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

## West Virginia School of Osteopathic Medicine

Policy Year: 2024 – 2025
Policy Number: 686149
https://www.aetnastudenthealth.com
(877) 480-4161

This is a brief description of the Student Health Plan. The plan is available for West Virginia School of Osteopathic students and their eligible dependents. 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 **https://www.aetnastudenthealth.com.** If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

## WEST VIRGINIA SCHOOL OF OSTEOPATHIC MEDICINE HEALTH SERVICES

The Robert C. Byrd Clinic is located on the two WVSOM campuses and is available to students when seeking care.

RCBC Lewisburg Clinic
400 N Jefferson Street
Lewisburg, WV 24901

Hours of Operation
Monday through Friday, 8:00 am to 5:00 pm
Saturday and Sunday, Closed

RCBC Rupert Clinic
356 Nicholas Street
Rupert, WV 25984

Hours of Operation
Monday through Friday, 8:00 am to 4:00 pm
Saturday and Sunday, 8:00 am to 4:00 pm

For more information, call either Robert C. Byrd Clinics at (304) 645-3220. In the event of an emergency, call 911.

### Coverage Periods

**Students:** Coverage for all insured students enrolled in the Plan 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 below.

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

| Coverage Period | Coverage Start Date | Coverage End Date | Enrollment/Waiver Deadline |
|---|---|---|---|
| **Annual** | 07/01/2024 | 06/30/2025 | 06/15/2025 |
| **Fall** | 07/01/2024 | 12/31/2024 | 06/15/2025 |
| **Spring/Summer** | 01/01/2025 | 06/30/2025 | 01/15/2025 |

**Late Start (First Year Only)**

| Coverage Period | Coverage Start Date | Coverage End Date | Enrollment/Waiver Deadline |
|---|---|---|---|
| **Annual** | 07/22/2024 | 06/30/2025 | 07/15/2024 |
| **Fall** | 07/22/2024 | 12/31/2024 | 07/15/2024 |
| **Spring/Summer** | 01/01/2025 | 06/30/2025 | 01/15/2025 |

### Rates

| | Annual | Fall Semester | Spring/Summer Semester |
|---|---|---|---|
| **Student Only** | $5,542 | $2,771 | $2,771 |
| **Spouse Only** | $5,542 | $2,771 | $2,771 |
| **1 Child Only** | $5,542 | $2,771 | $2,771 |
| **2 or More Children** | $11,084 | $5,542 | $5,542 |

**Rates - Late Start (First Year Only)**

| | Annual | Fall Semester | Spring/Summer Semester |
|---|---|---|---|
| **Student Only** | $5,222 | $2,451 | $2,771 |
| **Spouse Only** | $5,222 | $2,451 | $2,771 |
| **1 Child Only** | $5,222 | $2,451 | $2,711 |
| **2 or More Children** | $10,444 | $4,902 | $5,542 |

## Student Coverage

West Virginia School of Osteopathic Medicine requires all full-time students to maintain health insurance coverage. Eligible students are automatically enrolled in the Student Health Insurance Plan unless you can certify that you have comparable coverage. Student must be enrolled in the Student Health Insurance Plan, in order for Dependents to obtain coverage. This applies to First Year Late Start students as well.

The Company maintains its right to investigate eligibility or student status and attendance records to verify that the policy Eligibility requirements have been met. If the Company discovers the Eligibility requirements have not been met, its only obligation is to refund premium.

## Enrollment

To enroll online for health insurance coverage, log on to https://app.hsac.com/wvsom and click the enroll tab at the top of the page.

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.)

## Dependent Coverage

### Eligibility

Covered students may also enroll their lawful spouse, domestic partner (same-sex, opposite sex), and dependent children up to the age of 26.

### Enrollment

To enroll the dependent(s) of a covered student, please complete the Enrollment submission for your dependent by visiting https://app.hsac.com/wvsom, and clicking on the enroll tab at the top of the page. HSA Consulting, Inc. (HSAC), the WVSOM student insurance plan administrator, will contact you directly to process your dependents enrollment. You may also contact HSAC at 1-888-978-8355 for any questions regarding dependent enrollment. Please refer to the Coverage Periods section of this document for coverage dates and deadline dates. Dependent enrollment applications will not be accepted after the enrollment deadline, unless there is a significant life change that directly affects their insurance coverage. (An example of a significant life change would be loss of health coverage under another health plan.)

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

Newborn child

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

Adopted child or a child legally placed with you for adoption

A child that you, or you and your spouse, civil union partner or domestic partner adopt or that is placed with you for adoption, is covered on your plan for the first 31 days after the adoption or the placement is complete.

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

Dependent coverage due to a court order

If you must provide coverage to a dependent because of a court order, your dependent is covered on your health plan for the first 31 days from the court order.

