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ATSU | A.T. Still University
FIRST IN WHOLE PERSON HEALTHCARE

Aetna Student Health
Plan Design and Benefits Summary

Preferred Provider Organization (PPO)

ATSU – A.T. Still University

Policy Year: 2024–2025
Policy Number: 686227
www.aetnastudenthealth.com
(877) 480-4161

This is a brief description of the Student Health Plan. The plan is available for ATSU - A.T. Still University students. The plan is insured by Aetna Life Insurance Company (Aetna). The exact provisions, including definitions, governing this insurance are contained in the Certificate issued to you and may be viewed online at https://app.hsac.com/atsu/. If there is a difference between this Plan Summary and the Certificate, the Certificate will control.

Who is eligible?

ALL students must enroll in the student-sponsored health plan or provide proof of other acceptable health coverage.

You must actively attend classes for at least the first 31 days after the date your coverage becomes effective.

Coverage Dates and Rates

Coverage Period	Coverage Start Date	Coverage End Date
All Continuing Students	07/01/2024	06/30/2025
Incoming ASDOH DMD, AUD, BioMed, DPT, KCOM DO, MOSDOH DMD, MSLP, MSOT, MSPA, OTDE, SOMA DO	07/15/2024	06/30/2025
Incoming CCPA	10/07/2024	06/30/2025
Ortho 2026	07/08/2024	06/30/2025
ASID-NDS	01/06/2025	06/30/2025

Rates

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

Programs	Student Only
All Continuing Students	$4,376
Incoming ASDOH DMD, AUD, BioMed, DPT, KCOM DO, MOSDOH DMD, MSLP, MSOT, MSPA, OTDE, SOMA DO	$4,209
Incoming CCPA	$3,202
Ortho 2025	$4,239
ASID-NDS	$2,111

Disclosure: All insurance coverage is subject to applicable state form and rate filing approval and, once approved, to the terms of the Master Policy. We have not yet received approval from the state insurance department for the benefits, features and rates described in this document. As part of the approval process, the State may require us to make changes to the benefits, features and/or rates.

Enrollment

The enrollment and waiver process is administered by HSA Consulting, Inc. (HSAC), the ATSU student insurance plan administrator. To enroll in the ATSU-sponsored plan, or if you have any questions regarding the enrollment or waiver process, contact HSAC at 1-888-978-8355, or visit https://app.hsac.com/atsu.

Medicare Eligibility Notice

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

Termination and Refunds

Withdrawal from Classes – Leave of Absence

If you withdraw from classes under a school-approved leave of absence, your coverage will remain in force through the end of the period for which premium payment has been received. No and no premiums will be refunded.

Withdrawal from Classes – Other than Leave of Absence

If you withdraw from classes within 31 days after the policy effective date, you will be considered ineligible for coverage. Your coverage will be terminated retroactively, and any premium paid will be refunded.

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

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

In-network Provider Network

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

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

Precertification

You need pre-approval from us for some eligible health services. Pre-approval is also called precertification. Your in-network physician is responsible for obtaining any necessary precertification before you get the care. When you go to an out-of-network provider, it is your responsibility to obtain precertification from us for any services and supplies on the precertification list. 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 www.aetnastudenthealth.com.

Precertification Call

Precertification should be secured within the timeframes specified below. To obtain precertification, call Member Services at the toll-free number on your ID card. You, your physician, or the facility must call us within these timelines:

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 a written notification to you and your physician of the precertification decision, where required by state law. If your precertified services are approved, the approval is valid for 60 days as long as you remain enrolled in the plan.

Aetna will not retroactively reduce or terminate a previously approved service or supply unless:
- Such authorization is based on a material misrepresentation or omission about the treated or cause of the health condition; or
- The plan terminated before services are provided; or
- Coverage terminated before the services were provided

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 Missouri Insurance Law(s).

Visit aetna.com/individuals-families/member-rights-resources/rights/disclosure-information.html to view or print your medical, dental or vision plan disclosures. Here, you can also find state requirements and information on the Women's Health and Cancer Rights Act.

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	$750 per policy year	$1,500 per policy year
Policy year deductible waiver		
The policy year deductible is waived for all of the following eligible health services: • In-network care for Preventive care and wellness, Physician, specialist including Consultants Office visits, Walk-in clinic visits, Urgent Care, Pediatric Dental Type A Services, Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy), Mental Health and Substance Abuse Outpatient office visits, Chiropractic Care, Hearing Aid Exams, and Pediatric Vision Care Services • In-network care and out-of-network care for Well newborn nursery care and Outpatient prescription drugs		
This is the amount you owe for in-network and out-of-network eligible health services each policy year before the plan begins to pay for eligible health services. After the amount you pay for eligible health services reaches the policy year deductible, this plan will begin to pay for eligible health services for the rest of the policy year.		
Eligible health services applied to the out-of-network policy year deductible will not be applied to satisfy the in-network policy year deductible. Eligible health services applied to the in-network policy year deductible will not be applied to satisfy the out-of-network policy year deductibles.		
Maximum out-of-pocket limits	**In-network coverage**	**Out-of-network coverage**
Student	$7,150 per policy year	Unlimited
Eligible health services applied to the out-of-network maximum out-of-pocket limit will not be applied to satisfy the in-network maximum out-of-pocket limit and eligible health services applied to the in-network maximum out-of-pocket limit will not be applied to satisfy the out-of-network maximum out-of-pocket limit.		

