Quality health plans & benefits
Healthier living
Financial well-being
Intelligent solutions

Aetna Student Health
Plan Design and Benefits Summary

Academy of Art University

Policy Year: 2017 - 2018
Policy Number: 686162

www.aetnastudenthealth.com
(877) 480-4161

ACADEMY of ART UNIVERSITY
FOUNDED IN SAN FRANCISCO 1929
BY ARTISTS FOR ARTISTS

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

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 Deadline
Fall	8/15/2017	1/5/2018	10/15/2017
Spring	1/6/2018	5/29/2018	3/6/2018
Summer	5/30/2018	8/20/2018	8/20/2018

Rates

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

Rates Undergraduates and Graduate Students			
	Fall Semester	Spring Semester	Summer Semester
Student	$599.04	$599.04	$345.28

Student Coverage

Eligibility

All international students and all domestic athletes taking 6 or more credits, who are enrolled at Academy of Art University and who actively attend classes for at least the first 31 days, after the date when coverage becomes effective.

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.

Enrollment

Eligible students will be automatically enrolled in the Plan.

If you withdraw from school within the first **31 days** of a coverage period, you will not be covered under the Policy and the full premium will be refunded, less any claims paid. After **31 days**, you will be covered for the full period that you have paid the premium for, and no refund will be allowed. (This refund policy will not apply if you withdraw due to a covered Accident or Sickness.)

Medicare Eligibility

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

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

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

Preferred Provider Network

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

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

Pre-certification

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

If you want the insurance Plan to cover a service from a Non- Preferred Provider that requires precertification, you must call Aetna at the number on your ID card. After Aetna receives a request for precertification, we will review the reasons for your planned treatment and determine if benefits are available. You do not need to pre-certify the length of a hospital stay following a mastectomy and lymph node dissections. Your physician will determine the length of a hospital stay following those procedures. You also do not need to pre-certify pregnancy-related hospital stays for the delivery of a baby.

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

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

- Amytal Interview
- Applied Behavior Analysis (ABA)
- Bariatric Surgery
- Biofeedback
- Cardiac Surgeries
- Clinical Trials
- Complex Imaging
- Cosmetic Surgery
- Electric or Motorized Wheelchairs and Scooters
- Gender Reassignment (Sex Change) Treatment
- Genetic Testing
- Home health care related services (ie. private duty nursing including psychiatric home health care services)

- Hyperbaric Oxygen Therapy
- Implants and Trials (cochlear, dental, neurostimulators, cardiac, osseointegrated)
- Infertility Services (except Basic Infertility)
- Inpatient Services: Observation stays greater than 24 hours, inpatient hospital non-surgical, inpatient hospital surgical confinements, maternity confinements which exceed the standard length of stay (LOS)+, newborn confinements which exceed the standard length of stay (LOS)+, rehabilitation facility, skilled nursing facility, hospice stays in a hospital
- Intensive Outpatient Programs (IOP) – (mental disorder and substance abuse diagnoses)
- Kidney Dialysis
- Knee Surgeries
- Lower Limb Prosthetics
- Medical Injectables*
- Non-Emergency Ambulance Services (including fixed wing aircraft)
- Non-Preferred Care at a freestanding ambulatory surgical center
- Non-Preferred Care Providers for non-emergency services, being requested at an network provider benefit level
- Orthognatic Surgery Procedures (bone grafts, osteotomies and surgical management of the temporomandibular joint)
- Outpatient back surgery not performed in a physician's office
- Outpatient Detoxification
- Outpatient Electroconvulsive Therapy (ECT)
- Partial Hospitalization Treatment Programs (PHP) – (mental disorder and substance abuse diagnoses)
- Power Morcellator
- Proton Beam Radiotherapy
- Psychological Testing/Neuropsychological Testing
- Radiation Therapy
- Residential Treatment Facility or Residential Treatment Center admissions
- Sleep Studies
- Transplant services (pre-transplant, evaluation and post-transplant)

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

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

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

Pre-certification of non-emergency admissions

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

Pre-certification of emergency admissions

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

Pre-certification of urgent admissions
Urgent admissions must be requested before you are scheduled to be admitted.

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

Pre-certification of prenatal care and delivery
Pre-natal care medical services must be requested as soon as possible after the attending physician confirms pregnancy.

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

Please see the "Pre-certification" provision in the Master Policy for a list of services under the Plan that may require pre-certification. Please see the Schedule of Benefits for any penalty or benefit reduction that may apply to your coverage when pre-certification is not obtained for the listed services or supplies when received from a non-preferred care provider.

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

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

Metallic Level: Platinum, Tested at 95.84%.

DEDUCTIBLE	Preferred Care and Non-Preferred Care Combined
The policy year deductible is waived for Preferred Care covered medical expenses that apply to Preventive Care Expense benefits. In addition to state and federal requirements for waiver of the policy year deductible, the Insurance Plan will waive the policy year deductible for: Physician or Specialist Office Visit Expense, Consultant Expense, Walk-In Clinic Visit Expense, Outpatient Mental Health Expense, Outpatient Substance Abuse Treatment, Preferred Care Pediatric Dental Services and Preferred and Non Preferred Care Pediatric Vision Benefits. Per visit or admission Deductibles do not apply towards satisfying the Policy Year Deductible. ***Annual Deductible does not apply to these services**	Individual: **$50** per Policy Year