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

If you need information or have general questions on dependent enrollment, call Member Services at (877) 480-4161.

## Medicare Eligibility Notice

You are <u>not</u> 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

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

## In-network Provider Network

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

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

## Precertification

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

## Precertification information

Precertification should be secured within the timeframes specified below. To obtain precertification, submit a request through the link to the electronic portal [found on your ID card]. You, your physician or the facility must submit your request us within these timelines:

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

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

We will provide an electronic notification to you and your physician of the precertification decision within five business days of receipt of the request if all information as required is provided, or within two business days:

- after receipt of the additional information submitted by your provider if the information as required was not provided
- if the request is for medical care or other service(s) that could seriously jeopardize your or others life, health, or safety due to your psychological condition
- if your provider with knowledge of your medical condition determines you will have adverse health consequences without the requested care or treatment

## 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 West Virginia Insurance Law(s).

| **Policy year deductibles** | **In-network coverage** | **Out-of-network coverage** |
|---|---|---|
| You have to meet your policy year deductible before this plan pays for benefits. | | |
| Student | $350 per policy year | $700 per policy year |
| Spouse | $350 per policy year | $700 per policy year |
| Each child | $350 per policy year | $700 per policy year |
| Family | $700 per policy year | $1,400 per policy year |
| **Policy year deductible waiver** | | |
| The policy year deductible is waived for all of the following eligible health services:<br>• In-network care for Preventive care and wellness and Pediatric Dental Care Services<br>• In-network care and out-of-network care for Childhood Immunizations through age 16, Physician, specialist including Consultants Office visits, Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy), Chiropractic services; Walk-in Clinic Visit Expense; Emergency Room Expense, Dermatological treatment, Outpatient Mental Health and Substance Abuse Office Visits, Hearing Exam, Outpatient prescription drugs, Ambulance Services, and Pediatric Vision Care Services | | |
| **Maximum out-of-pocket limits** | | |
| | **In-network coverage** | **Out-of-network coverage** |
| Student | $5,000 per policy year | $10,000 per policy year |
| Spouse | $5,000 per policy year | $10,000 per policy year |
| Each child | $5,000 per policy year | $10,000 per policy year |
| Family | $10,000 per policy year | None |

| **Eligible health services** | **In-network coverage** | **Out-of-network coverage** |
|---|---|---|
| **Preventive care and wellness**<br>**Routine physical exams**<br>Performed at a physician's office | | |
| Routine Physical exam | 100% (of the negotiated charge) per visit<br>No policy year deductible applies | 60% (of the recognized charge) per visit<br>Policy year deductible applies |
| Routine physical exam limits for covered persons through age 21: maximum age and visit limits per policy year | Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures//Health Resources and Services Administration guidelines for children and adolescents. | |
| Routine physical exam limits for covered persons age 22 and over: maximum visits per policy year | 1 visit | |

| Eligible health services | In-network coverage | Out-of-network coverage |
|---|---|---|
| **Preventive care immunizations**<br>**Performed in a facility or at a physician's office** | | |
| Preventive care immunizations | 100% (of the negotiated charge) per visit<br>No 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 | |
| The following is not covered under this benefit:<br>• Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment or travel | | |
| **Well woman preventive visits**<br>**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<br>No policy year deductible applies | 60% (of the recognized charge) per visit |
| Well woman routine gynecological exam maximums | 1 visit | |
| **Preventive screening and counseling services** | | |
| Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer | 100% (of the negotiated charge) per visit<br>No 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 | |
| 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 limitations | |
| Routine cancer screenings | 100% (of the negotiated charge) per visit<br>No policy year deductible applies | 60% (of the recognized charge) per visit |

| Eligible health services | In-network coverage | Out-of-network coverage |
|---|---|---|
| Routine cancer screening maximums: | Subject to any age; family history; and frequency guidelines as set forth in the most current:<br>• 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<br>• The comprehensive guidelines supported by the Health Resources and Services Administration. | |
| Lung cancer screening maximums | 1 screening every 12 months | |
| Prenatal care services (Preventive care services only) | 100% (of the negotiated charge) per visit<br>No policy year deductible applies | 60% (of the recognized charge) per visit |
| Lactation counseling services | 100% (of the negotiated charge) per visit<br>No policy year deductible applies | 60% (of the recognized charge) per visit |
| Lactation counseling services maximum visits per policy year | 6 visits | |
| Breast pump supplies and accessories | 100% (of the negotiated charge) per item<br>No policy year deductible applies | 60% (of the recognized charge) per item |
| **Family planning services – female contraceptives**<br>**Counseling services** | | |
| Female contraceptive counseling services office visit | 100% (of the negotiated charge) per visit<br>No 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 | |
| Female contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit | 100% (of the negotiated charge) per item<br>No policy year deductible applies | 60% (of the recognized charge) per item |
| **Female Voluntary sterilization** | | |
| Inpatient provider services | 100% (of the negotiated charge)<br>No policy year deductible applies | 60% (of the recognized charge) |
| Outpatient provider services | 100% (of the negotiated charge)<br>No policy year deductible applies | 60% (of the recognized charge) |
| **The following are not covered under this benefit:**<br>• Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care<br>• Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA<br>• Male contraceptive methods, sterilization procedures or devices, except for male condoms prescribed by a provider | | |