Eligible health services	In-network coverage	Out-of-network coverage
Routine physical exams		
Routine Physical Exam	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Routine physical exam limits for covered persons through age 21: maximum age and visit limits per policy year	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents. For details, contact your physician or Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Routine physical exam limits for covered persons age 22 and over: maximum visits per policy year	1 visit	
Preventive care immunizations		
Performed in a facility or at a physician's office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Important note: Preventive care immunizations for covered persons from birth to age 5 are not subject to any deductible or copayment limits.		
The following is not covered under this benefit: • Any immunization that is not considered to be preventive care or recommended as preventive care, such as those required due to employment or travel		
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 or by the Missouri Department of Health and Senior Services. For details, contact your physician or Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Routine gynecological exams (including Pap smears and cytology tests)		
Performed at a physician's, obstetrician (OB), gynecologist (GYN) or OB/GYN office	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Well woman routine gynecological exam maximums	Subject to any age limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration and the American Cancer Society.	
Maximum visits per policy year	1 visit	

Eligible health services	In-network coverage	Out-of-network coverage
Preventive screening and counseling services In figuring the maximum visits, each session of up to 60 minutes is equal to one visit		
Preventive screening and counseling services for Obesity and/or healthy diet counseling, Misuse of alcohol & drugs, Tobacco Products, Sexually transmitted infection counseling & Genetic risk counseling for breast and ovarian cancer	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (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 or frequency limitations	
Routine cancer screenings	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Routine cancer screening maximums	Subject to any age; family history; and frequency guidelines as set forth in the most current: • Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; • The comprehensive guidelines supported by the Health Resources and Services Administration; and. • The American Cancer Society guidelines. For details, contact your physician or Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Mammogram maximums	• 1 baseline mammogram age 35 through 39 • 1 mammogram annually age 40 and over; or as recommended by a physician for those at above-average risk due to personal or family history	
Lung cancer screening maximum	1 screening every 12 months	

Eligible health services	In-network coverage	Out-of-network coverage
Preventive screening and counseling services (continued) In figuring the maximum visits, each session of up to 60 minutes is equal to one visit		
Prenatal care services (Preventive care services only)	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Lactation counseling services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Lactation counseling services maximum visits per policy year either in a group or individual setting	6 visits	
Breast pump supplies and accessories	100% (of the negotiated charge) per item No copayment or policy year deductible applies	70% (of the recognized charge) per item
Family planning services – contraceptives - counseling services		
Contraceptive counseling services office visit	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
Contraceptive counseling services maximum visits per policy year either in a group or individual setting	2 visits	
Contraceptive prescription drugs and devices provided, administered, or removed, by a provider during an office visit	100% (of the negotiated charge) per item No copayment or policy year deductible applies	70% (of the recognized charge) per item
Voluntary sterilization		
Inpatient provider services	100% (of the negotiated charge) No copayment or policy year deductible applies	70% (of the recognized charge)
Outpatient provider services	100% (of the negotiated charge) per visit No copayment or policy year deductible applies	70% (of the recognized charge) per visit
The following are not covered under this benefit: • Services provided as a result of complications resulting from a female voluntary sterilization procedure and related follow-up care • Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA		

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)	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit
Allergy testing and treatment		
Allergy testing performed at a physician's or specialist's office	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Allergy injections treatment performed at a physician or specialist office	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: • Allergy sera and extracts administered via injection		
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)	60% (of the recognized charge)
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • Services of another physician for the administration of a local anesthetic		
Outpatient surgery performed at a physician's or specialist's office or outpatient department of a hospital or surgery center by a surgeon (includes anesthetist and surgical assistant expenses)	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: • A stay in a hospital (Hospital stays are covered in the *Eligible health services and exclusions – Hospital and other facility care* section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		
Alternatives to physician office visits		
Walk-in clinic visits (non-emergency visit)	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit
Important note: Some walk-in clinics can provide preventive care and wellness services. The types of services offered will vary by the provider and location of the clinic. If you get preventive care and wellness benefits at a walk-in clinic, they are paid at the cost sharing shown in the *Preventive care and wellness* section.		

Eligible health services	In-network coverage	Out-of-network coverage
Hospital and other facility care		
Inpatient hospital (room and board) and other miscellaneous services and supplies) Includes birthing center facility charges	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission
In-hospital non-surgical physician services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
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
Alternatives to hospital stays		
Outpatient surgery (facility charges) performed in the outpatient department of a hospital or surgery center	80% (of the negotiated charge)	60% (of the recognized charge)
The following are not covered under this benefit: • A stay in a hospital (See the *Hospital care – facility charges* benefit in this section) • A separate facility charge for surgery performed in a physician's office • Services of another physician for the administration of a local anesthetic		
Home health care	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
The following are not covered under this benefit: • Nursing and home health aide services or therapeutic support services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities) • Transportation • Homemaker or housekeeper services • Food or home delivered services • 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 • 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		
Outpatient private duty nursing	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Skilled nursing facility - Inpatient	80% (of the negotiated charge) per admission	60% (of the recognized charge) per admission