COINSURANCE		
Coinsurance is both the percentage of covered medical expenses that the Insurance Plan pays, and the percentage of covered medical expenses that you pay. The percentage that the Insurance Plan pays is referred to as "plan coinsurance" or the "payment percentage," and varies by the type of expense. Please refer to the Schedule of Benefits for specific information on coinsurance amounts.	Covered Medical Expenses are payable at the Insurance Plan coinsurance percentage specified below, after any applicable Deductible.	
OUT-OF-POCKET MAXIMUMS	**Preferred Care and Non-Preferred Care Combined**	
Once the Individual or Family Out-of-Pocket Limit has been satisfied, Covered Medical Expenses will be payable at 100% for the remainder of the Policy Year. The following expenses do not apply toward meeting the Insurance Plan's out-of-pocket limits: • Non-covered medical expenses; and • Expenses that are not paid or pre-certification benefit reductions or penalties because a required pre-certification for the service(s) or supply was not obtained from Aetna.	Individual Out-of-Pocket: **$2,500** per Policy Year	
INPATIENT HOSPITALIZATION BENEFITS	**Preferred Care**	**Non-Preferred Care**
Room and Board Expense The covered room and board expense does not include any charge in excess of the daily room and board maximum.	After a **$100** Copay per admission, **100%** of the Negotiated Charge	After a **$100** Deductible per admission, **70%** of the Recognized Charge for a semi-private room
Intensive Care The covered room and board expense does not include any charge in excess of the daily room and board maximum.	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
Miscellaneous Hospital Expense Includes but not limited to: operating room, laboratory tests/X rays, oxygen tent, drugs, medicines and dressings.	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
Licensed Nurse Expense Includes charges incurred by a covered person who is confined in a hospital as a resident bed patient and requires the services of a registered nurse or licensed practical nurse.	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
Well Newborn Nursery Care	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
Non-Surgical Physicians Expense Includes hospital charges incurred by a covered person who is confined as an inpatient in a hospital for a surgical procedure for the services of a physician who is not the physician who may have performed surgery on the covered person.	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
SURGICAL EXPENSES	**Preferred Care**	**Non-Preferred Care**
Surgical Expense (Inpatient and Outpatient) When injury or sickness requires two or more surgical procedures which are performed through the same approach, and at the same time or immediate succession, covered medical expenses only include expenses incurred for the most expensive procedure.	**100%** of the Negotiated Charge	**70%** of the Recognized Charge

SURGICAL EXPENSES (continued)	Preferred Care	Non-Preferred Care
Anesthesia Expense (Inpatient and Outpatient) If, in connection with such operation, the covered person requires the services of an anesthetist who is not employed or retained by the hospital in which the operation is performed, the expenses incurred will be Covered Medical Expenses.	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
Assistant Surgeon Expense (Inpatient and Outpatient)	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
OUTPATIENT EXPENSES	**Preferred Care**	**Non-Preferred Care**
Physician or Specialist Office Visit Expense Includes the charges made by the physician or specialist if a covered person requires the services of a physician or specialist in the physician's or specialist's office while not confined as an inpatient in a hospital.	After a **$10** Copay per visit, **100%** of the Negotiated Charge	**70%** of the Recognized Charge
Laboratory and X-ray Expense	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
Hospital Outpatient Department Expense	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
Therapy Expense Covered medical expenses include charges incurred by a covered person for the following types of therapy provided on an outpatient basis: • Radiation therapy including a dental evaluation, x-ray, fluoride treatment and extractions necessary to prepare the jaw for radiation therapy of cancer in the head or neck; • Chemotherapy, including anti-nausea drugs used in conjunction with the chemotherapy; • Radiation therapy including a dental evaluation, x-ray, fluoride treatment and extractions necessary to prepare the jaw for radiation therapy of cancer in the head or neck; • Inhalation therapy; • Infusion therapy; • Kidney dialysis; • Respiratory therapy; • Tests and procedures; and • Expenses incurred at a radiological facility.	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
Pre-Admission Testing Expense Includes charges incurred by a covered person for pre-admission testing charges made by a hospital, surgery center, licensed diagnostic lab facility, or physician, in its own behalf, to test a person while an outpatient before scheduled surgery.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Ambulatory Surgical Expense Covered medical expenses include expenses incurred by a covered person for outpatient surgery performed in an ambulatory surgical center. Covered medical expenses must be incurred on the day of the surgery or within 24 hours after the surgery.	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
Walk-in Clinic Visit Expense	After a **$10** Copay per visit, **100%** of the Negotiated Charge	**70%** of the Recognized Charge

OUTPATIENT EXPENSES (continued)	Preferred Care	Non-Preferred Care
Emergency Room Expense Covered medical expenses incurred by a covered person for services received in the emergency room of a hospital while the covered person is not a full-time inpatient of the hospital. The treatment received must be emergency care for an emergency medical condition. There is no coverage for elective treatment, routine care or care for a non-emergency sickness. As to emergency care incurred for the treatment of an emergency medical condition or psychiatric condition, any referral requirement will not apply & any expenses incurred for non-preferred care will be paid at the same cost-sharing level as if they had been incurred for preferred care. **Important Notice:** A separate hospital emergency room visit benefit deductible or co-pay applies for each visit to an emergency room for emergency care. If a covered person is admitted to a hospital as an inpatient immediately following a visit to an emergency room, the emergency room visit benefit deductible or co-pay is waived. Covered medical expenses that are applied to the emergency room visit benefit deductible or co-pay cannot be applied to any other benefit deductible or co-pay under the Insurance Plan. Likewise, covered medical expenses that are applied to any of the Insurance Plan's other benefit deductibles or co-pays cannot be applied to the emergency room visit benefit deductible or co-pay. Separate benefit deductibles or co-pays may apply for certain services rendered in the emergency room that are not included in the hospital emergency room visit benefit. These benefit deductibles or co-pays may be different from the hospital emergency room visit benefit deductible or co-pay, and will be based on the specific service rendered. Similarly, services rendered in the emergency room that are not included in the hospital emergency room visit benefit may be subject to coinsurance. **Important Note**: Please note that Non-Preferred Care Providers do not have a contract with Aetna. The provider may not accept payment of your cost share (your deductible and coinsurance) as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Insurance Plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. Please send Aetna the bill at the address listed on the back of your member ID card and Aetna will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.	After a **$100** Copay per visit (waived if admitted), **100%** of the Negotiated Charge	After a **$100** Deductible per visit (waived if admitted), **100%** of the Recognized Charge

OUTPATIENT EXPENSES (continued)	Preferred Care	Non-Preferred Care
Durable Medical and Surgical Equipment Expense Durable medical and surgical equipment would include: • Artificial arms and legs; including accessories; • Arm, back, neck braces, leg braces; including attached shoes (but not corrective shoes); • Surgical supports; • Scalp hair prostheses required as the result of hair loss due to injury; sickness; or treatment of sickness; and • Head halters.	**100%** of the Negotiated Charge	**70%** of the Recognized Charge