| Eligible health services | In-network coverage | Out-of-network coverage |
|---|---|---|
| **Physicians and other health professionals** | | |
| Physician, specialist including Consultants Office visits (non-surgical/non-preventive care by a physician and specialist) (includes telemedicine consultations) | $25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies | 60% (of the recognized charge) per visit<br><br>No policy year deductible applies |
| **Allergy testing and treatment** | | |
| Allergy testing performed at a physician's or specialist's office | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| Allergy injections treatment performed at a physician's, or specialist office | 80% (of the negotiated charge) per visit | 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. | Covered according to the type of benefit and the place where the service is received. |
| **Physician and specialist surgical services** | | |
| Inpatient surgery performed during your stay in a hospital or birthing center by a surgeon (includes anesthetist and surgical assistant expenses) | 80% (of the negotiated charge) per admission | 60% (of the recognized charge) per admission |
| **The following are not covered under this benefit:**<br>• A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section)<br>• 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) | 80% (of the negotiated charge) per visit | 60% (of the recognized charge) per visit |
| **The following are not covered under this benefit:**<br>• A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section)<br>• A separate facility charge for surgery performed in a physician's office<br>• Services of another physician for the administration of a local anesthetic | | |

| Eligible health services | In-network coverage | Out-of-network coverage |
|---|---|---|
| **Alternatives to physician office visits** | | |
| Walk-in clinic visits (non-emergency visit) | $25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies | 60% (of the recognized charge) per visit<br><br>No policy year deductible applies |
| **Hospital and other facility care** | | |
| Inpatient hospital (room and board) and other miscellaneous services and supplies)<br><br>Includes birthing center facility charges | $150 copayment plus 80% (of the balance of the negotiated charge) per admission | $150 copayment plus 60% (of the balance of the recognized charge) per admission |
| Preadmission testing | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| In-hospital non-surgical physician services | 80% (of the negotiated charge) per admission | 60% (of the recognized charge) per admission |
| **Alternatives to hospital stays** | | |
| Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center | 80% (of the negotiated charge) per visit | 60% (of the recognized charge) per visit |
| **The following are not covered under this benefit:**<br>• A stay in a hospital (See the *Hospital care – facility charges* benefit in this section)<br>• A separate facility charge for surgery performed in a physician's office<br>• Services of another physician for the administration of a local anesthetic | | |
| Home health Care | 80% (of the negotiated charge) per visit | 60% (of the recognized charge) per visit |
| Maximum visits per policy year | 100 | |
| **The following are not covered under this benefit:**<br>• 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)<br>• Transportation<br>• Homemaker or housekeeper services<br>• Food or home delivered services<br>• Maintenance therapy | | |
| Hospice-Inpatient | 80% (of the negotiated charge) per admission | 60% (of the recognized charge) per admission |
| Hospice-Outpatient | 80% (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

| Eligible health services | In-network coverage | Out-of-network coverage |
|---|---|---|
| Outpatient private duty nursing | 80% (of the negotiated charge) per visit | 60% (of the recognized charge) per visit |
| Skilled nursing facility-<br>Inpatient | 80% (of the negotiated charge) per admission | 60% (of the recognized charge) per admission |
| Hospital emergency room | $150 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies | Paid the same as in-network coverage |
| Non-emergency care in a hospital emergency room | Not covered | Not covered |

**Important note:**

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

**The following are not covered under this benefit:**

- Non-emergency services in a hospital emergency room facility

| Eligible health services | In-network coverage | Out-of-network coverage |
|---|---|---|
| Urgent care - Urgent medical care provided by an urgent care provider | $50 copayment then the plan pays 80% (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 |
| **The following is not covered under this benefit:**<br>• Non-urgent care in an urgent care facility (at a non-hospital freestanding facility) | | |
| **Pediatric dental care (Limited to covered persons through the end of the month in which the person turns age 19)** | | |
| Type A services | 100% (of the negotiated charge) per visit<br>No copayment or deductible applies | 60% (of the recognized charge) per visit |
| Type B services | 70% (of the negotiated charge) per visit<br>No copayment or deductible applies | 50% (of the recognized charge) per visit |
| Type C services | 50% (of the negotiated charge) per visit<br>No copayment or deductible applies | 50% (of the recognized charge) per visit |
| Orthodontic services | 50% (of the negotiated charge) per visit<br>No copayment or deductible applies | 50% (of the recognized charge) per visit |
| Dental emergency services | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |

**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
  - 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 the purpose of splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion

- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) and craniomandibular joint dysfunction disorder (CMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services and exclusions – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another eligible health service
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered above and in the *Pediatric dental care* section of the schedule of benefits
- Pontics, crowns, cast or processed restorations made with high noble metals (gold)
- Prescribed drugs, pre-medication or analgesia (nitrous oxide)
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Routine dental exams and other preventive services and supplies, except as specifically provided in the *Pediatric dental care* section of the schedule of benefits
- Services and supplies:
  - Done where there is no evidence of pathology, dysfunction, or disease other than covered preventive services
  - Provided for your personal comfort or convenience or the convenience of another person, including a provider
  - Provided in connection with treatment or care that is not covered under your policy
- Surgical removal of impacted wisdom teeth only for orthodontic reasons
- Treatment by other than a dental provider

| Eligible health services | In-network coverage | Out-of-network coverage |
|---|---|---|
| Diabetic services and supplies (including equipment and training) | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| Podiatric (foot care) treatment<br>Physician and specialist non-routine foot care treatment | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |

**The following are not covered under this benefit:**

- Services and supplies for:
  - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches
  - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes
  - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
  - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet

| | | |
|---|---|---|
| Impacted wisdom teeth | 80% (of the negotiated charge) | 60% (of the recognized charge) |
| Accidental injury to sound natural teeth | 80% (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

| Eligible health services | In-network coverage | Out-of-network coverage |
|---|---|---|
| Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| **The following are not covered under this benefit:**<br>• Dental implants | | |
| Clinical trial (routine patient costs) | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| Coverage is limited to routine patient services from **in-network providers**.<br><br>**The following are not covered under this benefit:**<br>• Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e. protocol-induced costs)<br>• Services and supplies provided by the trial sponsor without charge to you<br>• The experimental intervention itself (except **medically necessary** Category B investigational devices and promising experimental or investigational interventions for **terminal illnesses** in certain clinical trials in accordance with **Aetna's** claim policies) | | |
| Dermatological treatment | $25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies | 60% (of the recognized charge) per visit<br><br>No policy year deductible applies |
| **The following are not covered under this benefit:**<br>• Cosmetic treatment and procedures | | |
| Obesity bariatric Surgery and services | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| **Obesity (bariatric) surgery and services**<br>**The following are not covered under this benefit:**<br><br>• 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:<br>- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications<br>- Hypnosis or other forms of therapy<br>- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement | | |

| Eligible health services | In-network coverage | Out-of-network coverage |
|---|---|---|
| Maternity care (includes delivery and postpartum care services in a hospital or birthing center) | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| **The following are not covered under this benefit:**<br>• Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries | | |
| Well newborn nursery care in a hospital or birthing center | 80% (of the negotiated charge) | 60% (of the recognized charge) |
| Voluntary sterilization for males- Inpatient surgical services | 80% (of the negotiated charge) | 60% (of the recognized charge) |
| Voluntary sterilization for males-outpatient surgical services | 80% (of the negotiated charge) | 60% (of the recognized charge) |
| **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. | Covered according to the type of benefit and the place where the service is received. |
| **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. | Covered according to the type of benefit and the place where the service is received. |
| **Important note:**<br>Your cost share for services provided by a licensed occupational therapist or occupational therapist assistant, licensed speech-language pathologist or speech-language pathologist assistant, licensed physical therapist or physical therapist assistant will not exceed the copayment, coinsurance, or office visit deductible amount charged for services provided by an osteopathic or primary care physician. | | |
| **Behavioral health** | | |
| **Mental health treatment** | | |
| Inpatient hospital (room and board and other miscellaneous hospital services and supplies) | 80% (of the negotiated charge) per admission | 60% (of the recognized charge) per admission |
| Outpatient office visits (includes telemedicine consultations) | $25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies | 60% (of the recognized charge) per visit<br><br>No policy year deductible applies |
| Other outpatient treatment (includes Partial hospitalization and Intensive Outpatient Program) | 80% (of the negotiated charge) per visit | 60% (of the recognized charge) per visit |

| Eligible health services | In-network coverage Network (IOE facility) | 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. | | |
| Transplant services-travel and lodging | Covered | Covered | Covered |
| Lifetime Maximum payable for Travel and Lodging Expenses for any one transplant, including tandem transplants | $10,000 | $10,000 | $10,000 |
| Maximum payable for Lodging Expenses per **IOE** patient | $50 per night | $50 per night | $50 per night |
| Maximum payable for Lodging Expenses per companion | $50 per night | $50 per night | $50 per night |