Eligible health services	In-network coverage	Out-of-network coverage
Emergency services and urgent care		
Hospital emergency room or facility to treat the emergency medical condition	$150 copayment then the plan pays 80% (of the balance of the negotiated charge) per visit	Paid the same as in-network coverage
Non-emergency care in a hospital emergency room	Not covered	Not covered
Important note: • As out-of-network providers do not have a contract with us the provider may not accept payment of your cost share, (copayment/coinsurance), as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this plan. If the provider bills you for an amount above your cost share, you are not responsible for paying that amount. You should send the bill to the address listed on the back of your ID card, and we will resolve any payment dispute with the provider over that amount. Make sure the ID card number is on the bill. • A separate hospital emergency room copayment/coinsurance will apply for each visit to an emergency room. If you are admitted to a hospital as an inpatient right after a visit to an emergency room, your emergency room copayment/coinsurance will be waived and your inpatient copayment/coinsurance will apply. • Covered benefits that are applied to the hospital emergency room copayment/coinsurance cannot be applied to any other copayment/coinsurance under the plan. Likewise, a copayment/coinsurance that applies to other covered benefits under the plan cannot be applied to the hospital emergency room copayment/coinsurance. • Separate copayment/coinsurance amounts may apply for certain services given to you in the hospital emergency room that are not part of the hospital emergency room benefit. These copayment/coinsurance amounts may be different from the hospital emergency room copayment/coinsurance. They are based on the specific service given to you. • Services given to you in the hospital emergency room that are not part of the hospital emergency room benefit may be subject to copayment/coinsurance amounts that are different from the hospital emergency room copayment/coinsurance amounts.		
The following are not covered under this benefit: • Non-emergency services in a hospital emergency room facility		
Urgent care	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	70% (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: • Non-urgent care in an urgent care facility (at a non-hospital freestanding facility)		

Eligible health services	In-network coverage	Out-of-network coverage
Pediatric dental care Limited to covered persons through the end of the month in which the person turns age 19.		
Type A services	100% (of the negotiated charge) per visit No copayment or deductible applies	70% (of the recognized charge) per visit
Type B services	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
Type C services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Orthodontic services	50% (of the negotiated charge) per visit	50% (of the recognized charge) per visit
Dental emergency treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received

Pediatric dental care exclusions

The following are not covered under this benefit:

- Any instruction for diet, plaque control and oral hygiene
- Asynchronous dental treatment
- Cosmetic services and supplies including:
  - Plastic surgery, reconstructive surgery, cosmetic surgery, personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
  - Augmentation and vestibuloplasty, and other substances to protect, clean, whiten, bleach or alter the appearance of teeth, whether or not for psychological or emotional reasons, except to the extent coverage is specifically provided in the *Eligible health services and exclusions* section
  - Facings on molar crowns and pontics will always be considered cosmetic
- Crown, inlays, onlays, and veneers unless:
  - It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material
  - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants and braces (that are determined not to be medically necessary), mouth guards, and other devices to protect, replace or reposition teeth
- Dentures, crowns, inlays, onlays, bridges, or other appliances or services used:
  - For splinting
  - To alter vertical dimension
  - To restore occlusion
  - For correcting attrition, abrasion, abfraction or erosion
- Treatment of any jaw joint disorder and treatments to alter bite or the alignment or operation of the jaw, including temporomandibular joint dysfunction disorder (TMJ) and craniomandibular joint dysfunction disorder (CMJ) treatment, orthognathic surgery, and treatment of malocclusion or devices to alter bite or alignment, except as covered in the *Eligible health services and exclusions – Specific conditions* section
- General anesthesia and intravenous sedation, unless specifically covered and only when done in connection with another eligible health service
- Mail order and at-home kits for orthodontic treatment
- Orthodontic treatment except as covered above and in the *Pediatric dental care* section of the schedule of benefits

(continued on next page)

Eligible health services	In-network coverage	Out-of-network coverage
Pediatric dental care exclusions (continued) The following are not covered under this benefit: • 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		
Specific conditions		
Diabetic services and supplies (including equipment and training)	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
Podiatric (foot care) treatment - Physician and specialist non-routine foot care treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Services and supplies for: - The treatment of calluses, bunions, toenails, flat feet, hammertoes, fallen arches - The treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working or wearing shoes - Supplies (including orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies - Routine pedicure services, such as cutting of nails, corns and calluses when there is no illness or injury of the feet		
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
Specific conditions (continued)		
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: • 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
The following are not covered under this benefit: • Services and supplies related to data collection and record-keeping that is solely needed due to the clinical trial (i.e., protocol-induced costs) • Services and supplies provided by the trial sponsor without charge to you • The experimental intervention itself (except medically necessary Category B investigational devices and promising experimental or investigational interventions for terminal illnesses in certain clinical trials in accordance with Aetna's claim policies)		
Cancer 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
The following are not covered services: • Services and supplies related to data collection and record-keeping needed only for the clinical trial (i.e., protocol-induced costs) and not used in the direct clinical management of the patient • Services and supplies provided by the trial sponsor without charge to you • The investigational item or service itself		
Dermatological treatment	Covered according to the type of benefit and the place where the service is received	Covered according to the type of benefit and the place where the service is received
The following are not covered under this benefit: • Cosmetic treatment and procedures		
Oral and maxillofacial treatment (mouth, jaws and teeth) - Treatment of mouth, jaws and teeth	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	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 exclusions • 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: - 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		