PREVENTIVE CARE EXPENSES

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

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

PREVENTIVE CARE EXPENSES	Preferred Care	Non-Preferred Care
Routine Physical Exam Includes routine vision & hearing screenings given as part of the routine physical exam.	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Preventive Care Immunizations	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Well Woman Preventive Visits Routine well woman preventive exam office visit, including Pap smears.	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Sexually Transmitted Infections Includes the counseling services to help a covered person prevent or reduce sexually transmitted infections.	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Obesity and/or Healthy Diet Screening and counseling services to aid in weight reduction due to obesity. Coverage includes: • Preventive counseling visits and/or risk factor reduction intervention; • Nutritional counseling; and • Healthy diet counseling visits provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Misuse of Alcohol and/or Drugs Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge

PREVENTIVE CARE EXPENSES (continued)	Preferred Care	Non-Preferred Care
Preventive Care Screening and Counseling Services for Use of Tobacco Products Screening and counseling services to aid a covered person to stop the use of tobacco products. Coverage includes: • Preventive counseling visits; • Treatment visits; and • Class visits; to aid a covered person to stop the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: • Cigarettes; • Cigars; • Smoking tobacco; • Snuff; • Smokeless tobacco; and • Candy-like products that contain tobacco.	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Depression Screening Screening or test to determine if depression is present.	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Preventive Care Routine Cancer Screenings Covered expenses include but are not limited to: Pap smears; Mammograms; Fecal occult blood tests; Digital rectal exams; Prostate specific antigen (PSA) tests; Sigmoidoscopies; Double contrast barium enemas (DCBE); Colonoscopies (includes: Bowel preparation medications, Anesthesia, Removal of polyps performed during a screening procedure, Pathology exam on any removed polyps); and Lung cancer screenings.	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Preventive Care Screening and Counseling Services for Genetic Risk for Breast and Ovarian Cancer Covered medical expenses include the counseling and evaluation services to help assess a covered person's risk of breast and ovarian cancer susceptibility.	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Preventive Care Prenatal Care Coverage for prenatal care under this Preventive Care Expense benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, fetal heart rate check, and fundal height). Refer to the Maternity Expense benefit for more information on coverage for maternity expenses under the Policy, including other prenatal care, delivery and postnatal care office visits.	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge

PREVENTTIVE CARE EXPENSES (continued)	Preferred Care	Non-Preferred Care
Preventive Care Lactation Counseling Services Lactation support and lactation counseling services are covered medical expenses when provided in either a group or individual setting.	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Preventive Care Breast Pumps and Supplies	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Preventive Care Female Contraceptive Counseling Services, Preventive Care Female Contraceptive Generic, Brand Name, Biosimilar Prescription Drugs and Devices provided, administered, or removed, by a Physician during an Office Visit, Preventive Care Female Voluntary Sterilization (Inpatient), Preventive Care Female Voluntary Sterilization (Outpatient) Includes counseling services on contraceptive methods provided by a physician, obstetrician or gynecologist. Such counseling services are covered medical expenses when provided in either a group or individual setting. **Voluntary Sterilization** Includes charges billed separately by the provider for female voluntary sterilization procedures & related services & supplies including, but not limited to, tubal ligation and sterilization implants. Covered medical expenses under this benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement. **Contraceptives** can be paid either under this benefit or the prescribed medicines expense depending on the type of expense and how and where the expense is incurred. Benefits are paid under this benefit for female contraceptive prescription drugs and devices (including any related services and supplies) when they are provided, administered, or removed, by a physician during an office visit.	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
OTHER FAMILY PLANNING SERVICES EXPENSE	**Preferred Care**	**Non-Preferred Care**
Voluntary Sterilization for Males (Outpatient), Reversal of Voluntary Sterilization for Males and Females (Inpatient), Reversal of Voluntary Sterilization for Males and Females (Outpatient) Covered medical expenses include charges for certain family planning services, even though not provided to treat a sickness or injury as follows. • Voluntary sterilization for males; and • Reversal of voluntary sterilization for males and females, including related follow-up care.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Voluntary Termination of Pregnancy (Outpatient)	**100%** of the Negotiated Charge	**70%** of the Recognized Charge