**The following are not covered under this benefit:**

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

| Eligible health services | In-network coverage | Out-of-network coverage |
|---|---|---|
| **Infertility services** | | |
| Treatment of basic infertility | 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. |

**Infertility services exclusions**

**The following are not covered under the infertility services benefit:**

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

policy.

| Eligible health services | In-network coverage | Out-of-network coverage |
|---|---|---|
| **Specific therapies and tests** | | |
| Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility | 80% (of the negotiated charge) per visit | 60% (of the recognized charge) per visit |
| Diagnostic lab work performed in a physician's office, the outpatient department of a hospital or other facility | 80% (of the negotiated charge) per visit | 60% (of the recognized charge) per visit |
| Diagnostic radiological services performed in a physician's office, the outpatient department of a hospital or other facility | 80% (of the negotiated charge) per visit | 60% (of the recognized charge) per visit |
| Outpatient Chemotherapy, Radiation & Respiratory Therapy | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| Outpatient infusion therapy performed in a covered person's home, physician's office, outpatient department of a hospital or other facility | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| The following are not covered under this benefit:<br>• Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan<br>• Enteral nutrition<br>• Blood transfusions and blood products<br>• Dialysis | | |
| Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy)<br><br>Combined for short-term rehabilitation services and habilitation therapy services | $25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies | 60% (of the recognized charge) per visit<br><br>No policy year deductible applies |
| Chiropractic services | $25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies | 60% (of the recognized charge) per visit<br><br>No policy year deductible applies |
| 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. | Covered according to the type of benefit or the place where the service is received. |

| Eligible health services | In-network coverage | Out-of-network coverage |
|---|---|---|
| **Other services** | | |
| Emergency ground, air, and water ambulance<br>(includes non-emergency ambulance) | 80% (of the negotiated charge) per trip<br><br>No policy year deductible applies | Paid the same as in-network coverage |
| **The following are not covered under this benefit:**<br>• Ambulance services for routine transportation to receive outpatient or inpatient care | | |
| Durable medical and surgical equipment | 80% (of the negotiated charge) per item | 60% (of the recognized charge) per item |
| **The following are not covered under this benefit:**<br>• Whirlpools<br>• Portable whirlpool pumps<br>• Sauna baths<br>• Massage devices<br>• Over bed tables<br>• Elevators<br>• Communication aids<br>• Vision aids<br>• Telephone alert systems<br>• Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician | | |
| Nutritional support | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| **The following are not covered under this benefit:**<br>• 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 | 80% (of the negotiated charge) per item | 60% (of the recognized charge) per item |
| **The following are not covered under this benefit:**<br>• Services covered under any other benefit<br>• 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<br>• Trusses, corsets, and other support items<br>• Repair and replacement due to loss, misuse, abuse or theft<br>• Communication aids<br>• Cochlear implants | | |
| **Hearing aids and Exams** | | |
| Hearing exam | $25 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit<br><br>No policy year deductible applies | 60% (of the recognized charge) per visit<br><br>No policy year deductible applies |

| | | |
|---|---|---|
| **The following are not covered under this benefit:**<br>• Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay | | |
| **Eligible health services** | **In-network coverage** | **Out-of-network coverage** |
| Hearing Aids | 80% (of the negotiated charge) per item | 60% (of the recognized charge) per item |
| Hearing aids maximum per ear | One hearing aid per ear every policy year | |
| **The following are not covered under this benefit:**<br>• A replacement of:<br>- A hearing aid that is lost, stolen or broken<br>- A hearing aid installed within the prior 6 month period<br>• Replacement parts or repairs for a hearing aid<br>• Batteries or cords<br>• Cochlear implants<br>• A hearing aid that does not meet the specifications prescribed for correction of hearing loss<br>• Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist | | |
| **Pediatric vision care (Limited to covered persons through the end of the month in which the person turns age 19)** | | |
| Performed by a legally qualified ophthalmologist or optometrist (includes comprehensive low vision evaluations) | 100% (of the negotiated charge) per visit<br>No policy year deductible applies | 60% (of the recognized charge) per visit<br>No policy year deductible applies |
| Maximum visits per policy year<br>Low vision Maximum<br>Fitting of contact Maximum | 1 visit<br>One comprehensive low vision evaluation every policy year<br>2 visits | |
| Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses | 100% (of the negotiated charge) per visit<br>No policy year deductible applies | 60% (of the recognized charge) per visit<br>No policy year deductible applies |
| Maximum number Per year:<br>Eyeglass frames<br>Prescription lenses<br>Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery) | One set of eyeglass frames<br>One pair of prescription lenses<br>Daily disposables: up to 3 month supply<br>Extended wear disposable: up to 6 month supply<br>Non-disposable lenses: one set | |
| Optical devices | Covered according to the type of benefit and the place where the service is received. | Covered according to the type of benefit and the place where the service is received. |
| Maximum 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. Coverage does not include the office visit for the fitting of prescription contact lenses. | | |