Eligible health services	In-network coverage	Out-of-network coverage
Specific conditions (continued)		
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: • 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) No policy year deductible applies	60% (of the recognized charge) No policy year deductible applies
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
The following are not eligible health services under this benefit: • Any treatment, surgery, service or supply that is not in the list above of eligible health services		
Autism spectrum disorder		
Autism spectrum disorder treatment, diagnosis and testing. Includes Applied behavior analysis and Physical, occupational, and speech therapy associated with diagnosis of autism spectrum disorder The cost share for physical and occupational therapy services will be no greater than the cost share for a physician's office visit.	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
Mental Health & Substance related 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)	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit
Other outpatient treatment (includes Partial hospitalization, Intensive Outpatient Program, and Non-residential treatment program - see policy for details	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
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	
Lifetime Maximum payable for Travel and Lodging Expenses for any one transplant, including tandem transplants	$10,000	
Maximum payable for Lodging Expenses per IOE patient	$50 per night	
Maximum payable for Lodging Expenses per companion	$50 per night	
Transplant travel and lodging important note: Detailed receipts for transportation and lodging expenses must be submitted when claims are sent to us. For lodging and ground transportation benefits, we will provide a maximum benefit up to the current limits set forth in the Internal Revenue Code 213 (d)(2)(B). Contact Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.		
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		
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. • Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue. • Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue. • 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. ***(continued on next page)***		

Eligible health services	In-network coverage	Out-of-network coverage
Infertility services exclusions (continued) The following are not covered under the infertility services benefit: • 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.		
Specific therapies and tests		
Diagnostic complex imaging services performed in the outpatient department of a hospital or other facility	80% (of the negotiated charge)	60% (of the recognized charge)
Diagnostic lab work performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge)	60% (of the recognized charge)
Diagnostic radiological services performed in a physician's office, the outpatient department of a hospital or other facility	80% (of the negotiated charge)	60% (of the recognized charge)
Outpatient Chemotherapy, Radiation & Respiratory Therapy	80% (of the negotiated charge) per visit	60% (of the recognized charge) per visit
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: • Drugs that are included on the list of specialty prescription drugs as covered under your outpatient prescription drug plan • Enteral nutrition • Blood transfusions and blood products • Dialysis		
Outpatient physical, occupational, speech, and cognitive therapies (including Cardiac and Pulmonary Therapy) Combined for short-term rehabilitation services and habilitation therapy services The copayment or coinsurance for physical and occupational therapy services will be no greater than a PCP or physician's office visit copay.	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit

Eligible health services	In-network coverage	Out-of-network coverage
Specific therapies and tests (continued)		
Chiropractic Care The cost share for a single chiropractic service will not be more than 50% of the negotiated charge or recognized charge, as applicable, for that service.	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit
Important note: We may require prior authorization or notification before any follow-up diagnostic tests are ordered by a chiropractor or for any office visits for treatment in excess of twenty-six per policy year.		
The following are not covered under this benefit: • Preventive care services • Services beyond the scope of the chiropractor's license • Services for examination and/or treatment of strictly non-neuromusculoskeletal disorders of the spine		
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
Other services		
Emergency ground, air, and water ambulance	80% (of the negotiated charge) per trip	Paid the same as in-network coverage
The following are not covered under this benefit: • Ambulance services for routine transportation to receive outpatient or inpatient care		
Durable medical and surgical equipment	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
The following are not covered under this benefit: • Whirlpools • Portable whirlpool pumps • Sauna baths • Massage devices • Over bed tables • Elevators • Communication aids • Vision aids • Telephone alert systems • Personal hygiene and convenience items such as air conditioners, humidifiers, hot tubs, or physical exercise equipment even if they are prescribed by a physician		
Early intervention for infants and toddlers (First steps) - office visit for children from birth to age 3	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.
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: • 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		

Eligible health services	In-network coverage	Out-of-network coverage
Other services (continued)		
Cochlear implants Coverage is limited to covered persons age 18 and over	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
Prosthetic Devices & Orthotics Includes Cranial prosthetics *(Medical wigs)*	80% (of the negotiated charge) per item	60% (of the recognized charge) per item
The following are not covered under this benefit: Services covered under any other benefit • Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes, or if the orthopedic shoe is an integral part of a covered leg brace • Trusses, corsets, and other support items • Repair and replacement due to loss, misuse, abuse or theft • Communication aids		
Hearing aids and exams		
Hearing exam	$30 copayment then the plan pays 100% (of the balance of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit
Hearing exam maximum	1 hearing exam every policy year	
The following are not covered under this benefit: • Hearing exams given during a stay in a hospital or other facility, except those provided to newborns as part of the overall hospital stay		
Hearing aids Coverage is limited to covered persons through age 17	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 4 years	
The following are not covered under this benefit: • A replacement of: - A hearing aid that is lost, stolen or broken - A hearing aid installed within the prior 24-month period • Replacement parts or repairs for a hearing aid • Cochlear implants • A hearing aid that does not meet the specifications prescribed for correction of hearing loss • Any ear or hearing exam performed by a physician who is not certified as an otolaryngologist or otologist		