AMBULANCE EXPENSE	Preferred Care	Non-Preferred Care
Ground, Air, Water and Non-Emergency Ambulance Includes charges incurred by a covered person for the use of a professional ambulance in an emergency. Covered medical expenses for the service are limited to charges for ground transportation to the nearest hospital equipped to render treatment for the condition. Air transportation is covered only when medically necessary.	**100%** of the Negotiated Charge	**100%** of the Recognized Charge
ADDITIONAL BENEFITS	**Preferred Care**	**Non-Preferred Care**
Allergy Testing and Treatment Expense Includes charges incurred by a covered person for diagnostic testing and treatment of allergies and immunology services.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Diagnostic Testing For Learning Disabilities Expense Covered medical expenses include charges incurred by a covered person for diagnostic testing for: • Attention deficit disorder; or • Attention deficit hyperactive disorder.	Payable in accordance with the type of expense incurred and the place where service is provided.	
High Cost Procedures Expense Includes charges incurred by a covered person as a result of certain high cost procedures provided on an outpatient basis. Covered medical expenses for high cost procedures include; but are not limited to; charges for the following procedures and services: • Computerized Axial Tomography (C.A.T.) scans; • Magnetic Resonance Imaging (MRI); and • Positron Emission Tomography (PET) Scans.	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
Urgent Care Expense	After a **$10** Copay per visit, **100%** of the Negotiated Charge	**70%** of the Recognized Charge
Dental Expense for Impacted Wisdom Teeth Includes charges incurred by a covered person for services of a dentist or dental surgeon for removal of one or more impacted wisdom teeth. Not more than the Maximum Benefit will be paid. Includes expenses for the treatment of: the mouth; teeth; and jaws; but only those for services rendered and supplies needed for the following treatment of; or related to conditions; of the: • mouth; jaws; jaw joints; or • supporting tissues; (this includes: bones; muscles; and nerves).	**100%** of the Negotiated Charge	**100%** of the Recognized Charge
Accidental Injury to Sound Natural Teeth Expense Covered medical expenses include charges incurred by a covered person for services of a dentist or dental surgeon as a result of an injury to sound natural teeth.	**100%** of the Negotiated Charge	**100%** of the Recognized Charge
Non-Elective Second Surgical Opinion Expense	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Consultant Expense Includes the charges incurred by covered person in connection with the services of a consultant. The services must be requested by the attending physician to confirm or determine a diagnosis. Coverage may be extended to include treatment by the consultant.	After a **$10** Copay per visit, **100%** of the Negotiated Charge	**70%** of the Recognized Charge
Skilled Nursing Facility Expense	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
Rehabilitation Facility Expense Includes charges incurred by a covered person for confinement as a full time inpatient in a rehabilitation facility.	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
Home Health Care Expense Covered medical expenses **will not** include: • Services by a person who resides in the covered person's home, or is a member of the covered person's immediate family • Homemaker or housekeeper services; • Maintenance therapy; • Dialysis treatment; • Purchase or rental of dialysis equipment; • Food or home delivered services; or • Custodial care.	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
Temporomandibular Joint Dysfunction Expense Covered medical expenses include physician's charges incurred by a covered person for non-surgical treatment of Temporomandibular Joint (TMJ) Dysfunction.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Dermatological Expense Includes physician's charges incurred by a covered person for the diagnosis and treatment of skin disorders. Related laboratory expenses are covered under the Lab and X-ray Expense benefit. Unless specified above, not covered under this benefit are charges incurred for: • Cosmetic treatment and procedures; and Laboratory fees.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Prosthetic and Orthotic Devices Expense Includes charges made for internal and external prosthetic devices and special appliances, if the device or appliance improves or restores body part function that has been lost or damaged by sickness, injury or congenital defect. The Insurance Plan covers the first prosthesis a covered person need that temporarily or permanently replaces all or part of an body part lost or impaired as a result of sickness or injury or congenital defects as described in the list of covered devices below for an: • Internal body part or organ; or • External body part.	**100%** of the Negotiated Charge	**70%** of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Prosthetic and Orthotic Devices Expense (continued) **Limitations** Unless specified above, not covered under this benefit are charges for: • Eye exams; • Eyeglasses; • Vision aids; • Hearing aids; • Communication aids.	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
Podiatric Expense Includes charges incurred by a covered person for podiatric services; provided on an outpatient basis following an injury. Unless specified above, not covered under this benefit are charges incurred for routine foot care, such as trimming of corns, calluses, and nails.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Hypodermic Needles Expense Includes expenses incurred by a covered person for hypodermic needles and syringes.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Maternity Expense Covered Medical Expenses for pregnancy, childbirth, and complications of pregnancy are payable on the same basis as any other Sickness. In the event of an inpatient confinement, such benefits would be payable for inpatient care of the Covered Person, and any newborn child, for a minimum of 48 hours after a vaginal delivery and for a minimum of 96 hours after a cesarean delivery. Any decision to shorten such minimum coverages shall be made by the attending Physician in consultation with the mother and done in accordance with the rules and regulations promulgated by State Mandate. Covered medical expenses may include home visits, parent education, and assistance and training in breast or bottle-feeding.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Non-Prescription Enteral Formula Expense Includes charges incurred by a covered person, for non-prescription enteral formulas for which a physician has issued a written order, and are for the treatment of malabsorption caused by: • Crohn's Disease; • Ulcerative colitis; • Gastroesophageal reflux; • Gastrointestinal motility; • Chronic intestinal pseudo obstruction; and • Inherited diseases of amino acids and organic acids. Covered medical expenses for inherited diseases of amino acids; and organic acids; will also include food products modified to be low protein.	**100%** of the Negotiated Charge	**70%** of the Recognized Charge