**The following are not covered under this benefit:**

- 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

**Outpatient prescription drugs**

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

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

**Outpatient prescription drug policy year deductible and copayment waiver for tobacco cessation prescription and over-the-counter drugs**

The outpatient prescription drug policy year deductible and the 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 or mail order, in-network and out-of-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%.

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

**Outpatient prescription drug policy year deductible and copayment waiver for contraceptives**

The outpatient prescription drug policy year deductible and the prescription drug copayment will not apply to female contraceptive methods when obtained at an in-network and out-of-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 policy year deductible and the prescription drug copayment continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at a in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.

| Eligible health services | In-network coverage | Out-of-network coverage |
|---|---|---|
| **Preferred generic prescription drugs** | | |
| For each fill up to a 30 day supply filled at a retail pharmacy | $20 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)<br><br>No policy year deductible applies | $20 copayment per supply then the plan pays 100% (of the balance of the recognized charge)<br><br>No policy year deductible applies |
| More than a 30 day supply but less than a 91 day supply filled at a retail or mail order pharmacy | $50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)<br><br>No policy year deductible applies | Not Covered |

| Eligible health services | In-network coverage | Out-of-network coverage |
|---|---|---|
| **Preferred brand-name prescription drugs** | | |
| For each fill up to a 30 day supply filled at a retail pharmacy | $50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)<br><br>No policy year deductible applies | $50 copayment per supply then the plan pays 100% (of the balance of the recognized charge)<br><br>No policy year deductible applies |
| More than a 30 day supply but less than a 91 day supply filled at a retail or mail order pharmacy | $125 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)<br><br>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 | $100 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)<br><br>No policy year deductible applies | $100 copayment per supply then the plan pays 100% (of the balance of the recognized charge)<br><br>No policy year deductible applies |
| More than a 30 day supply but less than a 91 day supply filled at a retail or mail order pharmacy | $250 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)<br>No policy year deductible applies | Not Covered |
| **Non-preferred brand-name prescription drugs** | | |
| For each fill up to a 30 day supply filled at a retail pharmacy | $100 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)<br><br>No policy year deductible applies | $100 copayment per supply then the plan pays 100% (of the balance of the recognized charge)<br><br>No policy year deductible applies |
| More than a 30 day supply but less than a 91 day supply filled at a retail or mail order pharmacy | $250 copayment per supply then the plan pays 100% (of the balance of the negotiated charge)<br><br>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)<br><br>No policy year deductible applies | $150 copayment per supply then the plan pays 100% (of the balance of the recognized charge)<br><br>No policy year deductible applies |

| Eligible health services | In-network coverage | Out-of-network coverage |
|---|---|---|
| **Diabetic Insulin** | | |
| 30 day supply at retail pharmacy | Paid according to the type of drug per the schedule of benefits above | Paid according to the type of drug per the schedule of benefits above |
| 91 day supply 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 |
| Important note:<br>Your cost share will not exceed $35 per 30 day supply of a covered prescription insulin drug filled at a network pharmacy. No deductible applies for insulin | | |
| Anti-cancer prescription drugs taken by mouth- For each fill up to a 30 day supply | 100% (of the negotiated charge)<br><br>No policy year deductible applies | 100% (of the recognized charge)<br><br>No policy year deductible applies |
| Preventive care drugs and supplements filled at a retail pharmacy<br><br>For each 30 day supply | 100% (of the negotiated charge per prescription or refill<br><br>No copayment or policy year deductible applies | Paid according to the type of drug per the schedule of benefits, above |
| Risk reducing breast cancer prescription drugs filled at a pharmacy<br><br>For each 30 day supply | 100% (of the negotiated charge) per prescription or refill<br><br>No copayment or policy year deductible applies | Paid according to the type of drug per the schedule of benefits, above |
| Maximums: | Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the United States Preventive Services Task Force. | |
| Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy<br><br>For each 30 day supply | 100% (of the negotiated charge per prescription or refill<br><br>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.<br>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. | |
| Contraceptives (birth control) | | |
| For each fill up to a 12 month supply of generic and OTC drugs and devices filled at a retail or mail order pharmacy | 100% (of the negotiated charge)<br><br>No policy year deductible applies | 100% (of the recognized charge)<br><br>No policy year deductible applies |
| For each fill up to a 12 month 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 |
| Dispense As Written (DAW)<br>If a provider prescribes a covered brand-name prescription drug when a generic prescription drug equivalent is available and specifies “Dispense As Written” (DAW), you will pay the cost share for the brand-name drug. If a provider does not specify DAW and you request a covered brand-name prescription drug, you will be responsible for the cost share that applies to the brand-name drug plus the cost difference between the generic drug and the brand-name drug. The cost difference related to a prescription not specified as DAW does not apply toward your policy year | | |

deductible or maximum out-of-pocket limit.