Eligible health services	In-network coverage	Out-of-network coverage
Pediatric vision care Limited to covered persons through the end of the month in which the person turns age 19.		
Pediatric routine vision exams (including refraction) performed by a legally qualified ophthalmologist or optometrist	100% (of the negotiated charge) per visit No policy year deductible applies	70% (of the recognized charge) per visit
Maximum visits per policy year Low vision Maximum Fitting of contact Maximum	1 visit One comprehensive low vision evaluation every policy year 1 visit	
Pediatric vision care services & supplies-Eyeglass frames, prescription lenses or prescription contact lenses	100% (of the negotiated charge) per item No policy year deductible applies	70% (of the recognized charge) per item
Maximum number Per year: Eyeglass frames Prescription lenses Contact lenses (includes non-conventional prescription contact lenses & aphakic lenses prescribed after cataract surgery)	One set of eyeglass frames One pair of prescription lenses Daily disposables: up to 3-month supply Extended wear disposable: up to 6-month supply Non-disposable lenses: one set	
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.		
The following are not covered under this benefit: • Eyeglass frames, non-prescription lenses and non-prescription contact lenses that are for cosmetic purposes		

Outpatient prescription drugs
Outpatient prescription drug copayment waiver for risk reducing breast cancer drugs
The outpatient prescription drug copayment will not apply to risk reducing breast cancer prescription drugs filled at a retail or mail order in-network pharmacy. This means that such risk reducing breast cancer prescription drugs are paid at 100%.
Outpatient prescription drug copayment waiver for tobacco cessation prescription and over-the-counter drugs
The outpatient prescription drug copayment will not apply to the first two 90-day treatment regimens per policy year for tobacco cessation prescription drugs and OTC drugs when obtained at a retail or mail order in-network pharmacy. This means that such prescription drugs and OTC drugs are paid at 100%. Your outpatient prescription drug copayment will apply after those two regimens per policy year have been exhausted.

Outpatient prescription drug copayment waiver for contraceptives

The outpatient prescription drug copayment will not apply to female contraceptive methods when obtained at an in-network pharmacy.

This means that such contraceptive methods are paid at 100% for:

- Certain over-the-counter (OTC) and generic contraceptive prescription drugs and devices for each of the methods identified by the FDA. Related services and supplies needed to administer covered devices will also be paid at 100%.
- If a generic prescription drug or device is not available for a certain method, you may obtain certain brand-name prescription drug or device for that method paid at 100%.

The outpatient prescription drug copayment will continue to apply to prescription drugs that have a generic equivalent, biosimilar or generic alternative available within the same therapeutic drug class obtained at an in-network pharmacy unless you are granted a medical exception. The certificate of coverage explains how to get a medical exception.

Eligible health services	In-network coverage	Out-of-network coverage
Preferred generic prescription drugs (including specialty 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) No policy year deductible applies	$20 copayment per supply then the plan pays 70% (of the balance of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy	$50 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$50 copayment per supply then the plan pays 70% (of the balance of the recognized charge) No policy year deductible applies
Preferred brand-name prescription drugs (including specialty drugs)		
For each fill up to a 30-day supply filled at a retail pharmacy	$40 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$40 copayment per supply then the plan pays 70% (of the balance of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy	$100 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$100 copayment per supply then the plan pays 70% (of the balance of the recognized charge) No policy year deductible applies

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)		
Non-preferred generic prescription drugs (including specialty drugs)		
For each fill up to a 30-day supply filled at a retail pharmacy	$60 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$60 copayment per supply then the plan pays 70% (of the balance of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$150 copayment per supply then the plan pays 70% (of the balance of the recognized charge) No policy year deductible applies
Non-preferred brand-name prescription drugs (including specialty drugs)		
For each fill up to a 30-day supply filled at a retail pharmacy	$60 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$60 copayment per supply then the plan pays 70% (of the balance of the recognized charge) No policy year deductible applies
More than a 30-day supply but less than a 91-day supply filled at a mail order pharmacy	$150 copayment per supply then the plan pays 100% (of the balance of the negotiated charge) No policy year deductible applies	$150 copayment per supply then the plan pays 70% (of the balance of the recognized charge) No policy year deductible applies
Anti-cancer drugs taken by mouth For each fill up to a 30-day supply	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
Preventive care drugs and supplements filled at a retail pharmacy or mail order pharmacy For each 30–day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Preventive care drugs and supplements maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered preventive care drugs and supplements, contact Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.	