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Vision Care Exam Expense **Routine Eye Exam Expenses**: Charges for a complete eye exam that includes refraction. A routine eye exam does not include charges for a contact lens exam. **Contact Lens Exam Expenses**: Charges for an eye exam performed for the sole purpose of the fitting of contact lenses. Covered medical expenses will not include charges for more than one routine eye exam and one contact lens exam (if covered) per policy year.	After a **$10** Copay per visit, **100%** of the Negotiated Charge	**70%** of the Recognized Charge
Acupuncture Expense Includes charges incurred by a covered person for acupuncture therapy.	After a **$10** Copay per visit, **100%** of the Negotiated Charge	**70%** of the Recognized Charge
Transfusion or Kidney Dialysis of Blood Expense Includes charges incurred by a covered person for the transfusion or kidney dialysis of blood, including the cost of: Whole blood; blood components; and the administration of whole blood and blood components.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Hospice Expense	After a **$10** Copay per visit, **100%** of the Negotiated Charge	**70%** of the Recognized Charge
Blood and Body Fluid Exposure/ Needle Stick Coverage Expense Limited to those charges related to a clinical related injury. Any expense related to the treatment of any sickness resulting from a clinical related injury is not covered under this benefit. Incidents include, but are not limited to needle sticks, unprotected exposure to blood and body fluid, and unprotected exposure to highly contagious pathogens.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Diabetes Benefit Expense Includes charges for services, supplies, equipment, & training for the treatment of insulin and non-insulin dependent diabetes &elevated blood glucose levels during pregnancy. Self-management training provided by a licensed health care provider certified in diabetes self-management training.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Reconstructive Breast Surgery Expense Covered medical expenses include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Reconstructive or Cosmetic Surgery and Supplies Expense Covered medical expenses include surgery performed on a covered person to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or a medical condition.	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
AIDS Vaccine Services Expense Covered medical expenses include charges for a vaccine for acquired immune deficiency syndrome (AIDS) that is approved for marketing by the U.S. Food and Drug Administration and that is recommended by the United States Public Health Service.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Telemedicine Expense Covered medical expenses include charges made by a physician or facility for services delivered through a two-way video communication that allows a health care provider to interact with a patient who is at an originating site.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Dialysis Care Expense Covered medical expenses include charges made on an inpatient and outpatient basis for acute and chronic dialysis services	Payable in accordance with the type of expense incurred and the place where service is provided.	
Aniridia Expense Covered medical expenses include coverage for the treatment of aniridia including related eye exams and contact lenses.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Anesthesia and Associated Charges for Certain Dental Care Services Expense Covered medical expenses include charges made for general anesthesia and associated hospital, surgery center or other licensed facility charges in connection with oral surgery.	Payable in accordance with the type of expense incurred and the place where service is provided.	
California Prenatal Screening Program **C**overed medical expenses include a covered person's participation in the Expanded Alpha Feto Protein (AFP) program, which is a statewide prenatal testing program administered by the California State Department of Health Services.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Diethylstilbestrol (DES) Treatment Expense Covered medical expenses include coverage for the treatment of conditions attributable to, or exposure to, diethylstilbestrol.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Nutritional Supplements Expense Covered medical expenses include charges incurred for nutritional supplements (formulas) as needed for the therapeutic treatment of branched-chain ketonuria, galactosemia and homocystinuria as administered under the direction of a physician.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Osteoporosis Services Expense Covered medical expenses include charges for services and supplies related to the diagnosis, treatment, and appropriate management of osteoporosis. The services include all U. S. Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed medically appropriate.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Genetic Testing Expense Covered medical expenses include genetic testing to establish a molecular diagnosis of an inheritable disease.	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Basic Infertility Expense Covered medical expenses include charges made by a physician to diagnose and to surgically treat the underlying medical cause of infertility.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Bariatric Surgery Expense Covered medical expenses for the treatment of morbid obesity include one bariatric surgical procedure including related outpatient services, within a two-year period, beginning with the date of the first bariatric surgical procedure, unless a multi-stage procedure is planned. The insurance plan will reimburse a covered person for some of the cost of their travel and lodging expenses.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Clinical Trials Expense (Experimental or Investigational Treatment) Includes charges made by a provider for experimental or investigational drugs, devices, treatments or procedures “under an approved clinical trial” only when a covered person has cancer or a terminal illness.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Clinical Trials Expense Routine Patient Costs Covered Percentage Includes charges made by a provider for "routine patient costs" furnished in connection with a covered person’s participation in an "approved clinical trial” for cancer or other life-threatening disease or condition, as those terms are defined in the federal Public Health Service Act, Section 2709.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Gender Reassignment (Sex Change) Treatment Expense Includes charges made in connection with a medically necessary gender reassignment surgery (sometimes called sex change surgery) as long the covered student has obtained pre-certification from Aetna. Covered medical expenses include: • Charges made by a physician for: - Performing the surgical procedure; and - Pre-operative and post-operative hospital and office visits. • Charges made by a hospital for inpatient and outpatient services (including outpatient surgery). • Charges made by a Skilled Nursing Facility for inpatient services and supplies. • Charges made for the administration of anesthetics. • Charges for outpatient diagnostic laboratory and x-rays. • Charges for blood transfusion and the cost of unreplaced blood and blood products. • Charges made by a behavioral health provider for gender reassignment counseling. No benefits will be paid for covered medical expenses under this benefit unless they have been pre-certified by Aetna. Refer to the Pre-certification section for more information.	Payable in accordance with the type of expense incurred and the place where service is provided.	

ADDITIONAL BENEFITS (continued)	Preferred Care	Non-Preferred Care
Chiropractic Treatment Expense Includes charges made by a physician on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
SHORT-TERM CARDIAC AND PULOMONARY REHABILIATION THERAPY SERVICES EXPENSE Inpatient rehabilitation benefits for the services listed will be paid as part of the Hospital Expense and Skilled Nursing Facility Expense benefits. **Cardiac Rehabilitation Benefits** Cardiac rehabilitation benefits received at a hospital, skilled nursing facility, or physician's office. This Insurance Plan will cover charges in accordance with a treatment plan as determined by a covered person's risk level when recommended by a physician. **Pulmonary Rehabilitation Benefits** Pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states.		
Cardiac Rehabilitation	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
Pulmonary Rehabilitation	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
SHORT-TERM REHABILITATION EXPENSE Includes charges for short-term rehabilitation services, as described below, when prescribed by a physician. Short-term rehabilitation services must follow a specific treatment plan that: • Details the treatment, and specifies frequency and duration; • Provides for ongoing reviews and is renewed only if continued therapy is appropriate; and • Allows therapy services, provided in a covered person's home, if the covered person is homebound. Inpatient rehabilitation benefits for the services listed will be paid as part of the inpatient hospital and skilled nursing facility benefits.		
Short-Term Rehabilitation Expense **Outpatient Physical, Occupational and Speech Rehabilitation and Habilitation Therapy Services (combined)**	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
HEARING AIDS	**Preferred Care**	**Non-Preferred Care**
Cochlear Implants	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
TREATMENT OF MENTAL DISORDER EXPENSE	**Preferred Care**	**Non-Preferred Care**
Inpatient Mental Health Expense & Residential Mental Health Treatment Facility Expense Covered medical expenses include charges made by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider for the treatment of mental disorders for Inpatient room and board at the semi-private room rate, and other services and supplies related to a covered person's condition that are provided during a covered person's stay in a hospital, psychiatric hospital, or residential treatment facility.	After a **$100** Copay per admission, **100%** of the Negotiated Charge	After a **$100** Deductible per admission, **70%** of the Recognized Charge

TREATMENT OF MENTAL DISORDER EXPENSE (continued)	Preferred Care	Non-Preferred Care
Inpatient Mental Health Physician Services per Admission Expense	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
Outpatient Mental Health Expense	After a **$10** Copay per visit, **100%** of the Negotiated Charge	**70%** of the Recognized Charge
Outpatient Mental Health Partial Hospitalization Expense	After a **$100** Copay per admission, **100%** of the Negotiated Charge	After a **$100** Deductible per admission, **70%** of the Recognized Charge
Residential Mental Health Treatment Facility Expense	After a **$100** Copay per admission, **100%** of the Negotiated Charge	After a **$100** Deductible per admission, **70%** of the Recognized Charge
ALCOHOLISM AND DRUG ADDICTION TREATMENT	**Preferred Care**	**Non-Preferred Care**
Inpatient Substance Abuse Treatment Covered medical expenses include charges made by a hospital, psychiatric hospital, residential treatment facility, physician or behavioral health provider for the treatment of mental disorders for Inpatient room and board at the semi-private room rate, and other services and supplies related to a covered person's condition that are provided during a covered person's stay in a hospital, psychiatric hospital, or residential treatment facility.	After a **$100** Copay per admission, **100%** of the Negotiated Charge	After a **$100** Deductible per admission, **70%** of the Recognized Charge
Inpatient Substance Abuse Physician Services per Admission Expense	**100%** of the Negotiated Charge	**70%** of the Recognized Charge
Outpatient Substance Abuse Treatment	After a **$10** Copay per visit, **100%** of the Negotiated Charge	**70%** of the Recognized Charge
TRANSPLANT SERVICE EXPENSE	**Preferred Care**	**Non-Preferred Care**
Transplant Services Expense Benefits may vary if an Institute of Excellence™ (IOE) facility or non-IOE or non-preferred care provider is used. Through the IOE network, the covered person will have access to a provider network that specializes in transplants. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure the covered person requires. Each facility in the IOE network has been selected to perform only certain types of transplants, based on quality of care and successful clinical outcomes.	Payable in accordance with the type of expense incurred and the place where service is provided.	
Transplant Travel and Lodging Expense The Insurance Plan will reimburse a covered person for some of the cost of their travel and lodging expenses.	**$50** per night Maximum Benefit for Lodging Expenses per IOE patient & **$50** per night Maximum Benefit for Lodging Expenses per companion up to **$10,000** per transplant.	