**Outpatient prescription drug exclusions**

**The following are not eligible health services:**

- Abortion drugs used for elective termination of pregnancy except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger
- Allergy sera and extracts given by injection
- Any services related to providing, injecting or application of a drug
- Compounded prescriptions containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
- Cosmetic drugs including medication and preparations used for cosmetic purposes
- Devices, products and appliances unless listed as an eligible health service
- Dietary supplements including medical foods
- Drugs or medications:
  - Administered or entirely consumed at the time and place they are prescribed or provided
  - Which do not require a prescription by law, even if a prescription is written, unless we have approved a medical exception
  - That are therapeutically the same or an alternative to a covered prescription drug, unless we approve a medical exception
  - Not approved by the FDA or not proven safe or effective
  - Provided under your medical plan while inpatient at a healthcare facility
  - Recently approved by the FDA but not reviewed by our Pharmacy and Therapeutics Committee, unless we have approved a medical exception
  - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
  - That are used to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape or appearance of a sex organ unless listed as an eligible health service
  - That are used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants or other medications
  - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature, unless there is evidence that the covered person meets one or more clinical criteria detailed in our precertification and clinical policies
- Duplicative drug therapy; for example, two antihistamines for the same condition
- Genetic care including:
  - Any treatment, device, drug, service or supply to alter the body’s genes, genetic makeup or the expression of the body’s genes unless listed as an eligible health service
- 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 stated in the schedule of benefits or the certificate
- Infertility:
  - Prescription drugs used primarily for the treatment of infertility
- Injectables including:
  - Any charges for the administration or injection of prescription drugs
  - Needles and syringes except for those used for insulin administration
  - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified provider or licensed certified health professional in an outpatient setting [with the exception of Depo Provera and other injectable drugs 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 plan's drug guide
  - That are used for the purpose of improving visual acuity or field of vision
  - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the person identified on the ID card
- Replacement of lost or stolen prescriptions
- Test agents [except diabetic test agents
- Tobacco cessation drugs, unless recommended by the USPSTF
- We reserve the right to exclude:
  - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's drug guide

Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's 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 In-net level of benefits.

## General Exclusions

**Abortion**

- Services and supplies provided for an abortion except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger

**Abortion drugs**

- Drugs used for elective termination of pregnancy except when the pregnancy is the result of rape or incest or if it places the woman's life in serious danger

**Acupuncture**

- Acupuncture
- Acupressure

**Air or space travel**

- Traveling in, on or descending from any aircraft, including a hang glider, while the aircraft is in flight. This includes descending by a parachute, wingsuit or any other similar device.

  This exclusion does not apply if:
  - You are traveling solely as a fare-paying passenger
  - You are traveling on a licensed, commercial, regularly scheduled non-military aircraft
  - You are traveling solely in a civil aircraft with a current valid "Standard Federal Aviation Agency Airworthiness Certificate" and:
    - The civil aircraft is piloted by a person with a current valid pilot's certificate with proper ratings for the type of flight and aircraft involved
    - You are as a passenger with no duties at all on an aircraft used only to carry passengers or you are a pilot or a part of the flight crew on an aircraft owned or leased by the policyholder performing duties for the policyholder

**Alternative health care**

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

**Armed forces**

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

**Behavioral health treatment**

- Services for the following based on categories, conditions, diagnoses or equivalent terms as listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association:
  - Stay in a facility for treatment for dementias and amnesia without a behavioral disturbance that necessitates mental health treatment
  - School and/or education service including special education, remedial education, wilderness treatment programs, or any such related or similar programs

- Services provided in conjunction with school, vocation, work or recreational activities
- Transportation
- Sexual deviations and disorders except as described in the *Eligible health services and exclusions* section
- Tobacco use disorders except as described in the *Eligible health services and exclusions – Preventive care and wellness* section

**Beyond legal authority**

- Services and supplies provided by a health professional or other provider that is acting beyond the scope of its legal authority

**Blood, blood plasma, synthetic blood, blood derivatives or substitutes**

Examples of these are:

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

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

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

**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

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

**Court-ordered services and testing**

- Court-ordered testing or care unless medically necessary

**Custodial care**

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

Examples of these are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care [except in connection with hospice care], adult (or child) day care, or convalescent care
- Institutional care. This includes room and board for rest cures, adult day care and convalescent care
- Help with walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- Any service that can be performed by a person without any medical or paramedical training

- For behavioral health (mental health treatment and **substance related disorders** treatment):
  - Services provided when you have reached the greatest level of function expected with the current level of care, for a specific diagnosis
  - Services given mainly to:
    - Maintain, not improve, a level of function
    - Provide a place free from conditions that could make your physical or mental state worse

**Dental care for adults**

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

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

**Educational services**

Examples of these services are:

- Any service or supply for education, training or retraining services or testing, except where described in the *Eligible health services and exclusions– Diabetic services and supplies (including equipment and training)* section in the certificate. This includes:
  - Special education
  - Remedial education
  - Wilderness treatment programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution)
  - Job training
  - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

**Examinations**

Any health or dental examinations needed:

- Because a third party requires the exam. Examples are, examinations to get or keep a job, or examinations required under a labor agreement or other contract
- Because a law requires it
- To buy insurance or to get or keep a license
- To travel
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity

**Experimental or investigational**

- Experimental or investigational drugs, devices, treatments or procedures unless otherwise covered under clinical trial therapies (experimental or investigational) or covered under clinical trials (routine patient costs). See the *Eligible health services and exclusions – Other services* section in the certificate.

**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, referral and precertification requirements* section in the certificate.

**Genetic care**

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

**Growth/Height care**

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

**Incidental surgeries**

- Charges made by a physician for incidental surgeries. These are non-medically necessary surgeries performed during the same procedure as a medically necessary surgery.

**Jaw joint disorder**

- Surgical treatment of jaw joint disorders
- Non-surgical treatment of jaw joint disorders
- Jaw joint disorders treatment performed by prosthesis placed directly on the teeth, surgical and non-surgical medical and dental services, and diagnostic or therapeutics services related to jaw joint disorders including associated myofascial pain

This exclusion does not apply to covered benefits for treatment of TMJ and CMJ as described in the *Eligible health services 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 service*s 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

**Personal care, comfort or convenience items**

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

**Private duty nursing**

**Riot**

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

**Routine exams**

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

**School health services**

- Services and supplies normally provided by the policyholder's:
  - School health services
  - Infirmary
  - Hospital
  - Pharmacy or

  by health professionals who
  - Are employed by
  - Are Affiliated with
  - Have an agreement or arrangement with, or
  - Are otherwise designated by the policyholder.

**Services not permitted by law**

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

**Services provided by a family member**

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

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

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

**Sexual dysfunction and enhancement**

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

**Sinus surgery**

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

**Specialty prescription drugs**

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

**Strength and performance**

- Services, devices and supplies such as drugs or preparations designed primarily for enhancing your:
  - Strength
  - Physical condition
  - Endurance
  - Physical performance

**Students in mental health field**

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

**Telemedicine**

- Services including:
  - 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 in the certificate
  - Hypnosis and other therapies
  - Medications, except as specifically provided in the *Eligible health services and exclusions – Outpatient prescription drugs* section in the certificate
  - 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 West Virginia School of Ostopathic Medicine 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 Health and Life Insurance Company and its applicable affiliated companies (Aetna).

### Sanctioned Countries

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

**Assistive Technology**

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

**Smartphone or Tablet**

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

**Non-Discrimination**

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

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

These aids and services include:

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

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

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

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

**Language accessibility statement**

***Interpreter services are available for free.***

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

**Español/Spanish**

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

**አማርኛ/Amharic**

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

**العربية/Arabic**

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

**Ɓàsɔ̀ɔ̀ Wùɖù/Bassa**

Dè dɛ nìà kɛ dyɛ́dɛ́ gbo: Ɔ jǔ kɛ́ m̀ dyi Ɓàsɔ̀ɔ̀-wùɖù-po-nyɔ̀ jǔ nɨ́, nɨ̀ì à wuɖu kà kò ɖò po-poɔ̀ ɓɛ́ m̀ gbo kpáa.
Ɖá **1-877-480-4161** (TTY: **711**).

**中文/Chinese**

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

**فارسی/Farsi**

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

**Français/French**

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

**ગુજરાતી/Gujarati**

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

**Kreyòl Ayisyen/Haitian Creole**

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

**Igbo**

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

**한국어/Korean**

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

**Português/Portuguese**

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

**Русский/Russian**

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

**Tagalog**

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

**Urdu/**اردو

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

**Tiếng Việt/Vietnamese**

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

**Yorùbá/Yoruba**

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

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