Eligible health services	In-network coverage	Out-of-network coverage
Outpatient prescription drugs (continued)		
Risk reducing breast cancer prescription drugs filled at a pharmacy For each 30–day supply	100% (of the negotiated charge) per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Risk reducing breast cancer prescription drugs maximums	Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered risk reducing breast cancer prescription drugs, contact Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Tobacco cessation prescription drugs and OTC drugs filled at a pharmacy For each 30–day supply	100% (of the negotiated charge per prescription or refill No copayment or policy year deductible applies	Paid according to the type of drug per the schedule of benefits, above
Tobacco cessation prescription drugs and OTC drugs maximums	Coverage is permitted for two 90-day treatment regimens only. Any additional treatment regimens will be subject to the cost sharing in your schedule of benefits. Coverage will be subject to any sex, age, medical condition, family history, and frequency guidelines in the recommendations of the USPSTF. For details on the guidelines and the current list of covered tobacco cessation prescription drugs and OTC drugs, contact Member Services by logging in to your Aetna website at https://www.aetnastudenthealth.com or calling the toll-free number on your ID card.	
Contraceptives (birth control)		
For each fill up to a 30-day supply of generic and OTC drugs and devices filled at a retail pharmacy or mail order pharmacy	100% (of the negotiated charge) No policy year deductible applies	100% (of the recognized charge) No policy year deductible applies
For each fill up to a 30-day supply of brand name prescription drugs and devices filled at a retail pharmacy 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
Outpatient prescription drugs important note: If a prescriber prescribes a covered brand-name prescription drug where a generic prescription drug equivalent is available and specifies "Dispense As Written" (DAW), you will pay the cost sharing for the brand-name prescription drug. If a prescriber does not specify DAW and you request a covered brand-name prescription drug where a generic prescription drug equivalent is available, you will be responsible for the cost difference between the brand-name prescription drug and the generic prescription drug, plus the cost sharing that applies to the brand-name prescription drug. The cost difference related to a prescription drug that is not specified as DAW is not applied towards your policy year deductible or maximum out-of-pocket limit.		

Outpatient prescription drugs exclusions

The following are not eligible health services:

- Abortion drugs used for elective termination of pregnancy except to prevent the death of the female
- 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

(continued on next page)

Outpatient prescription drugs exclusions (continued)

The following are not eligible health services:

- 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 Out-of-network level of benefits.

General Exclusions

Abortion

- Services and supplies provided for an abortion except to prevent the death of the female

Abortion drugs

- Drugs used for elective termination of pregnancy except to prevent the death of the female

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.

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, except for the treatment of autism spectrum disorder
  - Services provided in conjunction with school, vocation, work or recreational activities
  - Transportation

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 service 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

Cartilage transplants
- Cartilage (autologous chondrocyte implant or osteochondral allograft or autograft) transplants

Cosmetic services and plastic surgery
- Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body, whether or not for psychological or emotional reasons.

This exclusion does not apply to:
- Surgery after an accidental injury when performed as soon as medically feasible. (Injuries that occur during medical treatments are not considered accidental injuries even if unplanned or unexpected.)
- Coverage that may be provided under the *Eligible health services and exclusions - Gender affirming treatment* section.

Court-ordered testing
- Court-ordered testing or care unless medically necessary

Custodial care
Services and supplies meant to help you with activities of daily living or other personal needs.
Examples of these are:
- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of a stable tracheostomy (including intermittent suctioning)
- Care of a stable colostomy/ileostomy
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings
- Care of a bladder catheter (including emptying/changing containers and clamping tubing)
- Watching or protecting you
- Respite care 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

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

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)*, or *cancer clinical trials (routine patient costs)*. See the *Eligible health services and exclusions – Other services* section.

Facility charges
For care, services or supplies provided in:
- Rest homes
- Assisted living facilities
- Similar institutions serving as a persons' main residence or providing mainly custodial or rest care
- Health resorts
- Spas or sanitariums
- Infirmaries at schools, colleges, or camps

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

Gene-based, cellular and other innovative therapies (GCIT)
The following are not eligible health services unless you receive prior written approval from us:
- All associated services when GCIT services are not covered. Examples include infusion, laboratory, radiology, anesthesia, and nursing services.

Please refer to the *Medical necessity and precertification requirements* section.

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

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

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

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

This exclusion does not apply to covered benefits for treatment of TMJ and CMJ as described in the *Eligible health services and exclusions – Temporomandibular joint dysfunction (TMJ) and craniomandibular joint dysfunction (CMJ) treatment* section.

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

Mandatory no-fault laws
- Treatment for an injury to the extent benefits are payable under any state no fault automobile coverage.

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

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

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

Non-U.S. citizen
- Services and supplies received by a covered person (who is not a United States citizen) within the covered person's home country but only if the home country has a socialized medicine program

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

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

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

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, stepchild, brother, sister, in-law or any household member

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

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.

Sports
- Any services or supplies given by providers as a result from play or practice of collegiate or intercollegiate sports, not including intercollegiate club sports and intramurals

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

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

Telemedicine
- Services including:
  - Telephone calls
  - Telemedicine kiosks
  - Electronic vital signs monitoring or exchanges, (e.g., Tele-ICU, Tele-stroke)

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

Tobacco cessation

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

Treatment in a federal, state, or governmental entity

- Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws

Vision care for adults

- Routine vision exam provided by an ophthalmologist or optometrist, including refraction and glaucoma testing
- Vision care services and supplies

Voluntary sterilization

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

Wilderness treatment programs

See *Educational services* within this section

Work related illness or injuries

- Coverage available to you under worker's compensation or under a similar program under local, state or federal law for any illness or injury related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered "non-occupational" regardless of cause.

Utilization review - claim decisions and procedures

A claim is a request for payment that you or your health care provider submits to us when you want or get eligible health services. There are different types of claims. You or your provider may contact us at various times, to make a claim, to request approval, or payment, for your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit.

It is important that you carefully read the previous sections within *What the plan pays and what you pay*. When a claim comes in, we review it, make a decision, and tell you how you and we will split the expense. The amount of time we have to tell you about our decision on a claim depends on the type of claim.