PEDIATRIC DENTAL SERVICES EXPENSE (Coverage is limited to covered persons until the end of the month in which the covered person turns 19.)	**Preferred Care**	**Non-Preferred Care**
Type A Expense (Pediatric Routine Dental Exam Expense) Benefits limited to **2** visits per policy year.	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge
Type B Expense (**Pediatric Basic Dental Care Expense)**	**70%** of the Negotiated Charge*	**50%** of the Recognized Charge
Type C Expense (**Pediatric Major Dental Care Expense)**	**50%** of the Negotiated Charge*	**50%** of the Recognized Charge
Pediatric Orthodontia Expense Orthodontics-Medically necessary comprehensive treatment Replacement of retainer (limit one per lifetime).	**50%** of the Negotiated Charge*	**50%** of the Recognized Charge
PEDIATRIC ROUTINE VISION (Coverage is limited to covered persons until the end of the month in which the covered person turns 19.)	**Preferred Care**	**Non-Preferred Care**
Pediatric Routine Vision Exams (including refractions) Includes charges made by a legally qualified ophthalmologist or optometrist for a routine vision exam. The exam will include refraction & glaucoma testing. Benefits limited to **one** visit per policy year.	**100%** of the Negotiated Charge*	**70%** of the Recognized Charge*
Pediatric Visit for the fitting of prescription contact lenses, Pediatric Eyeglass Frames, Prescription Lenses or Prescription Contact Lenses Includes charges for the following vision care services and supplies: • Office visits to an ophthalmologist, optometrist or optician related to the fitting of prescription contact lenses. • Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a preferred care provider. • Eyeglass frames, prescription lenses or prescription contact lenses provided by a vision provider who is a non-preferred care provider. Coverage includes charges incurred for: • Non-conventional prescription contact lenses that are required to correct visual acuity to 20/40 or better in the better eye and that correction cannot be obtained with conventional lenses. • Aphakic prescription lenses prescribed after cataract surgery has been performed. As to coverage for prescription lenses in a policy year, this benefit will cover either prescription lenses for eyeglass frames or prescription contact lenses, but not both.	**100%** of the Negotiated Charge *	**70%** of the Recognized Charge *

Breast Cancer:

This insurance Plan provides coverage for the screening, diagnosis, and treatment of breast cancer.

PRESCRIBED MEDICINES EXPENSE

COVERED PERCENTAGE*	Preferred Care	Non-Preferred Care
Preventive Care Drugs and Supplements Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force.		
Risk Reducing Breast Cancer Prescription Drugs For each **30**-day supply filled at a retail pharmacy.	Refer to the Co-pay and Deductible Waiver Provision later in this Schedule of Benefits.	**100%** of the Recognized Charge
Tobacco Cessation Prescription Drugs and Over-the-Counter Drugs. For two **90**-day treatment regimens only)	**100%** per supply	**100%** of the Recognized Charge
Other preventive care drugs and supplements For each **30**-day supply filled at a retail pharmacy.	**100%** per supply	**100%** of the Recognized Charge
CONTRACEPTIVES	**Preferred Care**	**Non-Preferred Care**
FDA-Approved Female Generic Over-the-Counter Contraceptives (Non-Emergency) For each **30**-day Supply	**100%** per supply	**100%** of the Recognized Charge
FDA-Approved Female Generic Emergency Contraceptives	Refer to the Co-pay and Deductible Waiver Provision later in this Schedule of Benefits.	**100%** of the Recognized Charge
ALL OTHER PRESCRIPTION DRUGS	**Preferred Care**	**Non-Preferred Care**
For each **30**-day supply filled at a retail pharmacy.	**100%** of the Negotiated Charge	**100%** of the Recognized Charge

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

PRESCRIPTION DRUG CO-PAY	Preferred Care	Non-Preferred Care
Generic Prescription Drugs For each **30**-day supply filled at a retail pharmacy.	**$10** Co-pay per supply	**$10** Deductible per supply
Preferred Brand-Name Prescription Drugs For each **30**-day supply filled at a retail pharmacy.	**$20** Co-pay per supply	**$20** Deductible per supply
Non-Preferred Brand-Name Prescription Drugs For each **30**-day supply filled at a retail pharmacy.	**$40** Co-pay per supply	**$40** Deductible per supply
Orally Administered Anti-Cancer Prescription Drugs (including Chemotherapy Drugs)	Payable on the same basis as covered cancer chemotherapy medications that are administered intravenously or by injection.	

A covered person, a covered person's designee or a covered person's prescriber may seek an expedited medical exception process to obtain coverage for non-covered drugs in exigent circumstances. An "exigent circumstance" exists when a covered person is suffering from a health condition that may seriously jeopardize a covered person's life, health, or ability to regain maximum function or when a covered person is undergoing a current course of treatment using a non-formulary drug.

