربية**/Arabic**

ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-866-639-1420** (رقم الهاتف النصي: **711**).

Bàsɔ̀ɔ̀ Wùqù/Bassa

Dè dɛ nìà kɛ dyeɖeˈ gbo: ɔ juˇ keˈ m̀ dyi Bàsɔ̀ɔ̀-wùqù-po-nyɔ̀ juˇ niˈ, nìiˈ à wuqu kà kò qɔ̀ po-poɔ̀ ɓɛ́ m̀ gbo kpaˈa. Ɗaˈ **1-866-639-1420** (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 **1-866-639-1420** (TTY: **711**)。

فارسی**/Farsi**

توجه: اگر به زبان فارسی صحبت می کنید، خدمات زبانی رایگان به شما ارایه میگردد، با شماره **1-866-639-1420** (TTY: **711**) تماس بگیرید.

Français/French

Attention : Si vous parlez français, vous pouvez disposer d'une assistance gratuite dans votre langue en composant le **1-866-639-1420** (TTY: **711**).

ગુજરાતી**/Gujarati**

ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો ભાષાકીય સહાયતા સેવા તમને નિ:શુલ્ક ઉપલબ્ધ છે. કૉલ કરો **1-866-639-1420** (TTY: **711**).

Kreyòl Ayisyen/Haitian Creole

Atansyon: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele **1-866-639-1420** (TTY: **711**).

Igbo

Nrụbama: Ọ bụrụ na ị na asụ Igbo, ọrụ enyemaka asụsụ, n'efu, dịịrị gị. Kpọọ **1-866-639-1420** (TTY: **711**).

한국어/Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스가 무료로 제공됩니다. **1-866-639-1420** (TTY: **711**)번으로 전화해 주십시오.

Português/Portuguese

Atenção: a ajuda está disponível em português por meio do número **1-866-639-1420** (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 **1-866-639-1420** (TTY: **711**).

Tagalog

Paunawa: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-866-639-1420** (TTY: **711**).

اردو/Urdu

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت دستیاب ہیں - **1-866-639-1420** (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 **1-866-639-1420** (TTY: **711**).

Yorùbá/Yoruba

Àkíyèsí: Bí o bá nsọ èdè Yorùbá, ìrànlọ́wọ́ lórí èdè, lófẹ̀ẹ́, wà fún ọ. Pe **1-866-639-1420** (TTY: **711**).

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