Claim type and timeframes

For the purposes of this section, any reference to "you" and "your" also refers to an authorized representative or provider designated by you to act on your behalf.

There are different types of claims. The amount of time that we have to tell you about our decision on a claim depends on the type of claim.

Emergency care claim

An emergency claim is one that involves emergency services necessary to screen and stabilize you and does not require prior authorization. When you receive an emergency service that requires immediate post evaluation or post stabilization services, we will make a decision within 60 minutes. If we do not make the decision within 60 minutes, the services will be deemed approved.

Pre-service claim

A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we precertify them. We will make a decision within 36 hours, which shall include one working day of obtaining all necessary information regarding a proposed admission, procedure or service requiring a review determination. "Necessary services" includes the results of any face-to-face clinical evaluation or second opinion that may be required to make our decision.

In the case of a determination to certify an admission, procedure, or service, we will notify the provider rendering the service by telephone or electronically within 24 hours of making the certification. We will also provide written or electronic confirmation to you and the provider within two (2) working days of making the certification.

In the case of an adverse determination, we will notify the provider rendering the service by telephone or electronically within 24 hours of making the adverse determination. We will also provide written or electronic confirmation to you and the provider within one working day of the adverse determination.

Post-service claim

A post service claim is a claim that involves health care services you have already received. We will make a decision within 30 days of receiving all necessary information. We will provide written notice of our decision to you within 10 working days of our determination.

Concurrent care claim extension

A concurrent care claim extension occurs when need us to approve more services than we already have approved. Examples are extending a hospital stay or adding a number of visits to a provider. You must let us know you need this extension 24 hours before the original approval ends. We will have a decision within one (1) working day of receiving all necessary information.

In the case of a determination to certify an extended stay or additional services, we will notify the provider rendering the service by telephone or electronically within one (1) working day of making the certification. We will also provide written or electronic confirmation to you and the provider within one (1) working day of making our decision. The written notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

In the case of an adverse determination, we will notify the provider rendering the service by telephone or electronically within 24 hours of making the adverse determination. We will also provide written or electronic confirmation to you and the provider within one (1) working day of making our decision

Concurrent care claim reduction or termination

A concurrent care claim reduction or termination occurs when we decide to reduce or stop payment for an already approved course of treatment. If we deny your request for a concurrent care claim extension, we will notify you of such a determination. You will have enough time to file a grievance of an adverse determination. Your coverage for the service or supply will continue until you receive a final grievance decision from us or an external review by an independent review organization if the situation is eligible for external review.

During this continuation period, you are still responsible for your share of the costs, such as copayments, coinsurance and deductibles that apply to the service or supply. If we uphold our decision at the final internal grievance, you will be responsible for all of the expenses for the service or supply received during the continuation period.

If we have already approved covered services under this plan, we will not change our decision, except if you have intentionally misrepresented your health condition or if your coverage ends before the covered services are provided.

Timely access to review

A toll-free telephone number is listed on the back of your member ID card, if you or your provider need to contact Aetna's review staff.

Filing a claim

When you see a network provider, that office will usually send us a detailed bill for your services. If you see an out-of-network provider, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you or your provider must send us notice and proof within 12 months of the date you received services, unless you are legally unable to notify us. Failure to send us notice or proof within such time will not invalidate nor reduce any claim. You must provide the proof of loss as soon as reasonably possible. You must send it to us with a claim form that you can either get online or contact us to provide. If you are unable to complete a claim form, you must send us a description of the services, the bill of charges, and any medical documentation you received from your provider.

We will send you a claim form within 15 days after we receive your notice of a claim. If we do not send you a claim form within those 15 days, you will automatically be considered to have met the proof of loss requirements. You should always keep your own record of the date, providers, and cost of your services.

The benefit payment determination is made based on many things, such as your deductible or coinsurance, the necessity of the service you received, when or where you receive the services, or even what other insurance you may have. We may need to ask you or your provider for some more information to make a final decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay the claim within 30 processing days after we receive your filed claim, or as soon as we receive all the information necessary to support the claim.

Adverse benefit determinations

Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely. Any time we deny even part of the claim that is an "adverse determination" or "adverse decision". It is also an "adverse benefit determination" if we:

- Rescind your coverage entirely
- Deny your request for
    - An admission
    - Availability of care
    - Concurrent claim extension, or
    - Other health care service or supply

because we determined, based upon the information provided, it does not meet our requirements for medical necessity, appropriateness, healthcare setting, level of care or effectiveness or are experimental or investigational.

Rescission means you lose coverage going forward and going backward. If we paid claims for your past coverage, we will want the money back.

We will give you our adverse decision in writing. This will include the main reason(s) for the determination. It will also include instructions for submitting a grievance or reconsideration of the determination, and for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination.

You may not agree with our decision. There are several ways to have us review the decisions. Please see certificate of coverage for that information.

Complaints and grievances procedures

For the purpose of this section, any reference to "you" or "your" also refers to an authorized representative or provider designated by you to act on your behalf.

The difference between a complaint and a grievance

Complaint

You may not be happy about a provider or an operational issue, and you may want to complain. You can contact us at any time. This is a complaint. Your complaint should include a description of the issue. We will review your complaint as quickly as possible. Complaints are resolved on an informal basis.