The request for an expedited review of an exigent circumstance may be submitted by contacting Aetna's Pre-certification Department at **1-855-240-0535**, faxing the request to **1-877-269-9916** or submitting the request in writing to:

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

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

Co-pay and Deductible Waiver

Waiver for Risk-Reducing Breast Cancer Prescription Drugs

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

Waiver for Prescription Drug Contraceptives

The per prescription co-pay/deductible and policy year deductible will not apply to:

- Female contraceptives that are:
  - Oral prescription drugs that are generic prescription drugs.
  - Injectable prescription drugs that are generic prescription drugs.
  - Vaginal ring prescription drugs that are generic prescription drugs, brand-name prescription drugs and biosimilar prescription drugs.
  - Transdermal contraceptive patch prescription drugs that are generic prescription drugs, brand-name prescription drugs, and biosimilar prescription drugs.
- Female contraceptive devices.
- FDA-approved female:
  - generic emergency contraceptives; and
  - generic over-the-counter (OTC) emergency contraceptives.
  - when obtained at a preferred care pharmacy. This means that such contraceptive methods will be paid at 100%.
  - The per prescription co-pay/deductible and policy year deductible continue to apply:
- When the contraceptive methods listed above are obtained at a non-preferred pharmacy.
- To female contraceptives that are:
  - Oral prescription drugs that are brand-name prescription drugs and biosimilar prescription drugs.
  - Injectable prescription drugs that are brand-name prescription drugs and biosimilar prescription drugs.
- To female contraceptive devices that are brand-name devices.
- To FDA-approved female:
  - brand-name and biosimilar emergency contraceptives; and

- brand-name over-the-counter (OTC) emergency contraceptives.

- To FDA-approved female brand-name over-the-counter (OTC) contraceptives.
- To FDA-approved male brand-name over-the-counter (OTC) contraceptives.

However, the per prescription co-pay/deductible and policy year deductible will not apply to such contraceptive methods if:

- A generic equivalent, biosimilar or generic alternative, within the same therapeutic drug class is not available; or
- A covered person is granted a medical exception; or
- A physician specifies “Dispense as Written” (DAW).

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

Exclusions

This Insurance Plan does not cover nor provide benefits for:

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

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

3. Expense for which benefits are paid under any Workers' Compensation or Occupational Disease Law.

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

5. Expense incurred for treatment provided in a governmental hospital unless there is a legal or regulatory obligation to pay such charges in the absence of insurance.

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

7. Expense incurred for cosmetic surgery, reconstructive surgery, or other services and supplies which improve, alter, or enhance appearance whether or not for psychological or emotional reasons, except to the extent needed to:
   - Improve the function of a part of the body that is not a tooth or structure that supports the teeth and is malformed as a result of a severe birth defect, including cleft lip/cleft palate, webbed fingers or toes, or as direct result of disease or surgery performed to treat a disease or injury.

8. Expense paid by any other valid and collectible medical, health or accident insurance.

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

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

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

12. Expense for injury to the extent first party medical benefits are paid under any state no-fault automobile coverage or any other mandatory No-fault law.

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

14. Expense incurred for custodial care, including assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine). This exclusion does not apply to assistance with activities of daily living that is provided as part of covered hospice, skilled nursing facility, home health care, or inpatient hospital care.

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

16. Expense incurred for, or in connection with, drugs, devices, procedures, or treatments that are experimental or investigational except as specifically covered under the Policy.

17. Expenses incurred for breast reduction/mammoplasty except when medically necessary.

18. Expenses incurred for any sinus surgery, except for acute purulent sinusitis.

19. Expenses incurred for care, treatment, services, or supplies for or related to obstructive sleep apnea and sleep disorders including CPAP and UPP.

20. Expense incurred by a covered person not a United States citizen for services performed within the covered person’s home country if the covered person’s home country has a socialized medicine program.

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

22. Expense for: (a) care of flat feet; (b) supportive devices for the foot; (c) care of corns, bunions, or calluses; (d) care of toenails; and (e) care of fallen arches, weak feet or chronic foot strain. This exclusion will not apply to the extent required for the treatment of, or to prevent, complications of diabetes or the covered person suffers from circulatory problems.

23. Expense paid under other valid and collectible automobile medical payment insurance; whether or not claim is made for such benefits. The Policy will only pay for those losses which are not paid under the automobile medical payment insurance Policy.

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

25. Expense for telephone consultations (except Telemedicine Services), charges for failure to keep a scheduled visit, or charges for completion of a claim form.

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

27. Expense for services or supplies provided for the treatment of obesity and/or weight control except as specifically covered under the Policy. Not covered is any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity including but not limited to:
    - Liposuction;
    - Stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications unless a prescription drug is needed for the treatment of morbid obesity;
    - Counseling, coaching, training, hypnosis, or other forms of therapy; and
    - Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy, or other forms of activity or activity enhancement.

28. Expense for incidental surgeries and standby charges of a physician.

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

30. Expenses incurred for massage therapy.

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

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

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

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

35. Expenses incurred for vision-related services and supplies for covered persons ages 19 and older, except as specifically covered in the Policy.

36. Expense incurred for private duty nursing services during a stay in a hospital, and outpatient private duty nursing services. Skilled nursing services are covered as specifically described in the Policy in connection with
    - Home Health Care and Hospice basic health care services; and
    - Skilled Nursing Facility Care.

37. Expense incurred in a facility for care, services or supplies provided in:
    - Rest homes;
    - Assisted living facilities;
    - Similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
    - Health resorts;
    - Spas, sanitariums;
    - Infirmaries at schools, colleges or camps; and
    - Wilderness Treatment Programs or any such related or similar program, school and/or education service.

38. Expense incurred for early intensive behavioral interventions (including Applied Behavior Analysis, Denver, LEAP, TEACHH, Rutgers, floor time and similar programs) except as specifically covered in the Policy.

39. Expense incurred for applied behavioral analysis unless it is medically necessary for the treatment of autism spectrum disorders, severe mental illnesses, or serious emotional disturbance of a child.

40. 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).

41. Expense incurred for contraception except as specifically covered in the Policy.

42. Expense incurred for disposable outpatient supplies (except as specifically covered in the Policy.). Any outpatient disposable supply or device, including but not limited to sheaths, bags, elastic garments, support hose, bandages, bedpans, blood or urine testing supplies, and other home test kits and splints, neck braces, compresses, and other devices not intended for reuse by another patient. This exclusion does not apply to self-injectable outpatient prescription drugs that are not dispensed in pre-filled syringes, spacers and inhalers for the administration of aerosol outpatient prescription drugs, diabetic lancets and insulin syringes, ostomy and

urological supplies, tracheostomy equipment and respiratory drug-delivery devices. Syringes for self-injectable outpatient prescription drugs that are not dispensed in pre-filled syringes are covered under this insurance plan.