Grievance

A grievance is a written complaint when you are unhappy about:

- The availability, delivery, or quality of the service you received (including a complaint resulting from a utilization review adverse determination)
- Claim payment, handling, or reimbursement for services
- The contractual relationship between you and us

Your grievance should include a description of the issue. You should include copies of any records or documents that you think are important. We will let you know in writing with 10 working days that we received your grievance.

Grievance procedures

You can ask in writing us to review your grievance. This is the internal grievance process.

You can submit a grievance for an adverse benefit determination. We will assign your grievance to someone who was not involved in making the original decision. You must file a grievance within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can send your written grievance to the address on the notice of adverse benefit determination or by contacting us. For a written grievance, you need to include:

- Your name
- The policyholder's name
- A copy of the adverse benefit determination
- Your reasons for making the grievance
- Any other information you would like us to consider

We will let you know in writing within 10 working days that we received your grievance.

We will conduct a complete review of the grievance within 15 calendar days after we receive a pre-service grievance or 20 working days after we receive a post-service grievance unless the review cannot be completed within this time. If more time or information is needed to make the determination, we will notify you in writing on or before the 20th working day and the review will be completed within 30 working days thereafter. The notice will include specific reasons why additional time is needed for the review.

Within 5 working days after the review is complete, the individual not involved in the circumstances that lead to your grievance or its review will decide upon the appropriate resolution and notify you in writing of our decision and your right to file a grievance for a second review. The notice will explain this decision, in terms that are clear and specific, and your right to file a grievance. You will be notified of the decision within 15 working days after the review is completed.

If you are unhappy with our decision, you may at any time contact the Missouri Department of Commerce and Insurance (DCI), at:

Missouri DCI
Division of Consumer Affairs
P.O. Box 690
Jefferson City, Missouri 65102-0690
Consumer Hotline: 800-726-7390
TDD: 573-526-4536

Expedited grievance review

You may request the grievance process be expedited if the time frames of the standard grievance procedures would seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of your physician, would cause you severe pain which cannot be managed without the requested services. A request for an expedited grievance review may be submitted orally or in writing.

We will notify you orally within 72 hours after receiving the expedited review request. We will send written confirmation to you within three (3) working days.

External review

External review is a review done by people in an organization outside of Aetna. This is called an independent review organization (IRO). You may request an external review if:

- Our claim decision involved medical judgment
- We decided the service or supply is not medically necessary or not appropriate
- We decided the service or supply is experimental or investigational
- You have received an adverse determination

You may also request external review if you want to know if the federal surprise bill law applies to your situation.

You do not have to exhaust our internal grievance process before you can request an external review. If you wish to pursue an external review, you may write to the Missouri Department of Commerce and Insurance (DCI) at:

Missouri DCI
Division of Consumer Affairs
P.O. Box 690
Jefferson City, Missouri 65102-0690

Include any information or documentation to support your request. If you have any questions or concerns during the external review process, you can call the DCI's Consumer Affairs Hotline at 800-726-7390.

You will pay for any information that you send and want reviewed by the IRO. We will pay for information we send to the IRO plus the cost of the review.

The Consumer Affairs Division ("Division") will review your grievance as any other consumer complaint. The Division will contact us and request our decision in writing and all supporting documentation. The Division will first review the matter to determine if they can resolve the issue instead of referring to the IRO. However, if the grievance remains unresolved after exhausting the Division's consumer complaint process, then the Director shall refer the unresolved grievance to an IRO to perform an independent review of you claim. Unresolved grievances include a difference in opinion between the treating health care professional and us concerning:

- Appropriateness
- Effectiveness of the healthcare service
- Health care settings
- Level of care
- Medical necessity

If the claim is eligible for external review, the Division will notify you and us. You and we will have 15 working days to provide any additional medical information that you and we wish to have reviewed and considered. All additional information must be received by the Division in writing.

The IRO will:

- Assign the grievance to one or more independent clinical reviewers that have the proper expertise to do the review
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Notify the Director of its opinion within 20 calendar days or receiving your grievance

The IRO may request additional time for its investigation, but not more than 5 calendar days.

How long will it take to get an IRO decision?

After the Director receives the IRO's opinion, the Director will issue a decision which shall be binding on you and us, with limited exceptions for judicial review. The Director's decision will be in writing and provided to you and us within 25 calendar days of receiving the IRO's opinion. At no time will the IRO decision take longer than 45 calendar days from the date the IRO receives your request for an external review, and all the information to be considered, to the date you and we are notified of the Director's decision.

Sometimes you can get a faster IRO decision. You must call us or the Division as soon as possible.

You may be able to get a faster external review for an adverse decision if a delay in your receiving health care services would:

- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (in the case of experimental or investigational treatment) or
- The adverse determination concerns an admission, availability of care, continued stay or health care service for which you received emergency services, but have not been discharged from a facility

If your situation qualifies for this faster review, you and we will receive a decision from the Director within 72 hours of the IRO getting your request. If the decision is not in writing, the Director will send you and us the written decision within 48 hours after the notification.

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

Sanctioned Countries

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

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

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 dyɛ́ɖɛ́ 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**).

اردو/Urdu

توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت دستیاب ہیں ۔ (TTY: **711**) **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).