43. Expense incurred for drugs, medications and supplies, except as specifically covered in the Policy. Not covered are:
    - A prescription drug purchased illegally outside the United States, even if otherwise covered under this insurance plan within the United States;
    - Immunizations related to work;
    - Needles, lancets, and other injectable aids, except as needed or covered for diabetic supplies, and for a covered drug;
    - Drugs related to the treatment of non-covered medical expenses;
    - Performance enhancing steroids;
    - Implantable drugs and associated devices;
    - Injectable drugs if an alternative oral drug is available, unless medically necessary per your physician; and
    - Any expenses for prescription drugs, and supplies covered under the Pharmacy Plan will not be covered under this medical expense plan. Prescription drug exclusions that apply to the Aetna Pharmacy plan will apply to the medical expense coverage.

44. Expense incurred for educational services:
    - Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
    - Services eligible under the Individuals with Disabilities in Education Act (IDEA).

45. Expenses incurred for any food item, including infant formulas, nutritional supplements, vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition. . Please Note: This exclusion will not apply to enteral and parenteral nutrition or FDA approved OTC drugs required by the USPSTF A&B recommendations list (e.g. aspirin, vitamin D, folic acid, and iron supplements) when prescribed by a physician.

46. Expense incurred in relation to genetics: Except as specifically covered in the Policy, the insurance plan does not cover any treatment, device, drug, service or supply to alter the body's genes, genetic make-up, or the expression of the body's genes except for the correction of congenital birth defects.

47. Expense incurred for any treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth, including surgical procedures, devices to stimulate growth, and growth hormones except as specifically covered in the Policy.

48. Expense incurred for outpatient cognitive therapy, physical therapy, and occupational therapy, except as specifically covered in the Policy. Not covered under the Policy are charges for:
    - Educational services;
    - Any services unless provided in accordance with a specific treatment plan;
    - Any services which are covered medical expenses in whole or in part under any other group plan sponsored by an employer;
    - Services provided during a stay in a hospital, skilled nursing facility or hospice facility except as specifically covered in the Policy;

- Services provided by a home health care agency;
- Services provided by a physician or treatment covered as part of Chiropractic Treatment. This applies whether or not benefits have been paid under the Chiropractic Treatment benefit;
- Services not performed by a physician, occupational or physical therapist or under the direct supervision of a physician;
- Services provided by a physician or physical or occupational therapist who resides in your home; or who is a member of your family, or a member of your spouse's or your domestic partner's family; and
- Special education to instruct a person to function. This includes lessons in sign language.

49. Expense incurred for outpatient speech therapy. Except as specifically covered in the Policy, not covered are charges for:
    - Any services unless provided in accordance with a specific treatment plan;
    - Services provided during a stay in a hospital, skilled nursing facility or hospice facility except as specifically covered in the Policy;
    - Services provided by a home health care agency;
    - Services not performed by a physician, or speech therapist or under the direct supervision of a physician;
    - Services provided by a physician or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's or your domestic partner's family; and
    - Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

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

- Sleep therapy;
- Thermograms and thermography.

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

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

52. Expenses incurred for 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 covered in the Policy. Facings on molar crowns and pontics will always be considered cosmetic.

53. Expenses incurred for crown, inlays and 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.

54. Expenses incurred for dental examinations that are:
    - Required by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
    - Required by any law of a government, securing insurance or school admissions, or professional or other licenses;
    - Required to travel, attend a school, camp, or sporting event or participate in a sport or other recreational activity; and
    - Any special medical reports not directly related to treatment except when provided as part of a covered service.

55. Expenses incurred for braces (orthodontics), mouth guards, and other devices to protect, replace, or reposition teeth that are not medically necessary.

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

57. Expenses incurred for dentures, crowns, inlays, onlays, bridges, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, abfraction or erosion.

58. Expenses incurred for general anesthesia and intravenous sedation, except as specifically covered in the Policy and only when done in connection with another medically necessary covered service or supply.

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

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

61. Expenses incurred for pontics, crowns, cast or processed restorations made with gold.

62. Expenses incurred for prescribed drugs or pre-medication.

63. Expenses incurred for 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.

64. Expenses incurred for replacement of teeth beyond the normal complement of 32.

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

66. Expenses incurred for space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth.

67. Expenses incurred for the surgical removal of impacted wisdom teeth only for orthodontic reasons except as medically necessary.

68. Expenses incurred for treatment by other than a dentist or dental provider that is licensed to furnish dental services or supplies.

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

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

IMPORTANT NOTICES:

Sanctioned Countries:
If coverage provided by this policy violates or will violate any economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or a country under sanction by the United States, unless permitted under a written Office of Foreign Asset Control (OFAC) license.

For more information, visit **http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx**.

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

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

If you need a qualified interpreter, written information in other formats, translation or other services, call 1-877-480-4161.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:
Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705), **CRCoordinator@aetna.com**.

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

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

TTY: 711

To access language services at no cost to you, call 1-877-480-4161.

Para acceder a los servicios de idiomas sin costo, llame al 1-877-480-4161. (Spanish)

如欲使用免費語言服務，請致電 1-877-480-4161。(Chinese)

Afin d'accéder aux services langagiers sans frais, composez le 1-877-480-4161. (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-877-480-4161. (Tagalog)
Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-877-480-4161 an. (German)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-877-480-4161. (Arabic)

Pou jwenn sèvis lang gratis, rele 1-877-480-4161. (French Creole-Haitian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-877-480-4161. (Italian)

言語サービスを無料でご利用いただくには、1-877-480-4161までお電話ください。(Japanese)

무료 언어 서비스를 이용하려면 1-877-480-4161 번으로 전화해 주십시오. (Korean)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-877-480-4161 تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-877-480-4161. (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-877-480-4161. (Portuguese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-877-480-4161. (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-877-480-4161. (Vietnamese)